Board of Directors

6 June 2024 | 1.00pm | Lecture Room 1, Education Centre 1,
Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, Lancashire, PR2 9HT

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	P White
2.	Apologies for absence	1.01pm	Verbal	Information	P White
3.	Declaration of interests	1.02pm	Verbal	Information	P White
4.	Minutes of the previous meeting held on 4 April 2024	1.03pm	✓	Decision	P White
5.	Matters arising and action log update	1.04pm	✓	Decision	P White
6.	Chair's opening remarks and report	1.05pm (5mins: Pres)	✓	Information	P White
7.	Chief Executive's report	1.10pm (10mins: Q&A)	✓	Information	S Nicholls
8.	Patient Story	1.20pm (10mins: Pres) (5mins: Q&A)	Pres	Assurance	D O'Mahoney
9.	Board Assurance Framework including Annual Review of Risk Appetite/Tolerance	1.35pm (10mins: Disc)	✓	Decision	S Regan
10.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
10.1	Safety and Quality Committee Chair's Report	1.45pm (10mins: Q&A)	✓	Information	K Smyth/ T Ballard
10.2	Maternity and Neonatal Services Report	1.55pm (5mins: Q&A)	✓	Assurance	J Lambert
10.3	Fuller Review Phase 1 Recommendations	2.00pm (10mins: Pres)	✓	Assurance	G Skailes
11.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
11.1	(a) Workforce Race Equality Standard (WRES) Report 2024 (b) Workforce Disability Equality Standard (WDES) Report 2024	2.10pm (10mins: Q&A)	✓	Decision	L Graham
12.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
12.1	Finance and Performance Committee Chair's Report	2.20pm (10mins: Q&A)	✓	Information	T Whiteside
12.2	Corporate Objectives 2024-25	2.30pm (10mins: Pres)	✓	Decision	G Doherty
12.3	Single Improvement Plan Targets and Measures	2.40pm (10mins: Pres)	✓	Assurance	S Nicholls
12.4	Integrated Performance Report as at 30 April 2024 including Finance update *(considered by appropriate Committees of the Board)*	2.50pm (10mins: Pres) (10mins Q&A)	✓	Assurance	I Devji/ C Gregory/ L Graham/ J Wood

№	Item	Time	Encl.	Purpose	Presenter
13.	**GOVERNANCE AND COMPLIANCE**				
13.1	Audit Committee Chair's Report	3.10pm (10mins: Pres)	✓	Information	T Watkinson
13.2	Board Appointments	3.20pm (5mins: Pres)	✓	Decision	J Foote
14.	**ITEMS FOR INFORMATION**				
14.1	(a) NHP Assurance Committee Chair's Report (b) Infection Prevention and Control Annual Report 2023-24 and Action Plan 2024-25 (c) Bi-annual Midwifery Staffing Report (d) Patient Experience Annual Report 2023-24 (e) PSIRF and Annual Report of Incidents Reported to StEIS (f) New Hospitals Programme Q4 Report		✓		
14.2	Date, time and venue of next meeting: *1 August 2024, 1.00pm, Lecture Hall, Education Centre 3, Chorley and South Ribble Hospital*	3.25pm	Verbal	Information	P White

Board of Directors

4 April 2024 | 1.00pm
Lecture Room 1, Education Centre 1, Royal Preston Hospital

Part I

Present:

Mr P White	Chair
Dr T Ballard	Non-Executive Director
Ms V Crorken	Non-Executive Director
Ms S Cullen	Chief Nursing Officer
Mr I Devji	Chief Operating Officer
Professor S Nicholls	Chief Executive
Professor P O'Neill	Non-Executive Director
Dr G Skailes	Chief Medical Officer
Ms K Smyth	Non-Executive Director
Mr T Watkinson	Non-Executive Director
Mr J Whitaker	Non-Executive Director
Mrs T Whiteside	Non-Executive Director
Mr J Wood	Chief Finance Officer

In attendance:

Mrs K Brewin	Associate Company Secretary *(minutes)*
Mrs A Brotherton	Director of Continuous Improvement
Mr S Dobson	Chief Information Officer
Mr G Doherty	Director of Strategy and Planning
Mrs N Duggan	Director of Communications and Engagement
Mrs J Foote	Company Secretary
Ms E Holden	Maternity Matron for Safety and Quality *(for minute 54/24)*
Ms J Lambert	Interim Divisional Nursing and Midwifery Director *(for minute 54/24)*
Mr U Patel	Associate Non-Executive Director
Mr N Pease	Chief People Officer
Mr S Regan	Associate Director of Risk and Assurance *(for minute 55/24)*
Mr M Wearden	Associate Non-Executive Director

Governors observing:
L Bamber, Dr M France, S Heywood, J Miller, L Purcell, F Robinson and G Robinson

47/24 Chair and quorum

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

48/24 Apologies for absence

Apologies for absence were received from Mr P Wilson.

49/24 Declaration of interests

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

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

50/24 Minutes of the previous meeting

The minutes of the meeting held on 1 February 2024 were approved as a true and accurate record.

51/24 Matters arising and action log

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

52/24 Chair's opening remarks and report

The report provided a summary of work and activities undertaken during February and March 2024 by the Trust Chair including a resume of the items discussed in the part II Board meeting on 1 February.

The Chair confirmed that since the report had been produced he had met with the Lead Governor. In addition, the Chair had met with local politicians regarding the New Hospital Programme. The Chair and Chief Executive had also met with the Health and Mental Health Lead from Preston City Council to hear about the work they were undertaking around community engagement.

It was noted the Trust was immersed in the annual planning round which was a feature on both the public and private Board agendas, and financial planning and the future were the key focus areas during meetings.

53/24 Chief Executive's report

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

The report marked the end of the year and thanks were extended to the Executive Management team, staff, and colleagues for their efforts during 2023-24. Significant inroads had been made into elective and cancer performance and at the end of the year the Trust was in a good position. The report referenced the work being undertaken with community colleagues to further improve performance over the next 12 months. The financial position remained challenging although last year was the strongest financial performance that had been delivered for some time.

In response to a question regarding Pride and Joy and whether a sustained positive impact would be seen, it was confirmed that an evaluation meeting was planned with the wards involved in the initiative to ensure feedback was obtained. Expert analysis of the data would also be undertaken with the results being communicated to the Board in due course.

Clarification was requested on the evidence available of working towards transformation to ensure only people who needed urgent or emergency care presented for those services. It was explained that there was a range of individual initiatives in place although the work was diffuse and a single clinical model was not available across Place (Chorley, Preston and beyond). Work had commenced with colleagues in the ICB and with lead commissioners in Preston to look at the position and work would then be required to analyse the data. In addition, there was also work being undertaken to understand through Pride and Joy what could be influenced and enacted to improve and transform urgent and emergency care services. Finally, work was being completed with local Councils looking at demand for packages of care. When data from those strands of work was clearly understood then it would then be possible to identify the gaps and potential opportunities.

The Chair recognised the positive performance during the past year in relation to finances and services to patients although acknowledged that there was additional work to be done. Thanks were extended to all staff for their contribution throughout the year.

54/24 Patient Story: Lived Experience of Miscarriage

Representatives from the Midwifery team delivered the patient story which focused on the lived experience of a young couple and some distressing experiences at the Trust following a number of miscarriages. In addition to the sadness of their losses, the couple were given contradictory advice, had to receive their bad news in a constrained space where other families were receiving good news and celebrating, experienced a lack of compassion and clarity in the Emergency Department, and felt humiliated when they were questioned about whether there had been a pregnancy.

The Board heard about the approach the Midwifery team had taken to dealing with the concerns that had been raised. Rather than deal with the concerns through the traditional complaints process, the interim Divisional Nursing and Midwifery Director visited the couple at home and the team worked with the couple to bring about significant change to improve the future experience of families in similar circumstances. The changes introduced included the co-design of a refurbished gynaecology and early pregnancy assessment unit which opened in January 2024, the introduction of an early pregnancy bereavement service funded by the Baby Beat charity, and additional training for staff around how to break bad news.

Clarification was requested on the plans to audit performance to ensure the actions introduced had created the required improvements. It was explained that the Midwifery leadership held a weekly meeting with the Patient Experience and PALS team and were aware of some themes therefore some plans had already been introduced prior to the couple's concerns being raised. Trend analysis would continue to be reviewed and the team would also look at introducing an additional performance dashboard. An Early Pregnancy Lead was identified within the team who would also be involved in the improvement discussions.

Board was informed that the team recognised what the couple had to say about their experience was important and as part of PSIRF principles had looked at a partnership approach. The family appeared to welcome the process and contact had been maintained with the couple throughout the investigation which had helped to regain some of the trust that had been lost. A full clinical investigation was undertaken and it was identified that inconsistent advice had been provided by different clinicians therefore

the standard operating procedures had been reviewed to ensure a consistent approach. A meeting had been held with the couple to review the report and they would continue to have the opportunity to contribute and confirm they were satisfied with the final report prior to presentation to the PSIRF Oversight Panel.

Reference was made to the feedback regarding a lack of compassionate patient centred care and the wider learning across the Trust. The team had recognised that there was transferable learning for the organisation and the story received by the Board today had been presented at the March Patient Experience and Improvement Group, where Patient Safety Champions had reflected about improvements that could be introduced in services such as cancer where patients currently received good and bad news in the same waiting space. In terms of feedback from women using maternity services, the Early Pregnancy Loss Bereavement Specialist Nurse had a close and trusting relationship with the women and feedback was obtained to help with improvements. There was close working with the Maternity and Neonatal Voices Partnership Lead who had visited the service and undertaken the 15-steps process to allow for a fresh perspective on the services provided. The service had also welcomed a couple of 'view and enter' visits by Healthwatch who would also provide service users' views to the team. In terms of improving communications, the BadgerNet system would help to keep a continuous record with a visible symbol to inform health professionals if the mother had had pregnancy loss which would help to ensure the patient was not repeating their history.

It was noted that the Early Pregnancy Loss Bereavement Specialist Nurse had been funded for two years through charitable funds and the team was considering how additional funds could be identified to provide sufficient evidence on the value the service provided to ensure funding for the future. The Trust was ahead when compared to other organisations in terms of supporting and responding to early pregnancy loss and the Board expressed its gratitude for the financial support provided by the charity.

The Board agreed it would be helpful to have an update on outstanding actions, for example the waiting room reconfigurations, which could be provided in the regular Maternity and Neonatal Service report presented to Board.

The Chair asked that the Board's thanks be passed to the team and, in particular, to the family for allowing their story to be heard. It was emphasised that it was important the Board heard about all aspects of patient experience not merely success stories to ensure that improvements were made to the care provided.

55/24 Board Assurance Framework

The report provided details of risks that might compromise the achievement of the Trust's high level strategic objectives. It was noted that the risks were scrutinised by relevant Committees of the Board, apart from the Fit for the Future and specialist services risks which were reviewed by the Board. The strategic risks detailed in appendix 2 were those that had been presented to Committees or had been reviewed in preparation for the next Committee meeting at the time the Board report was produced.

It was confirmed that there had been no changes to the six strategic risk scores since the February Board meeting. Three operational risks remained escalated to the Board relating to exit block (risk ID 25); elective restoration (risk ID 1125); and ongoing strike action (risk ID 1182). Following discussion at the appropriate forums it was agreed that

risk ID 1157 (increased cases of Clostridium difficile) be referred to the April Board as an escalated risk for oversight due to higher than planned rates of *C.difficile* infection. In addition, the Board was asked to consider de-escalation of risk ID 1182 (ongoing strike action) and the risk score be reduced from 20 to 16.

Concern was expressed regarding the low risk score for specialised services when compared to the higher scores for risks relating to Fit for the Future and Education, Training and Research. It was explained that the specialised services risk was more about commissioning and the intention or future direction of services. It was recognised that further work needed to be completed on risk management across the organisation. The Risk Management Group had now been established and the first meeting had been held in March. There was a need to determine and identify the high risks and which risks needed to be presented to the Board. In addition, staff training would be needed so there was clarity on what constituted a risk as opposed to an issue, and there was work to be undertaken on some legacy risks such as health and safety.

Reference was made to the escalated risk in respect of *C.difficile*. It was acknowledged that the Safety and Quality Committee had looked at the risk for some time and escalating to the Board ensured the risk was visible. However, it was felt the actions to improve the position were not clear including the resources to be brought to bear that could not be introduced earlier to ensure improvements were made. The Board was advised that there were material issues in terms of the ageing estate particularly at Royal Preston Hospital, including some issues in clinical and non-clinical areas which created greater risk around *C.difficile* infection. Estates and facilities colleagues had been asked to look at the issues along with a reworked estates strategy as actions needed to be taken now rather than wait for the new hospital build and there may be a need to lobby for additional funding to cover the interim period. In the meantime, it was recognised that improvements could be made, such as reminding people about good housekeeping practices in their areas.

The Board RESOLVED that the updates to the Board Assurance Framework be approved including de-escalation of risk ID 1182 and reduction of the risk score from 20 to 16.

56/24 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee meetings on 26 January and 23 February 2024 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Assurance on the management and outcomes of the Equality Quality Impact Assessment process with evidence of Executive scrutiny and approval.
- Reduction in the total number of PALS requests during December and compliance with complaint response rates.
- Over 50% of areas had achieved STAR Gold status.
- The positive results from the maternity survey.
- Assurance on the preparations for the measles outbreak.
- Confirmation that the Thrombectomy service was now operating seven days per week, 9am to 5pm, although there was some fragility in the delivery of the service which was being managed by the team.

In response to a question regarding timescales for funding for the Thrombectomy service to be introduced on a 24/7 basis, the Board was advised that the issues related to having in place appropriately trained staff rather than pure funding. There was a national shortage of appropriately trained staff and whilst recruitment opportunities would be explored there was no immediate solution and all organisations were competing to recruit. Discussion were ongoing regarding the possibility of changing rota arrangements or job plans in an attempt to be competitive when recruiting although balance would be required as potential changes could bring negative consequences.

Discussion was held regarding the significant increase in occupancy levels due to boarded patients across inpatient areas and the expected timescale to move away from that practice. The Board was advised that there would be no immediate change and potential steps that could be introduced to ease the position would need a decision by the Board. A clear plan to deescalate boarded patients was being worked through alongside community colleagues.

57/24 Annual Safe Staffing Review for Nursing 2023-24

The report detailed the findings of the 2023-24 nurse staffing review to set nurse staffing establishments for 2024-25 which included 51 clinical areas, including the Emergency Departments, assessment areas, adult inpatient areas, neonates, and children and young people areas. It was noted the review was carried out during January and February 2024 and conducted as a desktop review revisiting the previous year's outcome data with staffing levels, feedback from leaders and staff, and the professional guidelines associated with safe staffing. Overall, the establishments recommended by the Chief Nursing Officer as part of the review would deliver safe, effective, and sustainable staffing levels for the Trust and meet the requirements of the NICE Safe Staffing Guidelines (2014) and the National Quality Board 'Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time (2016)'. It was noted that escalation areas and boarded beds were not included in the review nor did the review address enhanced levels of care. The report had been considered in detail by the Safety and Quality Committee.

It was reported that fill rates from international nurse recruitment had made a positive contribution to the workforce and had assisted with the reduction in agency spend. The report outlined what would be required over the next 12 months in terms of safe staffing levels and ensure the appropriate balance was struck, taking into account instructions from NHS England regarding management of the headcount and also regulatory considerations. The proposal was to accept the recommendations in the report based on planning assumptions that the Trust would achieve the rebate every year. In terms of urgent and emergency care the Chief Nursing Officer had been tasked with reviewing the run rate and moving some people into permanent contracts which would see a reduction in the run rate and potentially assist with improvements in staff sickness although there was a need to see the data in that respect. In addition, whilst the safe staffing report was historically presented bi-annually, it was proposed that for urgent and emergency care and maternity the Board should be reviewing the position on an annual basis.

The Chief Finance Officer informed the meeting that confirmation had been received from the ICB that funding would be provided to support the recommendations for the additional staffing as outlined in the report.

Reference was made to the section of the cover report relating to previous considerations and it was noted that the report had been considered by both the Safety and Quality Committee and Executive Management team, although this was not evident. It was agreed that future reports would contain the recommendation to the Board by the Executive Management team.

The Board RESOLVED that:

1. **the staffing review to set establishments for 2024/25 be approved; and**
2. **in line with the recommendation from NHS Improvement Workforce Safeguards guidance, the outcome of the annual safe staffing assessment be confirmed and whilst risks remained present, it was recognised that staffing was safe, effective, and sustainable.**

58/24 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee meeting on 13 February 2024 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Four new metrics had been added to the mandatory training group in September 2023 relating to the Patient Safety Incident Response Framework (PSIRF).
- Scrutiny of the Education Quality Surveillance Report including the importance of addressing concerns regarding training and education within some specific medical specialties.
- The annual report and feedback from the National Institute for Health and Care Research in respect of the Lancashire Clinical Research Facility which was outstanding in relation to research and development within the Trust.

Discussion was held regarding the poor feedback received from Year 4 Undergraduate Medical Education students in Neurology, the known staffing gaps in that service, and the capacity for doctors to complete their training. It was confirmed that a piece of work was being undertaken by the Clinical Director for Renal Medicine to understand the position. Actions had been introduced to mitigate some of the staffing gaps, such as a change in the Training Lead, and the concerns raised by the Committee had been referred to the Workforce Committee for discussion.

59/24 Workforce Committee Chair's report

The Chair of the Workforce Committee provided an overview of the meeting held on 18 March 2024, including items discussed and issues to be brought to the Board's attention, items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Management of sickness levels and the actions being taken to reduce current sickness absence rates.
- Low turnover rates and vacancies on a positive trajectory with vacancy control starting to show positive results.
- Violence and aggression remained a concern. There had been a communications campaign across the Trust regarding the organisation's stance.
- An overview of the results of the 2023 Staff Survey and scrutiny of the action plan.

60/24 2023 National Staff Survey Report

The report outlined the national Staff Survey results compared with the national benchmarks. It was noted that the results of the 2023 Staff Survey showed the Trust was above the national average for all elements of the People Promise themes with the exception of Staff Engagement Measures where the Trust had met the national average. An overview of the results was provided including the recommended areas for priority action at both a Trust and divisional level and next steps to develop a corporate level action plan aligned with the People Plan 2023-26 strategic actions.

Discussion was held regarding the low response rate (45%) when compared to other organisations. It was noted the survey was validated in terms of whether the response rates were significantly different across Trusts. Work would be undertaken to look at how the survey was undertaken moving forward to determine whether a different approach was needed to increase the response rate. Checks would also be undertaken with peers regarding the management of staff surveys, and a review of how other sectors surveyed their staff would also be undertaken.

Reference was made to visible leadership and how that would be engendered and built across the Trust. The Board was advised that there was focus on visible leadership as part of the Trust's developing Single Improvement Plan (SIP), which would include a range of elements including visibility and approachability, communication skills, and working in a highly pressured environment, which would focus on leadership at every level. The Executive Management team would also be working through a development programme over the next six months. In addition, there would be changes introduced to the communications framework and forums introduced as part of a refresh to evolve a leadership-wide team. The new communications approach would support the SIP and make it easier for colleagues to attend a forum to express their feedback and comments outside a once-a-year survey. It was noted that the work being undertaken would be reported back through the Workforce Committee.

61/24 2024-25 Single Improvement Plan

The report provided an update on the development and transition to delivery of the Trust's new Single Improvement Plan (SIP). All priority elements of improvement being undertaken across the Trust would be contained within the SIP, providing a streamlined and consistent structure, and supporting matrix working which would eliminate silo working and minimise duplication. The aim was to ensure a different way of working as one wider senior leadership team, supporting the divisions and specialty teams with delivery. The proposed reporting and governance arrangements were outlined for the six pillars within the SIP through the respective Committees of the Board, with the exception of the Well Led domain which would be reported directly to the Board.

In response to a question regarding the Trust's strategic plan and how the current strategy (Our Big Plan) would align, it was confirmed that the Director of Strategy and Planning would be working with stakeholders on what the 10-year strategy would look like. For clarity, it was explained that the SIP was about improvement rather than a short-term strategic plan. There was a need to engage with a wide range of internal and external colleagues including public and private sector organisations rather than a top-down driven exercise. Whether the current strategy remained as Our Big Plan was yet to be determined and the decision would be informed by the work which was being

undertaken during the summer period. The Board would also be discussing the design authority, scheduling, and sequencing of the strategic plan at a future Board Workshop.

The Chair referred to a range of questions regarding the SIP that had been received from a governor prior to the Board meeting. It was confirmed that the responses would be contained in the SIP presentation scheduled for the Council of Governors meeting on 16 April as it was important that governors were involved in shaping the strategy.

The Board RESOLVED that the proposed reporting and governance arrangements be approved.

62/24 Clinical Services Strategy

The report provided an update regarding the development of a revised Clinical Strategy for the Trust covering a range of key areas including key strategic issues currently being faced; an update on current relevant work streams and activities in Lancashire and South Cumbria; key areas where it was suggested further work was required to develop and strengthen the existing Trust strategy; additional key areas of focus and proposed model of strategy development; and proposed next steps.

Clarification was requested on the status of the work undertaken on the clinical strategy two years ago and the status of clinical services reconfiguration. The Board was advised that there had been a range of successes from the strategy, such as the development of the surgical hub on the Chorley site and the national Ophthalmology Unit. It was recognised there remained challenges still to be addressed and one of the key processes moving forward would be to reflect on what still needed to be achieved. A larger piece of work was also being undertaken regarding the ambition of the organisation in the future. In respect of clinical services reconfiguration, it was noted that work was being undertaken which was due to be completed by the end of July and the position should be clearer at that point. There was a process for developing the strategy and over the coming weeks the plan should be finalised with touchpoints. It was recognised that there was a need to engage with people managing already challenging diaries and this would need to be taken into account although time-out sessions had already been planned and all internal and external key stakeholders, including governors, had been listed in the engagement plan for the strategy.

Discussion was held regarding the ambition to introduce new models of care as part of the ‘left shift’ in healthcare and a focus on population health. Board was advised that plans at system or place level were not yet clear and the Trust would need to be involved in shaping that agenda. Part of the strategy would be how the Trust would maximise its contribution and how it would be able to shape the thinking in terms of keeping people well and happy. Discussion was also held regarding whether the Trust could produce a clinical strategy in isolation rather than through a broader system strategy. It was explained that there were fixed points where the NHS landscape did not change and the Trust was currently in that position. However, that did not mean the Trust should not be involved in shaping the environment. The organisation had experience previously in considering the catalyst for change so conversations would be needed to draw out those insights.

The Board CONFIRMED the report provided assurance regarding the planned development of the revised Clinical Services Strategy for the Trust.

63/24 Green Plan

The report was presented to provide assurance on the progress being made against the Trust's agreed Green Plan. It was noted that the Trust's three-year Green Plan was in the process of being updated ahead of submission for Board approval in quarter four of 2024/25. An overview was provided of how the Trust measured against benchmarking, the positive improvements that had been seen, and the plans for the future.

Clarification was requested on whether the Trust was looking at nitrox oxide waste and whether there were plans to look at the pharmaceutical load. The Director of Strategy and Planning confirmed that both elements were included in the action plan.

The Board CONFIRMED that the report provided assurance on progress against the Trust's Green Plan.

64/24 Charitable Funds Committee Chair's report

The Chair of the Charitable Funds Committee provided an overview of the meeting held on 19 March 2024, including items discussed and issues to be brought to the Board's attention, items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Strong financial performance for the Rosemere Charity with income exceeding expectations by the end of month 10.
- Three requests for charitable funding had been approved by the Committee reflecting the commitment to enhance patient care.
- An in-depth revised proposal for Bowland House had been requested by the Committee demonstrating thorough consideration and management of decision making in relation to charitable funds.
- The Committee had requested significant data be provided when applications for funding were put forward to ensure robust governance practices when considering requests for charitable funds.

The Chair, on behalf of the Board, recognised the generosity of people across a wide range of communities in terms of charitable donations, particularly in the context of the financial challenges being experienced across the country.

65/24 Finance and Performance Committee Chair's report

The Chair's reports from the Finance and Performance Committee meeting on 22 January and 27 February 2024 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Recognition of improvements in single tender waivers which had previously been a concern, as evidenced in the update presented by the Procurement Collaborative.
- Spotlight on the elderly/frail population as a key area for demographic-driven care, including work from Engineering Better Care. A deep dive had been requested by the Committee to provide further assurance.
- Continued preparation of a three to five year plan to achieve a sustainable balance in performance across the quadruple aims.
- A comprehensive update on the IT Strategy.

- Scale of the financial challenge which remained significant although the Committee felt a lot of work was being undertaken to improve the financial position.

66/24 Integrated Performance Report as of 29 February 2024

The integrated performance report as of 29 February 2024 provided an overview of key performance indicators aligned to Our Big Plan. Detailed scrutiny of the metrics aligned to the four ambitions was undertaken by respective Committees of the Board. Key messages were highlighted from each of the key ambitions in addition to those already reported by respective Committee Chairs.

(a) ***Consistently Deliver Excellent Care*** – an overview of the access standards was provided including the year-end position. The focus for the organisation was improving admission avoidance and increasing the front door capacity was being explored alongside the time patients presented at the Emergency Department. A piece of work was also being completed with the senior team from Lancashire County Council looking at place-based work and the proposal when received would be shared with the Board. Good progress was being made with Virtual Wards which in April would increase from 60 to 80. An overview was provided on cancer trajectories and the expectation that the Trust would achieve target compliance which would provide a good foundation moving forward. In terms of diagnostics, the approach from the NHSE national team was that surveillance patients were incorporated with diagnostic patients which would cause a 1% negative drift when compared to the current position.

Reference was made to elective care transformation and the need to balance the financial position and the elective strategy, particularly repatriation from the private sector, and clarification was requested on the plans for the next 12 months. The Chief Operating Officer would be meeting with Trust financial leads to review where the money was spent and the services being purchased. In addition, consideration would need to be given to internal capacity to ensure patients could be repatriated back into the NHS rather than outsourcing that activity.

Attention was drawn to the Urology cancer pathway redesign and the time taken to develop the business case for capital funding to upgrade the scanner and clarification was requested on whether all funding sources had been explored including charitable funding. It was confirmed that funding sources had been explored and the Cancer Alliance was supporting the Trust in looking at the possibilities. The Trust had in place advanced care practitioners to ensure there was more capacity being utilised, however, the CT scanner was crucial to the pathway redesign. Currently the Trust had a two-stop rather than a one-stop model meaning patients would have their scan at Preston prior to attending their appointment at Chorley and the ambition was to ensure patients had access to both processes on the same day at Chorley. In terms of the business case, capital would be required and there were opportunities to bid for funding although the process was not straightforward. In response to the potential to secure charitable funds it was confirmed that the rules would not allow charitable funds to be used as it was the responsibility of the NHS to fund this type of equipment.

With regard to safety and quality issues, Purpose T (new national guidance relating to the management and prevention of pressure ulcers) had been introduced to the organisation and formed part of the improvement plan. Extended length of stay in the Emergency Department was impacting the ability to improve further at the present time and improvement work was centred on increased compliance with risk assessments.

Improved staffing fill rates were expected to have a positive impact on falls although this was constrained due to the increase in patients within the urgent and emergency care pathway and boarding within ward areas and the Emergency Department. As part of the STAR framework there was focus on improvement work which included mandating compliance in terms of infection prevention and control and risk assessment standards. With regard to the 54 CQC must and should do recommendations following their 2023 inspection, 44 of the recommendations had now been delivered and the Board would receive an update report as part of the cycle of business.

(b) ***Great Place to Work*** – improvement in sickness absence rates remained a key area of focus and the Executive Management team had received a plan outlining four key areas where improvement needed to be seen which would be reported through the Workforce Committee. In respect of violence and aggression, incidences of dysregulated behaviour were an area of concern for staff and the Trust was involved in some partnership working and training to try to improve the position. During the reporting period there had been no occasions where off-framework agency had been utilised and the rate card was helping to reduce spend on agency staff across the system.

(c) ***Deliver Value for Money*** – there had been a significant movement in the Trust's plan in month due to national funding to reduce the original plan deficit. The Trust's annual plan had reduced from a deficit of £15.3m to a deficit of £0.4m. The variance to plan had remained the same at £35.2m and as a result the Trust's forecast deficit was £35.6m. The Trust was reporting a year-to-date month 11 deficit position for 2023/24 of £31.8m against a £2.6m deficit plan, with a year-to-date variance on plan of £29.2m. There was a £16.4m system support gap (£18.5m for the year) and £8.7m under-delivery of the Cost Improvement Plan. There were a range of operational financial pressures associated with industrial action and double running of international nurses and funding of pay awards that were to some extent offset by operational underspends and financial recovery actions. An overview was provided of the capital and cash positions, cost improvement programme, and use of resources as outlined in the report.

The Board confirmed its assurance in respect of the actions being taken to improve performance.

67/24 Appointment of Internal Audit and Counter Fraud Provision

The report provided an update in relation to the Internal Audit and Counter Fraud contract (referred to as IAS for the purpose of the report) held by the Trust and the wider Lancashire and South Cumbria ICS. It was noted the current contract for IAS from Mersey Internal Audit Agency (MIAA) ended on 31 March 2024. Despite efforts by the Trust to achieve a timely outcome, a long-term strategic direction had yet to be agreed and the collaborative intention from the Trust and other provider organisations in Lancashire and South Cumbria was to consider engagement and procurement of Internal Audit and Counter Fraud Services on a system basis. Should that direction be agreed then it was anticipated that a market test would be made in a collaborative procurement process in 2025-26 ready for the start of a new contract in 2026-27. In the meantime, the Trust needed to have IAS in place therefore the Board was asked to consider an option for a 12-month contract period be entered into with MIAA and a direct award be made with an existing framework for a period of two years plus one.

The Audit Chair confirmed that the Committee was supportive of the recommendations and was content with the service provided by MIAA. It was also noted that Audit Chairs across the system were aware of the collaborative intention and it was disappointing that it had not yet been possible to work through that process. The importance of going to market in due course was recognised rather than roll forward the contract however in terms of the Trust's current position it was felt that the recommendation provided a pragmatic solution.

The Board RESOLVED that:

1. **the appointment of MIAA for Internal Audit and Counter Fraud Services as set out in option 2 for a term of two years with an option to extend by a further 12 months be approved.**
2. **the proposal to undertake a market engagement exercise in 2025-26 ready for a new contract term from 2026-27 be endorsed.**
3. **an assurance report be submitted to the Audit Committee on proposals for a collaborative provision of IAS be endorsed.**

68/24 Board Safety and Experience Programme 2023/24

The report provided a review of the Board Safety and Experience Programme during 2023/24 which provided the opportunity for Board members to spend time with teams and meet patients in 27 of the Trust's services. The programme was one part of a series of interactions the Board had with teams and services. The review had identified there was recognised value in the programme with opportunities to enhance the programme for 2024/25. The Board was asked to endorse the approach to the safety and experience programme as outlined in the report.

During discussion it was suggested that consideration be given to less formal visits in the future. It was also suggested that the feedback loop needed to be strengthened in line with the arrangements introduced when the programme had originally been developed: verbal feedback at Board Workshops and a letter sent to the ward or department teams by the Chair and Chief Executive incorporating feedback following the visit.

The Board agreed it would be important to get the feedback right and close the loop following each visit. The visits were a valuable tool for Non-Executive Directors to triangulate what they saw on the visits with the information provided in reports. There were also ongoing discussions regarding Non-Executive Director and governor engagement.

The Board RESOLVED that the safety and experience programme for 2024/25 be endorsed.

69/24 Items for information

The following reports were received and noted for information:

(a) Data Quality Assurance report
(b) Use of Common Seal
(c) 2024 Governor Election report
(d) Maternity and Neonatal Services report

70/24 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday, 6 June 2024 at 1.00pm in Lecture Room 1, Education Centre 1, Royal Preston Hospital.

Signed: _____
Chair

Date: _____

Action log: Board of Directors (part I) – 4 April 2024

There are no outstanding actions from previous Board meetings.

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

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	54/24	4 Apr 2024	*Patient Story: Lived Experience of Miscarriage* – an update to be provided within the Maternity and Neonatal Service report once the outstanding improvement actions have been delivered.	Chief Nursing Officer	6 Jun 2024	**Closed** **Update for 6 June 2024** – updates to be provided in the report as actions progress. Recruitment has commenced to the roles agreed as part of the safe staffing review.
2.	57/24	4 Apr 2024	*Annual Safe Staffing Review for Nursing 2023-24*: (a) Urgent and emergency care and maternity safe staffing reports to be produced annually. (b) Future reports to contain the Executive Management team recommendations to the Board.	Chief Nursing Officer	6 Jun 2024	**Closed** **Update for 6 June 2024**: (a) Cycle of business updated. (b) To be included in future reports.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chair's Report			
Report to:	Board of Directors	**Date:**	6th June 2024
Report of:	Chair of the Trust	**Prepared by:**	Rebecca Black System Collaborative Business Manager
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

None

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.

Finney House
Along with Silas Nicholls, I visited Finney House on the 25th April. The team do a fantastic job supporting people who are awaiting a home first discharge, a package of care/residential home or ongoing rehabilitation and Finney House continues to be a vital part of our approach to supporting our patients, and managing discharges and patient flow.

External Visit – Lord Victor Adebowale
On 14th May, Lord Victor Adebowale, Chair of the NHS Confederation visited the Trust and met with Silas Nicholls, Jonathan Wood, Ailsa Brotherton and our Vice Chair, Paul O'Neill and discussed Trust finances and our Single Improvement Plan, this was followed by a tour of key areas across the Royal Preston site. The visit was a great success and I am delighted that what teams within the Trust are doing is being recognised on a national level.

Part II Board of Directors' meetings – 4th April 2024
The items discussed at the April part II Board meeting are outlined below along with a brief resume of the discussions.

1. **Fit for the Future Strategic Risk** – the Board received the risk report for information.
2. **2024/25 Annual Operating Plan** – the Board was assured with the development of the 2024/25 Annual Plan recognising that further work was required to develop fully robust delivery plans within the Trust and with system partners.
3. **Financial Plan 2024/25** – the plan was approved including the revenue budget, income and productivity plan, core cost improvement plan, and the capital programme.
4. **Financial Recovery Plan 2024/25** – the Board supported the work to be undertaken at pace to mature the associated plans for delivery.
5. **New Hospitals Programme (Land Acquisition)** – the Board supported and approved the plan for the business case as the first element of a land assembly process.
6. **Single Tender Waiver Extension** – the Board approved a direct award contract for a 12-month period from 1 April 2024.
7. **ONE LSC Partnership** – an update was provided on the current status of the creation of ONE LSC and the Board held a detailed discussion around risk, governance and assurance.
8. **Maternity Serious Untoward Incidents** – the Board received the report in line with Ockenden recommendations.
9. **Staff Suspensions Report** – the Board received the up-to-date position regarding staff suspensions.
10. **Minutes of meetings** – the Board received copies of relevant approved minutes from meetings of Committees of the Board.

2. Chair's attendance at meetings

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

Date	Activity
April 2024	
2nd April	Non-Executive Appraisal
2nd April	Cllr Brown/LTHTR Chief Executive
2nd April	Lead Governor
2nd April	K Fletcher, MP
4th April	Non-Executive Meeting
4th April	Board of Directors
4th April	High Sheriff of Lancashire, County Hall
9th April	Non-Executive Appraisal
9th April	NW System Leaders
9th April	Interview Panel – Consultant Oncologist
9th April	Governor Working Group
11th April	Chair, East Lancashire Hospitals
11th April	Provider Chairs
11th April	Provider Collaboration Board
12th April	Nominations Committee
12th April	Chief Information Officer
16th April	NHP Assurance Committee
16th April	Council of Governors
17th April	Integrated Place Leader – Central Lancashire
18th April	Chief Operating Officer Interview Panel
18th April	Chief Executive, LTHTR
23rd April	Board Workshop
25th April	Visit to Finney House
25th April	Board Agenda Setting
25th April	Chief Executive, LTHTR
30th April	Company Secretary
30th April	Head of Hospital Charities/Chair of Rosemere

May 2024	
14th May	Board Workshop
16th May	Chief Executive/Non-Executive Directors - LHS
16th May	Chief Executive, Integrated Care Board
16th May	Lead Governor
28th May	Interim Chair, Integrated Care Board
30th May	Chief Executive Appraisal

3. Financial implications

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

4. Legal implications

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

5. Risks

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

6. Impact on stakeholders

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

7. Recommendations

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

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chief Executive's Report			
Report to:	Board of Directors	**Date:**	6 June 2024
Report of:	Chief Executive	**Prepared by:**	N Duggan
Part I	✓	**Part II**	

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

Executive Summary:

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

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Not applicable

CHIEF EXECUTIVE'S REPORT

Our pressures, priorities and progress

I must begin my report by acknowledging the outstanding efforts of colleagues across the Trust for their incredible efforts amid sustained pressure, particularly in Urgent and Emergency Care (UEC). Increasingly high demand for UEC services is a trend being experienced across our providers in Lancashire and South Cumbria as well as the wider healthcare system nationally and improving this situation is our top priority for 2024/25. Patients experiencing long waits, receiving care in our corridors, boarding on wards and the continuous strain on our workforce is not sustainable, nor the care or experience that our communities and colleagues deserve.

This will not be an easy task. A full walkout by junior doctors is due to commence at 7am on 27th June 2024 and finish at 7am on 2nd July, which will be the 11th strike by junior doctors in this dispute, creating significant challenges for the NHS. Extensive communications will go out across our system and at a regional and national level to ensure the public are aware of the pressure the health service will be under and know the best way to access care during that time. Resources will be prioritised to protect emergency treatment, critical care, neonatal care, maternity, and trauma, and ensure we prioritise patients who have waited the longest for elective care and cancer surgery. As ever, we will only reschedule appointments and procedures where necessary and will rebook immediately, where possible.

Whilst managing UEC demand is our main priority, we mustn't lose focus on the impressive inroads we have made in our elective care and cancer restoration programmes following Covid. You may remember that in 2022/23 NHSE put in place a tiering system for Trusts reflecting the performance concerns for routine elective care and >62 day cancer backlog with Lancashire Teaching Hospitals (LTH) being placed into Tier 1 (high concern). However, thanks to the grip and control measures we have put in place over the last two years, and the collective effort of colleagues towards improving our position, I can confirm that we have been removed from the tiering process for elective recovery. However, given our challenges with the diagnostic standard (DM01) and its impact on cancer pathways, both of these elements remain areas of concern placing the Trust in Tier 1 (for these 2 elements).

The NHS Planning Guidance 2024/25 has since outlined the national ambition across DM01, Cancer and Elective care measures, to 95% of patients receiving their diagnostic test within 6 weeks by March 25, improved performance in 62-day standard to 70% and Faster Diagnosis Standard to 77% by March 25 and to eliminate waits of over 65 weeks by September 2024. Trajectories of improvement, underpinned by improvement plans, have been put in place to support these ambitions and robust strategies are also in place to continue to drive down waiting times for patients and to achieve 65-week recovery by September 2024.

General Election

On Wednesday 23 May, Prime Minister Rishi Sunak announced a General Election that will take place on Thursday 4 July. Undoubtedly, the NHS will be a hot topic over the next six weeks but we as an organisation, and our colleagues, will follow the longstanding pre-election period guidance to ensure we do not influence the election outcomes, whether inadvertently or intentionally. It is important to note that the start of the pre-election period came into effect on 00.01 on Saturday 25 May and will be in place until 00.01 on 5 July or until the date at which a new government is formed.

Improving our financial position

There is no doubt that one of the most significant dilemmas across the wider NHS and social care system is the continued increase in demand on patient services at a time when there are many competing priorities on the public purse. Whilst all Trusts are affected by this situation, it's particularly pertinent to LTH, as the cost of delivering our services and delivering patient care, has been greater than the income received for a number of years now, resulting in a significant gap in our finances. In addition to an increase in demand for UEC services, we have had inflationary cost pressures, high numbers of patients in high-cost hospital beds who instead require social care or home care support, a dependency on high-cost agency in medical and hard to

recruit roles and structural challenges in funding arrangements which do not reflect the costs of service delivery - these have all had an adverse impact on our financial position.

There has been huge effort from all of our clinical and corporate divisions to improve this situation and at the end of the financial year 2023/24 we reported a financial improvement of £36.9m through our cost improvement plans (CIP) – the highest value in the Trust's history. However, even with this level of improvement, we still have a significant financial gap and it is our responsibility to reduce this at pace. Our 2024/25 financial plan is to deliver a deficit of £24.3m, which means we need to deliver a £58m financial improvement – significantly more than we achieved last year.

We have therefore implemented a comprehensive Financial Recovery Programme aimed at continuing to deliver high quality services to patients whilst resetting the approach we have to managing our finances leading to a stabilised position over the next three years. In the short term we will be bringing in a number of additional controls around vacancies, agency and bank spending and tight restrictions on non-pay and discretionary pay items which will be challenging for our colleagues.

In mid-May, all colleagues were sent an update on our financial position, outlining and explaining the reasons for a number of additional restrictions. We have enlisted experienced support, including Turnaround Director Jitka Roberts and specialists from PA Consulting, to spearhead our recovery efforts. They will work alongside our teams to identify savings opportunities and implement effective financial controls. It won't be something that we can turn around overnight but doing nothing isn't an option. We are facing increased scrutiny at a national level to develop a comprehensive Cost Improvement Plan (CIP) and the meeting I mentioned with Julian Kelly earlier forms part of this monitoring. A robust Equality and Quality Impact Assessment process is in place to ensure that we remain fully sighted on the impact of all proposed actions before they are implemented with quality and patient safety remaining firmly at the heart of all that we do.

Single Improvement Plan

Throughout April and May, colleagues have continued to work very hard to develop our Single Improvement Plan (SIP) and have made good progress. The SIP will really help us to focus on the things that will make the most difference in all our core areas of work, particularly operational performance, patient safety, patient and colleague experience and finance. The plan will then inform the objectives of the Executive which will feed into the wider objectives of teams throughout the Trust so that we all have a clear way forward. Working in this way will enable us to prioritise the things that will make the most difference to our patients, and ensure that we are ready to embrace the opportunities that the New Hospitals Programme (NHP) represents in terms of being able to provide patient care very differently within fit for purpose modern facilities. In the meantime, though, we will continue to use the Big Plan metrics for reporting through to our Sub Board Committees.

To help support the wider SIP, we have remodelled our internal communications and engagement activities to help enable all colleagues to have the opportunity to ask questions of the Executive and wider leadership teams. This includes a monthly team brief for all colleagues and a monthly leadership forum together with a weekly vlog from an executive lead. The initial events were well attended with over 400 and 200 colleagues joining each forum respectively.

National Regional and Local Recognition

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

- **VIP Visitors**

Recently, we were fortunate enough to host two exciting visits to both Royal Preston and Chorley and South Ribble Hospitals. The Minister of State for the Department of Health and Social Care, Andrew Stephenson, visited Chorley's Elective Surgical Hub and Lord Victor Adebowale, Chair of the NHS Confederation, visited the Royal Preston site. At Chorley, I was joined by Steve Canty and Kate Hudson, who facilitated a visit in wards and theatres across the elective hub and we were pleased to receive positive feedback from the

Minister on his visit. At Preston, I was joined by Ailsa Brotherton, Jonathan Wood and our Chair, Peter White, to discuss Trust finances and our SIP, ending with a tour of key areas. Again, Lord Adebowale gave some encouraging feedback, so it is great to see us recognised on a national level.

- **Broadoaks Child Development Centre**

It was good to see the Broadoaks Child Development Centre in Leyland get some recognition for their fine work with the Kentown Children's Palliative Care Programme recently celebrating its first birthday. The service has supported over 128 families across Lancashire and South Cumbria, with the help of a Specialist Children's Palliative Care Nurses from five NHS Trusts across the patch. Victoria Adamson, based at Broadoaks, is the Trust's Palliative Care Community Nurse Specialist, helping the collaborative programme with the needs of children with life-limiting and life-threatening illnesses – and their families, who have described the initiative as 'transformative'. The project combines nursing care, social care and information and awareness, and is reaching growing numbers of families with children and young people by providing nursing, practical and emotional support and signposting to services in families' communities.

The Trust's Children's Bladder and Bowel Service, which sits under Children's Community Nursing and Specialist Nurses based at Broadoaks, have also made great strides since being established and commissioned in November 2021 by the ICB. Despite being a relatively new team, there have been several key achievements, including being identified as providing a gold standard service provision across the LSC ICB footprint, as well as being nominated for National Bladder and Bowel UK awards. The service provides paediatric specialist assessments and treatment plans for children from the age of 5 for daytime and nighttime wetting, constipation/soiling and specific toilet training plans for children with additional needs that attend a mainstream school. Any child that meets these criteria and is registered with a GP in Preston, Chorley and South Ribble, can be referred to the service.

- **Educational achievements**

I recognise that we do not always shout about our excellent education provision as much as we perhaps should. Therefore, I am only to pleased to congratulate three winners at the 6th Annual NHSE North West Specialty and Specialist (SAS) Awards at Haydock, which was part of the Annual SAS Conference. Dr Rajesh Kumar claimed the SAS Lifetime Achievement Award, while Dharmendra Mittal was SAS Lead/Tutor of the Year, and Natalie Suffield was SAS Administrator of the Year. There were also four entrants Highly Commended - SAS Postgraduate Educator Award: Dr Avinash Jha; SAS Undergraduate Educator Award: Dr Brian Chivima; SAS Quality Improvement Award: Dr Shravan Nanda; and SAS Champion Award: Lisa Eccles.

Speaking of awards, our partnership with Northumbria University has ended on a high, with the University winning Nursing Apprenticeship Provider of the Year at the Student Nursing Times awards at the Grosvenor Hotel in London. In March, the Trust completed its contract with Northumbria University to deliver a Registered Nurse Apprenticeship for the Lancashire and South Cumbria region. The partnership was initiated in September 2020 and has yielded remarkable success. The apprenticeship is a "top up" opportunity accessible to nursing associates and assistant practitioners, spanning an 18-month duration and culminating in NMC registration as a registered nurse. A total of 83 nurses have graduated through the partnership and secured registered nurse positions across the region, 38 of whom have taken up registered nurse positions within LTH.

- **Improving Patient Safety**

I was also pleased to hear that Deputy Chief Medical Officer, Mr Arnab Bhowmick and Head of Nutrition Nursing Service, Jessica Quayle, recently presented at the National Patient Safety Specialist Meeting in May after their work was highlighted at the annual British Association of Parenteral and Enteral Nutrition (BAPEN) conference in November 2023. Their work focused on improving patient safety specifically around Nasogastric (NG) tube insertion and management using flow coaching methodology and by bringing together subject experts including patients. The team saw some incredible results including the avoidance of 1,027 chest X-rays in the space of 23 months making a cost saving of around £25,000 and vastly improving the patient experience. The team have been asked to present at a future internal Leaders Forum so their approach to leadership in patient safety can be used elsewhere across the Trust.

- **Enlisting the help of our communities to "Bin the Wipes"**

Our 'Bin the Wipes' campaign was launched at the start of May, aimed at raising awareness about the effect that wipes and other sanitary items have on the drains and sewer systems in our hospitals. A plumbing incident can result in an increased risk of an infection outbreak and an extended stay on our wards. It also puts extra pressure on our ward, estates and domestic staff, who have deal with these incidents and their aftermath. The campaign was well-publicised in the local media, and Cliff Howell, Acting Director of Estates and Facilities, also spoke about it on the Jeremy Vine Show on BBC Radio 2, which you can listen to here. We are asking everyone to only flush the 3Ps – poo, paper and pee down the loo to help keep our toilets free from blockages.

- **Celebrating the Specialist Mobility Rehabilitation Centre**

And finally, former Trust technician Steve Whalley recently celebrated an extraordinary milestone - 50 years of an unwavering relationship with what is now the Specialist Mobility Rehabilitation Centre (SMRC), following a motorbike accident. Back in October 1973, Steve lost his right leg following a life-changing crash and underwent surgery at Preston Royal Infirmary. Steve was fitted with an aluminium prosthetic limb, which he wore out in public for the first time for his 18th birthday, in March, 1974. Within eight months he was back at work with Ribble Motors, resuming his apprenticeship as a vehicle builder, before redundancy in 1989 led him into a fulfilling career in Occupational Therapy as a Cardiac and Orthopaedic technician at the Royal Preston Hospital. Steve, now 68, admits he wouldn't be here, or have been able to have achieved any of the remarkable successes in his career, but for the care he has received from the NHS, a point he made on BBC Radio Lancashire's Graham Liver Show.

It is stories like Steve's which reminds us why we do what we do in the NHS.

1. RECOMMENDATIONS

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

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Board Assurance Framework (BAF) Risk Report

Report to:	Board of Directors	**Date:**	6th June 2024
Report of:	Associate Director of Risk and Assurance	**Prepared by:**	K Clay
Part I	✓	**Part II**	

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

Executive Summary:

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

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

Strategic Risks

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

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

There has been no change in score for:

- Risk to delivery of the Trust's Strategic Ambition of Delivering Value for Money – remains 20.
- Risk to delivery of the Trust's Strategic Ambition to Consistently Deliver Excellent Care – remains 20.
- Risk to delivery of the Trust's Strategic Aim to be a Great Place to Work – remains 16.
- Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research – remains 16.
- Risk to delivery of the Trust's Strategic Ambition of Fit for the Future – remains 15.
- Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service – remains 8.

Review of Risk Appetite and Risk Tolerance scoring

A Board Workshop was held on 14 May 2024 to support the annual review of the Risk Appetite Statement and Risk Tolerance for all Strategic Risks. Potential changes to the Risk Appetite and Tolerances were explored. However, members of the Board who were present agreed that the Risk Appetite Statement and Risk Tolerances remain appropriate and the recommendation to Board is to approve the decision that the Risk Appetite Statement and Risk Tolerances remain the same for 2024/25. Details of the proposed Risk Appetite Statement and Risk Tolerances are included in Appendix 1.

Re-alignment of Specialised Services and Fit for the Future strategic risks

At a Board Workshop on 14th May 2024, it was recommended that the Risk to the delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services, and the Risk to the delivery of the Trust's Strategic Ambition of Fit for the Future be re-aligned for oversight from the Board of Directors to Finance & Performance Committee from June 2024.

It was also recommended that the Risk to the delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services be moved to the "controlled" status, as the score has remained at 8 for a sustained period of time and this fits with the Trust's agreed Risk tolerance level.

Operational High Risks for Escalation/De-escalation

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

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

Risk ID 1182 - Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, has been de-escalated from Board following agreement in April 2024.

It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.
ii. Review and approve the Risk Appetite Statement and Risk Tolerances for 2024/25.
iii. Review and approve the recommendation for the Strategic Risks for Specialised Services and Fit for the Future to be re-aligned to Finance & Performance Committee for oversight.
iv. Review and approve the recommendation for the Strategic Risk for Specialised Services to be controlled.

Appendix 1 – Board Assurance Framework
Appendix 2 – Strategic Risks

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Risk Management Group – May 2024
Committees of the Board in line with cycles of business
Board Workshop – 14th May 2024

1. Background

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

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

2. Discussion

2.1 Board Assurance Framework (BAF)

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

2.2 Risk Appetite Statement & Risk Tolerances Annual Review

2.2.1 The Board of Directors are required to review the Risk Appetite and Tolerance scores for all Strategic Risks within the Board Assurance Framework at least annually but more frequently if required.

2.2.2 A Board Workshop was held on 14 May 2024 to support the annual review of the Risk Appetite Statement and Risk Tolerance for all Strategic Risks. Potential changes to the Risk Appetite and Tolerances were explored. However, members of the Board who were present agreed that the Risk Appetite Statement and Risk Tolerances remain appropriate and the recommendation to Board is to approve the decision that the Risk Appetite Statement and Risk Tolerances remain the same for 2024/25.

2.2.3 Details of the proposed Risk Appetite Statement and Risk Tolerances are included in Appendix 1.

2.3 Strategic Risk Register

2.3.1 There has been no change in score for:

- Risk to delivery of the Trust's Strategic Ambition of Delivering Value for Money – remains 20.
- Risk to delivery of the Trust's Strategic Ambition to Consistently Deliver Excellent Care – remains 20.
- Risk to delivery of the Trust's Strategic Aim to be a Great Place to Work – remains 16.
- Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research – remains 16.
- Risk to delivery of the Trust's Strategic Ambition of Fit for the Future – remains 15.
- Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services – remains 8.

2.3.2 At a Board Workshop on 14th May 2024, it was recommended that the Risk to the delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services, and the Risk to the delivery of the Trust's Strategic Ambition of Fit for the Future be re-aligned for oversight from the Board of Directors to Finance & Performance Committee from June 2024. This is to ensure the risks are reviewed at a Committee of the Board in advance of the Board of Directors meeting.

2.3.3 It was also recommended that the Risk to the delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services be moved to the "controlled" status, as the score has remained at 8 for a sustained period of time and this fits with the Trust's agreed Risk tolerance level.

2.3.4 It is recommended that the Board of Directors approve the proposals.

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

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

2.4 Operational Risk Register

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

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

2.4.2 Risk ID 1182 - Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, has been de-escalated from Board following agreement in April 2024.

2.4.3 The Risk Management Group (RMG) has discussed Risk ID 499 - Failure to effectively manage staff absence and achieve Trust and National target rates. The score was proposed to be increased to 20 from 16, based on the sickness rates and that the Trust is an outlier regionally and nationally. It was agreed that this should be escalated to Workforce Committee to consider escalating to the Board of Directors, however the Workforce Committee was stood down in May 2024 due to lack of quoracy and as a result, the discussions are yet to be held. The discussions will take place at the next scheduled Workforce Committee and any subsequent recommendations will be made to Board in due course (if required).

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

3. Financial implications

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

4 Legal implications

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

5. Risks

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

6. Impact on stakeholders

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

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

7. Recommendations

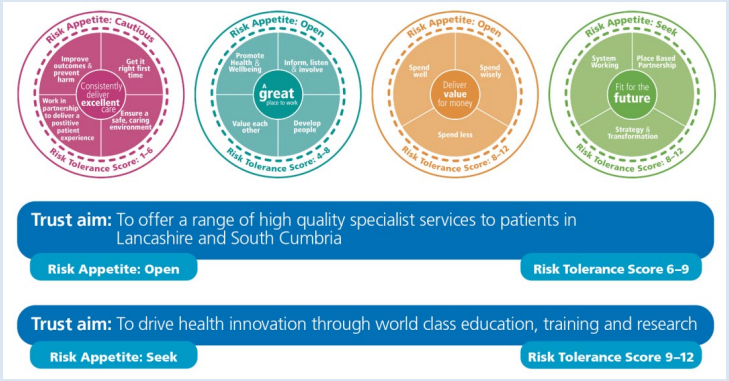
7.1 **It is recommended that Board of Directors:**

i. Note and approve the updates to the BAF.
ii. Review and approve the Risk Appetite Statement and Risk Tolerances for 2024/25.
iii. Review and approve the recommendation for the Strategic Risks for Specialised Services and Fit for the Future to be re-aligned to Finance & Performance Committee for oversight.
iv. Review and approve the recommendation for the Strategic Risk for Specialised Services to be controlled.

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

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Trust Aims and Ambitions



Current principal risks on the Strategic Risk Register – June 2024

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

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

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

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Strategic Risk Summary

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

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

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

Key Operational Risk Summary for Escalation to the Board

Lancashire Teaching Hospitals NHS Foundation Trust

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

Escalated Risks

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

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

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

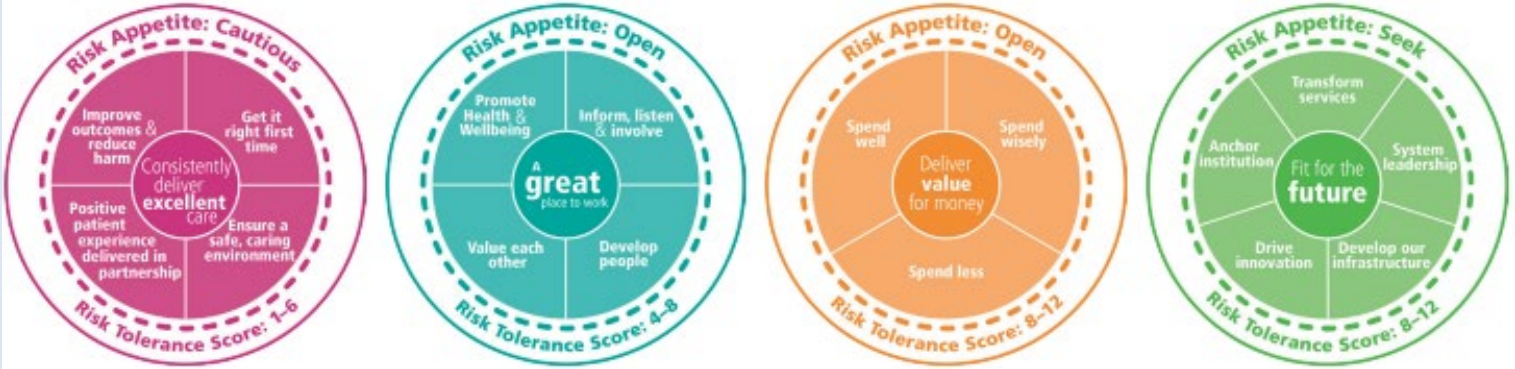
- **Increased cases of clostridioides difficile (C.*difficile*) Infection (Risk ID 1157 – Initial score 16, Current score 20)** - The Trust continues to see higher than planned rates of C.*difficile* infection and whilst a number of actions have been taken and remain ongoing, this risk was recommended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

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

Lancashire Teaching Hospitals NHS Foundation Trust

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

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



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

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

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

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

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

Lancashire Teaching Hospitals
NHS Foundation Trust

Trust Risk Appetite Statement

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

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

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

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

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

Risk ID: 855
Risk owner: Chief Nursing Officer
Date last reviewed: 20th May 2024

Risk

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

This may, result in adverse patient outcomes and experiences.

Risk Appetite:

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

Risk Tolerance

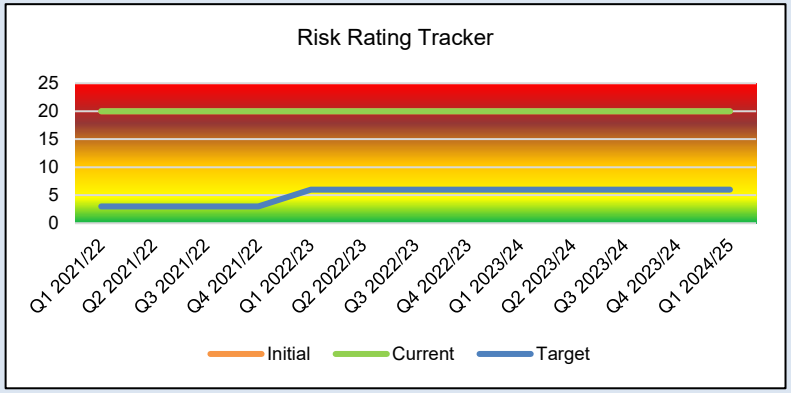
1-6

Rationale for Current Score

- There is currently a reliance on temporary workforce due to sickness levels in excess of 4% and greater than 5% vacancy levels resulting in variation in care delivery.
- The requirement to deliver a Cost Improvement Programme of 5.5% and an overall Financial Improvement Plan of 8.5%.
- Continued deterioration in the backlog maintenance position and the impact on both buildings and equipment.
- Estate does not meet HTN standards, limiting consistent adherence to safety and aesthetic estate standards.
- Occupancy levels are in excess of 95% leading to extended length of stay in the ED and additional patients boarding on inpatient wards.
- Patients are routinely waiting longer than some national standards for treatments and in the Emergency Department.
- Adult inpatient experience feedback is identifying room for improvement.
- The ability to live within the resources available is dependent upon scalable system wide transformation. The foundations for this work remain formative.
- C.*Difficile* rates exceed expected rates and allocated trajectory (managed through Risk ID 1157 – Increased risk score now at 20 associated with C. *difficile* Infection)
- Recognised health inequalities in the communities we serve.
- The annual safe staffing recommendations are delayed in implementation due to financial constraints.
- The CQC rating for the organisation has remained at 'Requires Improvement'.
- There are some specialty services that are considered fragile and this presents a risk to consistent delivery.

Risk Rating Tracker * (Likelihood x Consequence)

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



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

Future Risks

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

Future Opportunities

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

Controls	Gaps in Control	Assurances	Gaps in Assurances
• Workstream related strategies and plans in place ○ Always Safety First ○ Clinical Strategy ○ STAR Quality Assurance Framework ○ Patient Experience and Involvement Strategy ○ Risk Management Policy ○ Our Big Plan ○ Continuous Improvement Strategy ○ Equality, Diversity and Inclusion Strategy ○ Workforce and OD Strategy ○ Education, Training and Research Strategy ○ Financial Strategy ○ Health and Wellbeing Strategy ○ Communication Strategy ○ Targeted recruitment & plans and temporary staffing arrangements (inc international and healthcare support workers) ○ Safety and Quality Policies and Procedures ○ Workforce Policies and Procedures ○ Health & Safety Plan ○ Operational Plan ○ Restoration and Recovery Plan ○ Safe staffing reviews ○ Safeguarding Board • Accountability Framework • Freedom to Speak Up, Guardian of Safe Working and Person in Position of Trust (PIPOT) arrangements • Safety Forums • GIRFT programme of work. • Capital planning process • EQIA policy and procedures • Transformation programme • Integration of services and pathways and effective system-based working • Confirmation received of progression to the next stage of the NHP in May 2023 • Capital investment case created expand the MAU and SAU. • Health Inequalities delivery plan - Core20PLUS5 adults and children. • Medical device and replacement programme and process in place with increased oversight through Finance & Performance Committee • Planned programme of work commenced focused on fragile services across the ICS.	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups ***(Ref CDEC 020)***. • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection ***(Ref CDEC 019).*** • The current environment within the ED requires upgrading to reduce the risk of environmental decontamination. ***(Ref CDEC 019)*** • The current environment within medical and surgical assessment units does not meet demand. ***(CDEC 014)*** • The implementation of the national cleaning standards is not yet complete. ***(CDEC 018)*** (02/24 - 25% compliant for domestic standards, 100% compliant for nursing standards.) • The capital required to address backlog maintenance is not sufficient. ***(CDEC 019)***	**<u>Internal</u>** •STAR Assurance Framework •Always Safety First Group •Safety and Learning Group •Divisional Governance Structures and arrangements •Divisional Improvement Forums •Safety and Quality Committee •Workforce Committee •Finance and Performance Committee •Education, Training and Research Committee •Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system •CNST internal assurance reporting •Nurse, Midwifery and AHP safe staffing review annual review and recommendations •Medical Staffing Review Plan in place to strengthen assurance of testing safe medical staffing •Equality Quality Impact Assessment (EQIA) procedure and reporting in place. •Transformation programme Board •Strengthened IPC BAF •Director of Strategy and Planning reports updates on clinical reconfiguration programmes to Finance and Performance Committee. •Bi annual safe nurse staffing assessment completed with inclusion of covering safe staffing recommendations for 2023 Birthrate plus assessment. **<u>External</u>** •National Surveys •Clinical Negligence Schemes for Trust •External regulators and benchmarking •Medical Examiner's Office, Perinatal Mortality Tool •Internal Audit •External system assurances, PLACE based arrangements, ICB and PCB •NHS England performance monitoring	[None identified]

Action Plan (Actions completed in 2023/24 have been archived)

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
CDEC 014	Completion of planned expansion of MAU and SAU	Chief Nursing Officer	30 November 2024		Ongoing	Control	• The current environment within medical and surgical assessment units does not meet demand.
CDEC 016	Determine mechanism to fund safe staffing recommendations for 2023 Birthrate plus assessment.	Chief Financial Officer	30 April 2024	6 April 2024	Completed	Assurance	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints.
CDEC 017	Bi annual safe nurse staffing assessment to be undertaken given the time elapsed since previous assessment and changes in operating environment.	Chief Nursing Officer	30 April 2024	6 April 2024	Completed	Assurance	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints.
CDEC 018	The national cleaning standards implementation requires delivery – Priority 1.	Chief Financial Officer	31 August 2024		Ongoing	Control	• The implementation of the national cleaning standards is not yet complete. 25% compliant for domestic standards, 100% compliant for nursing standards.
CDEC 019	The capital planning group will continue to assess the risks relating to backlog maintenance and determine the priorities from within the capital funding envelope provided.	Chief Financial Officer	ongoing		Ongoing	Control	• The capital required to address backlog maintenance is not sufficient. • The current environment within the ED requires upgrading to reduce the risk of environmental decontamination. • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection.
~~DVFM 031~~	~~Refine approach to making risk based strategic decisions~~	~~Chief Nursing Officer~~	~~30 April 2024~~		Stood Down	~~Assurance~~	• ~~Enhanced approach to risk based decision making~~
CDEC 020	To develop a plan in conjunction with the Director of Public Health, that aligns with the Health and Wellbeing Board's Health Inequalities Plan	Chief Nursing Officer	~~31st May 2024~~ 30 June 2024		Ongoing	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups.

Summary of review – April and May 2024

- Actions within the Action Plan that were completed in 2023/24 have been archived and removed from the risk document for the new financial year
- Actions CDEC 016 and 017 have been completed, leading to the gap in assurance "Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints" being removed and a new assurance "Bi annual safe nurse staffing assessment completed with inclusion of covering safe staffing recommendations for 2023 Birthrate plus assessment" being identified.
- Action DVFM031 relating to strategic decisioning criteria has been stepped down following discussion with the new Chief Executive. The Board of Directors' approach to utilisation of risk appetite and tolerance will form part of the planned review and refresh of the Board Assurance Framework (BAF). In the meantime, risks continue to be scored in line with the Risk Management Policy and any risk-based decisions will continue to be made in conjunction with the Risk Appetite statement and tolerances set by the Board of Directors.
- Content of risk reviewed, and no updates required.
- Action CDEC 018 – There is currently no solution to complying with the national cleaning standards, therefore this presents a risk to delivery within the agreed timescale.
- Action CDEC 020 – Due date extended in recognition of the need for Director of Public Health and local expertise being required. The plan is on track for completion by 30 June 2024.

Risk Title: Risk to delivery of the Trust's Strategic Objective of Delivering Value for Money

Risk ID: 857
Risk owner: Chief Finance Officer
Date last reviewed: 21st May 2024

Risk

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

Risk Appetite:

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

Risk Tolerance

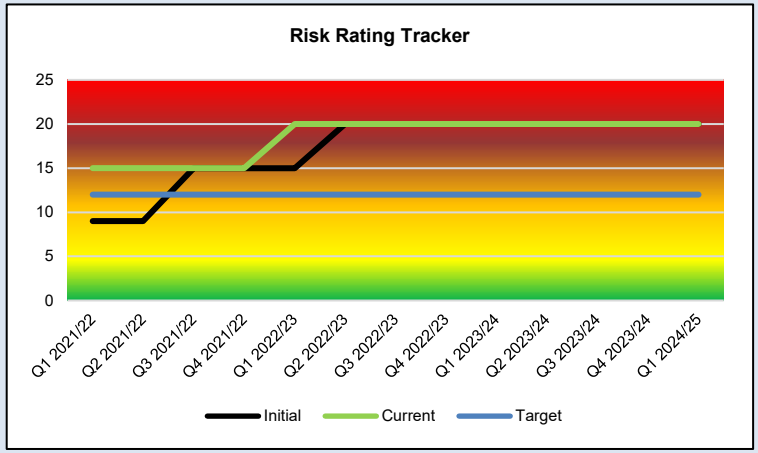
8-12

Rationale for Current Score

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

Risk Rating Tracker (Likelihood x Consequence)

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



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

Future and Escalating Risks

- **Investment** – The Trust in the meantime has an underlying overspend which will need to be addressed. The failure to improve financial performance is likely to impact on future major investment decisions facing the Trust, along with potential future risk of failing to deliver the Trust's challenging FRP.
- **Placed based leadership** – The place-based roles are continuing to form and are considered to be pivotal in the optimisation of the health and care 'eco-system'. There is a risk that the evolution of these arrangements do not sufficiently impact on the optimisation processes and that leadership arrangements between sub place, place and system are confusing with unclear accountability.
- **Rising demand** – Failure to develop a credible and meaningful urgent and emergency care strategy at system and place to respond to a growing population with increased complexity/comorbidity will result in residents accessing inappropriate services which could impact detrimentally on value for money for public services as a whole.
- **Planned care -** The failure to reorganise planned care across the system will result in waste and unwarranted variation, resulting in impact on overall value for money.
- **Cost control –** There is a risk that input costs rise faster than activity output further eroding VFM.
- **Commissioning decisions –** In light of the wider system financial challenges it is likely that the ICB will need to disinvest in services which are likely to exacerbate the financial and operational challenges if unmitigated.

Future Opportunities

- Benchmarking indicates opportunities remain to reduce waste and the underlying overspend.
- There is an opportunity to reduce financial risk through reorganisation, adoption of technologies, automation and the removal of unnecessary duplication and waste.
- There is opportunity to participate in the national support offer for NHS IMPACT, which will focus on increasing productivity in priority areas
- There remains an opportunity to increase margins through non-NHS activities.
- There remains opportunity through the ICS and the place-based arrangements to reduce the unnecessary duplication of NHS services.
- There is an opportunity to work with the Provider Collaboration Board to identify and pursue collaboration opportunities at scale.
- There remains an opportunity to commission more effective services to mitigate hospital attendances.
- There remains a partnership opportunity at system and place to better manage patient pathways and reduce inappropriate demand and unnecessary cost escalation.
- There remains an opportunity for partners to support more timely discharge from hospital, reducing the overall cost to the taxpayer and improve outcomes.
- To meet increasing demand and complexity the ICB will need to determine what commissioned services will be afforded for its population and whether some services will need wider reconfiguration to support sustainability.
- Better understand why relative productivity has decreased and seek to mitigate where possible.
- There is opportunity to commission end to end pathways to maximise out of hospital care, closer to home.

Controls

- Workstream related strategies in place
  - Workforce and OD Strategy,
  - Continuous Improvement Strategy
  - Clinical Strategy
  - Financial Strategy
  - IM&T Strategy,
  - Estates Strategy,
  - Annual Business Plan Planning framework established to track delivery of schemes.
  - Always safety first
  - Urgent and Emergency Care Board
  - ICS Transforming Community Services Programme

Gaps in Control

- Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs.
- Service disruption due to ongoing industrial tensions (Managed through operational risk ID 1182 (probability of strike action))
- Inability to sufficiently influence externally impacting directly on services provided by LTH (e.g., partner organisation strategies and decision taking, financial rules for NHS services, NHS wide workforce development and investment and some processes and

Assurances

Internal

- Specialty Performance meetings
- Divisional Improvement Forums
- Performance Review Group
- Outpatient Improvement Group
- Integrated Performance reporting at Finance and Performance Committee and Board
- Audit Committee assurance processes to test effectiveness of financial infrastructure and internal control system
- Temporary monitoring of undertakings internally (The Trust has been placed in segment three for the NHS Oversight Framework (NOF)).
- Use of Resources assessments now reported through Finance & Performance Committee.
- Regular embedded cycle of sharing information relating to the wider programme of change in place

Gaps in Assurance

- The Trust needs to identify how it will return its services to financial balance and deliver a challenging cost improvement programme whilst closing unfunded infrastructure or securing the associated funding. (***DVFM 010)***
- Inability to demonstrate delivery of key financial and operational metrics ***(DVFM 033)***

• Scheme of delegation/Standing Financial Instruction • Accountability Framework • Long term case for change the New Hospitals Programme • Contract management and activity under regular monitoring • National Planning Framework and Capital now given to ICS areas. • A system wide vacancy and control panel introduced providing additional oversight of the roles that are being recruited to across the system, particularly but not exclusively in non-clinical areas, consultancy, leases and contracts. • A system wide non pay control group has been established with the aim of prohibiting discretionary spend and improving value for money.	decision making at system and PLACE such as priority setting in development and deployment of system and PLACE Urgent and Emergency Care Strategy) • The financial run rate may improve at a slower rate than that which is required. Recovery plans need to ensure that there is sufficient pace or alternative mitigation to drive change quickly and de-risk the financial position appropriately, whilst maintaining a focus on safety. • Lack of a clear organisational plan to ensure improvements in finance & operational performance ***(DVFM010 & DVFM034-35)*** • Delays in planning cycle ***(DVFM036)*** • Lack of adequately resourced programme management office for the scale of financial recovery programme required ***(DVFM037)***	• Report on elective productivity and plans for improvement completed to better understand the impact on elective productivity together with movements in the underlying drivers together with plans for improvement. • A monthly update is provided on transformation programmes and the progress on the Financial Recovery Programme • Quarterly monitoring and action plans associated with Use of Resources. Routine reporting has been reintroduced. • Temporary Workforce Controls have been reviewed by internal audit and gained substantial assurance. In addition, a further review of adequacy of controls will be undertaken in 24-25. • A Single Improvement Board has been established, chaired by the CEO which will report into Finance and Performance Committee • Workforce and Digital transformation programmes now designed, and the board has been established, to oversee the implementation. This work will transition as the new single improvement plan is established • Updates on the drivers of financial and operational performance shared with Finance & Performance Committee **External** • Head of Internal Audit Opinion/Going concern review • Benchmarking model hospital/GIRFT • External Auditor review • External system assurances, PLACE, ICB and PCB including a new system improvement board, chaired by the NHS England regional team. • The contract monitoring report is shared with FPC to provide stronger assurances on the underlying trading position and associated activity now reintroduced.	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
DVFM 010	~~Develop a medium-term plan with a supporting financial model to outline the route to recovery. To be signed off by the Board of Directors. This plan will be a key component of the Single Improvement Plan (see below).~~ Develop Financial Sustainability Plan as part of the single improvement plan	Chief Financial Officer and Director of Strategy and Planning	~~04.04.24~~ 30.06.24		Ongoing	~~Assurance~~ Control	~~The Trust needs to identify how it will return its services to financial balance and deliver a challenging cost improvement programme whilst closing unfunded infrastructure or securing the associated funding.~~ Lack of a clear organisational plan to ensure improvements in finance & operational performance
DVFM 026	Refine approach to benefits realisation and embedding in arrangements for programme assurance	Director of Improvement and Transformation	30.04.24	12.04.24	Complete	Assurance	In relation to its transformation programmes, the Trust needs to improve its identification and release of benefits.
DVFM 029	Update drivers of financial and operational performance	Chief Finance Officer	04.04.24	04.04.24	Complete	Assurance	Gaps are mitigated adequately within the Financial Recovery Programme
~~DVFM 031~~	~~Refine approach to making risk-based strategic decisions~~	~~Chief Nursing Officer~~	~~30.04.24~~		Stood down	~~Assurance~~	~~Enhanced approach to risk-based decision making~~
DVFM 032	Development of a Single Improvement Plan to improve Board Assurance	Director of Improvement and Transformation	04.04.24	04.04.24	Complete	Assurance	There is a need to focus on the actions which will lead to an improvement in the Trusts NOF rating.
DVFM 033	Review performance and accountability framework	Deputy Chief Executive Officer	30.06.24		NEW	Assurance	Inability to demonstrate delivery of key financial and operational metrics
DVFM 034	Develop the People and Culture Plan as part of the Single Improvement Plan and the associated Financial Recovery Plan.	Chief People Officer	30.06.24		NEW	Control	Lack of a clear organisational plan to ensure improvements in finance & operational performance
DVFM 035	Develop an Operational Performance plan as part of the Single Improvement Plan and the associated Financial Recovery Plan.	Chief Operating Officer	30.06.24		NEW	Control	Lack of a clear organisational plan to ensure improvements in finance & operational performance
DVFM 036	To review planning cycle ahead of 2025/2026.	Director of Strategy and Planning	30.09.24		NEW	Control	Delays in planning cycle
DVFM 037	Review approach to benefits realisation for programme management and continuous improvement	Director of Improvement, Research and Innovation	30.08.24		NEW	Control	Lack of adequately resourced programme management office for the scale of financial recovery programme required

Summary of updates to risk – April and May 2024

- Actions within the Action Plan that were completed in 2023/24 have been archived and removed from the risk document for the new financial year. All action detail remains within the Datix system.
- Action DVFM 026 – marked as completed as detailed work has been undertaken as part of the single improvement plan to develop measures and trajectories, identifying the benefits against the quadruple aim. The completion of this action leads to the removal of "In relation to its transformation programmes, the Trust needs to improve its identification and release of benefits" as a gap in assurance and a new assurance "The single improvement plan has been developed to support the Trust to improve its NOF rating. The plan includes measures and trajectories, identifying the benefits against the quadruple aim and incorporates a three year financial recovery plan" being identified.
- DVFM 027 – marked as completed as a digital transformation programme is now designed and the board has been established to oversee the implementation. This work will transition as the new single improvement plan is established. The completion of this action leads to the removal of "To supplement its existing transformation programmes two further programmes with be added to the assurance framework: Workforce and Digital" as a gap in assurance and a new assurance "Workforce and Digital transformation programmes now designed, and the board has been established, to oversee the implementation. This work will transition as the new single improvement plan is established" being identified.
- DVFM 029 - marked as completed following an updated paper being presented at Finance & Performance Committee, which leads to the gap in assurance "Gaps are mitigated adequately within the Financia Recovery Programme" and a new assurance identified "Updates made to the drivers of financial and operational performance, shared with Finance & Performance Committee"
- Action DVFM 031 relating to strategic decisioning criteria has been stepped down following discussion with the new Chief Executive. The Board of Directors' approach to utilisation of risk appetite and tolerance will form part of the planned review and refresh of the Board Assurance Framework (BAF). In the meantime, risks continue to be scored in line with the Risk Management Policy and any risk-based decisions will continue to be made in conjunction with the Risk Appetite statement and tolerances set by the Board of Directors.
- DVFM 032 – marked as completed as the new single improvement plan has been developed and is now being mobilised. The plan will be iterative with new projects being added as requested. The completion of this action leads to the removal of the gap in assurance "There is a need to focus on the actions which will lead to an improvement in the Trust's NOF rating" and identifies a new assurance "The single improvement plan has been developed to support the Trust to improve its NOF rating. The plan includes measures and trajectories, identifying the benefits against the quadruple aim and incorporates a three year financial recovery plan"
- Gaps in assurance linked to actions DVFM 019 (completed May 2023), DVFM 020 (completed Sept 2023) and DVFM 022 (stood down Jan 2024) removed from risk content as actioned historically and now covered by assurances listed in the content of the risk.

Action number	Action	Previous gap in assurance	Included within assurance
DVFM 019	Strengthen executive oversight of transformation and subsequent reporting to Committee	To support the drive for improved delivery the governance arrangements require some amendment.	• A monthly update is provided on transformation programmes and the progress on the Financial Improvement Programme • Improved oversight of the reporting of actions relating to the Improvement and Assurance Group with the Integrated Care Board via sharing of minutes and actions of IAG meeting with FPC
DVFM 020	Evolve performance accountability framework	To support the drive for improved delivery the governance arrangements require some amendment.	• A monthly update is provided on transformation programmes and the progress on the Financial Improvement Programme • Improved oversight of the reporting of actions relating to the Improvement and Assurance Group with the Integrated Care Board via sharing of minutes and actions of IAG meeting with FPC
DVFM 022	Develop a 'value add' reporting for collaborative arrangements	There is an opportunity to better describe how partnering/ collaborative arrangements e.g. through the Provider Collaborative Board can help to improve value for money	• Improved oversight of the reporting of actions relating to the Improvement and Assurance Group with the Integrated Care Board via sharing of minutes and actions of IAG meeting with FPC

- Additional Gap in Controls and Assurances identified
- Updated Assurances to include reference to Single Improvement Board and system improvement board chaired by NHSE
- Updated DVFM010 to align to the Single Improvement Plan.
- Identification of actions for DVFM 033 – 037 in response to identification of new gaps in controls and assurances.

Risk Title: Risk to delivery of the Trust's Strategic Objective to be a Great Place to Work

Risk ID: 856
Risk owner: Chief People Officer
Date last reviewed: 24th April 2024

Risk

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

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

Risk Appetite:

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

Risk Tolerance

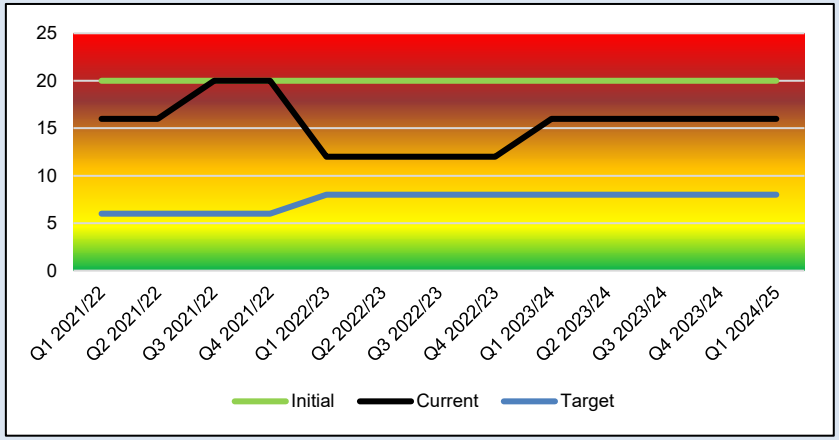
4-8

Rationale for Current Score

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

Risk Rating Tracker (Likelihood x Consequence)

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



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

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

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

• Freedom to Speak Up and Guardian of Safe working arrangements • Education & Training strategy • Risk Management Strategy • Health and Safety Plan • Always Safety Strategy • Safe staffing reviews • Our Big Plan • Communications strategy • Accountability Framework • Safety Forums • New Hospitals Programme • Resourcing plan for Workforce and OD staffing to support the delivery of Workforce and OD strategy and meet demands on current service provision included within the revised People Plan launched in April 2023 • Chief People Officer and Deputy/Associate Directors are present at all People and Transformation Meetings at the Provider Collaborative Board		• rostering review by NHSI indicating excellence in rostering practice	

Action Plan (actions completed 2023/24 archived)

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
GPTW002	Incorporate transformational schemes that support long term sustainability and workforce re-modelling as part of annual planning cycle	Director of Strategy and Planning	31st May 2024		Ongoing	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.
~~DVFM 031~~	~~Refine approach to making risk-based strategic decisions~~	~~Chief Nursing Officer~~	~~30.04.24~~		Stood Down	~~Assurance~~	~~• Enhanced approach to risk-based decision making~~

Risk updates – April and May 2024

- Following review for May 2024, there are no updates to the content of the risk.
- Action DVFM031 relating to strategic decisioning criteria has been stepped down following discussion with the new Chief Executive. The Board of Directors' approach to utilisation of risk appetite and tolerance will form part of the planned review and refresh of the Board Assurance Framework (BAF). In the meantime, risks continue to be scored in line with the Risk Management Policy and any risk-based decisions will continue to be made in conjunction with the Risk Appetite statement and tolerances set by the Board of Directors.

Risk Title: Risk to delivery of the Trust's Strategic Objective of Fit for the Future

Risk ID: 858
Risk owner: Director of Strategy and Planning/Chief Medical Officer
Date last reviewed: 14th May 2024

Risk

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

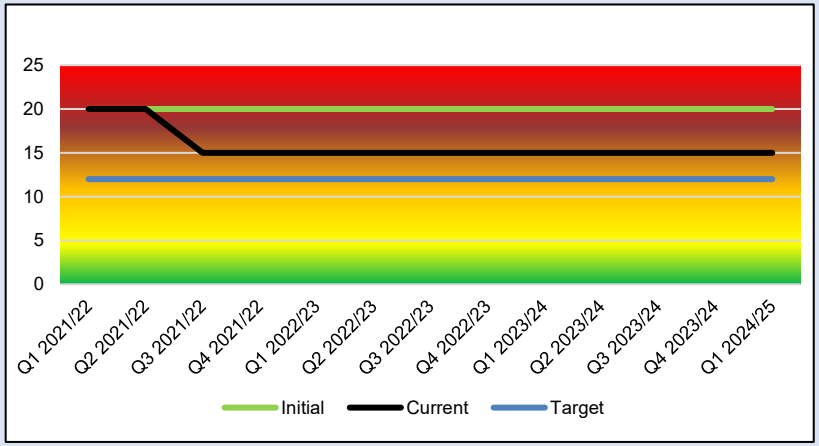
Risk Appetite: Seek – Eager to be innovative and to choose options offering higher rewards, despite inherent business risk.

Risk Tolerance
8-12

Rationale for Current Score

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

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



Future Risks

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

Future Opportunities

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

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

Controls	Gaps in Control	Assurances	Gaps in Assurances

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

Action Plan

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

Updates – April and May 2024

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

- **FFTF 001 - link LTHTR strategies with Place, Provider Collaborative and ICS Strategies and FFTF 003 - Ensure maximum LTH influence on/contribution to Place and System working** - Positive PCB workshop on the 9th of May. Paper received at Execs outlining progress and way forward in relation to service integration with LSCFT. External support has been commissioned and project teams have been set up to take forward the development of a clinical "blueprint" – however the timescale for completion has slipped to Q3.
- **FFTF 004 Develop and deliver Digital Northern Star strategy** – the LTH CIO has been appointed as the Digital Lead for OneLSC. The Lessons Learmned tender for EPR/LIMMS/Digital Pathology has been published.
- **FFTF 005 Deliver staff engagement/comms strategy (including reputation monitoring/management)** – Successfully introduced strengthened Staff engagement mechanisms including fortnightly All Colleague Briefings, fortnightly Senior Leadership Forums and weekly Executive VLOGs. Several hundred colleagues have attendance the events and feedback has been positive.
- **FFTF 008 - strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change** – The PMO has been established, with existing resources supported by temporary additional consultancy support. The key metrics for the Single Improvement Plan have been developed and agreed by Execs and will be presented to Board at a workshop on the 14th of May. Consultation has begun on our Clinical Strategy with the following bodies being met with to date : Preston, Chorley & South Ribble Maternity and Neonatal Voices Partnership, Lancashire Teaching Hospitals Trust Cancer Patient and Carers Forum, Lancashire Visual Impairment Forum & Preston Health and Wellbeing Partnership.

Risk Title: Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services

Risk ID: 859
Risk owner: Chief Medical Officer
Date last reviewed: 24th May 2024

Risk Description:
There is a risk to the Trust's ability to continue delivering its strategic aim of providing high quality specialist services due to integration and reconfiguration of specialist services across the ICS. This may impact on our reputation as a specialist services provider and commissioning decisions leading to a loss of services from the Trust portfolio and further unintended consequences affecting staff and patients.

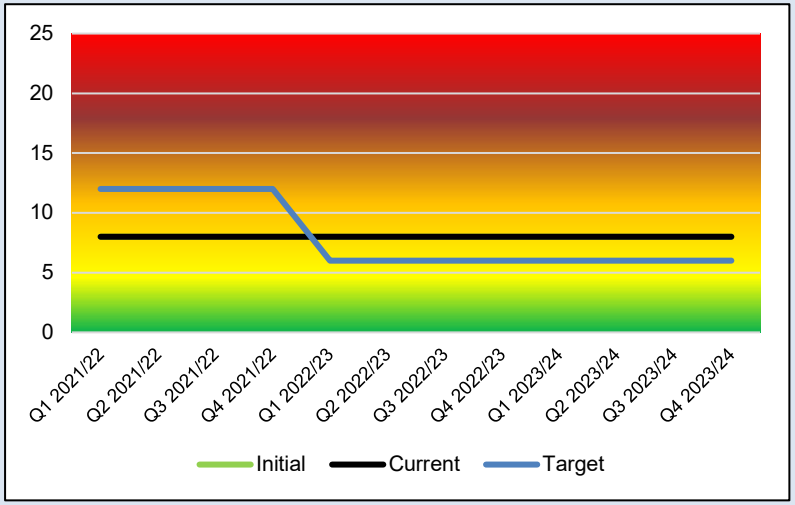
Risk Appetite: Open to Risk - prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.

Risk Tolerance
6-9

Rationale for Current Score

- Place and System based working are developing both in terms of personnel, roles, governance, strategies, and plans.
- Even when a greater level of maturity is reached the delivery of more effective, integrated pathways and services is a major challenge and will require both LTH and its partners to work differently and to successfully balance organisational interests alongside Place/System interests and commitments. In addition to ways of working/partnership culture capacity/time is a major challenge in relation to Place/System working.
- Within Central Lancashire there are a relatively high number of service providers and LTH is the Tertiary Centre for L&SC – as such we have a particular opportunity but also a particular challenge in relation to partnership working.
- LTH has a particular challenge and a particular opportunity in relation to our service configuration and estate – unless we are able to address these, we will be unable to deliver the services our patients and partners rightly expect, and our staff will be focused on immediate operational challenges rather than service and pathway integration.
- The New Hospitals Programme is a once in a lifetime opportunity to work as a system level to access the funding needed to create a high quality, sustainable estate/service configuration.
- ICS and LTH Clinical Strategy developed.
- Provider Collaborative Board Clinical Strategy approved.
- Limited availability of NHS capital prevents further rationalisation of the estate to more effectively provide specialist services (i.e. Neurosciences, Trauma Services, Stroke Services, and Vascular Services).
- Aging estate with significant backlog of maintenance will produce ongoing limitations with implementing options for service developments in the interim before the new hospitals programme.
- Geography and mutually dependent infrastructure.
- With the transition to the new year the financial rules which apply resource allocation within the NHS in England have transitioned. These rules give some clarity in the allocations awarded to Integrated Care Systems but not to how allocations will be distributed across those systems. The Trust will need to monitor funding allocations and patient access as the changes begin to take shape. Any changes in the commissioning arrangements may cause challenges in developing a future state operating model.

Risk Rating Tracker * (Likelihood x consequence)
Initial: 2x4 = 8 Current: 2x4 = 8 Target 6-9



*Initial score also 8 throughout but covered by current score line on above graph

	Future Risks	Future Opportunities
	• Risk of New Hospital Programme not progressing. • Commissioning risks to lower volume/low priority services. • Potential risks associated with changes in specialised commissioning arrangements.	• ICS networks and collaboration leading to reconfiguration of services. • New Hospitals Programme investment leading to establishment of Lancashire Specialist Hospital which may include additional specialist services. • Increasing research and innovation profile of specialist services. • Harnessing innovative ways of working using technology

Controls	Gaps in Control	Assurances	Gaps in Assurances
• Workstream related strategies in place - LTHTR Clinical Strategy - ICS Clinical Strategy - PCB Clinical Strategy - Estates Strategy - Finance Strategy and Plans • New Hospitals Programme • LTHTR Executive leads with Place/ICS responsibilities e.g. Chief Medical Officer located on a number of network bodies e.g. Chair of Cancer Alliance, Chair of Clinical Oversight Group for New Hospitals Programme, Lead Medical Director for the PCB • Quality and safety controls support the retention of specialist services. *Full details of controls associated with quality and safety of specialist services will be noted in the Strategic Risk associated with the Strategic Ambition to Consistently Deliver Excellent Care. • ICS Speciality Boards in place for a number of specialist services • Statutory development of the ICS. • Capital Planning Group arrangements in place to provide structure and organised approach to capital investment. • Specialist services included within the planning framework. • PCB/ICB Clinical Strategy Configuration Events held in August and November 2023 with further work planned in 2024	• Services being compliant with the service specification ***(SPEC 002)***	**Internal** • Speciality Boards • Divisional Governance Structures and Arrangements • Divisional Improvement Forums • Safety and Quality Committee • Finance and Performance Committee • Strengthened updates to Board and Audit Committee regarding Specialised Services risk **External** • Scheduled contractual reviews with Specialised Commissioners including Executive Management Team forums to progress and resolve issues. • New Hospitals Programme Oversight Group • ICS and ICB system delivery Boards	• None documented.

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
SPEC 001	Link LTHTR and ICB Clinical strategies with PCB Clinical Strategy	Chief Medical Officer	30th September 2023	25th September 2023	Complete	Control	• Integration of services and pathway and effective Place and system-based working • PCB clinical strategy still in development
SPEC 002	Agree interim and longer term plan for reconfiguration of specialised services across Lancashire and South Cumbria, aligned to the New Hospitals Programme.	Chief Medical Officer	30th September 2024		Ongoing	Control	• Services being compliant with the service specification

Updates to risk – May 2024

- Following review in March 2024 and discussions at Board Workshop on 14th May 2024 where proposal to control the risk were made, the content of the risk currently does not require any further updates.

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

Risk ID: 860
Risk owner: Chief People Officer (with input from Deputy Director of Education and Deputy Director of Research & Innovation)
Date last reviewed: 28th March 2024

Risk

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

Risk Appetite:

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

Risk Tolerance

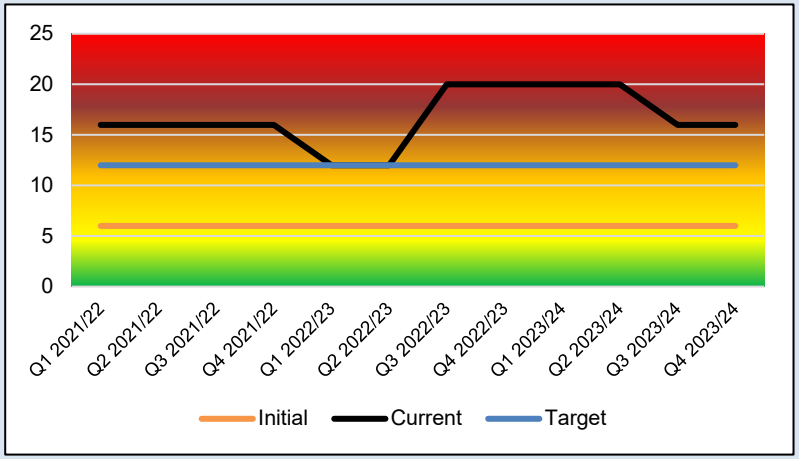
9-12

Rationale for Current Score

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

Risk Rating Tracker (Likelihood x Consequence)

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



Future Risks

- NHSE Long Term Workforce Plan will impact education and training pathways for new and emerging roles.
- Potential impact of new NHS Education Funding Agreement that will replace the NHS Education Contract in April 2024
- Potential impact of OneLSC on Education and Training provision at LTH.
- Capacity for effective marketing and communications.
- Potential impact of the New Hospitals Programme on Education and Research estate.
- Impact of the increased allowance for simulated placements for nursing students delivered by HEIs – this could result in a reduction in NMET tariff income.
- Impact of place-based placement allocation systems (currently emerging) – this could result in a reduction in NMET tariff income.
- UK becoming less competitive/losing commercial research trials
- Impact of UGME capacity scoping exercise being undertaken by HEE

Future Opportunities

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

	• Potential income deficit position for education as a result of tariff changes and audit requirements for income deferral • Innovation opportunities may be stifled due to reluctance to accept in-year funding developments where income cannot be flexibly utilised across multiple financial years • Potential impact of shared service development across ICS • Potential reduction in CPD/Workforce Development funding and/or potential bid income.	• O'Shaughnessy Report (2023) encourages more active prioritisation of commercial work which will assist commercial and financial growth

Controls	Gaps in Control	Assurances	Gaps in Assurances

• Workstream related strategies in place:
  ○ Education & Training Strategy
  ○ Research Strategy
  ○ Our Big Plan, Annual Business Plan Planning framework
  ○ Workforce & OD Strategy
• Ring-fencing of education and research funding.
• Divisional education contracts.
• NHS Education Contract.
• Policies in place with review cycle.
• Business continuity plans in place.
• Head of R&I now part of New Hospitals Programme and ICB programme working parties.
• Enhanced plans identified within Research & Innovation Strategy to leverage more opportunity to increase funding and assist recovery processes
• Full review of deferred income has been conducted by finance evidencing and ensuring drawdown of income from deferred position/reserves is matched in line with expenditure and the Education Contract on an ongoing basis
• Categorised investment requirements for education infrastructure now in place, which is being worked through with Capital Investment Team
• International education programmes to be incorporated into 2024-27 strategy.
	• Lack of research leads embedded in divisions ***(ETR 007)***	**Internal**
		• Sub-committees for education, training and research incorporating risk reviews.
		• Quality assurance and performance management of education activity.
		• Strategy progress for Research and Education reviewed each year at ETR Committee.
		• Learner improvement forum.
		• Monthly training compliance reports.
		• Divisional performance reviews
		• Paper to include R&I involvement at DIFs and Divisional Boards has been drafted for approval by the CMO
		• Monthly finance reviews with corporate finance team and quarterly with R&I budget holders
		• Education, Training & Research Committee
		• Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system.
		• Board.
		
		External
		• NHSE Monitoring the Learning Environment review meetings.
		• Full OFSTED inspection completed August 2022 with 'Good' rating achieved.
		• ESFA audits
		• HEE self-assessment return.
		• Matrix accreditation.
		• Annual and interim performance reviews with Manchester Medical School
		• National Student Surveys.
		• National Education Trainee Surveys.
		• STAR accreditation for Clinical Research Facility.
		• Engagement in range of external forums and committees.
		• Quarterly strategy meetings with local HEIs
		• Trust Involvement/leadership in ICS discussions re education and R&I
			• [None identified]

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
ETR 001	Reset research provision to develop an affordable portfolio and refer to this in the refreshed Research and Innovation Strategy.	Head of Research & Innovation	30.04.23	30.04.23	Complete	Control	• Ongoing losses in research income which necessitate a recovery plan.
ETR 004	Include development of international education programmes post-Covid in Education and Training Strategy.	Deputy Director of Education	31.12.23	04.12.23	Complete	Control	• No mechanism to utilise educational income to support capital developments
ETR 005	Identify solutions to facilitate and support creation and delivery of a capital programme for education.	Chief Finance Officer, Associate Director of Education	30.07.23	25.07.23	Complete	Control	• No mechanism to utilise educational income to support capital developments • Ability to income generate in current economic climate
ETR 006	Identify a plan to mitigate identified risks associated with change in deferred income	Chief People Officer/Chief Finance Officer	30.04.23	30.04.23	Complete	Control	• Control of in-year adjustments relating to income deferral
ETR 007	Have Research roles in place within 2 Divisions – Suggested Medicine and Women's and Children's Divisions	Head of Research & Innovation	~~31.03.24~~ 31.03.25		Ongoing	Control	• Lack of research leads embedded in divisions.
~~DVFM 031~~	~~Refine approach to making risk based strategic decisions~~	~~Chief Nursing Officer~~	~~30.04.24~~		Stood Down	~~Assurance~~	• ~~Enhanced approach to risk-based decision making~~

Summary of Updates – March 2024

- Review of the risk carried out by Chief People Officer, Deputy Director of Education and Deputy Director of Research & Innovation. Updates made to the rationale for the score, future opportunities, risks and assurances.
- Updated ETR007 with details of the divisions and extended by 12 months to attempt to secure finances.
- Action DVFM031 relating to strategic decisioning criteria has been stepped down following discussion with the new Chief Executive. The Board of Directors' approach to utilisation of risk appetite and tolerance will form part of the planned review and refresh of the Board Assurance Framework (BAF). In the meantime, risks continue to be scored in line with the Risk Management Policy and any risk-based decisions will continue to be made in conjunction with the Risk Appetite statement and tolerances set by the Board of Directors.

Chair's Report to Board		
Chair: Non-Executive Directors Ms Kate Smyth - (March) Prof Paul O'Neill / Dr Tim Ballard - (April)	Safety and Quality Committee	
Date: 22 March 2024 & 26 April 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Consistently Deliver Excellent Care	→	• The recommendation of the formal de-escalation of risk id 1182 for the probability of ongoing strike action. • Bi-annual Safe Staffing Review for Nursing (April Board) • Bi-annual Maternity Safe Staffing Report (June Board)

ALERT

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

The outstanding implementation of adult and maternity safe staffing recommendations due to financial constraints. This item was subsequently discussed with the ICB and approved in April 2024.
The Committee received an update detailing the boarding practice across the organisation and the impact this was having on staff and patients. It is not yet clear what the plan is to reverse this practice. This observation and the report on boarding were referred to FPC for discussion and action.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

A cross committee referral to the Finance and Performance Committee to seek assurances on the plan to reverse the boarding practice.
A cross committee referral to the Finance and Performance Committee to review financial aspects of the Community Healthcare Hub report and the long term strategy for Finney House.
A cross committee referral to the Education, Training and Research Committee to discuss the unresolved CQC must and should do's relating to profession specific training metrics, with specific focus on the system supporting this and manual handling and life support training.

ASSURE

Assurance received; Matters of positive note.

The overall staffing fill rate for adult inpatient wards in February was 101%. Chorley District Hospital fill rate for February was 109%, with Royal Preston Hospital overall fill rate being 99%.
The Committee were assured with the outcome of the Bi-annual Maternity Safe Staffing Review.
The Committee Effectiveness Review was undertaken and suggestions around improving the way the committee captured patients stories, the staff voice and safety and quality related freedom to speak up matters were agreed to be enhanced in future committees.

Safety and Quality Committee

22 March 2024 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Information	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 23 February 2024	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.50pm	✓	Assurance	C Gregory
7.2	Bi-annual Adult and Children Safe Staffing Review	1.00pm	✓	Assurance	S Cullen
7.3	Maternity and Neonatal Report	1.10pm	✓	Assurance	S Cullen
7.4	Boarded Patient Deep Dive	1.30pm	✓	Assurance	C Gregory
7.5	Equality Quality Impact Assessment Report	1.40pm	✓	Assurance	Ian Ward
8.	GOVERNANCE AND COMPLIANCE				
8.1	Never Event Update	1.55pm	✓	Assurance	S Cullen
8.2	Strategic risk register review	2.10pm	✓	Decision	K Smyth
8.3	Items for referral to the Board or to/from other Committees	2.15pm	Verbal	Information	K Smyth
8.4	Reflections on the meeting and adherence to the Board Compact	2.20pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Terms of Reference: a) Ethics Committee b) Health and Safety Governance Group		✓		

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

Safety and Quality Committee

26 April 2024 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	P O'Neill
2.	Apologies for absence	12.31pm	Verbal	Information	P O'Neill
3.	Declaration of interests	12.32pm	Verbal	Information	P O'Neill
4.	Minutes of the previous meeting held on 22 March 2024	12.33pm	✓	Decision	P O'Neill
5.	Matters arising and action log a) FPC Referral	12.35pm	✓	Decision	P O'Neill S Cullen
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.50pm	✓	Assurance	C Gregory
7.2	Bi-annual Maternity Safe Staffing Report	1.00pm	✓	Assurance	J Lambert
7.3	Children and Young People Staffing Report	1.10pm	✓	Assurance	S Cullen
7.4	Always Safety First Strategy 2021-24	1.20pm	✓	Assurance	C Gregory
7.5	Finney House Review	1.30pm	✓	Assurance	A Kirkham
8.	GOVERNANCE AND COMPLIANCE				
8.1	Committee Effectiveness Review	1.40pm	✓	Assurance	J Foote
8.2	Strategic risk register review	2.10pm	✓	Decision	P O'Neill
8.3	Items for referral to the Board or to/from other Committees	2.15pm	Verbal	Information	P O'Neill
8.4	Reflections on the meeting and adherence to the Board Compact	2.20pm	✓	Assurance	P O'Neill
9.	ITEMS FOR INFORMATION				
9.1	Exception report from Divisional Improvement Forums		✓		

№	Item	Time	Encl.	Purpose	Presenter
9.2	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) Mortality and End of Life Care Committee d) PSIRF Oversight Group e) Always Safety First Learning and Improvement Group f) Medicines Governance Committee g) Patient Experience and Involvement h) Health and Safety Governance Group i) Health Inequalities Group – **no meeting**		✓		
9.3	Date, time and venue of next meeting: *31 May 2024, 12.30pm, Microsoft Teams*	2.25pm	Verbal	Information	P O'Neill

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Maternity and Neonatal Services Update

Report to:	Board of Directors	**Date:**	06 June 2024
Report of:	Chief Nursing Officer	**Prepared by:**	Jo Lambert
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

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

The perinatal quality surveillance outcomes (PQSO) tables continue to be split by indicator type to provide clarity of understanding of clinical outcomes and key safety intelligence across the continuum. Safe staffing, clinical indicators, perinatal quality experience, regulation and clinical escalation are detailed to provide both the specified minimum data set requirements and additional local level indicators required by NHS England.

The fill rates for Registered Midwives (RM) (88% day. 88% night) and Maternity Support Workers (MSW) (81% day and 94% night) in April 2024 demonstrates a continued sustained, lower than planned fill rate, which is reflected in the year-to-date projection and is synonymous with the established vacancies. The service has responded to establishment vacancies using workforce profiling and for the first time over offering to midwifery posts during key times in the recruitment calendar.

All shifts are sent to bank and the service continue to be supported to improve fill rates with agency shifts and an ongoing recruitment advert is out to reduce the 12.41 WTE vacancy. As part of the service response to the staffing establishment within the unit, divert arrangements are used when required when appropriate and whilst this mitigates the risk to women, when it occurs, it adversely affects the experience of women who live locally and have chosen to give birth in Lancashire and south Cumbria.

The service is recruiting to all posts funded by phase 1 of the Birthrate plus (BR +) following the agreement from the executive Board to fund the specialist and support worker elements. Phase 2 requirements continue to present a risk to the service, until a funding approach has been agreed. The additional uplift must be considered as part of the financial planning and the second bi-annual safe staffing review planned for October 2024.

The perinatal quality surveillance tables indicate an overall stable position with positive escalations related to 1:1 care and an improvement in BAPM nurse compliance. There were no moderate or severe harms, no CQC enquiries and no regulatory breaches and no maternity diverts. It is important to recognise that pressure is still

evident in the neonatal service with 2 intrauterine transfer declines and 5-unit closures associate with critical care activity.

Red flags associated with deferred community visits reflect the largest pressure points within the service. This is closely followed by delay in review in Triage and delays in induction. The trend in reporting is consistent and provides a reliable data point to indicate the areas of pressure within the service.

Recommendations

The Board of Directors are asked to:

I. Receive the Maternity and Neonatal Service update including safe staffing position.
II. Note the CNST update report and recommendations.
III. Receive the associated action plans for assurance.
IV. Note the ongoing workforce requirements across the perinatal continuum.

Appendices

1. Board Reporting criteria for year 6 Summary
2. Progress Tracker MBRRACE MIS 1
3. Neonatal Workforce Action Plan MIS 4
4. Training Compliance MIS 8
5. Safety Champions Tracker MIS 9
6. MNSI Tracker MIS 10 MNSI/HSIB CASE MIS 10 SUMMARY CNST MIS YEAR 6
7. Red Flags

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 May 2024

1. INTRODUCTION

The purpose of this report is to provide an overview of the safety and quality programmes of work and present the monthly staffing position within the maternity and neonatal services. The report also triangulates workforce information with safety, patient experience and clinical effectiveness indicators for Board assurance and oversight. The report details any immediate priorities or exceptions.

2. MATERNITY INCENTIVE SCHEME (MIS)

The Trust received formal notification from NHS Resolution on 23 March 2024 that its submission against Year 5 of the scheme had been externally verified. To date, the service has not yet received the award and cannot yet confirm the financial renumeration.

The updated NHS Resolutions Maternity Incentive Scheme (MIS) standards were published on 2 April 2024 and is now operating in the sixth year. The ten safety actions continue to drive standards for safer maternity and neonatal care under the remit of the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries by 50% before the end of 2025.

Boards have a broad scope of responsibility to provide strategic direction and oversight of maternity and neonatal services. As part of this remit it is essential that the pertinent priorities and exceptions are identified. Therefore, as part of the cycle of business, reports and associated action plans will continue to be presented periodically to the Safety and Quality Committee and the Board of Directors for oversight.

A summary of the position for CNST MIS year 6 regarding the attainment of all ten safety actions is detailed below. (Table 1). The service remains on track with 8/10 standards, with standard 4 and 5 declared as at risk due to the financial requirements associated with BR+ and British Association of Perinatal Medicine (BAPM) recommendations. The remaining 8 standards are on track, but achievement of all standards at the end of the reporting period is reliant on continued reporting and Board assurance being provided across Quarter 1, 2 and 3. The Board requirements are detailed in appendix 1 for information.

Table 1: Progress Tracker

Safety Action	Progress Update	RAG Rating
Safety Action 1 - PMRT	On track	
Safety Action 2 - MSDS	On track	
Safety Action 3 - ATAIN	On track	
Safety Action 4 – Clinical Workforce planning	At Risk	
Safety Action 5 – Midwifery workforce staffing	At Risk	
Safety Action 6 – SBLV3	On track	
Safety Action 7 – Maternity and Neonatal Voice Partnership (MNVP)	On track	
Safety Action 8 – Training Core Competency Framework	On track	
Safety Action 9 – Board Assurance	On track	
Safety Action 10 – MNSI (formally HSIB)	On track	

3. SAFETY ACTIONS UPDATE

SAFETY ACTION 1: ARE YOU USING THE NATIONAL PERINATAL MORTALITY REVIEW TOOL (PMRT) TO REVIEW PERINATAL DEATHS FROM 8 DECEMBER 2023 TO 30 NOVEMBER 2024 TO THE REQUIRED STANDARD? (• All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth).

To meet the requirements of standard 1, a quarterly report should be received by the Trust Executive Board each quarter from 2 April 2024 that includes details of the deaths reviewed from 8 December 2023, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards have been met. Details of deaths are included in the Maternity Serious Incident Report and as part of this paper.

Since 8th December 2023, there were 9 cases reported, 8 of which are eligible for PMRT review (Appendix 2). All cases were notified to MBRRACE-UK within seven working days and surveillance completed within one calendar month of the death. The service is on track to meet the defined thresholds for multi-disciplinary reviews using the PMRT, where 95% are started within two months of the death, and a minimum of 60% of multi-disciplinary reviews are completed and published within six months. Table 2 details the current position for all perinatal mortality reviews.

Table 2: Perinatal Mortality Tool progress tracker

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

***Exclusions:** If the surveillance form needs to the assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts,

should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.

SAFETY ACTION 2: ARE YOU SUBMITTING DATA TO THE MATERNITY SERVICES DATA SET (MSDS) TO THE REQUIRED STANDARD?

Standard 2 relates to quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. Trust Boards must assure themselves that at least 10 out of 11 MSDS Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024.

The service continues to consistently achieve 11 out of 11 CQIMs and data integration continues to be undertaken and monitored monthly.

SAFETY ACTION 3: CAN YOU DEMONSTRATE THAT YOU HAVE TRANSITIONAL CARE SERVICES IN PLACE AND UNDERTAKE A QUALITY IMPROVEMENT TO MINIMISE SEPARATION OF PARENTS AND THEIR BABIES?

Pathways of care into transitional care and Avoiding Term admissions to the neonatal unit (ATAIN) continue to be prioritised, jointly agreed, and monitored by the maternity and neonatal teams and guidance is in place which supports a care pathway from 34+0 in alignment with the BAPM Transitional Care (TC) Framework for Practice.

In addition, the division continues to track performance and monitor outcomes for babies requiring neonatal admission or transitional care. The TC and ATAIN reports, and improvement action plans continue to be shared with LMNS and ICB Quality Assurance Panel for oversight of the pathway. Analysis from trend data will be used to define a Quality Improvement (QI) initiative to reduce separation and a project will be commenced within the reporting period. An update to the committee will be provided in due course as to the direction of improvements is defined and agreed.

SAFETY ACTION 4: CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF CLINICAL WORKFORCE PLANNING TO THE REQUIRED STANDARD?

a) Obstetric medical workforce

Provider Boards are accountable for ensuring the fundamental quality standards are delivered, including having the appropriate workforce to deliver safe care. To meet the standard requirements for the obstetric medical workforce, regular audits and reviews are undertaken to provide assurance. These are detailed in table 3.

Table 3 MIS Year 6 requirements for obstetric medical staffing.

REQUIRED STANDARD OBSTETRIC MEDICAL	PROGRESS	EVIDENCE
NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota.	On Track	Checked on employment by CD. 6 monthly Audit. Held on MS Team Channel
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with	On Track	Checked on employment by CD. 6 monthly Audit. Held on MS Team Channel

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

Obstetric workforce planning is in progress and to meet 96.5 hours a minimum of 1 further consultant is required. The action plan is ongoing has been shared in previous iterations of this report and will be re-shared in due course.

b) Anaesthetic medical workforce

To comply with the anaesthetic medical workforce requirements associated with CNST year 6, a copy of the anaesthetic rota for all months during the reporting period is held as evidence for monitoring purposes by the service, confirming that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day. To date the service is 100% compliant with this standard.

c) Neonatal medical workforce

The Trust is required to formally record in Trust Board minutes whether it meets the relevant British Association of Perinatal Medicine (BAPM) recommendations for the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.

The most recent local workforce review of the neonatal medical staffing requirement to achieve BAPM standards identified that the Trust is not yet complaint with BAPM standards for neonatal medical workforce and the current

position is detailed in table 4. Work is ongoing to recruit to the tier 1 and 2 rotas via the ORDER programme and 2 further consultant post are required to meet a 1 in 8 BAPM recommendation. A business case is underway to support the requirements for consultants and an action plan has been continued from the year 5 MIS. (Appendix 3).

Table 4 Neonatal Medical Workforce Requirements to meet BAPM standards.

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

d) Neonatal nursing workforce

The Trust is required to formally record in the Trust Board minutes compliance to BAPM nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.

The Northwest Neonatal Network monitor staffing levels against BAPM standards using the Clinical Reference Group neonatal nurse calculator. Compliance with the standard was last presented within the Activity Capacity Demand (ACD) report in the 2022/23 reporting period. Compliance to the BAPM standard was achieved based on the average activity for the previous 3 years. This report confirmed and provided assurance that the current establishment meets the requirement for BAPM nurse staffing, and no further action is required. The report (2023-2024) is awaited and will detail the updated position and any associated actions dependent on the outcome.

SAFETY ACTION 5: CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF MIDWIFERY WORKFORCE PLANNING TO THE REQUIRED STANDARD?

In line with the Ockenden report and the Three-Year Delivery Plan for Maternity and Neonatal services (March 2023) Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate Plus (BR+). In addition, regular workforce planning reviews must detail the agreed plan, including timescale for achieving the appropriate uplift in funded establishment and include mitigation to cover any shortfalls. They should do this as soon as possible no later than by 2027/2028.

The latest BR+ assessment undertaken in 2022, recommended that the service required 190.10 WTE. To align the workforce to a 90/10 skill mix split for postnatal and community work, 171.09 WTE Registered Midwives and 19.01WTE Midwifery Support Workers (MSW) are required. Specifically, 16.67 WTE registered midwives, 5.93 WTE Midwifery Support Workers and 5.53 WTE Health Care Assistants (HCA) would be needed at a total cost of £1,576,043.

In April 2024, phase 1 of the overall requirement was funded at a cost of £487,794. A further 14.36 WTE midwives is still required to meet the full requirements. Table 5 details the requirements in phase 2. A plan to meet the required uplift will be requested as part of the second bi-annual staffing report of 2024 and will require consideration in early 2024/2025.

Table 5 Phased approach to achievement of BR+

Phase 1 April 2024 APPROVED	WTE required	Costs
MSW (Band 3)	4.6 (already funded) +1.33	£62,533
HCA (Band 2)	5.53	£248,358
Specialist Midwives (Band 7) (Mon-Fri 9-5)	2.31	£176,903
Total		**£487,794**
Phase 2 October 2024 OUTSTANDING	**WTE required**	**Costs**
Midwives (Band 6)	10.16	£770,480
Staffing uplift of 25% for midwives (Band 6)	4.20	£317,769
Total		£1,088,249

BR + advises that any additional specialist workforce should equate to approximately 10% of the funded clinical midwifery establishment to support for the provision of a safe service. The service has 19.01 WTE and meets the 90/10 requirements.

Table 6 Specialist Midwife Ratio's in current establishment and recommended by BR+ 2022.

Birth Rate Plus Recommendation (10%) 2022	Funded
19.01	19.01

Registered Midwifery fill rate is 88% in the day 88% at night and the fill rates continue to be monitored monthly. As part of responding to the continued reduced staffing establishment within the unit, attendance at the daily huddles and LMNS staffing calls support continued oversight of the ongoing pressures. Divert arrangements are utilised when appropriate to do so and whilst this mitigates the risk to women, when it occurs, it can adversely affect the experience of women who live locally and are required to access care with an alternative provider within Lancashire and south Cumbria.

As a service and Trust, it is essential that systematic evidence-based workforce planning is undertaken to assess the total multiprofessional staffing requirements (number and skill mix) for their maternity services. This includes understanding the profile of the workforce and acting in response to the findings, particularly when there are national shortfalls in availability of qualified midwives. In planning for a sustainable model of recruitment, it is essential that alternative approaches are considered.

For the first time, over offering of midwife posts has been agreed to provide a flexible workforce solution to meet demand, which if successful will significantly reduce the requirement for bank and agency spend, whilst also avoiding recruitment costs associated with repeated recruitment. A paper detailing the workforce, maternity leave and leaver rates profiling has been approved by the executive team and over offering post by 5 WTE has been enacted. Other mitigations are included in table 7.

Table 7 Mitigating Actions to support safe staffing.

Mitigating Actions		
Recruitment and retention	Escalation and oversight	System Support
Concurrent advert to all midwifery vacancies	All shifts sent to bank and agency override in place across service.	Established regional escalation policy
Specialist clinical posts available	Matron of the Day (Monday to Friday)	Daily LMNS Gold System provider call (Mutual Aid as required)
Over offer of 5 WTE during April to September 2024	RED Flag oversight	
Preceptorship Lead midwife in post	Safety Huddles	

SAFETY ACTION 6: CAN YOU DEMONSTRATE THAT YOU ARE ON TRACK TO ACHIEVE COMPLIANCE WITH ALL ELEMENTS OF THE SAVING BABIES' LIVES CARE BUNDLE VERSION THREE (SBLV3)?

As previously discussed with the Board of Directors the SBLCBv3 standards are incorporated within the NHS Resolutions MIS, and minimum and stretch targets must be achieved to be fully compliant.

Currently, the service can evidence an unverified 90% compliance and a verified percentage of 86 against all six elements of the care bundle. The quarterly assurance meetings will continue with the LMNS/ ICB, with the revalidation being next undertaken in June 2024. Table 8 details the progress against each element. It is expected that the quality leads will verify the additional evidence to meet over 90%.

Table 8 Current compliance to SBLV3

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	60%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	93%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	90%	Partially implemented	86%	CNST Met

SAFETY ACTION 7: LISTEN TO WOMEN, PARENTS AND FAMILIES USING MATERNITY AND NEONATAL SERVICES AND COPRODUCE SERVICES WITH USERS.

The Maternity and Neonatal Voices Partnership (MNVP) and the maternity and neonatal services continue to work on the priorities defined within the joint work plan into 2024. The productive partnership between the maternity and neonatal service and the MNVP continues to yield important experience intelligence for service users and staff alike. Listening to families and using this intelligence to influence provider decision-making is

key. Themes from the CQC maternity survey, local stakeholder engagement events and national priorities have been used to update the joint work plan to ensure that care continues to be co-produced. Events undertaken over the last few months have included enter and view visits, walk the patch sessions and a 15 steps assessment. The findings of the reports will be shared in due course and are an important part of understanding the mile deep needs of services users. The MNVP lead also attends safety champions and speciality safety and quality committee's for both maternity and neonatal services and this provides a wider balance and experience perspectives to the safety agenda.

SAFETY ACTION 8: CAN YOU EVIDENCE THE FOLLOWING 3 ELEMENTS OF LOCAL TRAINING PLANS AND 'IN-HOUSE', ONE DAY MULTI PROFESSIONAL TRAINING?

The service confirms that the full Training Needs Analysis (TNA) standards continue to be fully aligned with version 2 of the Core Competency Framework (CCF) and the programme of training has been shared with the Divisional Safety Champions and MNVP lead. Specifically, the service must confirm that 90% of attendance in each relevant staff group have attended fetal monitoring training, multi-professional maternity emergencies training and Newborn basic life support training over a 12-month period.

A slight reduction in compliance has been demonstrated with the Obstetric trainee group. This is related to cyclical rotation of doctors and the intake of a new cohort. This was expected and all new colleagues have been booked onto the training programme in the next month. A breakdown of the compliance is included in appendix 4.

It should be noted that the additional training requirements, detailed in the updated CCF V2 has increased the training burden on the service. The additional study day was anticipated and has been included in the BR + phase 2 request. This translates to an uplift from 23% to 25% and 4.2 WTE midwives.

SAFETY ACTION 9: CAN YOU DEMONSTRATE THAT THERE IS CLEAR OVERSIGHT IN PLACE TO PROVIDE ASSURANCE TO THE BOARD ON MATERNITY AND NEONATAL, SAFETY AND QUALITY ISSUES?

The expectation of the Trust Board is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; complaints triangulation: minimum staffing in maternity services and training compliance are continuing to take place monthly.

Analysis of the Perinatal Quality Surveillance Table (PQST) (Tables A-E) is provided in part 2 of the paper to ensure that clinical quality is reviewed regularly, and appropriate check and challenge is undertaken support by the insights provided by the board-level perinatal safety champions. The safety champions bi-monthly meetings and monthly safety walk rounds provide valuable, first-hand source of safety intelligence that is used to consider when actions or response is required so that executive members can appraise the Trust Board and prompt actions.

In April 2024 the maternity and neonatal services undertook the SCORE survey as part of the Perinatal Culture and Leadership Programme which is aligned to NHS Resolutions MIS. The findings from the survey are being analysed and QUAD coaching sessions designed to enable each team to interrogate the data and collate a culture plan begin in May 2024. The agreed actions will be incorporated into the Divisional cultural improvement plan in due course with a board update as required.

SAFETY ACTION 10: HAVE YOU REPORTED 100% OF QUALIFYING CASES TO MATERNITY AND NEWBORN SAFETY INVESTIGATIONS (MNSI) PROGRAMME AND TO NHS RESOLUTION'S EARLY NOTIFICATION (EN) SCHEME FROM 8 DECEMBER 2023 TO 30 NOVEMBER 2024?

In line with national reporting recommendations, details of all MNSI referrals are included in this report to enable the committee to triangulate incidents with safety outcome data and for oversight. Appendix 7 details the MNSI investigations referred by the Trust since December 2023. The service confirms that it has reported all qualifying cases to HSIB reporting 100% compliance to the standard. It also confirms that it complies with Regulation 20 of the Health and Social Care Act 2008 in relation to appropriate and timely Duty of Candour (DOC).

THE PERINATAL QUALITY SURVIELLENCE DASHBOARD- PART 2

Maternity staffing metrics are displayed on the perinatal quality surveillance table (PQST) each month as part of the safe staffing report submitted to Safety and Quality Committee for oversight which is also shared with the Executive Trust Board.

In determining safe staffing requirements, services should hold a helicopter view of safety data and intelligence which must be used as an early warning system or a call to action for safety critical staffing decisions. Approaches to determining appropriate staffing levels in maternity services must be flexible and use the full range of intelligence to include Maternity and Newborn Safety Investigations (NMSI), CQC enquiry, thematic learning from Patient Safety Incident Response Framework (PSIRF), the national Perinatal Mortality Review Tool (PMRT), low, moderate harm incidents, safe staffing fill rates for midwifery and obstetric acute cover, coronal regulation 28 cases and safety champion's oversight. The PQST tracks performance over time in relation to key safety indicators. (Table A-E)

Table A Clinical Safety Indicators April 2023 to March 2024

Metric	Red flag		Green flag		May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
CNST 10 Key safety actions (Year 5 scheme)					100%	40%	40%	60%	60%	80%	90%	100%	100%	100%	100%	On track
CQC Rating Overall					Good	Good	Good	Good	Good	Good	RI	RI	RI	RI	RI	RI
Births					339	371	362	369	352	344	327	315	377	334	333	349
Total stillbirths represented as a number. New Dec 23											3	1	0	0	1	3
Total stillbirth rate (per 1,000 births)	>	4.9	≤	4.9	2.9	0.0	2.8	5.4	2.8	2.9	9.2	3.2	0	0	3.0	8.6
Stillbirth rate excluding termination for fetal abnormality					2.9	0.0	2.8	5.4	2.8	2.9	9.2	3.2	0	0	3.0	8.6
Neonatal Death within 7 days New															2	0
Examination of the newborn completed within 72 hours	<	95%	≥	95%	96.2%	95.7%	96.7%	96.5%	92.6%	95.1%	93.5%	95.2%	95.8%	96.4%	95.8%	95.1%
Breastfeeding initiation	<	70%	≥	70%	76.3%	77.6%	79.8%	77.9%	76.1%	78.4%	74.7%	80.3%	76.4%	77.8%	81.6%	79.8%
Booked by 9+6	<	50%	≥	50%	51.5%	51.3%+	47.4%	48%	30.3%	32.5%	35.1%	52%	48.4%	55.6%	55.2%	50.4%
Booked by 12+6	<	90%	≥	90%	92.7%	90.3%	48%	85.5%	81.5%	83.1%	87.3%	92.3%	90.3%	90.2%	89.9%	90.7%
Women giving birth in a midwife-led setting	<				14.2%	15.8%	15.2%	14.2%	12.5%	14.8%	16.3%	11.9%	14.4%	12.8%	17.2%	17.6%
Home birth	<				3.2%	2.4%	2.5%	3.3%	2.3%	2.9%	3.7%	1.6%	1.6%	2.1%	2.7%	3.4%

Incidence of severe tears grade 3 and above	≥	2.4 %	<	2.4%	1.5%	2.7%	2.6%	1.8%	2.9%	3.0%	4.6%	1.1%	4.0%	2.1%	4.5%	3.7%

Table A (i) incident breakdown Stillbirths

Classification	Narrative and Action
Stillbirth	33 weeks gestation multiple pregnancy. Known complex congenital anomaly with one twin and had had feticide at St Mary's hospital Manchester in the preceding 48 hours. Admitted feeling generally unwell and antenatally diagnosed fetal death in-utero was confirmed. Labour induced and both babies born with no signs of life. Blood cultures later confirmed maternal staphylococcus aureus *(MSSA).* An after-action review has been undertaken and PMRT investigation is ongoing. St Mary's hospital Manchester is aware of the outcome and will be involved in the PMRT review.
Stillbirth	26+3 weeks gestation known isolated exomphalos with otherwise normal anatomy and declined amniocentesis. Admitted to the emergency department with severe abdominal pain and transferred to the delivery suite. Fetal heart could not be heard on transfer to the delivery suite and an antenatally diagnosed fetal death in-utero was confirmed. Labour progressed rapidly and a stillborn infant was born. An after-action review has been undertaken and PMRT investigation is ongoing.

Table B Perinatal Quality Experience and Regulation April 2023-March 2024 (MIS Standard 9)

Metric	Red flag	Green flag	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
Incidents of moderate harm and above	--	--	0	3	0	3	2	3	6	3	1	2	4	0
Maternity and Newborn Safety Investigations Programme (Formally HSIB referrals opened.	--	--	0	0	0	0	2	2	1	0	1	1	1	0
Complaints	--	--	2	2	1	2	2	3	3	1	2	2	1	1
Prevention of future deaths regulation 28	--	--	0	0	0	0	0	0	0	0	0	0	0	0
CQC Enquiries	--	--	0	0	0	0	0	2	1	0	0	0	0	0
Maternal Death	> 1	<1	2	0	0	0	0	0	0	0	0	0	0	0

Table B incidents breakdown MNSI

NMSI Classification	Narrative and Action
Closed MI-35266 Term neonatal death.	The mother was seen in maternity assessment suite at term with vaginal bleeding and irregular uterine activity. Following spontaneous rupture of membranes, significant antepartum haemorrhage occurred. Transferred to theatre for emergency caesarean section. Baby born in poor condition, resuscitated and transferred to NICU. Cooling commenced; however, decision made to stop cooling and reorientate care to palliative. Baby died shortly after the reorientation of care.

	MNSI issued no safety recommendations as the findings from the analysis of the information shared with MNSI during the investigation did not contribute to the outcome.
Closed MI-32957 Therapeutic cooling in a term infant.	Spontaneous onset of labour, admitted to birth centre. Progressed to normal birth, baby born in poor condition. Resuscitated and transferred to the neonatal unit for therapeutic cooling. Post cooling MRI showed moderate to severe HIE. **MNSI issued the Trust one safety recommendation, to ensure that staff are supported to complete a full holistic risk assessment when a mother attends any birth setting in labour. A full action plan has been developed in response to the incident and the completion of the action plan is being monitored by the maternity safety and quality committee.**

Table C Safe Staffing April 2023-March 2024 (MIS Standard 5)

Metric	Red flag	Green flag	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
One-to-one care in labour in Delivery Suite.	< 100 %	= 100%	97.6%	100%	100%	100%	99.5%	100%	100%	100%	100%	100%	100%	100%
One-to-one care in labour in Preston Birth Centre	< 95%	= 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
One-to-one care in labour in Chorley Birth Centre	< 95%	= 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
HDU trained per shift.	< 89%	= 90%	99.57%	99.57%	100%	100%	98%	98%	98%	97%	100%	100%	99%	97%
Supernumerary status of DS coordinator	< 95%	= 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Births per Funded Clinical Midwife WTE	>28	≤26	23	24	26	25	24	23	23	21	25	24	22	24
Neonatal Nurse Staffing compliance to BAPM (Badger Net report)	<90%	>90%			90%	98%	65%	69%	93%	77%	97%	74%	47%	91.6%
Unable to provide Transitional care Nurse NEW*													5	3
Staff sickness rate	4%	4%	8.47%	8.6%	8.7%	8.8%	8.6%	9.0%	9.2%	6.9%	6.3%	5.9%	4.1%	5.9%
Fill rate RM Day	<85%	>85%	NA	93%	95%	91%	74%	79%	84%	84%	87%	86%	86%	88%
Fill rate MSW Day	<85%	>85%	NA	93%	90%	86%	76%	74%	79%	71%	77%	75%	80%	81%
Fill rate RM Night	<85%	>85%	92%	90%	84%	82%	82%	81%	87%	87%	89%	87%	88%	88%
Fill rate MSW Night	<85%	>85%	94%	89%	91%	100%	94%	98%	100%	98%	98%	95%	94%	94%
Registered Midwife shifts sent to agency per month.	--	--	110	110	127	127	146	146	151	152	121	142	155	119
Registered Midwife Agency hour fill rate percentage.	--	--	46%	45%	39%	49%	42%	42%	52%	51%	64%	54%	57%	60%
Maternity Triage BSOT standard (15min)			90%	91%	93%	89%	91%	92.4%	89.4%	94.6%	89%	93%	87%	87.5%
Maternity Triage NICE standard (30 min)			98%	98%	98%	98%	97%	97%	97%	100%	95.7%	99%	92.5 %	93.5%

Table D Obstetric Medical Staffing April 23- March 2024 MIS Standard 4

Metric	Red flag	Green flag	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
Number of Consultant hours on obstetric unit	<70 hrs	=/> 96.5hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs
RCOG obstetric benchmarking compliance	<100%	100%	100%	100%	91%	100%	100%	100%	91%	98.4%	100%	100%	100%	100%
24-hour acute obstetric medical staffing fill rate	<95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table E Clinical Escalation April 23- March 2024

Metric	Red flag	Green flag	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	March 24	Apr 24
Maternity Diverts	> 1	<1	0	0	1	0	2	0	0	0	0	0	0	0
Women who transfer to an alternative provider during induction of labour (New Jan 24) Internal mutual aid.	--	--										2	4	0
In- utero transfers declined to accept from other units (maternity)	--	--	2	5	4	5	5	5	3	2	2	2	0	0
In- utero transfers declined to accept from other units (NICU)	--	--	1	1	2	0	4	10	4	4	3	2	0	2
In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal)	--	--	10	0	0	1	1	0	0	0	0	2	0	0
NICU Closure	> 1	<1	13	1	1	0	1	2	0	2	1	6	5	5

EXCEPTIONS

STILLBIRTH

The stillbirth rate continues to be monitored monthly by maternity Safety and Quality Committee. In April 2024 the stillbirth rate was 8.6 per 1000 births. As detailed above this was 3 babies but included one twin multiple so equated to 2 cases overall. In the case of multiple birth one of the babies had feticide at St Mary's hospital Manchester in the preceding 48 hours. Admitted feeling generally unwell and antenatally diagnosed fetal death in-utero was confirmed. Labour induced and both babies born with no signs of life. This can be a complication of the procedure. Blood cultures later confirmed maternal staphylococcus aureus *(MSSA).* All cases are reviewed locally for immediate learning and as part of the PMRT process and trends will continue to be monitored.

INTRAUTERINE TRANSFER (IUT) NEONATAL AND MATERNITY

The service continues to collect data related to inability to accept intrauterine transfers (IUT). To provide wider triangulation of the operational pressures on the maternity and neonatal service, the maternity specific safety and quality matrix includes a separate breakdown of all IUTs declined by maternity and those declined by the neonatal unit. In total the number of IUTs declined by the maternity and neonatal service was 2 because of neonatal service capacity or staffing. None were declined by the maternity service.

SICKNESS ABSENCE

Sickness absence has seen a small increase in month from 4.1% to 5.9%. Work continues to ensure close scrutiny of long-term absence and monthly review of cases with workforce teams continue.

CLOSURES OR DIVERTS

In the month of April 2024 there were no maternity diverts however, there were five instances of neonatal unit closure. Closures were related to critical care cot activity and not BAPM nurse staffing.

DELAYS IN INDUCTION OF LABOUR

To demonstrate the ongoing impact of established vacancies, the uptake of mutual aid during the induction of labour process is included in table E. During times of high acuity, women who require induction or who are being induced but are delayed, are offered transfer to alternative providers for augmentation of labour. Whilst mutual aid is part of the North West clinical escalation policy and is usually facilitated within the Lancashire and South Cumbria region, the impact of transfer should not be underestimated. In April 2024 no women transferred their care because of reduced midwifery staffing.

RED FLAGS

The incidence of maternity red flags continues to be monitored by the maternity service. In addition, the red flags are added to the associated risks on the register for additional oversight by the Division. The service reported 207 maternity red flag Datix incidents in the month of April 2024. The breakdown by category is provided in appendix 7. The highest number of red flags was reported in the category of deferred and rearranged planned consultations in midwifery led services, there were no maternity red flag incidents associated with harm. Increased maternity red flag incident reporting was observed in April 2024, this is attributed to changes which were made to the maternity morning safety huddle where discussion of incidents and responsive reporting was added to the matron's daily safety huddle template. This new process has encouraged live reporting of safe staffing red flags each day.

4. CONCLUSION

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

The perinatal quality surveillance dashboard indicates some areas that require close monitoring. Specifically, the red flag reporting also indicates pressure points in the induction of labour pathway, postnatal care and timely review in triage and this must be acknowledged. Workforce requirements across the perinatal continuum require further consideration as part of the 2024/25 planning round.

5. RECOMMENDATIONS

The Board of Directors are asked to:

I. Receive the Maternity and Neonatal Service Update including safe staffing position

II. Note the CNST update report and recommendations.

III. Receive the associated action plans for assurance.

IV. Note the ongoing workforce requirements across the perinatal continuum.

Appendix 1 Board Reporting Criteria for MIS Year 6

	Requirement		Completed	Evidence Source
SA1	A quarterly report should be received by the Trust Executive Board each quarter from 2 April 2024 that includes details of the deaths reviewed from 8 December 2023, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards have been met.	Q1	Yes	May 2024
		Q2	No	Planned
		Q3 (third report may fall outside MIS reporting period)		
SA3	If not already in place, an action plan should be signed off by Trust and LMNS Board for a move towards the transitional care pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	By 30/11/24	Yes	MIS Year 5
SA4	Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance with Trust Board, Trust Board level safety champions and at LMNS meetings.	By 30/11/24	Yes	MIS Year 5
	Trust positions with compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' should be shared with Trust Boards	By 30/11/24	Yes	MIS Year 4
	The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	By 30/11/24	Yes	Bi annual staffing and Maternity Neonatal report
	The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.	By 30/11/24	Yes	Bi annual staffing and Maternity Neonatal report

	Requirement		Completed	Evidence Source
SA5	A midwifery staffing oversight report that covers staffing/safety issues should be received by the Trust Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.	Q1 & Q2	Yes	Quarter 1 April 24 Bi-annual Staffing Report
			Planned	Quarter 2 Planned October 2024
		Q3 & Q4 (second report may fall outside MIS reporting period)		
	In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	By 30/11/24	Yes	April Bi-annual Staffing Report and Maternity and Neonatal Report
SA6	Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.	By 30/11/24	Required	
SA9	Evidence that a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)	By 30/11/24	Yes	In place JD

	Requirement		Completed	Evidence Source
	Evidence that a monthly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set. This should be presented by a member of the perinatal leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	By 30/11/24	Yes	Safe Staffing Report, Maternity and Neonatal Board Report
	Evidence that in addition to the monthly Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.	Q1	Yes	Safety Champions Meeting Directorate Safety and Quality.
		Q2	Planned	
		Q3 (third report may fall outside MIS reporting period)	Planned	
	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Apr/May	Yes	
		Jun/Jul	Planned	

	Requirement		Completed	Evidence Source
		Aug/Sep	Planned	
		Oct/Nov	Planned	
	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	By 30/11/24	Yes	Maternity and Neonatal Report
	Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of bi-monthly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 3 meetings held in the MIS reporting period.	Q1	Yes	Maternity and |Neonatal QUAD Meeting
		Q2	No	Planned
		Q3	No	Planned
SA10	Trust Board must have sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	By 30/11/24	Yes	Maternity and Neonatal Report
	Trust Board must have sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme.	By 30/11/24	Yes	Maternity and Neonatal Report
	Trust Board must have sight of evidence of compliance with the statutory duty of candour.	By 30/11/24	Yes	Maternity and Neonatal Report

Appendix 2 PMRT MIS 1 Tracker CNST Year 6

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

APPENDIX 3 Neonatal Medical Workforce Action Plan

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	Neonatal Medical workforce review	Local review of neonatal medical workforce to benchmark current establishment against BAPM standard.	Clinical Director for Neonatal Divisional Director	30/10/2023	07/09/2023 Workforce review of WTE medical neonatal workforce per tier groups undertaken to identify further funded establishment required to meet 1:8 ratios for safe neonatal staffing based on BAPM recommendations	**3**
					12/09/2023 Paper to be collated to detail the gap analysis and funded establishment required to meet 1:8 ratio for safe neonatal staffing based on BAPM recommendations.	**4**
1	Tier 1 (ST1-3) does not currently meet BAPM standards of 1 in 8 rota requirements. Currently achieving 1:7	2 ANNP's in training. Planned to integrate into tier 1 rota by July 2023	Clinical Director for Neonatal services	~~05/02/2023~~ ~~05/02/2024~~ 05/12/2024	**Action carried over from year 4.** 8/09/23: ANNP completed training and now integrated into the Tier 1 rota. There are plans to review current staffing to transition to 1 in 8 rota.	**4**
					18/05/24 Ongoing discussions with medical staffing and rota coordinators to transition Tier 1 rota to 1 in 8 from September 2024	**2**
2	Funding: Tier 2 (ST4-8) does not currently meet BAPM standards, 1 in 8 rota requirements.	ANNP's to be integrated into medical rota to support Tier 2 rota as non-medical (8b)	Clinical Director for Neonatal services	~~05/2/2023~~ ~~01/12/2023~~ 05/12/2024	15/11/22 Paper planned for Divisional Board in December 22 to move ANNP's with appropriate competencies onto middle grade rota. 08/09/23 -ANNP transitioned to Tier 2 rota on 3rd April 2023. Currently rota does not meet BAPM compliance until further	**2**

	Currently achieving 1:7				recruitment of 2 posts to Tier 2. 1 post out to recruitment Via ORDER program. 18/05/24 -2 posts recruited via ORDER program. One currently in post and another post to commence in July 24. On going discussions to transition Tier 2 rota to 1 in 8 from September 2024. A 4th ANNP at 8b to support Tier 2 from the previous business case to be incorporated into budget through business case.	
3	Recruitment Maternity leave back fill	To recruit 2 senior clinical fellow to replace specialty doctors (on maternity leave)	Clinical Director for Neonatal services	01/09/2022	23/2/22 Recruited 1 senior clinical fellows and 1 Medical Training Initiative MTI to replace specialty doctors who are on maternity leave.	**4**
	Expansion of workforce Consultant's rota does not currently meet BAPM standards 1 in 8 requirements (Based on the birth-rate and admission to NICU) Currently achieving 1:7	To prepare business case for 2 additional consultants to support Tier 2 and Tier 3 rota and enable expansion of Tier 2 and Tier 3 cover to achieve (1 in 7 rota)	Raju Narasimhan	30/06/2020	Business case for 2 additional resident consultants approved July 2020.	**4**
		Recruited to 2 WTE consultant posts as above following approval of business case	Raju Narasimhan	01/09/2024	1/5/22 All post now recruited. (This facilitated a move from 1 in 6 to 1 in 7)	**4**

6	Expansion of workforce Consultant's rota does not currently meet BAPM standards 1 in 8 requirements (Based on the birth-rate and admission to NICU)	To prepare a business case to recruit 2 additional consultants to move Tier 3 rota to 1 in 8 and become BAPM compliant	Clinical Director Neonatal services/ Divisional Director	~~31/04/2024~~ 31/03/2025	07/09/2023 Business case being collated to fund 2 additional consultants to align neonatal consultant staffing to BAPM recommendations. 18/05/24 There are delays for the business case for two additional consultants in view of the current Trust financial position. It is expected that the business case will be collated from Dec 2024 once Tier 1 & 2 rotas have transitioned to 1 in 8.	**2**
		Report and escalate workforce gaps to the Executive Board and agree a plan to meet BAPM.	Divisional Midwifery and Nursing Director	~~31/03/2025~~ 30/06/24	18/05/24. BAPM requirements included in the Bi-annual safe staffing review Maternity paper and in the bi-monthly Maternity and Neonatal Board report	**3**
					18/05/24.Incude Neonatal workforce requirements in the new Trust Single Delivery Plan.	**2**

APPENDIX 4 TRAINING COMPLIANCE MIS 8

Training Compliance by Staff Group 1st April 2024

	MIDWIVES	CONSULTANTS	DOCTORS	COMPLIANCE PERCENTAGE OVERALL
CTG update (Delivered as part of PROMPT or attendance at CTG meeting)	**98%** *175 compliant out of 183*	**100%** *11 compliant out of 11*	**100%** *19 compliant out of 19*	**96%** (Increase 3%) *205 compliant out of 213*
Fetal Monitoring training Attendance at full day fetal monitoring training	**98%** *175 compliant out of 178*	**100%** *11 compliant out of 11*	**100%** *19 compliant out of 19*	**99%** (Same) *205 compliant out of 208*
CTG Equipment	**98%** *175 compliant out of 178*	**100%** *11 compliant out of 11*	**100%** *19 compliant out of 19*	***99%*** (Same) *205 compliant out of 208*
GAP/GROW	**91%** *166 out of 183*	**91%** *10 out of 11*	**100%** *19 out of 19*	**92%** (Decrease 1%) *195 compliant out of 213*
Human Factors (attended PROMPT or fetal monitoring)	**100%** *183 out of 183*	**100%** *11 out of 11*	**70%** *19 out of 27*	**96%** (Decrease 3%) *213 compliant out of 221*

	MIDWIVES	CONSULTANT	DOCTORS	ANAESTHETISTS	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT)	**95%** 173 out of 183	**91%** 10 out of 11	**70%** 19 out of 27	**96%** 24 out of 25	**98%** 48 out of 49	**93%** (Decrease 1%) *274 compliant out of 295*
Pool Evacuation	**99%** *181 out of 183*	**91%** *10 out of 11*	**66%** *18 out of 27*	**96%** 24 out of 25	**90%** 44 out of 49	**94%** (Decrease 2%) 277 out of 295

APPENDIX 05 MIS 9 ACTION LOG SAFETY CHAMPIONS

Date	Decision/action agreed	Forum	Action Owner	Actions	RAG
Carried over	Charitable bid to be submitted for PBC, delivery suite and main corridor in SGU for staff rest areas.	Safety Champions Walk round	Area Leads and Matrons	17.8.2023 PBC delivery suite and main corridor bids approved. Work awaiting start dates. 21.12.2023 Delivery suite rest area completed, 12.1.24 Ground Floor ongoing and dates awaited early January 24 from D&G PBC work to commence. 14.2.24 Action completed. Works agreed for all rest areas.	
8/8/2023	Neonatal Safety Champion to contact network to consider whether additional clinical SBAR can be provided when IUT is requested to aid decision making.	Safety Champions forum	Neonatal Safety Champion	9.8.2023 Email sent and plans in place to review process. 21.12.2023 Feedback provided to the Northwest Connect Team. Action closed	
8/8/2023	Consider whether training budget can train core midwives on maternity B and Birth centres to support capacity and flow	Safety Champions forum	Matron for Safety and Quality	17.08.2023 Training budget to be reviewed with practice educator. Applications to be submitted for maternity B. Email to Birth centre managers to confirm names from midwifery led services. 21.12.2023 Core staff allocated funding to undertake NIPE training. Action closed.	
8/8/2023	Review arrangement for postnatal wellbeing checks for women whose baby is on NICU or for women in Bowland house	Safety Champions forum	Matron for Complex Care	17.8.2023 Meeting to be arranged to consider relocation of postnatal appointments to day unit once service has been relocated. 21.12.2023 Postnatal clinics relocated to ANC. Action completed.	
8/8/2023	Documentation key themes learning template to be generated by the audit midwives to ensure key information is documented in the right place within the EPR	Safety Champions forum	Matron for Safety and Quality	17.8.2023 Matron for Safety and Quality to liaise with specialty audit and IT to create a PowerPoint and learning template for sharing with obstetric and midwifery teams. 12.1.2024 Work ongoing with Digital team to create update user guides for documentation and a working party will be convened to agree a plan	
8/8/2023	Training for Badger| Net and key themes to be added to agenda for clinical audit.	Safety Champions forum	Matron for Safety and Quality	17.8.2023 Matron for Safety and Quality to liaise with specialty audit and IT to create a power point and learning template for sharing with obstetric and midwifery teams. 21/12/2023- Completion of Badger Net process mapping to update operational guides to improve consistency of documentation and any inaccuracies are being flagged to system C.	
8/8/2023	ANC clinic templates to be reviewed with CD to consider type of clinic allocated	Safety Champions forum	Clinical Director and Matron for Complex care	17.8.2023 Email to CD detailing action sent. To review whether clinic organisation can be reviewed. 21.12.2023 Wider actions in relation to ANC templates ongoing with CD and consultant team. Action extended. 12.1.24 ANC to be considered for MCA programme. 14.2.2024 Outpatient staffing and template review to be considered.	

Date	Decision/action agreed	Forum	Action Owner	Actions	RAG
20/02/24	Face to face visit to EPGAU. Weekend staffing discussed in view of the increasing demand for services at weekend	Safety Champions forum	Executive Safety Champion	Weekend staffing of the EPGAU to be considered as part of the annual staffing review planned for March 24. Paper being prepared by Chief Nursing Officer	
20/02/24	Finishing touches to EPGAU to be signed off by Charity to ensure environment is reflective of service needs.	Safety Champions forum	Matron for Gynaecology and Baby Beat lead	20/02/24 Confirmed that Additional baby beat bid had been signed off	
20/02/24	Challenges to ability to ring fence dedicated space for women who require care following baby loss.	Safety Champions forum	Clinical Business Manager	20.2.24 Paper to be prepared and presented to SOG to request 2 dedicated side room for responsive provision of private care following pregnancy loss. 20.04.2024 Paper presented to SOG to ringfence 2 side rooms on Gynaecology for early pregnancy loss.	
21/3/23	Virtual Session with midwives	Safety Champions forum	Executive Safety Champion	Virtual session held as open feedback session	
4.4.2024	Walk Round Neonatal	Safety Champions forum	Executive Safety Champion	As per notes	

Safety Champions Staff Updates

Area of discussion	What's improved?	What needs to improve further? Ideas to improve for the future?
Coordination of induction of labour and the delivery suite	- Dedicated leadership in elective section pathways has helped manage the pressure on the coordinator on delivery suite.	- Forward plan over the 24 hour period - Especially at weekends, this triangulated with the EPGAU walk round. - Friday clinic with complex women can lead to increase workload when fewer people around at weekend.
Gaps in matron and consultant midwife positions.	- Full recruitment to matron, Consultant Midwife and deputy Divisional Midwifery Director position - This has enabled a move to nominated matron of the day	Regular updates via multiple forums to ensure staff are aware of and included in service development and delivery.

Midwives moving from area of preference to a different area presents difficulties for midwifes who find it hard to move.	- Staffing improved since summer and moves occurring less. - Birth centre drop in sessions hosted to help staff familiarise themselves with the birth centre. When staff attended, they reported they found that helpful, but attendance was low. - Rotational midwives are gaining experience in the community, but continuity is challenging at times. There is some discussion of changing the way rotation occurs to give more continuity in the community. - PMA activity is increasing, more funding available and they are there to support and guide the midwifes.	- How can we support staff more moving between areas to reduce anxieties and worries? - Rotational midwives are presenting some challenges with continuity of following up on blood results. - Safety net in place to handover follow up requirements, but system not formalised and would benefit from further structure and formalising processes. - Discussion on approach to managing this required. - Exploring increasing appointment times from 20 to 30 mins to enhance the quality of interactions, cover the required topics and include blood review follow up.
Maternal Medicine	- Positive teamworking across the LMNS. - Badgernet access is helping across the LMNS.	- Functions being used differently across the LMNS. - Opportunity to standardise this would enhance safety. - Badgernet newsletter would help staff learn more about the system. - Other systems are using badgernet in different ways and safety nets being created but not necessarily being implemented in all organisations, missed opportunity for systems learning. - Each trust in the LMNS has agreed to move to mandated fields approach to be aligned. This is work in progress. - This should be raised with LMNS.

APPENDIX 6 MNSI/HSIB CASE MIS 10 SUMMARY CNST MIS YEAR 6

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

APPENDIX 7 RED FLAG REPORTING

Red flag Reporting Metrics	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
Delay in time critical activity.	54	22	17	17	50	43	34	38	23	10	28	51	38	16
Missed or delayed care> 60 mins in washing or suturing	1	0	0	1	2	0	0	0	0	1	1	0	1	0
Failure for women to receive the medication required.	1	0	0	0	0	0	0	0	1	0	0	0	0	0
>30-minute wait for pain relief.	1	0	0	0	3	2	3	0	1	0	1	1	0	0
Lack of full examination when woman presents in labour.	1	0	0	0	0	1	1	1	1	0	1	0	1	0
>2-hour delay in induction?	10	1	6	4	30	10	16	10	7	0	23	9	18	9
Delay in recognition of and action of abnormal signs.	2	2	0	0	0	2	0	0	4	0	1	0	1	0
Inability to provide one to one care in labour?	2	0	0	0	7*	0	1	0	0	0	0	0	0	0
>30-minute delay for assessment by a midwife when presenting in labour. Replaced by BSOTS														
>15 minute delay following presentation for BSOTS midwife assessment. (New parameter August 2023)						5	21	18	13	1	12	18	29	43
>30-minute wait for obstetric triage.	40	15	15	15	29	29	25	11	10	5	9	15	12	30
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)	0	0	0	0	1	0	0	0	1	0	4	1	0	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation? (New parameter Oct 22)	7	3	5	3	24	5	15	8	19	0	23	18	12	5
Was there a delay in transfer once labour was established? (New parameter Oct 22)	1	0	0	1	3	1	1	1	1	0	2	1	2	0
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)	0	0	0	0	0	1	0	0	1	0	0	0	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)	0	0	1	0	0	1	0	0	1	0	0	0	0	0
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)	2	0	1	0	7	1	3	1	1	0	0	1	1	0
Has there been any cancelled or delayed community work? (New parameter Oct 22)	4	1	27	177	31	4	85	14	5	0	28	38	28	95
Did redeployment of staff to other services/ sites/ wards occur? (New Parameter December 2023)										0	19	18	2	9
Total numbers of red flags	**126**	**44**	**72**	**218**	**187**	**105**	**205**	**103**	**90**	**17**	**156**	**170**	**146**	**207**

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Fuller Inquiry – Phase 1 Recommendations			
Report to:	Board of Directors	**Date:**	6 June 2024
Report of:	Chief Medical Officer	**Prepared by:**	R Dineley
Part I	✓	**Part II**	

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

Executive Summary:

David Fuller's dreadful crimes at Maidstone and Tunbridge Wells NHS Trust are deeply shocking and have had a significant impact on many people.

The purpose of this paper is to consider the recommendations from the Independent Inquiry into the issues raised by the David Fuller case and to provide assurance to the Board of Directors that the operational procedures of the mortuary and body stores at both Preston and Chorley Hospital sites comply with the Human Tissue Authority's (HTA) standards and guidance.

The Fuller Inquiry involves two phases. Phase 1 examined what happened at Maidstone and Tunbridge Wells NHS Trust with the subsequent report being published in November 2023 with 17 recommendations made specifically to Maidstone and Tunbridge Wells NHS Trust. However, the Trust have reflected on these to consider its current position against the recommendations, in the interest of learning and improvement.

Phase 2 of the inquiry is underway and will consider the broader national picture, to understand the procedures and practices across the country that are in place to protect the deceased person. The Trust will respond to any requests to support Phase 2 as needed.

In March 2023 the Trust were inspected by the HTA and the findings were reported to the Safety and Quality Committee in May 2023. All findings have since been closed by the HTA.

It is recommended that Board of Directors:

I. Note the findings from Phase 1 of the Fuller Inquiry.
II. Confirm they are assured of the processes in place to protect the safety and dignity of the deceased person.

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 – May 2024

1. Background

1.1 David Fuller's dreadful crimes at Maidstone and Tunbridge Wells NHS Trust are deeply shocking and have had a significant impact on many people.

1.2 The Fuller Inquiry involves two phases. Phase 1 examined what happened at Maidstone and Tunbridge Wells NHS Trust with the subsequent report being published in November 2023 with 17 recommendations made.

1.3 The purpose of this paper is to consider the recommendations from Phase 1 of the Independent Inquiry into the issues raised by the David Fuller case and to provide assurance to the Board of Directors that the operational procedures of the mortuary and body stores at both Preston and Chorley Hospital sites comply with the Human Tissue Authority's (HTA) standards and guidance.

1.4 The Human Tissue Authority's (HTA) regulatory remit is defined in the Human Tissue Act 2004. The HTA regulates the Post-Mortem sector.

1.5 The HTA is the regulator that sets licencing standards for mortuaries where post-mortem examinations are carried out, including those aspects of security relevant to their remit.

1.6 Establishments licensed in the Post-Mortem sector are required to notify the HTA of serious incidents and near-miss incidents that may affect the dignity of the deceased person, and damage public confidence. Incidents that are required to be reported to the HTA are termed 'HTA Reportable Incidents' (HTARIs).

1.7 In March 2023 the Trust was inspected by the HTA with all findings being subsequently closed and a report was provided to Safety & Quality Committee, a sub-committee of the Board of Directors, in May 2023.

1.8 Phase 2 of the inquiry is underway and will consider the broader national picture, to understand the procedures and practices across the country that are in place to protect the deceased person. The Trust will respond to any requests to support Phase 2 as needed.

2. Phase 1 Fuller Report Recommendations

2.1 In November 2023 the Phase 1 report from the Fuller inquiry was published and 17 recommendations were made specifically to Maidstone and Tunbridge Wells NHS Trust. However, the Trust have reflected on these to consider its current position against the recommendations, in the interest of learning and improvement.

2.2 A summary of the Trust's assessment of the position against the recommendations can be seen in Table 1.

Table 1 – Overview of the Trust's position against the recommendations from Phase 1 of the Fuller inquiry

Recommendations from Phase 1 of the Fuller Inquiry	Recommendations considered applicable solely to the Trust	Trust considers that it complies with recommendations in full	Trust considers that further work is required to meet the recommendations
17	16	16	0

2.3 Recommendation 12 relates to the Local Authority and the Trust are unable to comment on behalf of external partners. However, the Trust are supportive of the Local Authority undertaking any checks to

assure themselves of the safety and dignity of the deceased person, should this be required. The Trust are reviewing ancillary services, which may interact with a deceased person where contracts exist, as part of reflecting on this recommendation holistically.

2.4 A more detailed update on the Trust's position against the 17 recommendations from Phase 1 of the Fuller Inquiry Report is included in Table 2.

Table 2 – Detailed overview of the Trust's position against each of the recommendations from Phase 1 of the Fuller inquiry

Recommendation 1
Maidstone and Tunbridge Wells NHS Trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Trust mortuary is accessible with a swipe card and digit lock code during working hours. Staff or other visitors without access must ring the doorbell to gain access to the mortuary. Out of hours a key and the alarm code are also required.
- Only anatomical pathology technicians (APTs), Porters, Security and bereavement team have swipe access to the mortuary and only these staffing groups can gain access out of hours.
- Porters require access out of hours, to transfer a deceased person from the wards to the mortuary and to accept a deceased person from the community who need to be transferred to the mortuary by funeral directors. When porters bring a deceased person from the wards they are in pairs. Porters are allocated jobs via an electronic system that the Trust use to allocate tasks called smart page. This has an audit trail and allows visibility of which porters are dealing with a task, such as transferring a deceased person to the mortuary.
- The Bereavement team require access out of hours to perform eye retrievals. They require a porter to remove the deceased person from the fridge and to cross check the identity. Porters will leave the bereavement nurse alone in the mortuary until the deceased person needs returning to the fridge. The bereavement team must sign in and out of the mortuary and this access will also be seen on the swipe card access system and the CCTV.
- Security may need to gain access to the mortuary in case of an emergency. However, these cases are rare and the on-call APT must be contacted to notify them and the APT will attend the site. Any access by Security can be identified by swipe card access and CCTV review.
- All non-mortuary staff that require access to the mortuary when the APTs are not in, must complete an e-learning training package. This is reviewed by the Designated Individual (DI) bi-annually to check compliance. Any staff who are not complying with this requirement will have their swipe access removed from the mortuary. The training package includes the use of trolleys, security, Human Tissue Authority (HTA), HTA reportable incidents (HTARis) and how to report and incident.
- All maintenance and external contractors that enter the mortuary are supervised by the APTs. They cannot access the mortuary in or out of hours without an APT, as they do not have swipe access or the codes for the digit locks, or the alarm.
- Compliance with swipe access is audited monthly against the CCTV. Currently 7 days are picked at random. However, from June 2024, daily auditing will be undertaken. Any variation from expected practice is reported as an incident via the trust datix system and escalated to the Divisional Safety and Quality Committee.
- The same applies to the mortuary at Chorley District Hospital (CDH). The only difference between the

sites is that CDH does not receive a deceased person from the community and that the Chorley mortuary is also accessed via swipe access and a key, which is kept in a key safe with a lock.

Recommendation 2

Maidstone and Tunbridge Wells NHS Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- It is against the Trust's standard practice to leave a deceased person out of the fridge overnight or while maintenance is being undertaken and it has never been known or identified to have happened previously at the Trust.
- This practice is also against HTA standards, and the Trust consider that this is not respectful to a deceased person or their families and loved ones.
- A deceased person is only removed from fridges for certain reasons, e.g. for a viewing or a post mortem (PM) and this will happen just before the viewing, or the PM.
- The deceased person is returned to the fridge as soon as the viewing or PM is completed.
- CCTV monitors the fridge room, so it can be seen when a deceased person is removed and returned to the fridges.
- When the department is locked up every night the APTs will lock all PM rooms, so if there was an instance whereby someone was left out this would be seen at this time. Offices are locked and the viewing room is checked every night before the APTs leave.
- There is no PM room at Chorley and when a viewing has taken place, the deceased person is returned to the fridge as soon as the viewing has ended. CCTV captures all viewings.

Recommendation 3

Maidstone and Tunbridge Wells NHS Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Trust is compliant with its own current policy on criminal records checks.
- The level of Disclosure and Barring Service (DBS) checks undertaken for Trust staff has been determined using DBS guidance on role eligibility.
- All maintenance and external contractors that enter the mortuary are supervised by the APTs. They cannot access the mortuary in or out of hours without an APT, as they do not have swipe access or the codes for the digit locks, or the alarm.

It is noted that the Inquiry will consider the wider issue of the use and effectiveness of criminal record checks for employment that involves access to the deceased person in Phase 2 of its work.

Recommendation 4

Maidstone and Tunbridge Wells NHS Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Mortuary Designated Individual (DI) is the Head Biomedical Scientist (BMS) who works in Cellular Pathology.
- The Senior APT is the Mortuary Manager (from herein referred to as the Mortuary Manager) who runs the mortuary day-to-day, and is a qualified member of staff with a certificate and diploma in Anatomical pathology, foundation degree (level 5) in mortuary science, Leadership management course (ILM3), appraisal training and adult post mortem consent training and other internal courses.
- The Senior APT has regular meetings with the DI for the HTA Post-Mortem sector.
- Both attend the departmental meeting and Deceased Operational Group meeting which reports into the Mortality End of life Committee (MEOL) which subsequently reports into Safety and Quality Committee, a sub-committee of the Board of Directors. Any incidents are reported on Datix and escalated through to Divisional Safety and Quality Committee which is a sub-Committee of the Divisional Board which reports into the Divisional Improvement Forum (DIF) meeting, which is Chaired by members of the Executive Team and this reports into Committees of the Board by exception, providing appropriate opportunities for escalation to the Board of Directors, if this was required.
- As well as the Designated Individual for the Mortuary, there are a number of Persons Designate who, although they do not have statutory duties, support compliance with HTA requirements. Persons Designate at the Trust include staff from the Mortuary, Gynaecology, Bereavement Team and Diagnostics Clinical Business manager.

Recommendation 5

The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Mortuary Manager has a full-time dedicated role overseeing the mortuary on the Preston and Chorley sites.
- The Mortuary Manager has regular meetings with her line manager (who is also the Designated Individual with the Human Tissue Authority (HTA), providing appropriate routes to raise any issues or concerns.
- The Mortuary Manager is subject to the Trust's appraisal process.

Recommendation 6

Maidstone and Tunbridge Wells NHS Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The mortuaries at both sites are classed as restricted areas, the swipe access list to the mortuary is controlled by the mortuary staff, who review any requests for staff to be added and decide whether this is needed.
- The full swipe access list for both mortuaries is audited every three months by mortuary staff, and anyone that doesn't require access will be removed by either the mortuary or security staff
- Internal mortuary entrances on both sites can only be accessed by staff with swipe card access; at Preston this is also accompanied by a digi-lock and a key, that only appropriate staff have access to, at Chorley there is also a key required but no digi-lock.
- At Preston, any keys to the mortuary that are in circulation are controlled by mortuary, portering, bereavement and security staff.
- The allocation of the 9 mortuary keys at Preston is: 5 APTs keys, 1 Security key, 1 Bereavement staff key and 2 Porters keys.
- At Chorley, the key to access the fridge room is secured in a lock box with a code within the mortuary, which only appropriate staff have access to. Portering staff also have access to 1 key for the fridge room at Chorley.
- Any external entrances to the mortuaries, such as the Funeral Director's entrance are secured by a roller shutter door, which can only be operated from inside and is policed by mortuary staff and the porters to allow non-trust staff to enter.
- When the mortuary at Preston is closed, an alarm is set which covers all areas, and can only be set and silenced by staff with access to the code, this includes mortuary, portering, security and bereavement staff.
- The alarm is triggered upon entering the mortuary, and if not silenced, will send an alert to the switchboard to contact the security team to investigate the matter.
- Any sensitive areas within the mortuary that only require APT access (such as the offices) are also secured by separate keys when the mortuary is closing and being secured, which only mortuary staff have access to (5 keys for every staff member).
- The post-mortem room is locked from the inside when the mortuary is closed, and can only be accessed by APTs.
- Any staff in addition to those mentioned above, such as estates staff, external contractors, funeral directors or NHS Blood and Transplant (NHS BT) are constantly supervised when in the mortuary by mortuary staff or portering staff.
- All non-mortuary staff are required to complete an online e-learning course before being granted access to the mortuary, this covers HTA, HTA reportable incidents and how to report them, moving and handling in the mortuary, and wellbeing.
- All of these details described above can also be found within the Mortuary Security Standard Operating Procedure (SOP) (SP-620) internally.

Recommendation 7

Maidstone and Tunbridge Wells NHS Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- Mortuary access is by swipe access and digit code lock during working hours at RPH and swipe access and key at CDH.
- The mortuaries at both sites are classed as restricted areas, the swipe access list to the mortuary is controlled by the mortuary staff, who review any requests for staff to be added and decide whether this is needed.
- Swipe access lists are reviewed quarterly ensuring only those requiring access are granted it and those who have left the Trust have been removed.

- Although some groups of staff have swipe access during working hours, access out of hours also requires a digit code, alarm code or key locker code, and access to these are restricted. For example, Pathologists have swipe access 9-5 Monday to Friday but have no access to keys or alarm codes, so can only access the mortuary when an APT is present.
- The Trust have CCTV which monitors access to the mortuaries and the body storage areas at both Preston and Chorley mortuaries which is regularly audited on a monthly basis by selecting 7 random days.
- From June 2024 a trial of daily auditing will be undertaken at Preston to ensure it is more robust. Similarly at Chorley, an audit will be conducted when staff visit on a Tuesday and a Thursday but the audit will be undertaken against CCTV for every day.
- When auditing the swipe access and CCTV are cross checked to review staff access for those days and the reasons behind doing so.

Recommendation 8

Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Chief Medical Officer and Deputy Chief Nurse have visited the mortuary at Preston and reviewed security arrangements in place. There are also plans to do the same at Chorley.
- The mortuaries at both sites are classed as restricted areas, the swipe access list to the mortuary is controlled by the mortuary staff, who review any requests for staff to be added and decide whether this is needed.
- The mortuary staff are able to see the swipe access system to monitor staff entering and leaving the mortuary 24/7.
- The Trust supported the extension of CCTV at both Preston & Chorley mortuaries to enhance security.
- Some staff members are restricted to just during the day and others can be removed by the mortuary if they should not have access.
- Mortuary security incidents are escalated through the division of Diagnostic and Clinical Support Services, which has a reporting route through to Safety and Quality Committee, and ultimately, the Board of Directors. This includes the reporting and escalation of any Human Tissue Authority Reportable Incidents (HTARIs), as required.

Recommendation 9

Maidstone and Tunbridge Wells NHS Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- CCTV is installed covering all access points to the Mortuaries and body stores at Preston and Chorley.
- There is no CCTV in the post mortem room at Preston. However, the doors to the post mortem (PM) room are covered by a camera. At Maidstone and Tunbridge Wells NHS Trust the setup was different in that the back of fridges containing a deceased person could be accessed from the PM room and were not covered by CCTV. This is not the case at Lancashire Teaching Hospitals as fridges cannot be accessed from the PM room, meaning any removal of a deceased person would be visible on CCTV in the process of moving to the PM room. The Trust considers this sufficient so as to not

impact on the privacy and dignity of a deceased person during a post mortem.

- There is no post mortem room at Chorley and all areas are covered by CCTV.
- There is usually always at least 1 APT and 1 pathologist present in the PM room during a post mortem, unless it is an out of hours home office post mortem where the pathologist has finished the post mortem and left the lone APT to finish reconstructing and cleaning.
- There are 8 CCTV cameras at Preston and 5 cameras at Chorley.
- The retention period for CCTV images at Preston is 5 months but is only 30 days at Chorley. This still allows sufficient time to complete the audits as they are carried out monthly. This is due to change to an audit of activity on every day across both sites, as indicated in recommendation 7.

Recommendation 10

Maidstone and Tunbridge Wells NHS Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- An audit of CCTV is examined in conjunction with the swipe access on a regular basis and recorded on the Trust's quality management system.
- From June 2024 the mortuary will undertake a trial to change this to a daily audit so every day will be checked.
- Swipe access lists are reviewed quarterly ensuring only those requiring access are granted it and those who have left the Trust have been removed.
- Any CCTV incidents are raised at the Divisional Safety and Quality meeting, which can escalate through the Trust's governance structure to the Board of Directors if required, as referred to in the response to recommendation 4.

Recommendation 11

Maidstone and Tunbridge Wells NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Trust considers Human Tissue Authority (HTA) inspection reports at the Trust's Safety & Quality Committee, a sub-committee of the Board of Directors. Representatives from the Integrated Care Board (ICB) are invited to, and attend the Safety and Quality Committee, and also receive the papers, which includes the outcomes of any inspections that occur.
- The Trust has a Quality Review Meeting (QRM) with the ICB where quality is routinely monitored, and any issues, including the outcome of inspections are discussed as required.
- The Local Authority attend the Trust's Deceased Operational Group meeting where HTA inspection outcomes are discussed and can request further information as needed.
- As with any inspection, the Trust's HTA inspection reports can be accessed on the HTA website should external partners wish to access this at any time.

It is noted that the Inquiry will consider the current legislation and system of regulation and oversight of mortuaries, the legislation in relation to safeguarding with regard to the deceased, and the responsibilities of the various regulators charged with ensuring the security and dignity of the deceased in more detail in Phase 2 of its work.

Recommendation 12

Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased.

Assurance Statement

The Trust are unable to comment on behalf of external partners. However, the Trust are supportive of the Local Authority undertaking any checks to assure themselves of the safety and dignity of the deceased person, should this be required. To note:

- The Trust has a Service Level Agreement (SLA) with Lancashire County Council (LCC) and the coroner, and representatives of both attend both the Deceased Operational Group and the Post Mortem Computerised Tomography (PMCT) meetings to gain assurance that the trust is effective in protecting the safety and dignity of the deceased person.
- The PMCT meeting reports to the Deceased Operational Group meeting and in turn reports to Mortality and End of Life Care Committee, which reports into Safety and Quality Committee, a sub-committee of the Board of Directors, therefore any issues raised can be escalated.
- The Trust are reviewing ancillary services, which may interact with a deceased person where contracts exist, as part of reflecting on this recommendation holistically.

It is noted that the Inquiry intends to consider the role and responsibilities of local authorities in respect of the provision of mortuary services in Phase 2 of its work.

Recommendation 13

We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- Governance in relation to the mortuary is escalated through the division of Diagnostic and Clinical Support Services, which has a reporting route through to Safety and Quality Committee, and ultimately, the Board of Directors. This includes the reporting and escalation of any Human Tissue Authority Reportable Incidents (HTARIs), as required.
- The Trust has a Deceased Operational Group in place, which is chaired by the Designated Individual. This reports to the Mortality and End of Life Care Committee, chaired by a Deputy Chief Medical Officer, which in turn reports to the Safety and Quality Committee, which is a sub-committee of, and reports to the Board of Directors.
- The Trust had a HTA inspection in March 2023. The outcome and corrective and preventative actions were reported to the Safety and Quality Committee on behalf of the Board of Directors, in sufficient detail and supported the Designated Individual to ensure the requirements of the HTA were met.
- As part of the Annual reporting cycle for Safety and Quality Committee, there is an Annual Pathology Report provided, which includes Mortuary updates as required.

Recommendation 14

Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- HTA inspection outcomes and any corrective and preventative actions are reported to the Safety and Quality Committee, a sub-committee of the Board of Directors.
- As part of the Annual reporting cycle for Safety and Quality Committee, there is an Annual Pathology Report provided, which includes Mortuary updates as required.
- The Trust's HTA Designated Individual (DI) has several routes available to report to the Board of Directors:
    - Via normal line management arrangements within the Division of Diagnostic and Clinical Support Services (DCS).
    - The Trust has a Deceased Operational Group in place, which is chaired by the DI. This reports to the Mortality and End of Life Care Group, chaired by a Deputy Chief Medical Officer, which in turn reports to the Safety and Quality Committee, which reports to the Board of Directors.
    - The Mortuary is part of the division of Diagnostic and Clinical Support Services, which has a reporting route through to Safety and Quality Committee, and ultimately, the Board of Directors. This includes the reporting and escalation of any Human Tissue Authority Reportable Incidents (HTARIs), as required.
    - The DI has direct access to the Trust's Chief Medical Officer, who is a member of the Board of Directors, and they can escalate any matters as required.

Recommendation 15

Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- HTA inspections, outcomes and any corrective and preventative actions are overseen at a Corporate and Divisional level, and reported to the Safety and Quality Committee, a sub-committee of the Board of Directors.
- As part of the Annual reporting cycle for Safety and Quality Committee, there is an Annual Pathology Report provided, which includes Mortuary updates as required.
- The DI has direct access to the Trust's Chief Medical Officer, who is a member of the Board of Directors, and they can escalate any matters as required.
- Support is available to the Designated Individual to meet the HTA standards, as required.

Recommendation 16

The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.

Assurance Statement

The Trust considers that it complies with this recommendation in full on the following basis:

- The Chief Medical Officer is responsible for assuring the Board of Directors in relation to the security and dignity of the deceased person.
- The DI has direct access to the Trust's Chief Medical Officer, who is a member of the Board of Directors, and they can escalate any matters as required.
- The Chief Nursing Officer is responsible for Clinical Governance and works together with the Chief Medical Officer to ensure the necessary assurances are received at the Safety and Quality Committee on behalf of the Board of Directors.
- The Chief Medical Officer and Deputy Chief Nurse have visited the Mortuary at Preston and reviewed security arrangements in place.

Recommendation 17 *Maidstone and Tunbridge Wells NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.*
Assurance Statement The Trust considers that it complies with this recommendation in full on the following basis: • Policies, processes and procedures to safeguard the deceased person are continually reviewed and monitored, and organisational support has been provided where required to improve the arrangements. • Any Human Tissue Authority Reportable Incidents (HTARIs) are appropriately reported and investigated with the aim of learning and improvement. • The Mortuary Manager audits security arrangements to ensure the dignity and safeguarding of deceased person(s).

3. Conclusion

3.1 Following review of the Phase 1 Fuller recommendations made in relation to Maidstone and Tunbridge Wells NHS Trust, the Trust considers that the operational procedures for the mortuaries and body stores at both hospital sites are in accordance with the recommendations.

3.2 As indicated, the Trust are unable to respond to recommendation 12 on behalf of external partners. However, the Trust are reviewing ancillary services, which may interact with a deceased person where contracts exist, as part of reflecting on this recommendation holistically

4. Financial implications

4.1 There are no financial implications in relation to this report.

5. Legal implications

5.1 The Trust are appropriately licensed and regulated by the Human Tissue Authority (HTA) in relation to practices within the mortuary.

5.2 Any identified deficiencies in adherence to regulations could result in regulatory or legal action.

6. Risks

6.1 This paper considers risks to security within the mortuary alongside the controls and assurances in place.

7. Impact on stakeholders

7.1 Any identified deficiencies in caring for the deceased person and impacting their safety and dignity could have a significant impact on relatives and family members, as identified in Phase 1 of the Fuller Inquiry.

8. Recommendation

8.1 It is recommended that Board of Directors:

I. Note the findings from Phase 1 of the Fuller Inquiry.

II. Confirm they are assured of the processes in place to protect the safety and dignity of the deceased person.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Workforce Race Equality Standard (WRES) Report 2024							
Report to:	Board			**Date:**	6th June 2024		
Report of:	Chief People Officer			**Prepared by:**	E Hickman		
Part I	*X*			**Part II**			
Purpose of Report							
For assurance	☒	**For decision**	☐	**For information**	☐		

Executive Summary:

The purpose of this report is to share the data which will form the submission and subsequent publication of the 2024 Workforce Race Equality Standard (WRES) for our Trust. It sets out priority areas for action based on analysis of the results which include workforce data and findings from the latest staff survey. The Committee are asked to review and approve the contents of the report for publication and to consider the areas for action and associated next steps which are to consult with the Ethnicity Inclusion Forum with regards to the results, understand their lived experience, the actions which will make the greatest impact and to co-design a draft action plan, making changes where necessary. The Trust is part of the Lancashire and South Cumbria Integrated Care Board (ICB) Belonging Delivery Group and are working collaboratively on a number of projects with the aim of improving the WRES data.

The priority areas recommended for action are those which indicate ethnic minority colleagues are being adversely impacted or disadvantaged according to the four-fifths rule:
Indicator 2 – Relative likelihood of staff being appointed from short listing across all posts.
Indicator 8 – In the last 12 months, have you personally experienced discrimination at work from your manager or colleagues.
Indicator 1 and **9** – Increased representation of ethnic minority colleagues in senior, VSM or voting Board member roles.

It is recommended that the Board;

I. receive the report
II. note the content
III. note the priority areas for action and
IV. approve external publication of our results.

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 – May 2024

INTRODUCTION

The Workforce Race Equality Standard (WRES) is a mandated requirement through the NHS standard contract and is the ninth report since it was established in 2016. Organisations are mandated to report and publish their WRES data on an annual basis, illustrating organisational progress against nine indicators relating to workforce race equality. This report allows us as an organisation to understand where the data indicates the areas of greatest challenge and where we are performing well. It also enables us to benchmark our position as a Trust against nationally available findings for each of the 9 WRES Indicators.

RESULTS

For each of the indicators the data is compared for White and Ethnic Minority colleagues. National staff survey averages and organisational results for the last 4 years have been included for comparative purposes (where applicable) to the metric being reviewed. This year we have requested additional reports from Picker to help us interrogate our staff survey results further and understand how colleague experience in white and ethnic minority subgroups may vary across Division and Band. Unfortunately, this data has not been available to us in time for the writing of this report however we will utilise the information to help us develop more targeted actions moving forwards.

Completion rates

	Total Org Response	**White colleagues**	**Ethnic Minority colleagues**	**Unknown**
2023	4539	3503	986	50
2022	4440	3538	862	40
2021	4311	3413	626	272

The table above shows the numbers of colleagues completing the staff survey each year. We can see how the numbers of ethnic minority colleagues completing the survey have increased significantly from 2021 to 2023; what we don't currently understand is what percentage of colleagues who are invited to complete the staff survey each year, use the opportunity to share their views and experiences. This is something we are hoping to be able to understand working with the OD Projects team moving forwards.

Summary Data

The approach used by both the national WRES team and the Race Disparity Unit, with regard to the ongoing Race Disparity Audit work, is to utilise what is referred to as the four-fifths (or "80 percent") rule to highlight whether practices have an adverse impact on an identified group e.g., a sub-group of ethnicity. If the relative likelihood of an outcome for one sub-group compared to another is **less than 0.8 or higher than 1.25**, then the process would be identified as having an adverse impact on one of those sub-groups.

Improvements have been seen for Ethnic Minority colleagues across the following WRES indicators;

- **Indicator 3 – Likelihood of entering a formal disciplinary process.**
  This score has improved since last year and indicates no adverse impact for ethnic minority colleagues.
- **Indicator 4 – Access to non-mandatory training and continuous professional development.** This metric has improved since last year. The race disparity ratio is 1.00 and indicates the experience for both white and ethnic minority colleagues is the same.
- **Indicator 7 - Percentage believing the Trust provides equal opportunities for career progression or promotion.** The percentage of ethnic minority colleagues reporting they believe there are equal opportunities for career development or promotion has improved slightly since last year from 48.5% to 49.7%. The race disparity ratio has also improved to 1.25 indicating there is no adverse impact on colleagues from ethnic minority groups.

The following indicator shows a **deterioration** in the experience of our Ethnic Minority colleagues;

- **Indicator 1 – Representation.** Action is needed to increase the representation of ethnic minority colleagues in more senior roles.
- **Indicator 2 – Relative likelihood of appointment from shortlisting.** The metric score has worsened from last year illustrating white colleagues are 1.4 times more likely to be appointed from shortlisting.
- **Indicator 8 – Percentage of colleagues experiencing discrimination from managers or colleagues.** The percentage of colleagues reporting they've experienced discrimination from managers or colleagues has worsened sightly since last year from 12.9% to 15.6%. The race disparity ratio is 2.84 and an indication that ethnic minority colleagues are almost 3 times as likely to report experiencing discrimination from managers or colleagues than white colleagues.
- **Indicator 9 – Ethnic diversity of Voting Board Members**. At present there are no voting Board members who belong to an ethnic minority group. Action needs to be taken to further enhance the diversity of our Board so it is proportionately representative of our wider workforce and community.

There are two staff survey metrics which show a deterioration in experience for ethnic minority colleagues and white colleagues, so whilst the data indicates ethnic minority colleagues have reported a worsening experience this is true for all colleagues and does not indicate an adverse impact on one subgroup in particular. These are;

- **Indicator 5 – Percentage of colleagues experiencing bullying, harassment or abuse from the public.** The staff survey result has worsened since last year from 17.2% to 22.5% however the race disparity ratio is 1.03 indicating the experience of ethnic minority colleagues and white colleagues is almost the same.
- **Indicator 6 – Percentage of colleagues experiencing bullying, harassment or abuse from colleagues.** This score has worsened slightly since last year from 22.7% to 23.4%, the race disparity ratio is 1.14 indicating there is no adverse impact on ethnic minority groups.

INDICATOR 1 – REPRESENTATION

This section details the percentage of colleagues in each of the AFC bands 1-9 and VSM for both clinical and non-clinical colleagues from white and ethnic minority backgrounds compared with colleagues in the overall workforce. As of 31 March 2024, the Trust Headcount was 10,336. White 7370 (71.3%), ethnic minority 2838 (27.5%), unknown 128 (1.2%).

As detailed below the greatest representation of ethnic minority colleagues in non-clinical roles are in bands 2 and below (below band 1 tend to be apprentices). Across the remaining bands (band 3 and above) ethnic minority colleagues are under-represented when compared against the Trust wide ethnic minority workforce.

From a clinical workforce perspective, the highest percentage of ethnic minority colleagues can be found in band 5

roles. We have seen increases in clinical band 5 and band 6 roles which may be attributed to the successful recruitment of nurses from overseas. Aside from band 5 clinical roles, ethnic minority colleagues are under-represented in all other bands when compared against the Trust wider ethnic minority workforce.

It is positive to note that across the majority of the agenda for change bands in a non-clinical role have seen an overall increase in the percentage of ethnic minority colleagues within our workforce in the last 12 months. However in clinical roles we have seen an overall decrease in the percentage of ethnic minority colleagues within our workforce. Areas for improvement are to increase the percentage of ethnic minority colleagues in more senior roles 8a and above, specifically in band 9 and VSM roles.

Agenda for Change Workforce

Non-Clinical	% Ethnic Minority Background 2023	% Ethnic Minority Background 2024	Clinical	% Ethnic Minority Background 2023	% Ethnic Minority Background 2024
Under Band 1	71.4	71.4	**Under Band 1**	100	75.0
Band 1	40.0	33.3	**Band 1**	-	-
Band 2	25.8	27.9	**Band 2**	21.0	26.3
Band 3	14.0	16.4	**Band 3**	23.9	16.0
Band 4	9.1	11.3	**Band 4**	13.1	11.6
Band 5	11.4	11.9	**Band 5**	44.6	49.5
Band 6	13.8	12.9	**Band 6**	17.1	19.5
Band 7	14.3	10.7	**Band 7**	9.6	9.21
Band 8a	7.5	6.4	**Band 8a**	10.6	11.0
Band 8b	7.4	8.3	**Band 8b**	6.4	6.9
Band 8c	16.7	13.8	**Band 8c**	4.5	4.6
Band 8d	-	7.1	**Band 8d**	9.1	7.7
Band 9	10.0	-	**Band 9**	-	-
VSM	-	-	**VSM**	-	-
Total	**17.8**	**18.9**	**Total**	**29.5**	**27.3**

Medical and Dental Workforce

Role	% Ethnic Minority Background 2023	% Ethnic Minority Background 2024
Consultants	52.6	52.7
Of which Senior Medical Manager	37.7	42.2
Non-consultant career grade	69.3	71.0
Trainee grades*	71.4	76.7

*Excludes Lead Employer Medical and Dental Trainees

The medical and dental workforce has a higher proportion of ethnic minority colleagues in most roles, other than Senior Medical Manager, than white colleagues.

Towards the end of 2019 the WRES team issued “A Model Employer” document which set out the challenge of ensuring Black, Asian and Minority Ethnic representation at all levels of the workforce by 2028, particularly across senior management bands (8a and above). If we review the trajectory as shown below we can see that as a Trust we have made strong progress in achieving and for some bands exceeding the expected trajectory for 2024 for bands 8a – 8d, however as mentioned earlier in the narrative for this indicator, further work is needed to support the progression or recruitment of colleagues from an ethnic minority background into band 9 and VSM roles.

Model Employer Proposed Trajectory for bands 8a and above

Band	2020		2021		2022		2023		2024	
	Ambition	Actual	Ambition	Actual	Ambition	Actual	Ambition	Actual	Ambition	Actual
8a	17	**16 (-1)**	19	**21 (+2)**	20	**27 (+7)**	22	**32 (+10)**	23	**36 (+13)**
8b	5	**6 (+1)**	5	**8 (+3)**	6	**8 (+2)**	6	**5 (-1)**	7	**6 (-1)**
8c	1	**1**	2	**1 (-1)**	2	**3 (+1)**	3	**5 (+2)**	4	**5 (+1)**
8d	0	**0**	0	**1 (+1)**	1	**1 (-)**	1	**1 =**	1	**2 (+1)**
9	0	**0**	0	**0**	1	**0 (-1)**	1	**1 =**	1	**0 (-1)**
VSM	0	**0**	0	**0**	1	**0 (-1)**	1	**0 (-1)**	1	**0 (-1)**

INDICATOR 2 – LIKELIHOOD OF APPOINTMENT FROM SHORTLISING

The table below, indicates the likelihood of white and ethnic minority candidates being appointed from shortlisting. The race disparity ratio for this indicator has deteriorated since last year, moving to 1.4 (from 1.34). This means white candidates are 1.4 times more likely to be appointed from shortlisting than candidates from an ethnic minority group. The disparity ratio is above the range of 0.8 – 1.25, therefore further action needs to be taken.

	2023		2024	
	White (n=)	**Ethnic Minority Background (n=)**	**White (n=)**	**Ethnic Minority Background (n=)**
Number of shortlisted applicants	6376	3793	4956	3450
Number appointed from shortlisting	2108	934	1745	865
Relative likelihood of appointment	33.06%	24.62%	35.2%	25.07%
Race disparity ratio	**1.34**		**1.4**	

INDICATOR 3 – LIKELIHOOD OF ENTERING FORMAL DISCIPLINARY PROCESSES

The data displayed in the table below shows that for this reporting year 2023 – 2024 we have seen the race disparity ratio decrease even further. This indicates that ethnic minority colleagues are less likely to enter the disciplinary process, meaning this is not a priority area for action in this reporting year.

	2022 - 2023		2023 - 2024	
	White (n=)	**Ethnic Minority Background (n=)**	**White (n=)**	**Ethnic Minority Background (n=)**
Average Number of colleagues entering the disciplinary process *(over 2yr rolling period)*	47.5	13.0	67	11.5
Race disparity ratio	**0.76**		**0.44**	

INDICATOR 4 – ACCESS TO NON-MANDATORY TRAINING AND CONTINUOUS PROFESSIONAL DEVELOPMENT

This indicator has improved over the last 12 months, with a race disparity ratio of 1.00 indicating colleagues from ethnic minority groups are as likely to access non mandatory and continuous professional development as white colleagues. The data for 2024 now includes continuous professional development education activities which have been funded through Health Education England – these have not previously been captured as part of this report.

The race disparity ratio for this indicator is at its lowest across the past 6 years.

	2023		2024	
	White (%)	Ethnic Minority Background (%)	White (%)	Ethnic Minority Background (%)
Percentage of colleagues accessing non-mandatory training and CPD	18.01%	17.7%	22.8%	22.7%
Race disparity ratio	**1.02**		**1.00**	

INDICATOR 5 – BULLYING AND HARRASSMENT FROM THE PUBLIC

As displayed in the organisation data for this indicator (taken from the National Staff Survey 2023 Results) 22.5% of ethnic minority staff and 21.7% of white colleagues have reported experiencing bullying, harassment or abuse from patients, relatives or other members the public in the last 12 months. The race disparity ratio of 1.03 indicates there is no adverse impact for ethnic minority colleagues for this indicator however this is a deterioration from last year's WRES submission due to the increased percentage of ethnic minority colleagues reporting experiencing bullying, harassment and abuse from the public. The percentage of colleagues reporting bullying and harassment, in addition to our race disparity ratio, are lower than the national benchmarks.

Organisation Data for 2023 and National Benchmark Comparator

	White	Ethnic Minority Background	Race Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	21.70%	22.51%	1.03	Deterioration
National Benchmark	24.72%	28.11%	1.14	No movement

Performance for this indicator, as shown in the table below, demonstrates a relatively consistent picture from a disparity ratio perspective over the last 5 years. The latest year's staff survey results mark the highest percentage of ethnic minority colleagues reporting experiencing bullying and harassment from the public at 22.5%, previous years show that less ethnic minority colleagues (compared to white colleagues) have reported experiencing bullying, harassment and abuse from the public.

Organisation Data Over Time

	White	Ethnic Minority Background	Race Disparity Ratio	Change From Previous Year
2023	21.7%	22.5%	1.03	Deterioration
2022	21.2%	17.2%	0.81	Deterioration
2021	21.6%	16.2%	0.75	Improvement
2020	22.5%	19.5%	0.87	Deterioration
2019	25.6%	19.5%	0.76	Improvement

Ethnic Group National Staff Survey Data 2023 (and 2022 for comparison)

		Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
	Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**
2023	**n = 4539**	**n = 738**	**n = 138**	**n = 72**	**n = 38**	**n = 3503**
	21.8%	20.5%	29.2%	27.8%	26.3%	21.7%
2022	**n = 4440**	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
	20.4%	17.5%	18.6%	15.8%	13.3%	21.2%

From reviewing National Staff Survey Data for this WRES indicator by ethnic minority group it was found that 29.2% of Black/African/Caribbean/Black British colleagues reported experiencing at least one incidence of bullying, harassment or abuse from patients, relatives or other members of the public over the previous 12 months. This is an increase of 10.6% on 2022's figure. In addition 27.8% of Mixed/ Multiple ethnic groups colleagues also reporting the experienced bullying, harassment and abuse from patients or other members of the public. This also represents a significant increase of 12% on last years' data. The data for 'other ethnic groups' has also almost doubled from 13.3% last year to 26/3% this year.

INDICATOR 6 – BULLYING AND HARRASSMENT FROM COLLEAGUES

The data displayed below for indicator 6, highlights a slight deterioration from last year's WRES reporting position with a race disparity ratio of 1.14 for colleagues experiencing harassment, bullying or abuse from colleagues in the last 12 months. As the 1.14 ratio falls between 0.8 and 1.25 is indicates there are no adverse impacts for ethnic minority colleagues. Our race disparity ratio is similar to the national benchmark, although the percentage of colleagues experiencing bullying and harassment from other colleagues is lower than the national benchmark.

Organisation Data for 2023 and National Benchmark Comparator

	White	Ethnic Minority Background	Race Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	20.4%	23.4%	1.14	Deterioration
National Benchmark	22.4%	26.2%	1.17	Improvement

As reflected in the table below, performance for this indicator over the last 5 years indicates a mixed picture and

inconsistent patterns or trends, with 2019 and 2021 seeing improvements and other years seeing a deterioration in both the race disparity ratio and the percentage of colleagues reporting they have experienced bullying and harassment from other colleagues.

Organisation Data Over Time

	White	Ethnic Minority Background	Race Disparity Ratio	Change From Previous Year
2023	20.4%	23.4%	1.14	Deterioration
2022	20.9%	22.7%	1.08	Deterioration
2021	20.3%	18.2%	0.90	Improvement
2020	23.6%	26.2%	1.11	Deterioration
2019	25.9%	24.0%	0.93	Improvement

Ethnic Group National Staff Survey Data 2023 (and 2022 for comparison)

		Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
	Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**
2023	**n = 4539**	**n = 738**	**n = 138**	**n = 72**	**n = 38**	**n = 3503**
	21.1%	22.9%	22.6%	31.9%	18.9%	20.4%
2022	**n = 4440**	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
	21.3%	22.3%	23.2%	23.4%	25.8%	20.8%

From reviewing the ethnicity group data set for this WRES indicator, it was found that colleagues who identified as being from Mixed/ Multiple ethnic group Background reported the greatest incidence of bullying, harassment and abuse from colleagues with 31.9% reporting one or more incident - this is an increase of 8.5% over last years' data. Colleagues in the Other ethnic groups category have reported a decrease of 6.9% on last year's data.

INDICATOR 7 – CAREER PROGRESSION AND PROMOTION

The data for this indicator shows 49.7% of ethnic minority colleagues and 62.4% of white colleagues believe our organisation provides equal opportunities for career progression and promotion. The race disparity ratio of 1.25 is just within the recommended range and indicates there is no adverse impact for colleagues from an ethnic minority background. Our race disparity ratio is slightly less favourable for ethnic minority colleagues than the national benchmark however our staff survey percentage results for ethnic minority colleagues are almost the same.

Organisation Data for 2023 and National Benchmark Comparator

	White	Ethnic Minority Background	Race Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	62.4%	49.7%	1.25	Improvement
National Benchmark	58.8%	49.6%	1.19	Improvement

Performance for this indicator as indicated in the table below has remained fairly static over the last 5 years with a dip in 2021.

Organisation Data Over Time

	White	Ethnic Minority Background	Race Disparity Ratio	Change From Previous Year
2023	62.4%	49.7%	1.25	Improvement
2022	62.0%	48.5%	1.28	Improvement
2021	60.7%	45.5%	1.33	Deterioration
2020	62.4%	49.5%	1.26	Same
2019	62.4%	49.7%	1.26	Improvement

Ethnic Group National Staff Survey Data 2023 (and 2022 for comparison)

		Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
	Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**
2023	**n = 4539**	**n = 738**	**n = 138**	**n = 72**	**n = 38**	**n = 3503**
	59.2%	51.5%	43.1%	47.9%	41.7%	62.4%
2022	**n = 4440**	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
	59.2%	49.6%	44.8%	42.1%	45.2%	62.0%

The National Staff Survey data when broken down by ethnic minority group found that colleagues from Other Ethnic Groups were most likely to state they did not believe there were equal opportunities for career progression or promotion, furthermore the percentage had decreased by 4.5% on the previous year's results. The category of mixed/multiple ethnic groups has seen the biggest positive increase in response (5.8% from last years' data).

INDICATOR 8 – EXPERIENCE OF DISCRIMINATION FROM MANAGER OR COLLEAGUES

The table below displaying the Organisation Data for indicator 8, shows that 15.6% of ethnic minority colleagues and 5.5% of white colleagues have reported experiencing discrimination at work from a manager, team leader or other colleagues through the national Staff Survey. This leads to a race disparity ratio of 2.84 which indicates there is likely to be a considerable negative impact for ethnic minority group colleagues for this indicator. The race disparity ratio for this indicator is the worst out of all the WRES indicators measured, has remained outside of the recommended disparity ratio consistently since 2019, and is less favourable than the national benchmark, therefore improvement work needs to take place as a matter of urgency to reduce discrimination against colleagues from ethnic minority backgrounds.

Organisation Data for 2023 and National Benchmark Comparator

	White	Ethnic Minority Background	Race Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	5.5%	15.6%	2.84	Deterioration
National Benchmark	6.7%	16.2%	2.40	Improvement

This year we have seen a further deterioration in the race disparity ratio. The results across the last 5 years have remained fairly static aside from an increase in ethnic minority colleagues reporting discrimination in 2020 and 2023. 2023 has also seen a reduction in the percentage of white colleagues reporting experiencing discrimination from managers, team leaders or other colleagues.

Organisation Data Over Time

	White	Ethnic Minority Background	Race Disparity Ratio	Change From Previous Year
2023	5.5%	15.6%	2.84	Deterioration
2022	6.5%	12.9%	1.98	Deterioration
2021	6.9%	12.5%	1.81	Improvement
2020	6.0%	17.6%	2.94	Deterioration
2019	5.8%	12.9%	2.22	Deterioration

Ethnic Group National Staff Survey Data 2023 (and 2022 for comparison)

		Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
	Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**
2023	**n = 4539**	**n = 738**	**n = 138**	**n = 72**	**n = 38**	**n = 3503**
	7.7%	15.6%	17.8%	17.1%	2.7%	5.5%
2022	**n = 4440**	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
	7.9%	13.4%	15.6%	10.4%	10.0%	6.5%

To look more closely of the experience of different ethnic minority groups the National Staff Survey data for this item was reviewed, it was found that colleagues who are from a Black / African / Caribbean ethnic group report experiencing the most discrimination with 17.8% stating they have personally experienced discrimination from their manager or colleagues, this was followed by Asian / Asian British colleagues at 17.1% which is a marked increase of 6.7% from last year. Colleagues who identify as 'Other ethnic groups' have recorded a marked decrease of 7.3% from last year.

INDICATOR 9 – BOARD MEMBERSHIP

Whilst we have 1 Board member who belongs to an ethnic minority group, at present none of the Board's 12 voting members belong to an ethnic minority background. Compared with an overall workforce representation of 27.5% this means representation is 27.5% lower than our workforce and is therefore not proportionately representative. There is no ethnic minority group representation within our 10 Executive Board members either, again meaning the representation is 27.5% lower than our workforce.

WRES ACTION PLAN

Nationally, NHS England have set six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

The improvement plan aims to improve the outcomes, experience and culture for those with protected characteristics under the Equality Act 2010 (although it is not limited to these groups) and links to the NHS People Plan. The six actions are as follows, all of which have been built into our strategic EDI action plan:

1) Chief Executives, Chairs and Board Members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2) Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3) Develop and implement an improvement plan to eliminate pay gaps.
4) Develop and implement an improvement plan to address health inequalities within the workforce.
5) Implement a comprehensive induction, onboarding and development programme for internationally-recruited colleagues.
6) Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Organisations are mandated to produce a detailed WRES action plan, elaborating on the priority areas identified in this report and setting out the next steps with milestones for expected progress against the WRES indicators. The actions will be formulated in conjunction with colleagues who participate in the organisation's Ethnicity Ambassador Forum and will be incorporated within both the Equality, Diversity and Inclusion Strategic Action Plan and the dedicated workforce focused actions as outlined in Our People Plan (which is the Workforce and Organisational Development Strategy for the strategic aim To Be Supportive and Inclusive).

In addition to the Trust wide EDI Strategy and People Plan, we are working collaboratively with the Lancashire and South Cumbria Integrated Care Board (ICB) Belonging Delivery Group. There is a ICB Belonging Group focus on improving the following key WRES metrics that are again in alignment with the Trust's EDI action plan:

- Increase diverse recruitment from shortlisting
- Targeted talent management and career development opportunities
- Reduction in bullying and harassment from the public and patients
- Equal board representation

An additional related piece of work which has been undertaken at a regional level is in respect of the NorthWest Black, Asian and Minority Ethnic Assembly Anti-Racist Framework which encourages organisations to take an unapologetically anti-racist stance, taking positive action to eliminate racism across NHS organisations. The five anti-racist principles are;

1) Prioritise Anti-Racism
2) Understand Lived Experience
3) Grow Inclusive Leaders
4) Act to Tackle Inequalities
5) Review Progress Regularly

These principles are supported by an assessment framework which is organised into three levels of achievement; Bronze, Silver and Gold, with each level building on the next. Each level contains a number of actions which organisations must evidence in order to be 'accredited' as working at that level.

The strategic action plan will address the priority areas for improvement as found through the analysis of our data against the 9 WRES indicators alongside the views, ideas and actions valued by colleagues in the Ethnic Minority Inclusion Forum. For clarity the areas of focus in the strategic action plan for the next 12 months to support WRES improvements are:

- Increasing the likelihood of candidates from an ethnic minority background being appointed from short listing across all posts/bands.
- Increase the percentage of colleagues from an ethnic minority background occupying more senior roles (specifically Band 9, VSM and voting Board member roles).
- Reducing the percentage of colleagues from an ethnic minority background experiencing discrimination at work from their manager, team leader or other colleagues

Work has already commenced to support the career progression of ethnic minority colleagues with the launch of the Inclusive Leadership in Lancs programme in 2021; a programme which was co-designed with colleagues, specifically to support our talented ethnic minority aspiring leaders of the future who currently occupy band 5-8a posts. The programme is being evaluated at the moment, incorporating colleague feedback as well as understanding career progression of those who attended the programme. The aim is to have a revised and updated offer available for colleagues before the end of 2024.

We have already taken positive action to ring fence a proportionally representative percentage of accredited (e.g. Institute of Leadership and Management Level 2, Consultant Leadership Development etc.) and non-accredited (e.g. Continuous Improvement Programmes, Core People Management Skills, Senior Leadership Development etc.) leadership/management development taught programmes for colleagues with protected characteristics and our Leadership team have attended the Ethnicity Inclusion forum to promote their development offers to colleagues.

A significant amount of work has been undertaken over the past 12 months to re-socialise the Zero Tolerance approach, toolkit and standards across the organisation; a campaign designed to encourage colleagues who are bystanders to challenge inappropriate behaviour whilst promoting an environment of safety, mutual care, respect and understanding, aiming to support a reduction in discrimination, violence, aggression, bullying and abuse.

Some actions scheduled for progression over the next twelve months are to; overhaul our recruitment processes in conjunction with the Head of Recruitment; design a talent management strategy that targets under-representation and lack of diversity at senior levels, specifically addressing issues around attracting and retaining younger talent as well as ensuring equity of career progression opportunities for staff of all protected characteristics (particularly internationally recruited staff) and to develop and deliver a comprehensive induction, onboarding and development programme for internationally recruited colleagues. We are also working across the Lancashire & South Cumbria ICB to advance a number of projects which will help progress the inclusion agenda namely; designing and delivering Cultural Awareness training, Delivering on Anti-Racism and Mutual Mentoring.

Next steps:

- To share this report with the Ethnic Minority Inclusion Forum to seek their views and lived experience in relation to these findings as well as to understand additional actions they believe will help to reduce

inequality and increase inclusion.

- To consult and co-produce with the Ethnic Minority Inclusion Forum on the strategic action plan for equality, diversity and inclusion and seek their views on the content, understand what else forum members would want to see and make further amendments based on feedback.
- Communicate results and action plan to our workforce through
    - Sharing results and actions with the Equality, Diversity and Inclusions Steering Group, for consideration as to how themes from the WRES report can support both corporate and divisional levels actions.
    - Sharing through Divisional Workforce Committee meetings.
    - Sharing further updates with the Ethnic Minority Inclusion forum.
    - Managers Update Sessions.
    - Specific organisation wide communications in conjunction with the Communications team.
- Publish our results and action plan externally on the Trust website
- The strategic action plan will be implemented, with progress measured through the Equality Strategy Group and outcomes will be reviewed utilising the Staff Survey in conjunction with workforce data results.

FINANCIAL IMPLICATIONS

Research evidence indicates that, when ethnic minority colleagues report greater engagement, there is a correlation with safer care for patients, reduced turnover, less sickness absence and improved financial performance.

LEGAL IMPLICATIONS

Unsatisfactory progress may leave the Trust open to legal challenges. We are required to demonstrate all colleagues have access to provision of services and are not discriminated against because of a protected characteristic.

RISKS

Unsatisfactory progress would be a risk to our reputation; both as a provider of Excellent Care with Compassion but also as an employer of choice.

IMPACT ON STAKEHOLDERS

There is a wide body of research evidence within the NHS which tells us that the experiences of our ethnic minority colleagues acts as a good barometer for the experience of our patients; the more positive the experience of our ethnic minority colleagues, the more positive the experience of our patients.

RECOMMENDATIONS

It is recommended that the Board;

I. receive the report
II. note the content
III. note the priority areas for action and
IV. approve external publication of our results.

THE WORKFORCE RACE EQUALITY STANDARD 2024

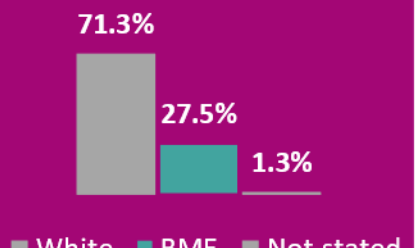
Together

NHS Lancashire Teaching Hospitals NHS Foundation Trust

The NHS Workforce Race Equality Standard (WRES) was devised to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. There are nine WRES indicators. The infographic (for 2023) below highlights any differences between the experience and treatment of White colleagues and ethnic minority colleagues, as an organisation we are committed closing those gaps through the development and implementation of actions to bring about continuous improvement over time.

OUR DATA AND KEY FINDINGS

REPRESENTATION



APPOINTMENTS

White candidates are **1.4** times more likely than **ethnic minority** candidates to be appointed from shortlisting

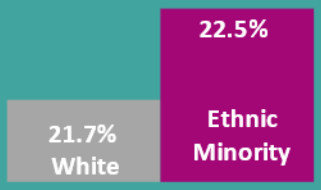
DISCIPLINARY PROCESS

Ethnic minority colleagues are **0.44** times less likely to enter a formal disciplinary process than **white** colleagues

TRAINING AND DEVELOPMENT

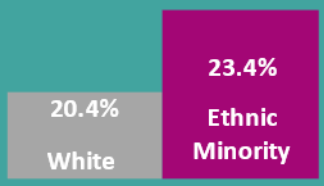
White colleagues are **1.00** times more likely to access non - mandatory training and CPD compared to ethnic minority colleagues

BULLYING AND HARRASSMENT FROM PAITENTS AND THE PUBLIC



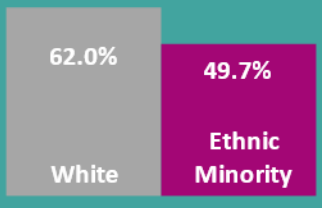
22.5% of Ethnic Minority colleagues experienced harassment, bullying or abuse from patients, relatives or public in the last 12 months

BULLYING AND HARRASSMENT FROM COLLEAGUES



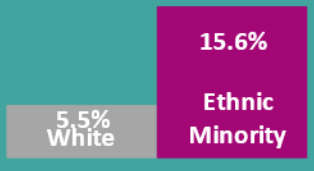
23.4% of **Ethnic Minority** colleagues experienced harassment, bullying or abuse from other colleagues in the last 12 months

CAREER PROGRESSION



49.7% of **Ethnic Minority** colleagues believe the Trust provides equal opportunities for career progression or promotion

DISCRIMINATION



15.6% of **Ethnic Minority c**olleagues reported experiencing discrimination from their manager / team leader / colleagues within last 12 months

BOARD MEMBERSHIP

1 Board Member identif ies as belonging to an ethnic minority group, out of a total of 22 Board Members

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Workforce Disability Equality Standard (WDES) Report 2024							
Report to:	Board			**Date:**	6th June 2024		
Report of:	Chief People Officer			**Prepared by:**	E Hickman		
Part I	*X*			**Part II**			
Purpose of Report							
For assurance	☒	**For decision**	☐	**For information**	☐		

Executive Summary:

The purpose of this report is to share the data which will form the submission and subsequent publication of the 2024 Workforce Disability Equality Standard (WDES) for our Trust. It sets out priority areas for action based on analysis of the results which include workforce data and findings from the latest staff survey. The Committee are asked to review and approve the contents of the report for publication and to consider the areas for action and associated next steps which are to consult with the Disability Inclusion Forum with regards to the results, understand their lived experience, the actions which will make the greatest impact and to seek feedback on the draft action plan, making changes where necessary.

The priority areas recommended for action are those which are indicating disabled colleagues are being adversely impacted or disadvantaged according to the four-fifths rule are:
Metric 3 – Likelihood of colleagues with a disability entering the formal capability process.
Metric 4a – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public.
Metric 4b – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from managers.
Metric 4c - Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from colleagues.
Metric 6 – Percentage of colleagues who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
Metric 7 - Percentage of colleagues saying that they are satisfied with the extent to which their organisation values their work.

It is recommended that the Board;

I. receive the report
II. note the content
III. note the priority areas for action and
IV. approve external publication of our results.

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 – May 2024			

INTRODUCTION

The Workforce Disability Equality Standard (WDES) is a mandated requirement through the NHS standard contract which was launched in April 2019, making this the sixth WDES report. Organisations are instructed to report and publish their WDES data on an annual basis, illustrating organisational progress against ten indicators relating to workforce disability equality.

RESULTS

For each of the indicators the data is compared for Disabled colleagues and non-disabled colleagues. National staff survey averages and organisational results for the last 5 years have been included for comparative purposes where applicable to the metric being reviewed.

The approach used by the national WDES team with regards to the ongoing Disability Disparity Audit work is to utilise the four-fifths ("4/5ths" or "80 percent") rule to highlight whether practices have an adverse impact on an identified group, e.g. a sub-group of ethnicity or disability. For example, if the relative likelihood of an outcome for one sub-group compared to another is **less than 0.8 or higher than 1.25**, then the process would be identified as having an adverse impact.

Summary Data

Improvements have been seen for Disabled colleagues across the following indicators;

- **Metric 1 – Representation**, we have seen some increases in the percentage of disabled colleagues across our workforce as a whole, furthermore it is positive to note increase in representation in bands 8a, 8b, and 8c roles. Whilst there is much more work to do to increase disclosure of disability and supporting disabled colleagues to progress we are making small steps forward.
- **Metric 4a – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public.** The disparity ratio indicates a negative impact on disabled colleagues, however it has improved since last year.
- **Metric 4b – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from managers.** The disparity ratio indicates a negative impact on disabled colleagues, however it has improved since last year.

- **Metric 4c - Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from colleagues.** The disparity ratio indicates a negative impact on disabled colleagues, however it has improved since last year.
- **Metric 4d - Percentage of colleagues saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.** This score has both improved since last year and is within the race disparity ratio boundaries to indicate no adverse impact for disabled colleagues.
- **Metric 5 - Percentage believing the trust provides equal opportunities for career progression or promotion.** This score has improved since last year, however it remains within the disability disparity ratio boundaries to indicate no adverse impact for disabled colleagues.
- **Metric 7 - Percentage of colleagues saying that they are satisfied with the extent to which their organisation values their work.** This score has improved since last year but it is above the disability disparity ratio boundaries to indicate there is an adverse impact for disabled colleagues.
- **Metric 8 - Percentage of disabled staff saying their employer has made adequate adjustments to enable them to carry out their work.** This score has improved this year and is above the Picker national average.
- **Metric 10 – Board Representation.** 11.1% of voting Board members identify as having a disability, this has increased since last year and above the NHS national average.

The following indicator shows a **deterioration** in the experience of our Disabled colleagues;

- **Metric 2 – likelihood of appointing disabled candidates from shortlisting.** This has deteriorated slightly this year but remains within the expected disparity ratio range of 0.8-1.25.
- **Metric 3 – Likelihood of entering formal capability process** The disparity ratio has deteriorated this year from 1.9 in 2022/23 to 2.07 in 2023/24. This shows that there is an adverse impact on disabled colleagues entering the formal capability process.
- **Metric 6 – Percentage of colleagues who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.** This score has deteriorated since last year, it still falls above the disparity ratio boundary indicating that there is an adverse impact for colleagues who are disabled.
- **Metric 9 – Staff Engagement**. The disparity ratio has deteriorated this year, is in line with the national average, and shows no adverse impact for disabled colleagues

METRIC 1 – REPRESENTATION

This section details the percentage of colleagues in each of the AFC bands 1-9 and VSM for both clinical and non-clinical colleagues who are disabled and non-disabled compared with colleagues in the overall workforce.

Currently we know that 573 of our colleagues have recorded they have a long-term condition or disability with ESR which equates to 5.5% of our workforce. We understand from the most recent National Staff Survey completion however that 25.3% of colleagues who took part in the staff survey indicated they have a long-term condition/disability (at least 1149 colleagues). If these colleagues updated ESR to reflect their long-term condition/disability, this would help to support more accurate data for the non-staff survey metrics i.e. 1 and 3.

As displayed in the table below, disabled colleagues have stronger representation in non-clinical roles which are at band 3, 4, 5, 8a, 8b,8C and VSM. For the majority of bands we have seen an increase in the percentage of disabled colleagues, of note is the band 4, 5 and 8c which all show an increase of over 2%.

For clinical roles, there has been an increase in disabled colleague representation in band 2, band 3, band 4, band 6, band 7, and band 8a, in comparison to 2023 data. For both clinical and non-clinical roles we need to take action to improve the percentage of disabled colleagues in more senior level roles, from band 8a and above.

Agenda for Change Workforce

Non-Clinical	% Disabled 2023	% Disabled 2024	Clinical	% Disabled 2023	% Disabled 2024
Under Band 1	14.3%	14.3%	**Under Band 1**	-	25.0%
Band 1	-	-	**Band 1**	-	-
Band 2	4.8%	5.0%	**Band 2**	6.3%	6.5%
Band 3	6.4%	7.0%	**Band 3**	4.9%	6.6%
Band 4	5.0%	7.2%	**Band 4**	7.3%	9.7%
Band 5	5.2%	7.9%	**Band 5**	4.7%	4.5%
Band 6	2.3%	3.6%	**Band 6**	5.6%	6.8%
Band 7	6.3%	5.7%	**Band 7**	3.6%	4.2%
Band 8a	7.5%	8.5%	**Band 8a**	5.3%	5.9%
Band 8b	7.4%	8.3%	**Band 8b**	2.1%	1.7%
Band 8c	4.2%	6.9%	**Band 8c**	4.5%	4.5%
Band 8d	-	-	**Band 8d**	-	-
Band 9	-	-	**Band 9**	-	-
VSM	10.0%	10.0%	**VSM**	50.0%	50.0%
Total	4.7%	6.1%	**Total**	4.8%	5.8%

With regards to the Medical and Dental Workforce, there is limited levels of self-declaration of long-term condition, illness of disability, as illustrated in the table overleaf. Work needs to be undertaken with this workforce group to encourage self-reporting, changing perceptions around disclosing a disability and creating feelings of psychological safety in sharing this information with us as an employer.

Medical and Dental Workforce

Role	% Disabled Background 2023	% Disabled Background 2024
Consultants	0.9%	0.8%
Non-consultant career grade	2.3%	3.2%
Trainee grades*	2.3%	2.8%

*Excludes Lead Employer Medical and Dental Trainees

METRIC 2– LIKELIHOOD OF APPOINTMENT FROM SHORTLISING

The table below, indicates the likelihood of disabled candidates being appointed from shortlisting. The disparity ratio for this indicator has deteriorated slightly since last year, moving from 1.13 in 2023 to 1.19 in 2024 this remains within the disparity ratio boundary of 0.80-1.25 indicating there's no adverse impact on disabled colleagues.

	2022 - 2023		2023 - 2024	
	Disabled (n=)	**Non-Disabled (n=)**	**Disabled (n=)**	**Non-Disabled (n=)**
Number of shortlisted applicants	842	9255	746	7601
Number appointed from shortlisting	225	2800	197	2388
% appointed from shortlisting	26.72%	41.7%	26.40%	31.41%
Disparity ratio	**1.13**		**1.19**	

METRIC 3 – LIKELIHOOD OF ENTERING FORMAL CAPABILITY PROCESSES

Metric 3 indicates disabled colleagues are 2.07 times more likely to enter the formal capability process, a deterioration from last year's results. This remains an area for action as it falls outside of the disparity ratio. Upon reviewing the supporting data, the average cases are very low therefore care must be taken before drawing a conclusion; across 2023 - 2024 there was an average of 15.5 formal capability cases per year involving disabled staff and an average of 85.5 for non-disabled colleagues.

	2022 - 2023		2023 - 2024	
	Disabled (%)	**Non-Disabled (%)**	**Disabled (%)**	**Non-Disabled (%)**
% of colleagues entering the formal capability process	0.52%	0.27%	0.87%	0.42%
Disparity ratio	**1.90**		**2.07**	

METRIC 4 – BULLYING, HARRASSMENT OR ABUSE

METRIC 4A – PERCENTAGE OF STAFF EXPERIENCING HARASSMENT, BULLYING OR ABUSE FROM PATIENTS, SERVICE USERS OR THE PUBLIC IN THE LAST 12 MONTHS

The data displayed overleaf highlights an improvement in the disparity ratio from last year's WDES report however the staff survey results show a slight deterioration with more disabled and non-disabled colleagues reporting they have experienced bullying, harassment or abuse from patients, service users or the public. With a disparity ratio of 1.36, this is it considered to have an adverse impact for colleagues with a disability, LTC or illness compared with colleagues without a disability, LTC or illness as it falls outside of the range of 0.8 – 1.25.

Organisation Data for 2023 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	27.0%	19.9%	1.36	Improvement
National Benchmark	30.4%	23.8%	1.28	Deterioration

Performance for this indicator as indicated in the table indicates that the disparity ratio continues to be an area for improvement.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2023	27.7%	19.9%	1.36	Improvement
2022	27.0%	18.5%	1.46	Improvement
2021	27.7%	18.7%	1.48	Deterioration
2020	27.1%	20.8%	1.30	Deterioration
2019	30.6%	23.6%	1.29	Improvement
2018	34.5%	24.0%	1.44	-

METRIC 4B – PERCENTAGE OF STAFF EXPERIENCING HARASSMENT, BULLYING OR ABUSE FROM MANAGERS IN THE LAST 12 MONTHS

The data displayed below focuses on colleagues who have experienced harassment, bullying or abuse from managers. The disparity ratio shows a greater adverse impact for disabled colleagues with this group being 1.75 times more likely to report experiencing harassment, bullying or abuse from managers in the last 12 months than non-disabled colleagues. The disparity ratio indicates there continues to be a need for further action.

Organisation Data for 2023 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	11.7%	6.7%	1.75	Improvement
National Benchmark	15.9%	8.7%	1.83	Deterioration

Performance for this indicator over time as displayed below has been mixed, with the 2021 data showing the worst position since WDES reporting was initiated. The disparity ratio has improved each year since then, however we still have a way to go before we are within the 0.80-1.25 range.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2023	11.7%	6.7%	1.75	Improvement
2022	13.2%	6.9%	1.91	Improvement
2021	14.7%	7.4%	1.98	Deterioration
2020	16.5%	9.8%	1.68	Improvement
2019	19.2%	11.3%	1.70	Deterioration

2018	20.4%	12.5%	1.63	-

METRIC 4C – PERCENTAGE OF STAFF EXPERIENCING HARASSMENT, BULLYING OR ABUSE FROM COLLEAGUES IN THE LAST 12 MONTHS

The data displayed below focuses on colleagues who have reported experiencing harassment, bullying or abuse from other colleagues. The disparity ratio shows an adverse impact for disabled colleagues indicating a need for further immediate action, although it is lower than the national benchmark.

Organisation Data for 2023 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	23.0%	16.0%	1.44	Improvement
National Benchmark	25.9%	16.6%	1.56	Deterioration

Performance for this indicator over time as displayed below has been mixed, with this year's results again indicating we are starting to see our second year of improvement.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2023	23.0%	16.0%	1.44	Improvement
2022	25.4%	16.2%	1.57	Improvement
2021	24.2%	14.0%	1.72	Deterioration
2020	26.7%	17.3%	1.54	Deterioration
2019	27.5%	18.5%	1.49	Improvement
2018	29.0%	18.1%	1.60	-

METRIC 4D – PERCENTAGE OF STAFF SAYING THAT THE LAST TIME THEY EXPERIENCED HARASSMENT, BULLYING OR ABUSE AT WORK, THEY OR A COLLEAGUE REPORTED IT

The data found that 50.6% of colleagues with a disability, LTC or illness and 52.0% of colleagues without a LTC or illness reported occasions where they experienced harassment, bullying or abuse. The disparity ratio falls between 0.8 – 1.25 indicating, for this metric, there is no adverse impact for colleagues with a disability, LTC or illness. The organisations score is similar to the national benchmark.

Organisation Data for 2023 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	50.6%	52.0%	1.03	Improvement
National Benchmark	50.4%	49.3%	1.02	Improvement

Performance for this indicator over time as displayed below is fairly static, however we have now seen a slight deterioration in staff survey responses for disabled colleagues over the last year.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2023	50.6%	52.0%	1.03	Improvement
2022	53.2%	51.7%	0.97	Deterioration
2021	46.6%	46.1%	0.99	Improvement

2020	49.4%	46.1%	0.93	Deterioration
2019	48.3%	47.2%	0.98	Deterioration
2018	46.5%	46.2%	0.99	No comparator

METRIC 5 – CAREER PROGRESSION AND PROMOTION

The data shows that 53.9% of colleagues with a disability and 61.0% of colleagues without a disability believed that our organisation provides equal opportunity for career progression or promotion. The disparity ratio falls just between 0.8 – 1.25 indicating for this metric there is no adverse impact for colleagues with a disability, LTC or illness. The organisations score is very similar to the national benchmark.

Organisation Data for 2023 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	53.9%	61.0%	1.13	Improvement
National Benchmark	51.5%	57.5%	1.12	Deterioration

Performance for this indicator over time as displayed below remains fairly constant, without much movement in disparity ratio or the staff survey responses.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2023	53.9%	61.0%	1.13	Improvement
2022	52.4%	61.4%	1.17	Deterioration
2021	52.8%	60.0%	1.14	Deterioration
2020	55.4%	61.6%	1.11	Improvement
2019	53.8%	61.8%	1.15	Deterioration
2018	51.8%	58.1%	1.12	-

METRIC 6 – PRESSURE TO COME TO WORK WHEN NOT FEELING WELL ENOUGH

The data found that 24.3% of colleagues with a disability and 16.0% of colleagues without a disability, LTC or illness felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. The disparity ratio falls outside of the 0.80 – 1.25 range at 1.51 indicating, for this metric, there is likely to be an adverse impact for colleagues with a disability, LTC or illness. The organisations score is very slightly worse than the national benchmark.

Organisation Data for 2023 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	24.3%	16.0%	1.51	Deterioration
National Benchmark	28.6%	19.5%	1.47	Deterioration

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2023	24.3%	16.0%	1.51	Deterioration
2022	26.1%	18.4%	1.42	Deterioration
2021	27.9%	21.7%	1.29	Improvement
2020	29.9%	21.9%	1.37	Deterioration

2019	29.4%	21.6%	1.36	Deterioration
2018	32.1%	24.0%	1.34	-

METRIC 7 – FEELING VALUED

The data found that 36.3% of colleagues with a disability and 49.8% of colleagues without a disability felt satisfied with the extent to which the organisation values their work. The disparity ratio falls outside of the 0.80 – 1.25 range at 1.37 indicating for this metric there is likely to be an adverse impact for colleagues with a disability, LTC or illness. The organisations score is slightly worse than the national benchmark although the disparity ratio has improved this year following deterioration year on year for the previous 4 years. The organisations score is very slightly worse than the national benchmark.

Organisation Data for 2023 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	36.3%	49.8%	1.37	Improvement
National Benchmark	35.7%	47.2%	1.32	Improvement

Performance for this indicator over time as displayed below shows that the disparity ratios have steadily declined since 2018.

Organisation Data Over Time

	Colleagues with a LTC or illness	Staff without a LTC or illness	Disparity Ratio	Change From Previous Year
2023	36.3%	49.8%	1.37	Improvement
2022	33.0%	48.4%	1.47	Deterioration
2021	35.8%	47.0%	1.31	Deterioration
2020	41.0%	51.4%	1.25	Deterioration
2019	39.5%	48.4%	1.23	Deterioration
2018	39.1%	47.0%	1.20	No comparator

METRIC 8 – ADEQUATE ADJUSTMENTS

This metric is concerned with the percentage of staff with a disability, LTC or illness who say the organisation has made adequate adjustments to enable them to carry out their work, 78.3% of colleagues with a disability, LTC or illness believed this has been their experience. We are unable to apply the disparity ratio to this metric as we do not have comparison data for colleagues who do not have a LTC or illness, as they are not invited to give feedback to this item in the National Staff Survey if they do not self-disclose to fall into having this protected characteristic. The organisations score is better than the national benchmark.

Organisation Data for 2023 and National Benchmark Comparator

	Colleagues with a disability, long term condition or illness	Change From 2022
Lancashire Teaching Hospitals	78.3%	Improvement
National Benchmark	73.4%	Improvement

Performance for this indicator over time has been mixed, typically with around 70-80% of colleagues with an LTC or illness feeling adequate adjustments have been made to support them to carry out their work across this period. The last two years have shown a continued positive improvement in this metric.

Organisation Data Over Time

	Colleagues with a disability, long term condition or illness	Change From Previous Year
2023	78.3%	Improvement
2022	75.1%	Improvement
2021	72.6%	Deterioration
2020	80.8%	Improvement
2019	74.7%	Improvement
2018	73.3%	-

METRIC 9 – ENGAGEMENT AND HAVING A VOICE

METRIC 9A – STAFF ENGAGEMENT SCORE

Colleagues with a disability had an engagement score of 6.5, those colleagues without a disability, LTC illness level of engagement was 7.1. This indicates that disabled staff continue to feel less engaged than non-disabled staff although the disparity ratio falls within the 0.8 – 1.25 range at 1.09 indicating for this metric there is no adverse impact for colleagues with a LTC or illness. The organisations score is very similar to the national benchmark.

Organisation Data for 2023 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2022
Lancashire Teaching Hospitals	6.5	7.1	1.09	Deterioration
National Benchmark	6.5	7.0	1.15	Deterioration

Performance for this indicator has remained very stable over time.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2023	6.5	7.1	1.09	Deterioration
2022	6.4	7.0	0.92	Same
2021	6.4	7.0	0.92	Improvement
2020	6.7	7.1	0.94	Same
2019	6.6	7.0	0.94	Deterioration
2018	6.6	7.0	0.95	-

METRIC 9B – FACILITATING THE VOICES OF DISABLED STAFF TO BE HEARD

Whilst this is not measured as part of the National Staff Survey therefore it is not possible to share performance in the last 12 months or the disparity ratio for this metric. There is a Living with Disability Ambassador Forum set up within the Trust, along with a Neurodiversity Group offering support and a forum to discuss lived experiences. We are fortunate to have Kate Smyth as Non-Executive Director to be a Board level champion and national lead for disabled colleagues to

ensure we continue to strive to improve the experiences of colleagues with a disability, LTC or illness and ensure their voices are heard with responsive actions taken.

METRIC 10 – BOARD MEMBERSHIP

11.1% of the Board's voting membership identify as having a disability, this is greater than the NHS average of 4.8% and increase from our position of 10.5% reported last year. Further actions are required to understand if there are a proportion of Board members who have not disclosed their disability or long-term illness/condition, as well as taking supportive actions which continue to increase the diversity of Board membership.

WDES ACTION PLAN

Nationally, NHS England have set six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. The improvement plan aims to improve the outcomes, experience and culture for those with protected characteristics under the Equality Act 2010 (although it is not limited to these groups) and links to the NHS People Plan. The six actions are as follows, all of which have been built into our strategic EDI action plan:

1) Chief Executives, Chairs and Board Members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2) Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3) Develop and implement an improvement plan to eliminate pay gaps.
4) Develop and implement an improvement plan to address health inequalities within the workforce.
5) Implement a comprehensive induction, onboarding and development programme for internationally-recruited colleagues.
6) Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Organisations are mandated to produce a detailed WDES action plan, elaborating on the priority areas identified in this report and setting out the next steps with milestones for expected progress against the WDES metrics. The actions to supporting improvements against WDES are incorporated within the Workforce and Organisational Development strategic action plan for equality, diversity and inclusion. The strategic action plan, alongside this WDES report will be co-designed with colleagues who participate in the organisations Living with Disability Inclusion Forum.

The strategic action plan will address the priority areas for improvement as found through the analysis of our data against the 10 WDES indicators alongside the views, ideas and actions valued by colleagues in the Disability Inclusion Forum. For clarity the strategic action plan for the next 12 months to support WDES improvements are:

- Increase the declaration rates of disabilities and long-term conditions by colleagues and reduce the % of ‘not known’ against the disability field in our electronic staff record
- Improve the experience of disabled colleagues in respect of experiencing harassment, bullying or abuse from patients, relatives or other members of the public; managers and other colleagues
- Increase the percentage of disabled staff saying they are satisfied with the extent to which the organisation values their work.

- Continue to increase the percentage of colleagues who say the organisation has made adequate adjustments to enable them to carry out their work

Over the last 12 months we launched a Zero Tolerance toolkit as part of a Trust wide campaign to encourage colleagues who are bystanders to challenge inappropriate behaviour whilst promoting an environment of safety, mutual care, respect and understanding, aiming to support a reduction in discrimination, violence, aggression, bullying and abuse. Work will continue over the next 12 months to get this further embedded into our organisation.

A significant amount of work was undertaken in respect of Reasonable/Adequate Adjustments; training around Reasonable/Adequate Adjustments has been provided to our recruitment team and a Managers Update session for line managers across the organisation, plus bespoke sessions for divisional workforce committees were delivered. A Neurodiversity toolkit has also recently been launched. Further work includes a review of the processes and touchpoints which can encourage colleagues to disclose a disability and/or report a recently acquired disability/long term condition, information sent out at interview stage to candidates (which encourages disclosure and to request adequate adjustments if needed) as well as guidance to Recruiting Managers. Consideration will also be given to centralising requests for adequate adjustments to enable monitoring and reporting in addition to ensuring the provision of a consistently positive experience for colleagues.

An action scheduled for progression over the next 6 months is to overhaul our recruitment processes and embed a talent management strategy that targets under-representation and lack of diversity and specifically addresses the issues around attracting and retaining younger talent, as well as equity of career progression opportunities for staff of all protected characteristics and particularly for internationally recruited staff.

Agreed actions will form part of the wider action plan for the Equality, Diversity and Inclusion agenda under the Equality Strategy and the Our People Plan.

Next steps:

- To share this report with the Living with Disability Inclusion Forum to seek their views and lived experience in relation to these findings as well as to understand the actions they believe will help to reduce inequality and increase inclusion.
- To share the Workforce and Organisational Development strategic action plan for equality, diversity and inclusion with the Living with Disability forum and seek their views on the content, understand what else forum members would want to see and make further amendments based on feedback.
- Submit results and action plan to the WDES team.
- Communicate results and action plan to our workforce through
    - Sharing results and actions with the Equality, Diversity and Inclusions Steering Group, for consideration as to how themes from the WDES report can support both corporate and divisional levels actions.
    - Sharing through Divisional Workforce Committee meetings.
    - Sharing further updates with the Disability Inclusion forum.
    - Managers Update Sessions.
    - Specific organisation wide communications in conjunction with the Communications team.
- Publish our results and action plan externally on the Trust website
- The strategic action plan will be implemented, with progress measured through the Equality Strategy Group and outcomes will be reviewed utilising the 2024 Staff Survey in conjunction with 2024 workforce data results.

FINANCIAL IMPLICATIONS

Research evidence indicates that, when organisations are more diverse and have a greater focus on inclusion colleagues report greater engagement, there is a correlation with safer care for patients, reduced turnover, less sickness absence and improved financial performance.

LEGAL IMPLICATIONS

Unsatisfactory progress may leave the Trust open to legal challenges. We are required to demonstrate all staff have access to provision of services and are not discriminated against because of a protected characteristic.

RISKS

Unsatisfactory progress would be a risk to our reputation; both as a provider of Excellent Care with Compassion but also as an employer of choice.

IMPACT ON STAKEHOLDERS

Research evidence within the NHS tells us that the experiences of our colleagues acts as a good barometer for the experience of our patients; the more positive the experience of our colleagues, the more positive the experience of our patients.

RECOMMENDATIONS

It is recommended that the Board:

I. receive the report
II. note the content
III. note the priority areas for action and
IV. approve external publication of our results.

The Workforce Disability Equality Standard 2024

Together

NHS Lancashire Teaching Hospitals NHS Foundation Trust

The Workforce Disability Equality Standard (WDES) is a set of ten specific metrics which enables NHS organisations to compare the workplace and career experiences of disabled and non -disabled staff. The infographic below (for 2023) highlights the differences between the experience and treatment of Disabled colleagues and Non-Disabled colleagues, as an organisation we are committed to closing those gaps through the development and implementation of actions to bring about continuous improvement over time.

OUR DATA AND KEY FINDINGS

REPRESENTATION

5.5% of colleagues have declared they have a disability or long-term health condition.

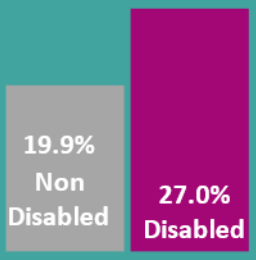
SHORTLISTING

Non-disabled colleagues are **1.19** times more likely to be appointed from shortlisting.

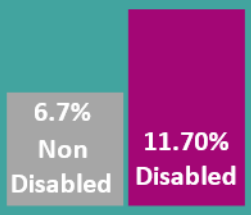
CAPABILITY PROCESS

Disabled colleagues are **2.07** times more likely to enter the formal capability process.

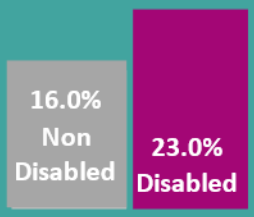
BULLYING, HARRASSMENT AND ABUSE



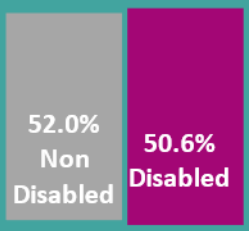
Colleagues experiencing harassment, bullying or abuse from patients, relatives or public



Colleagues experiencing harassment, bullying or abuse from managers



Colleagues experiencing harassment, bullying or abuse from colleagues



Colleagues reporting harassment, bullying or abuse

CAREER PROGRESSION

53.9%

of Disabled colleagues believe that the Trust provides equal opportunities for career progression or promotion, compared with 61.0% of Non-Disabled colleagues.

PRESSURE TO WORK

24.3%

of disabled colleagues have felt pressure from their manager to come to work, despite not feeling well enough to perform duties., compared with 16.0% of Non-Disabled colleagues.

FEELING VALUED

36.3%

of Disabled colleagues are satisfied with the extent to which their organisation values their work, compared with 49.8% Non-Disabled Colleagues.

REASONABLE ADJUSTMENTS

75.1%

Of Disabled colleagues saying their employer has made adequate adjustments to enable them to carry out their work.

STAFF ENGAGEMENT SCORE

Disabled colleagues feel less engaged at work

6.4/10 Disabled

7/10 Non-disabled

BOARD MEMBERSHIP

2 Board Members identify with having a disability or long-term health condition out of a total of 19 Board Members

Chair's Report

Committee:	Finance and Performance Committee
Chairperson and role:	Tricia Whiteside, Non-Executive Director
Date(s) of Committee meeting(s):	26 March 2024
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 26 March 2024. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee conducted a comprehensive review of the agenda's scheduled items, approved the meeting's minutes on 27th February 2024, subject to amendment by addendum to minute ref 38/24, and reviewed updates on associated Committee actions. Specific reports were received and scrutinised on the following standing agenda items:

Financial Performance:

Month 11 Finance Report: An extensive update on the Trust's financial performance for the year 2023/24 as at Month 11 was provided. The report highlighted:

- Deficit Plan: At the beginning of the year, the Trust had a deficit plan of £15.3 million. However, with additional national funding received in February, the deficit plan was reduced to just £0.4 million for the year 23/24. This change resulted in a surplus plan and actual achievement for February.
- Year-to-Date Deficit: The year-to-date deficit stood at £31.8 million against a plan of £2.5 million.
- Forecasted Deficit: The forecasted deficit for the year was revised to £35.6 million, down from the previous forecast.
- Additional Funding: Funding associated with industrial action was expected in March.
- Capital Investment: There was a significant amount yet to be spent in March, but the Trust was confident in delivering the capital target, ensuring that funds were appropriately justified and accounted for.
- Cash Management: Cash management remained under tight scrutiny, recognising the importance of vigilance in this area.

Operational Performance:

- **Performance Update:** An update was provided on the Trust's performance up to the end of February 2024, highlighting operational pressures and efforts to maintain safety and colleague well-being.

Strategy and Planning:

- **Planning Update:** The planning update highlighted ongoing efforts to achieve positive financial and systemic outcomes for the organisation. Challenges were discussed, including the lack of detailed guidance in urgent care transformation.

- **Transformation Update:** The Committee sought feedback from the Recovery and Transformation Board on year-end outcomes and overall sentiment. They emphasised the importance of highlighting organisational successes despite challenges, urging greater Board involvement in recognising achievements. Emphasis was placed on progress made and collective efforts needed to stabilise the organisation, acknowledging substantial work ahead. The multi-year nature of the transformational journey was acknowledged, underscoring the importance of celebrating achievements publicly to enhance the organisation's reputation and assure patients of quality care.

In addition, the Committee received reports for consideration/discussion for:

- **Financial Plan Update:** The financial plan update outlined the organisation's deficit and the challenges ahead in achieving financial targets, particularly regarding urgent and emergency care and elective procedures.

- **Financial Recovery Plan – Divisional Assurance:** Divisional Directors provided updates on initiatives and challenges within their respective areas, emphasising the need for collaboration and swift action to mitigate financial concerns.

- **NHP Land Assembly Business Case:** The Committee endorsed a proposal to the Board regarding a land assembly process in relation to the New Hospital Programme, with an emphasis on due diligence and risk assessment.

- **Costing Report:** The Trust's deficit was reviewed, and strategies for addressing deficits across service lines were discussed, emphasising the need for comprehensive reporting and strategic planning.

Items for the Board's attention

Positive escalation

- Engagement of divisional and clinical colleagues in planning activity, demonstrating a bottom-up approach aligned with top-down focus.
- Endorsement of the new hospital programme land assembly plan.
- Progress on Service Line Reporting (SLR) to ensure sustainable, affordable, and quality services.
- Consideration of more flexible and greater choice of contracts and support for staff well-being.
- Exploration of funding options to improve the built environment and staff comfort.

Negative escalation

- Operational pressures and challenges, particularly from the impacts of Boarding, and in addressing colleague experience and preventing burnout.
- Seeking further assurances across some underperforming areas of DNA, Diagnostics and Outpatients, and the revised recovery trajectories for ED.
- Concerns about the deliverability of the 2024/25 financial plan and the need to for careful vigilance in making decisions which are balanced across the quadruple aim.

Committee to Committee referral

Brought forward as an addendum to meeting held 27 February:

Referral to Safety & Quality: Negative escalation from Women & Children's DIF: Reduction in friends and family survey.

Referral to Workforce: Negative escalation from Women & Children's DIF:

a) a) OD training needs analysis to inform development plan.
b) b) Sickness review could be better Trust wide.

Items recommended to the Board for approval
None
Committee Chairs reports received
c) ICS, ICP, PCB system update d) Capital Planning Forum – no meeting e) SIRO/AIO Working Group f) IG and Records Committee – no meeting
Items where assurance was provided and/or for information
• Contract Performance • Deficit Protocol Controls Overview • Action Plans for DIFs **Feeder Group TOR:** • IG and Records Committee • IRO/AIO Working Group • Digital and Health Informatics Divisional Board • Strategic Risk Review • ICBIAG Update
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its Cycle of Business. The next meeting of the Committee will take place on 23 April 2024 using Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Finance and Performance Committee agenda (*26 March 2024*)

Chair's Report to Board		
Chair: T Whiteside	Committee: Finance and Performance	
Date(s): 23 April 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money - 20	⇨	Annual Operating Plan (endorsed)

ALERT

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

None

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

Forward Plan

- Annual Operating Plan: F&P endorsed the baseline plan whilst seeking further assurance of the associated single improvement plan to address financial sustainability; that operational ambitions are achievable in light of on-going challenges; and can be supported by adequate resource allocations including those of partner organisation and system colleagues - particular in respect of demand management impacts and dependant programme delivery.
- Integrated Performance Report, further work required to develop a robust suite of metrics upon which Board can monitor progress towards defined improvement outcomes; alignment of underlining assumptions upon which the plan was predicated; interlocked metrics with partner's, coupled with appropriate risk articulation on the plan's submissions given the scale of the challenge and where the Trust has critical dependencies.
- Planning Framework: on-going discussions continued on the need to tighten controls for Business Case Management; Strategic Decisioning; and the adequacy of the EQIA processes to protect unintended consequences of change and operational readiness for that change. The Committee acknowledged the aspiration to strengthen planning controls while recognising the risk of blind spots and the need for further clarity in key programme outcomes.

In Year Performance

- Financial Performance: The Trust continues to experience difficult financial pressures within a challenged

operating environment, and the resultant risks associated to cash drawings. Requires careful monitoring, with focus on income recovery, service break-even performance and CIP delivery, as encapsulated in the Financial Recovery Plan.

- Clinical Demand Management: further assurance sought on how the Trust is balancing the demand and supply of its clinical services, and where population demographics and local service provision are being brought together.
- Lancashire Procurement Collaborative: update received that future efforts would focus on tightening grip and control, improved contract management and setting more ambitious savings targets, leveraging collaborative opportunities across organisations. It was suggested that considered performance measures should be incorporated into the integrated performance report to ensure ongoing visibility and priority.

ASSURE

Assurance received; Matters of positive note.

- Year End: closing 23/24 year on plan for the committed financial targets, with appreciation expressed to all colleagues for the efforts in containing financial performance within the declared deficit target.
- Waiting Lists: significant shift achieved in-year on the 65-week elective with 29,000 waiting patients at the start of the year, reducing to 350 at year end. Thanks to all colleagues for their contribution and continued dedication to reduce waiting lists.
- Strategy Process Development: welcomed development of a new structured process, with feedback shared to ensure its robust in driving alignment between Trust and System goals. Emphasis was placed on being clear on the glide path of involvement and engagement events with local communities, external partners and stakeholders as progress is made towards the new Clinical Strategy.
- Committee Cycle of Business: further revisions are anticipated such as annual demand and capacity assessments, alignment of key processes and controls from the wider Risk Strategy work; and deep dives into specific high-risk transformation topics.

Finance and Performance Committee

26 March 2024 | 09.00 am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	09.00am	Verbal	Information	T Whiteside
2.	Apologies for absence	09.01am	Verbal	Information	T Whiteside
3.	Declaration of interests	09.02am	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 27 February 2024	09.03am	✓	Decision	T Whiteside
5.	Matters arising and action log	09.05am	✓	Decision	T Whiteside
6.	STRATEGY AND PLANNING				
6.1	a) Planning Update b) Financial Plan update	09.10am	✓	Assurance	G Doherty
6.2	Financial Recovery Plan – Divisional Assurance			Assurance	
	a) Overview (inc. Corporate)	09.30am	✓		A Mulholland-Wells
	b) Women & Children's	09.45am	✓		L Wilkinson
	c) Medicine	10.05am	✓		M Brown
	d) Surgery	10.25am	✓		K Hudson
	e) Diagnostics	10.45am	✓		R Dineley
11.05am - Comfort Break – 10 minutes					
7.	FINANCIAL PERFORMANCE				
7.1	NHP Land Assembly Business Case	11.15am	✓	Assurance	J Wood
7.2	Month 11 Finance Report	11.25am	✓	Assurance	A Mulholland-Wells

7.3	Costing Report (Q3 23-24 SLR)	11.40am	✓	Assurance	S Stow
8.	OPERATIONAL PERFORMANCE				
8.1	a) Performance Update b) Performance Assurance Report	11.50am 12.05am	✓ ✓	Assurance	I Devji
9.	GOVERNANCE AND COMPLIANCE				
9.1	Items for escalation to the Board or items to/from other Committees	12.15pm	Verbal	Information	T Whiteside
9.2	Reflections on the meeting and adherence to the Board Compact	12.25pm	✓	Information	T Whiteside
10.	ITEMS FOR INFORMATION				
10.1	Strategic Risk Review		✓		
10.2	Transformation Update		✓		
10.3	Action plans from Divisional Improvement Forums		✓		
10.4	Contract Performance		✓		
10.5	**Feeder Group TOR:** (a) IG and Records Committee (b) SIRO/AIO Working Group (c) Digital & Health Informatics Divisional Board		✓ ✓ ✓		
10.6	**Chairs' reports**: (a) ICS, ICP, PCB System update (b) Capital Planning Forum **– no meeting held** (c) IG and Records Committee **– no meeting held**		✓ ✓ ✓ ✓		
10.7	Deficit Protocol Controls Overview		✓		
10.8	ICBIAG Update		✓		
	Date, time and venue of next meeting: *23 April 2024 09.00am – 12.00pm* *Microsoft Teams*	12.30pm	Verbal	Information	T Whiteside

Finance and Performance Committee

23 April 2024 | 09.00 am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	09.00am	Verbal	Information	T Whiteside
2.	Apologies for absence	09.01am	Verbal	Information	T Whiteside
3.	Declaration of interests	09.02am	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 26 March 2024	09.03am	✓	Decision	T Whiteside
5.	Matters arising and action log	09.05am	✓	Decision	T Whiteside
6	Strategic Risk Review	09.10am	✓	Assurance	J Wood
7.	FINANCIAL PERFORMANCE				
7.1	M12 Finance Report	09.20am	✓	Assurance	A Mulholland-Wells
7.2	Lancashire Procurement Collaborative Update	09.35am	✓	Assurance	S Robson
7.3	Trading Accounts	09.45am	✓	Assurance	S Stow
8.	OPERATIONAL PERFORMANCE				
8.1	Performance Assurance Progress Report	09.55am	✓	Assurance	I Devji
9.	STRATEGY AND PLANNING				
9.1	Financial Recovery Plan Update	10.05am	Verbal	Information	J Wood
9.2	Single Improvement Plan	10.15am	✓	Information	J Wood
9.3	CI Annual Report	10.25am	✓	Information	A Brotherton

9.4	Planning Framework Update	10.35am	✓	Assurance	G Doherty
9.5	Strategy Process	10.45am	✓	Assurance	G Doherty
9.6	Annual Operating Plan	10.55am	✓	Assurance	G Doherty/J Wood
9.7	Stroke Business Case Update (min. ref: 25/24)	11.05am	✓	Assurance	G Doherty
9.8	Data Quality Assurance Report	11.15am	✓	Assurance	S Dobson
10.	GOVERNANCE AND COMPLIANCE				
10.1	Cycle of Business	11.25am	✓	Decision	J Foote
10.2	Committee Effectiveness Review	11.35am	✓	Decision	J Foote
10.3	Items for escalation to the Board or items to/from other Committees	11.45am	Verbal	Information	T Whiteside
10.4	Reflections on the meeting and adherence to the Board Compact	11.55am	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Action plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	**Feeder Group TOR:** (a) EPRR (b) Capital Planning Forum inc. expensive medical equipment		✓ ✓		
11.4	**Chairs' reports**: (a) ICS, ICP, PCB System update (b) Capital Planning Forum (c) EPRR (d) Digital & Health Informatics Divisional Board – stood down (e) ELFS Management Board Minutes – not submitted (f) CSESC Update		✓ ✓ ✓ ☒ ☒ ✓		
11.5	Deficit Protocol Controls Overview		✓		
11.6	Date, time and venue of next meeting: *28 May 2024 09.00am – 12.00pm* *Microsoft Teams*	12.00pm	Verbal	Information	T Whiteside

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

2024/25 Corporate Objectives			
Report to:	Board of Directors	**Date:**	6th June 2024
Report of:	Director of Strategy and Planning	**Prepared by:**	G Doherty/Lead Executives
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to present the 2024/25 Draft Corporate Objectives to the Board for approval. The 2024/25 Corporate Objectives are intended to lay out the key areas for action this year, including the measures of success, the Lead Director and which Board Subcommittee will receive assurance on delivery. The Corporate Objectives are intended to provide guidance for colleagues across the organisation in setting their departmental and individual objectives and are part of our new system of strategy and planning, along with the Single Improvement Plan and our developing Trust Strategy. As we develop our new system we will bring forward our planning timetable such that the draft Corporate Objectives will be presented in December to be finalised by March for the coming financial year.
It is recommended that the Board:

I. Approve the Draft Corporate Objectives

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

This report has not previously been to Board.

1. Context

The Trust is developing a new system of Strategy and Planning with three key outputs including a set of 1 year Corporate Objectives, a 3 year Single Improvement Plan and a Trust Strategy that will run up to 2030. This report presents the draft 2024/25 Corporate Objectives to the Board for approval.

2. Discussion

The attached draft Corporate Objectives have been developed by the Executive Team to lay out the key areas for action this year, including the measures of success, the Lead Director and which Board Subcommittee will receive assurance on delivery. The Corporate Objectives are intended to provide guidance for colleagues across the organisation in setting their departmental and individual objectives. Going forward, they will also support the development of divisional and corporate plans.

3. Next Steps

The Corporate Objectives are part of our new system of strategy and planning, along with the Single Improvement Plan and our developing Trust Strategy. As we develop our new system we will bring forward our planning timetable so the draft Corporate Objectives will be presented in December to be finalised by March for the coming financial year. The Trust Strategy is under development and is scheduled to come to the October Board. Once the Corporate Objectives are finalised they will be cascaded through our established systems to guide objective setting/appraisals.

4. Financial implications

There are no direct financial implications arising from the Corporate Objectives – any costs or benefits of the actions contained within the plan are already incorporated into our planning/budget setting cycle.

5. Legal implications

There are no direct legal implications arising from the Corporate Objectives.

6. Risks

There are no direct risks arising from the Corporate Objectives. Agreeing the Objectives and utilising them to drive the process of objective setting and appraisals will mitigate the risk of not delivering the Objectives themselves and the Single Improvement Plan.

7. Impact on stakeholders

There are no direct impact on stakeholders arising from the Corporate Objectives.

8. Recommendations

It is recommended that the Board:

I. Approve the Draft Corporate Objectives

Patients		Our ambition is to consistently deliver excellent care			
Purpose of the Objective		**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
1	Improve outcomes and prevent harm	• Review and improve the UEC pathway medical model. • Improvement in average time to see a clinician in ED • Progress in peer review compliance for specialist services. • Develop approach to medical staffing assurance. • Deliver medicines safety and optimisation programme • Lead delivery of CQC action plan • Implement PSIRF & demonstrate maturity in the approach to learning. • Conclude year 3 of the ASF strategy, develop the new ASF and learning strategy, • Deliver agreed C.difficile profile • Deliver 10 CNST safety actions • Deliver annual safe staffing requirements	• Improvement in time to see a clinician in ED • Patients will be seen by a senior decision maker in line with guidance UEC guidance. • % compliance with peer review recommendations • Documented approach to medical staffing assurance. • Improved verification and reconciliation compliance • % must and should do completion • Development of next Always Safety First and learning strategy • Deliver agreed C.difficile trajectory • Deliver 10 CNST safety actions • Deliver annual safe staffing requirements	Chief Medical Officer Chief Nursing Officer	Quality and Safety Committee
2	Deliver a positive patient experience	Improve the experience of inpatients, maintain position in ED, cancer and maternity	• Delivery of the Patient Experience & involvement strategy • Reduced numbers of patients in boarded beds • Implementation of Marthas rule • Evidence 90% complaints response times	Chief Nursing Officer/Chief Medical Officer	Quality and Safety Committee
3	To develop new ways of working across the system that lead to more effective patient interventions and pathways.	To deliver more services to patients outside of hospital: • Lead the approach to community transformation • Develop & deliver the community transformation plan • Change model of care at Finney House • Establish new ways of working with primary care to promote partnership approach to transformation • Clinically lead the transformation of patient pathways	• Integrated leadership team and decision-making forum for central Lancs community • Deliver agreed community transformation actions • New model of care/funding agreed for Finney House • Delivery of pathway specific improvement trajectories • Positive feedback in relation to partnership working across organisational boundaries	Chief Nursing Officer Chief Medical Officer	Quality and Safety Committee Finance and Performance Committee

Performance		Our ambition is to consistently deliver excellent care			
Purpose of the Objective		**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
7	To minimise the risk of harm to patients through the delivery of our cancer recovery plan	Delivery of additional elective activity to improve performance against cancer waiting times standards, working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access and working with locality partners to manage demand effectively.	• Improve performance against the headline 62-day standard to 70% by March 2025 • Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 • Maintain >62 day backlog at <151 patients	Chief Operating Officer	Finance & Performance Committee
8	To minimise the risk of harm to patients through the delivery of our elective recovery plan	Delivery of additional elective activity to improve performance against elective waiting times standards, working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access and working with locality partners to manage demand effectively.	• Maintain zero >78 week waits • Eliminate waits of over 65 weeks for elective care by September 2024 • Reduce waits of over 52 weeks to deliver agreed target by March 2025 • Reduce the DM01 backlog to achieve 95% of patients waiting <6 weeks	Chief Operating Officer	Finance & Performance Committee
9	To improve the responsiveness of urgent and emergency care	Working with our partners we will continue to transform urgent and emergency care to deliver safe, high-quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients and reducing length of stay.	• Improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2025 • Average time to senior clinical review of 60 minutes • Reduction in the number of patients waiting longer than 12 hours total time in department to deliver <4% by March 2025 (stretch target 2%)	Chief Operating Officer	Finance & Performance Committee

People		Our ambition is to be a great place to work			
Purpose of the Objective		**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
4	To enable better access to care by having the right people, in the right place, in the right number at the right time	• To deliver a workforce plan that meets the needs of the community	• Training and appraisal outcomes will be compliant at profession level. • Reduction in vacancies • Reduction in agency spend to at least meet the national target	Chief People Officer	Workforce Committee
5	To ensure we 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 and happy at work	• To maintain or improve position in staff survey • To progress staff advocacy scores relating to provision of care • Provision of suitable rest facilities for staff	Chief People Officer	Workforce Committee
6	To be consciously inclusive in everything we do	• To ensure staff are equipped with the skills to create inclusive cultures that deliver inclusive care	• Demonstrate maturing approach to EDI and extend further the scope of work to include health inequalities	Chief People Officer/Chief Nursing Officer	Workforce Committee

Productivity		Our ambition is to deliver value for money			
Purpose of the Objective		**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
7	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	• Delivery of agreed Financial Plan including the Financial Recovery Plan • The cash balance is sufficient to fund ongoing revenue commitments and planned capital investments. • Engage and communicate within the organisation to promote the Importance of sound financial management. • Deliver agreed capital programme	Chief Finance Officer	Finance & Performance Committee
8	To deliver sustained improvement evidenced through the single improvement plan	• To deliver against the plan and demonstrate this as improved outcomes for the organisation	• Progress in the System Improvement Board moving from NHSE to ICB oversight. • Delivery of the continuous improvement strategy	Director of Transformation and Improvement & Innovation	Board and committees of the Board
9	Improve our underlying productivity and efficiency	• To maximise our productivity through the deliver of our FRP, SIP and other transformation plans	• 85% capped theatre utilisation • Increased average cases per list • Improved New:Follow up rates • Increased diagnostic modality level utilisation (Minimum efficiency standards) • Reduced lengths of stay • Reduced escalation capacity and boarding • Reduced unit labour costs/premium rates	Executive Triumvirate/ Chief People Officer	Finance & Performance Committee

Partnership		Our ambition is to be fit for the future			
Purpose of the Objective		**Scope and Focus of the Objective**	**How will we know if it has been achieved?**	**Exec Lead**	**Assurance Committee**
10	To develop and deliver our plans for the New Hospitals Programme	• Ensure the successful delivery of our once in a lifetime opportunity to deliver a New Hospital for the residents of Central Lancashire and Lancashire and South Cumbria	• Agreed delivery of each key milestone within the programme • Lead the clinical model of care for the NHP	Chief Finance Officer Chief Medical Officer	NHP Assurance Committee
11	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.	• Deliver agreed metrics/plan for OneLSC • Deliver agreed metrics/plan for clinical reconfiguration & Fragile Services • Progress against key Anchor institute metrics • Deliver our health inequalities action plan • Develop and agree LTH Estates strategy	Chief Finance Officer Chief Medical Officer/Director of Strategy & Planning Director of Strategy & Planning Chief Nursing Officer Chief Finance Officer	Finance & Performance Committee
12	To make progress towards our ambition to be a University Teaching Hospital	• Work towards achieving University Hospital status	• Develop a plan and make progress to deliver the requirements for University status • Deliver the key metrics and measures within the research and innovation strategy	Director of Improvement, Transformation Research and Innovation	Education, Training and Research Committee

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Development of the Single Improvement Plan							
Report to:	Board of Directors			**Date:**	6th June 2024		
Report of:	Chief Executive Officer			**Prepared by:**	A Brotherton		
Purpose of Report							
For assurance	☒	**For decision**	☐	**For information**	☐		

Executive Summary:

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

Following discussion in the Board workshop, the Single Improvement Plan has been refined and now has five domains; Well-Led; Safety, Quality and Clinical Effectiveness; People and Culture; Operational Performance and Financial Sustainability. The Safety and Quality and Clinical Effectiveness domains have been merged to avoid duplication and the dividing of programmes of work. The plan also a significant focus on Strategy and Planning. A new way of working is now being adopted to increase the pace of delivery, including executive led weekly improvement huddles focused on ensuring the teams are on track with delivery and offering support to overcome any barriers. Benefits have been identified for each domain and work has now been completed to design reporting of the progress of the projects (Appendix 1). Key metrics for each domain have been discussed in a board workshop, refined and outlined in the paper. Final amendments are being made in light of further feedback received following the board workshop and will be reported to the relevant sub-board committees in June 2024.

Work is now underway to develop a Place based section of the Single Improvement Plan with partners to work collaboratively on key shared priorities.

The Board is asked to:

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

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒

To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

N/A

1. Context

The Trust has committed to the development of a Single Improvement Plan which brings together the Trust's priorities for the next three years into one comprehensive delivery plan. The Trust has taken the learning from both Morecambe Bay's Recovery Support Programme and the Liverpool University Foundation Trust approach to their recovery programme which has been highlighted as an exemplary approach. A System Improvement Board has been established by the NHS England Regional team with ICB colleagues to ensure that the Trust receives system support where required to deliver the priorities.

It was discussed and agreed at the first System Improvement Board meeting that there was a need to 'take a step back', work with our new Turnaround Director and the external support that is being secured from PA Consulting which is now in place, to review fully the governance structures and processes, strengthen them where needed and develop a focused priority financial recovery plan. This in essence extracts the high priority areas of the Trust's 3 year Single Improvement Plan into phase one of the work that will be undertaken to maximise our financial improvement and focus on the priority safety, quality and operational performance improvement required.

2. Discussion

This paper therefore outlines the progress made in two distinct phases; (i) the Financial Recovery Programme and (ii) progress with the with the design and oversight of the three year Single Improvement Plan.

Review of Financial Governance and Development of the Financial Recovery plan

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

- The Turnaround Around Director has **secured support** from the ICB and NHS England Regional Team for external support from PA Consulting who have commenced working with the Trust
- A **review** of the Trust's Financial Governance and reporting arrangements has been undertaken by the Turnaround Director
- The **Terms of Reference** for the Financial Recovery Programme (FRP) Board including its purpose, objectives, attendees, and scope has been developed and the governance and reporting strengthened and approved by the Finance and Performance Committee.
- The **cadence** of the FRP Board from early May including attendance over a five-week cycle has been developed, approved and is now in place.
- The **Change Control Process** that will be initiated when schemes are no longer expected to deliver the agreed plan has been developed and approved. All change requests will be reviewed and approved through the FRP Board.
- The FRP priorities have been agreed and detailed plans (with measures) are in development for review and approval. The five priority programmes are: workforce, productivity, service reviews, major projects/programmes and grip and control.

Establishing a Programme Management Office and Development and Oversight of the Trust's 3 year Single Improvement Plan.

The Trust has committed to the development of a 3 year Single Improvement Plan to ensure there is a medium term comprehensive improvement programme in place to deliver continuous improvement. The following work has been undertaken since the last Board meeting:

- ***Establishment of a PMO*** – internal resource has been redeployed to form a PMO reporting directly into the Turnaround Director
- ***Updated the detailed plans on a page*** – further work has been undertaken to develop the detailed plans on a page and the first phase of the Single Improvement Plan finalised (though this will be a live document that is continually updated)
- ***Streamlined the structure of the Single Improvement Plan*** - The Executive team has reviewed the developing plan and streamlined the structure of the report in line with the Trust's priorities and performance challenges.
- ***Developed the measures*** – Executive leads have undertaken work to develop the measures for each portfolio and these have been discussed in the Executive team meeting and with the Board in a Board workshop. Following the Board workshop the measures have been refined, reduced and prioritised and the proposed set of metrics for the Single Improvement Plan is proposed in Appendix 1.
- ***Executive led weekly improvement huddles*** are now in place to ensure the programmes/projects are on track and any barriers quickly unblocked.
- ***Development of the project reporting and measures*** – detailed work has been undertaken by the Digital team to develop our automated reporting (Appendix 2)***.*** This provides an 'at a glance heat map of progress against plan and key milestones.

Systemic issues in Central Lancashire that would be helpful to address with system partners as part of the System Improvement Board.

It has been acknowledged for some time that there are a number of systemic issues across Central Lancashire that are negatively impacting on the Trust's ability to recover. The key issues which the Trust would value system support to address are being discussed and progressed at the System Improvement Board, with support from partners.

3. Financial implications

Financial sustainability is a key element of the plan. Some programmes may require additional investment to realise the full benefit, this detail will be developed Director commences in with our Turnaround Director as required.

4. Legal implications

None.

5. Risks

Risks derived from individual projects and plans will be detailed and risk registers developed in line with our risk management policy. Further work will be undertaken to describe the overall single improvement plan risks as the reporting is developed.

6. Impact on stakeholders

A full communications plan is in development.

7. Recommendations

The Board is asked to:

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

Appendices

Appendix 1: Proposed Measures for each domain.

Appendix 2: Heat Map of the Progress of the Single Improvement Plan programmes of work

Lancashire Teaching Hospitals
NHS Foundation Trust

Appendix 1

Single Improvement Plan

Level of Monitoring of Measures

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

People & Culture – Board Measures

Board
50% of colleagues complete the NHS Staff Survey (Annual measure)
Above the national average for all People Promise Elements as measured via the NHS Staff Survey. (Annual measure)
Staff Engagement for recommend for place of work
Increased participation in the National Quarterly Pulse (25% per quarter)
Over 200 teams undertake TED each year, with the aspiration of every team completing a TED on an annual cycle (monthly measure)
Turnover (annual value assessed, in-month values reported) (source ESR crude)
Appraisal completion and appraisal quality audit results. (monthly and annual measures)
Overall sickness absence rate (annual value assessed, in-month values reported)

Safety & Quality – Board Measures

Board	
Programme	**Measure**
Deliver Annual Safe Staffing Requirements	Overall Fill rate RN and HCA
	Overall Fill rate RM and MSW
Patient Experience and Involvement	Friends and family -to recommend score – Adult inpatients; CYP ED; Inpatients; Maternity; CYP inpatients; Neonatal Intensive Care Unit
	Complaints per 1000 bed days
	STAR Accreditation (all trust ; wards; ED and Theatres
C Difficile Improvement Programme	Performance against national trajectory - no more than 122 HA cases (2009)
Always Safety First	Hospital Standardised Mortality Ratio (56 Basket – Adult)
	Standardised Mortality Rate (All Diagnoses – Adult)
	Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)
	Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)
	Pressure Ulcers per 100 beds days (Stage 2 and above)
	Falls (All falls) per 1000 bed day
	Never events
Maternity	Maintain compliance with 10 CNST Safety actions

Financial Sustainability – Board Measures

Board
PRIMARY KPIs
I&E Normalised run rate
FRP schemes delivery
WTE Run Rate
Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25 .
Pay Run Rate expenditure*
SECONDARY KPIs
Agree & Deliver revenue and capital financial plan with Board and ICB
Ensure 100% delivery of the Trust's Capital programme
Ensure revenue cash balance remain with Trust's agreed minimum
% of Budget Holders have completed Financial Management/Budget Management Training
Sign off of budget allocation / hierarchy by Exec, Divisions and individual budget holders
75% of "Budget Holders & Relevant Finance Staff" have attended Procurement Best Practice Training.
Delivery of Procurement Workplan

Operational Performance – Board Measures

Board	
UEC: Compliance with ambulance turnaround time target (15/30/60 minutes)	Diagnostics DM01: Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
UEC: Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	85% theatre utilisation (aggregate/RPH/CDH)
UEC: Maximum wait of 12 hours as Total Time in Department	Cancer: Improve performance against the headline 62-day standard to 70% by March 2025.
UEC: Bed occupancy to 92%	Cancer: Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026.
UEC: Medicine NEL LoS (Excluding 0 day LoS)	
UEC: NMC2R to 5%	
Elective : RTT: Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	
Elective : RTT: Eliminate waits of over 52 weeks for elective care by March 2025	
Elective & Cancer: RTT: Eliminate >78 week waits	

HEATMAP

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Appendix 2

LTHTR Improvement Portfolio	Overall	Overall DoT	Plan	Plan DoT	Issue	Issue DoT	Risk	Risk DoT	Resource	Resource DoT	Stakeholder	Stakeholder DoT
LTHTR Improvement Portfolio	A	→	G	→	A	→	A	→	G	→	A	→
1. Well Led Improvement Portfolio	A	→	Y	→	A	→	A	→	A	→	A	→
1.01 Clear Vision and Strategy	A	→	G	→	A	→	A	→	G	→	A	→
1.02 Information Improvement	A	→	Y	→	A	→	A	→	G	→	A	→
1.03 Learning, Continuous Improvement and Innovation	A	→	G	→	A	→	A	→	G	→	A	→
1.04 Corporate Communications Approach	A	→	Y	→	A	→	A	→	G	→	A	→
1.05 Regulator Assurance	A	→	G	→	A	→	A	→	G	→	A	→
1.06 Governance and Risk Maturity	A	→	G	→	A	→	A	→	G	→	A	→
1.07 Community Services Place	A	→	G	→	A	→	A	→	G	→	A	→
1.08 Digital	A	→	Y	→	A	→	A	→	A	→	A	→
1.09 Estates	A	→	Y	→	A	→	A	→	G	→	A	→
1.10 Strategy & Planning – Trust Planning Process	A	→	G	→	A	→	A	→	G	→	A	→
2. People and Culture Improvement Portfolio	A	→	Y	→	A	→	A	→	G	→	A	→
2.01 To Attract, Recruit and Resource	A	→	G	→	A	→	A	→	G	→	A	→
2.02 To Engage, Retain, Reward and Recognise	A	→	G	→	A	→	A	→	G	→	A	→
2.03 To Create a Positive Organisational Culture	A	→	G	→	A	→	A	→	G	→	A	→
2.04 To Be Well Led	A	→	G	→	A	→	A	→	G	→	A	→
2.05 Supporting the Health and Wellbeing of Colleagues	A	→	G	→	A	→	A	→	G	→	A	→
2.06 Being Consciously Inclusive in Everything We Do	A	→	G	→	A	→	A	→	G	→	A	→
2.07 Education, Training and Research	A	→	G	→	A	→	A	→	G	→	A	→
2.08 Junior Doctors	A	→	Y	→	A	→	A	→	G	→	A	→
2.09 Medical Staffing Improvements	A	→	G	→	A	→	A	→	G	→	A	→
3. Safety and Quality Improvement Portfolio	A	→	Y	→	A	→	A	→	G	→	A	→
3.01 Deliver annual safe staffing requirements	A	→	G	→	A	→	A	→	G	→	A	→
3.02 Patient Experience and Involvement	A	→	G	→	A	→	A	→	G	→	A	→
3.03 Safeguarding	A	→	G	→	A	→	A	→	G	→	A	→
3.04 C Difficile Improvement Programme	A	→	G	→	A	→	A	→	G	→	A	→
3.05 Deliver Always Safety First Strategy	A	→	G	→	A	→	A	→	G	→	A	→
3.06 Maternity and Neonatal	A	→	G	→	A	→	A	→	G	→	A	→
3.07 Childrens Improvement	A	→	G	→	A	→	A	→	G	→	A	→
3.08 Health Inequalities	A	→	G	→	A	→	A	→	G	→	A	→
3.09 Critical Care and Enhanced Care Areas	A	→	Y	→	A	→	A	→	G	→	A	→
3.10 Medication Safety	A	→	G	→	A	→	A	→	G	→	A	→
4. Financial Sustainability	A	→	G	→	A	→	A	→	G	→	A	→
4.01 3 year FRP – Identify and Develop	A	→	G	→	A	→	A	→	G	→	A	→
4.02 Budget Planning	A	→	G	→	A	→	A	→	G	→	A	→
4.03 Budget Holder Allocation and Personal Engagement	A	→	G	→	A	→	A	→	G	→	A	→
4.04 Procurement (LPC) & Contracts Hub	A	→	G	→	A	→	A	→	G	→	A	→
5. Operational Performance Improvement Portfolio	A	→	G	→	A	→	A	→	G	→	A	→
5.01 UEC In Flow	A	→	G	→	A	→	A	→	G	→	A	→
5.02 UEC Flow	A	→	G	→	A	→	A	→	G	→	A	→
5.03 UEC Outflow/Community Collaborative	A	→	G	→	A	→	A	→	G	→	A	→
5.04 Elective: General	A	→	G	→	A	→	A	→	G	→	A	→
5.05 Elective: Cancer	A	→	G	→	A	→	A	→	G	→	A	→
5.06 Outpatient Transformation	A	→	G	→	A	→	A	→	G	→	A	→
5.07 Major Trauma	A	→	G	→	A	→	A	→	G	→	A	→

Key:

Issues, risks and stakeholders have not yet been explored in detail so have all been scored amber.

Resource is green if an SRO and project lead have been appointed, amber if one is missing, red if both are missing.

Plan is green if a detailed plan has been developed and yellow if one is yet to be created. This scoring will be developed further to track progress against milestones.

G = Fully achieving or on trajectory for ALL benefits
Y = Achieving or on trajectory for most benefits, some slightly off track
A = All benefits slightly off track
R = Not achieving or on trajectory for any benefit

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Integrated Performance Report						
Report to:	Board of Directors		**Date:**	6th June 2024		
Report of:	Executive Team		**Prepared by:**	Executive Directors		
Part I	✓		**Part II**			
Purpose of Report						
For assurance	☒	**For decision**	☐	**For information**	☐	

Executive Summary:

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

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

Consistently Deliver Excellent Care

Performance commentary

Access Standards - Emergency Care Performance:

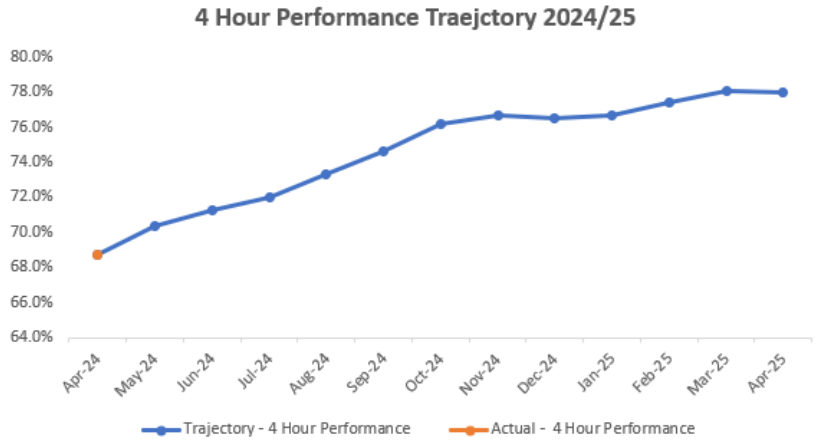
- 4 Hour ED performance is showing an improvement, with April 24 at 68.7%, compared to March 24 at 67.4%. The Trust is below the national average position of 74.4%.

- A proposed monthly improvement trajectory in relation to the 4-hour ED performance target has been agreed for 2024/25, with an expected improvement to 78% during March 2025. The trajectory is based on delivery of an improvement action plan relating to: time to 1st treatment; timely review of diagnostics; investigations; and improved access to assessment areas. A key delivery dependency of the trajectory is a reduction of patients not meeting the criteria to reside (NMCTR) to 5% (42 patients) against the actual 10% (84 patients). The Trust continues to experience significant pressure from an urgent and emergency care pathway perspective, which is understandably impacting on performance. Key issues include:

    - IPC issues (side room pressures) including norovirus impacting on bed flow.
    - Lack of assessment space due to escalation and corridor care.
    - Exit block due to lack of G&A beds including 84 patients on average (10% against the national target of <5%) not meeting the criteria to reside in an acute Trust but unable to leave hospital with the right support.
    - Delays in access to mental health bed once assessed (significant staff and capacity impact in terms of length of stay in ED with cubicles occupied to ensure safety for this cohort of patients)

4 Hour Trajectory: 2024/25

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Trajectory - 4 Hour Performance	68.7%	70.4%	71.2%	72.0%	73.3%	74.6%	76.2%	76.7%	76.5%	76.6%	77.4%	78.0%	78%
Actual - 4 Hour Performance	68.7%												



- Performance relating to the number of patients waiting over 12 hours (admitted and non-admitted) in ED for April remained at 10.3%.

- In April, 421 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, a decrease of 51 from last month. 308 patients waited over 60 minutes to be handed over from NWAS to the Trust in April 24, an improvement from 362 in March. Ambulance handover performance reflects increased Urgent and Emergency Care pathway pressures, with limited capacity across the Trust despite increased escalation. Ambulance handover delays remain a high priority and a local improvement collaborative is in place.

- The occupancy metric has been updated to reflect the new requirement to *reduce adult general and acute (G&A) bed occupancy to 92% or below*, with Trust occupancy for April of 94%, a decrease compared to last month's position. This is consistent with the flow pressures experienced.

- As part of the Trust Escalation Plan, boarding has been implemented to facilitate the safe movement of patients from an admitting area to a receiving ward prior to a bed space becoming available on the ward. Only enacted during periods of pressure, the use of boarded beds supports a reduction in the number of patients remaining in ED waiting for a bed and therefore spreads the risk and pressure across the organisation. On average 38 patients were boarded each day across both sites during April with 1141 associated bed days. These are predominantly medical patients requiring admission to an acute medical ward.

- The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) has increased slightly from last month's position of 10.8% to 11% in April 24. There has been good utilisation of available capacity in the Home First service, and the Community Healthcare Hub (CHH) at Finney House. However, there are 12 beds less due to pathway 1 delays (patients requiring crisis and packages of care) awaiting support at home for a safe discharge. The interim COO is working with LCC colleagues to look at options for managing this cohort in a timely manner to meet their support needs at home.

Unfunded capacity and operational changes – Bed Capacity:

There have been a number of changes to processes and services, including Finney House, Virtual Ward, reprofiling of space in the Emergency Department to create an Acute Assessment Unit and an update to the organisational response to demand related escalation. This has enabled the following changes to be put in place:

Ward/Area	Impact	Delivery Date	Status
Closure of Avondale	Reduction of 28 G&A beds	Mar-23	Completed
Closure of Cath Lab & RAU	Reduction of 14 G&A beds	May-23	Completed – require COO/CMO approval to open
Closure of acute ward	Reduction of 17 G&A beds	Jul-23	Completed
Establishment of Acute Assessment Unit	Reduced ED footprint, reducing long waits in ED	Apr-23	Completed
No overnight escalation into Same Day Emergency Care	Reduced need for additional staffing, protects SDEC function	May-23	Completed
No ED escalation into CT wait area in hours	Reduced need for additional staffing, protects CT function	Jun-23	Completed
Closure of additional acute ward	Reduction of 11 G&A beds	Aug- 24	Emergency pathway pressures have delayed delivery – currently reviewing plans for implementation in Q1 2024/25.
Co-location of Mental Health Urgent Access Centre (MHUAC)	Reduced cubicle space in ED, improved environment for patients awaiting MH assessment/treatment	Aug-24	Initial capital bid unsuccessful – joint LSCFT/LTH proposal being developed for Q1 2024/25
MAU/SAU Development	Right-sizing MAU and SAU to improve UEC pathways and increase direct access	2024/25	Capital bid successful – delivery underway

The Trust continues to work with health and social care organisations across the Central Lancashire system to support improvement. Several proposals have been submitted against the ICB UEC capacity investment funding for 2024/5, with the following specific to Central Lancashire confirmed as being funded:

- Therapy at front door for CDH
- Finney House (part funded, Q1 only)
- Virtual Ward
- Care Connexion (non-capital element funded)

The following set of system actions has been agreed at Central Lancashire place level:

- Demand management focused on the following streams:
  - top 20 attendances to urgent and emergency care settings by GP Practice
  - top 20 attendances to urgent and emergency care settings by Care Home
  - top 100 frequent users of urgent and emergency care

- Responding to frailty differently through using the outputs of the LSC Engineering Better Care programme for Frailty with a rapid focus on managing long terms conditions within primary and community settings rather than hospital and secondary care settings

- Mobilising and maximising our existing intermediate care capacity (including urgent community response, hospital at home, virtual ward and short term beds) to support both step up as an alternative to hospital admission and accelerate step down and discharge pathways to reduce length of stay, prevent deconditioning, improve outcomes and experience for admitted residents and optimise existing acute bed capacity

- A rapid process review and re-design of disease/condition specific pathways, with pathways to be determined.

- Additional executive level oversight from Chief Officers to ensure focus, pace and supportive leadership.

In addition to system plans, the Trust has its own internal programme of improvement being delivered through the Single Improvement Plan with oversight from the UEC Performance Recovery Group (twice a month) chaired by the interim COO and is aligned with the weekly improvement huddles for inflow, flow and outflow projects.

An Urgent and Emergency Care data driven diagnostic has been commissioned by the ICB across all areas in Lancashire and South Cumbria, delivered by The PSC, an external organisation. The Trust facilitated a visit across three days during May, the outputs are due to be shared this month and will primarily focus on opportunities with regards to financial efficiency.

Access Standards - Elective restoration

65 and 78 Week Access Standards

Clearing the 78 and 65-week waits is a priority for the divisional teams with performance under daily review for assurance by the Divisional teams.
It is expected that the Trust will reduce to 0 over 78 weeks from May 24 and eliminate 65 week waiters by the September 2024. However pressures are currently being experienced in Orthodontics, Special Care Dentistry, Colorectal Surgery, Occular Plastics. The Interim Chief Operating Officer continues to ensure daily assurance of progress with >65 week waits prioritising the continued elimination of >78 week waits due to non-clinical reasons.

- The end of April over 78 week position was 5, (Orthodontics, Paediatric Surgery, Special Care Dentistry) Patients have plans in place for treatment at either LTHTR or East Lancashire Trusts in May. Daily assurance takes place to ensure any risks to delivery are mitigated. Additional focus on identifying next steps for all patients is in place with risks addressed through PTL meetings and Performance Recovery Group.

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

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

- The 65-week snapshot position at the end of April was 328, made up of 198 admit and 130 non admit. Compared to a position of 350 at the end March 2024. This is a significant achievement considering the 65 week cohort starting point in April 2023 was over 29,000 patients.

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

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

Access Standards – Diagnostic Waits

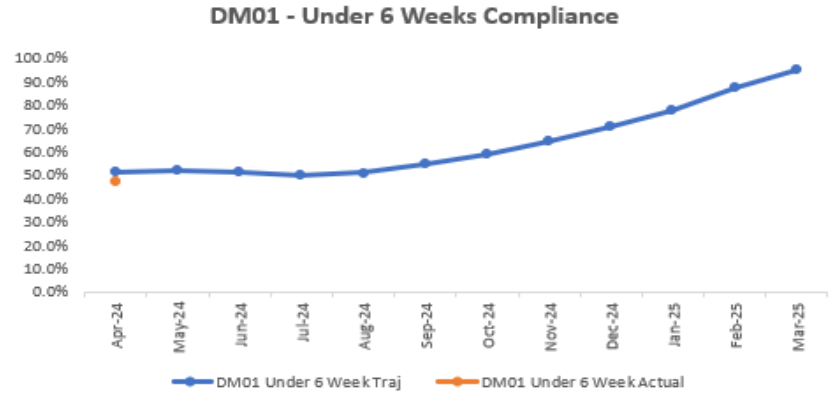
- Diagnostics performance beyond 6 weeks was 53.1% in April, an increase of 2.27% waiting over 6 weeks compared to the March position of 50.8%. The increase has predominantly been in the Echocardiography. Urgent and cancer patients are prioritised and seen within 2 weeks. The highest contributors of the backlog at modality level for the DM01 position are non-obstetric ultrasound (NOUS), endoscopy and echocardiography. In order to support NOUS capacity in the short term, outsourcing arrangements are in place. There is a plan in place to support backlog clearance for echocardiography with a mixture of weekend working, mutual aid and additional capacity.

- Endoscopy remains pressured with a further delay to increased service capacity relating to build. Agreed capital bids will provide additional capacity on the Preston site for endoscopy room 5. However, revenue business case in progress and will form part of the productivity workstream for a sustainable capacity moving away from premium cost.

- The Trust has developed a proposed improvement trajectory to deliver the national objective of 95% of DM01 patients waiting under 6 weeks by end March 2025. The trajectory is predicated on the agreement to deliver through additional capacity initially up to Q4 2024/25 and then through sustainable core capacity including productivity improvements into 2025/26.

2024/25 DM01 Compliance Trajectory:

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
DM01 Under 6 Week Traj	51.2%	52.1%	51.0%	49.9%	50.8%	54.6%	59.1%	64.2%	70.4%	77.8%	87.0%	95.0%
DM01 Under 6 Week Actual	46.90%											



- **Diagnostic Surveillance Patients**

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

Administrative validation of the overdue surveillance patients waiting for endoscopy and Radiology has commenced. There will be a proportion of patients who will require clinical validation and this will be co-ordinated with referring Specialties. The surveillance audit identified 1525 patients on a planned pathway that may require transfer to the active waiting list (DM01). Once validation has been completed 50% of the patients will be added to the active waitlist by the end of Q1 with the remaining 50% by the end of Q2. The Endoscopy Polyp Task & Finish group is working alongside this to identify patients on the surveillance pathway with the highest clinical risk so their procedure can be expedited.

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

Access Standards 2024/25 - Cancer Recovery:

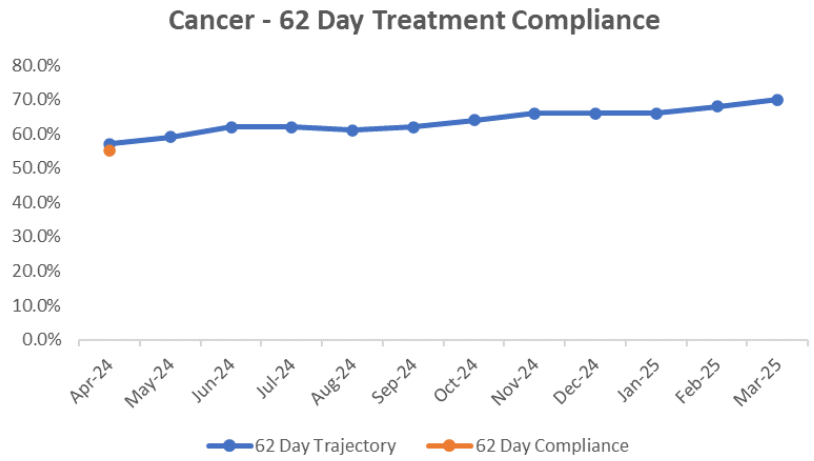
In 2024/25 the Trust will be monitored against 2 key cancer standards:

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

62 Treatment Compliance

The Trust has set a performance trajectory to achieve 70% compliance by end March 2024. Performance in April 2024 was 55.2%, slightly below the monthly trajectory. However, the performance is expected to worsen over Q1 whilst the backlog over 62 days is reduced.

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
62 Day Trajectory	57.0%	59.0%	62.0%	62.0%	61.0%	62.0%	64.0%	66.0%	66.0%	66.0%	68.0%	70.0%
62 Day Compliance	55.2%											



A Cancer Transformation Plan was in place to support delivery for 2023/24 reporting through the Elective Care Transformation Board. In 2024/25, Cancer tumour site plans will be part of the Single Improvement Plan supported by weekly huddles and reporting into the Elective Care Delivery Group.

Whilst Cancer performance is improving and the Trust is on track to achieve 2 week wait compliance for the first time since 2019, there are a small number of tumour groups with the greatest collective contribution to current performance challenges, an update on progress is detailed below:

- **Colorectal**
  The Colorectal pathway has been redesigned. The front end of the pathway is performing well with a Rapid Diagnostic Clinical triage occurring for each patient by day 6 of the referral being received. The improvement in Colorectal has been the biggest contributor in positive movement against the FDS standards, however, whilst there has been positive movement against the FDS standard, colorectal are below trajectory of 77%, and are currently at 41.3% compliance for March. The speciality has produced an action plan to improve 62 day compliance and FDS standard. There are a residual number of 62

day patients that are currently being resolved. When the remaining 62 day clearance is completed, ongoing, sustained 62 day compliance with trajectory is expected and to be achieved by March 2025.

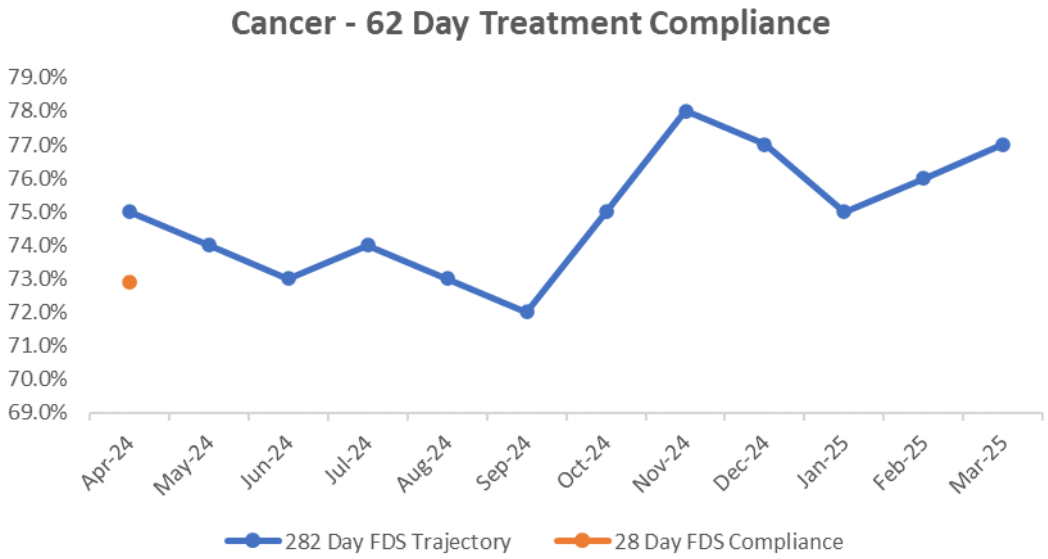
- **Urology**
  The Urology pathway has been redesigned, by training ACPs to undertake the front end of the pathway. Whilst this has improved performance and waiting times, a one stop model is unable to be fully realised until the MRI scanner at Chorley has been upgraded, this requires capital funding and a business case is currently in development. Urology are below FDS trajectory of 77% achieving 45.7% in April. A deep dive report into Urology was provided to Tier 1, which highlighted the factors in not meeting compliance is mainly due to reporting time of biopsy. As a short-term solution, 15 biopsies per week will be outsourced for external reporting to reduce backlog. Additionally, a gap analysis is being undertaken in histopathology, specifically relating to prostate biopsies, commissioned by the cancer alliance. Following results of this, any actions arising will be fed into the urology action plan.

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

28 Day Faster Diagnosis Standard

Performance compared to the Cancer FDS trajectory to March 2025 is shown below. The 2024/25 Operation Plan sets out the targets for the coming year with a cancer focus on 28 day Faster Diagnosis Compliance improvement to 77% by the end of March 2025. Tumour specific trajectories and action plans are being further developed to support delivery. Performance to the end April was 72.9% compared to the expected performance of 75%, there is continued validation of the position until deadline for submission for April on 1st June 2024.

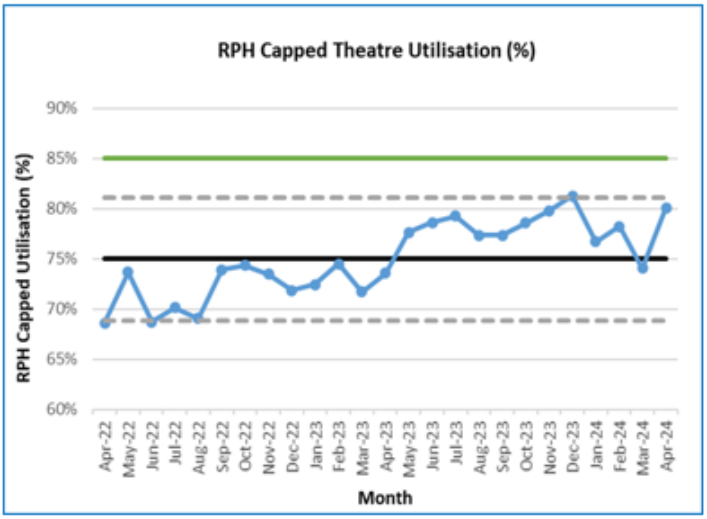
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
282 Day FDS Trajectory	75.0%	74.0%	73.0%	74.0%	73.0%	72.0%	75.0%	78.0%	77.0%	75.0%	76.0%	77.0%
28 Day FDS Compliance	72.9%											

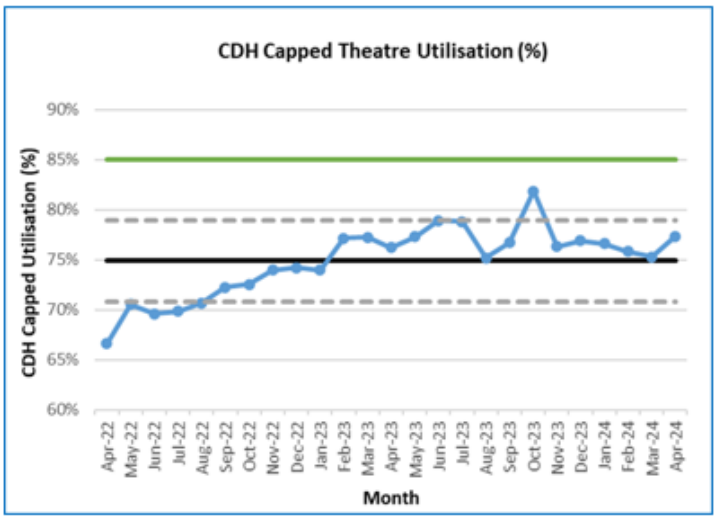


Theatre Efficiency Programme

The 65-week trajectories factor in any impact of improved theatre productivity, utilisation of the independent sector and waiting list initiatives. A Theatre Efficiency Programme reports progress through the Elective Care Transformation Board.

- The current capped theatre utilisation rates are shown below indicating an improving and consistent capped performance at CDH until Dec 23. Performance on the RPH site further deteriorated in March. Ongoing validation in relation to the March session time information is being undertaken to ensure consistency of reporting. Further consistency checks is in progress against the Model Hospital data which places the Trust in the top quartile. Paediatric Surgery has successfully moved to CDH and the national team has commended this achievement.





Outpatient transformation

The Outpatient Improvement Programme is led by the Chief Medical Officer and will be a key part of the productivity workstream (led by the Interim Chief Operating Officer). The plan is focussed on reducing follow ups, reforming triage before appointment bookings and digital to support patients' portal.

Next Steps

1. The mobilisation of the productivity workstream through the Single Improvement Plan for UEC, Elective Care and Cancer.
2. Continued focus on achievement of performance expectations in relation to cancer, long waiting patients and diagnostics as detailed in this report.
3. Developing the productivity workstream in May 24.

1. Financial implications

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

2. Legal implications

None to note.

3. Risks

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

- Further industrial action
- Workforce - sickness and vacancies
- Anaesthetist capacity
- Urgent care pressures – COVID, Flu, NMC2R and poor patient flow
- Number of complex cases and particular pressures in Orthodontics and with accommodating prisoners.

4. Impact on stakeholders

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

Recommendations

It is recommended that:

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

Safety and Quality

Pressure Ulcers
The pressure ulcer data demonstrated a positive shift in April 2023 with 7 data points below the mean, this continues to be maintained with a most recent positive special cause variation data point. The introduction of Purpose T in February 2024 has been an opportunity to refresh the improvement plan using evidence based national guidance to inform risk assessment, management, training, patient and carer involvement in safety and prevention of pressure ulcers. This has also led to a change in classification of pressure ulcers which may, in part, have contributed to a reduction in numbers. The extended length of stay in the Urgent and Emergency pathway has an impact and has also been an area of prevention focus as part of the improvement plan. The improvement work is centred on training, risk assessments and stratified care planning, increased compliance with risk assessment and intentional rounding.

Falls
The falls data demonstrated a positive shift in April 2023 with 7 data points below the mean, this has been maintained. The improved staffing fill rates are expected to have a positive impact on this metric although this is constrained at this time due to the increase in patients within the UEC pathway and boarding within ward areas and ED.

HSMR
Mortality metrics remain stable and within expected parameters.

STAR
STAR Quality assurance accreditation awards of silver and above is consistently higher than target. Analysis of this identifies an opportunity to undertake focused improvement work in ward areas where there is the most opportunity to improve. This will include mandating compliance with specific metrics (infection prevention and control and risk assessments) in order to progress to a green outcome.

Clostridium *difficile*
The data is demonstrating a variable picture with 3 improved data points followed by a negative special cause variation in the most recent month. The objective for 2024/2025 has not been received but the Trust position for 2023/2024 was 203 infections against an objective of 122. There is a Trust wide improvement action plan in place and increased focused work has continued.
Actions taken to date include:

a) Removal of cefuroxime for treatment of unexplained sepsis in July 2023
b) Introduction of a sporicidal agent for general cleaning on wards in September 2023
c) Refresh of ward staff cleaning checklists and implementation of national cleaning standards for nursing
d) Gradual roll out of the 2021 national cleaning standards, by domestic services, 15 areas are now fully compliant, a further 27 areas require implementation.
e) New system to track fogging compliance and bed movement
f) Refresh of mattress audit process
g) Strengthened assurance of IPC/cleaning standards through the “STAR” assurance framework
h) New IPC risk flag for estates remedial work requests from wards
i) Improvements in electronic “Side-room audit” which lists everyone in hospital who is in a side-room and why they were placed in the side-room

The outstanding action in this scheme of work relates to the implementation of the national cleaning standards in the remaining wards. This has been included in the financial pressures considerations for 2024/25. 75% of ward areas continue to be compliant with the 2017 domestic standards and all are compliant with 2021 nursing cleaning standards.

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

Care Quality Commission
At the end of April 2024, of the 54 'Must Do's' and 'Should Do's' included in the 2023/2024 CQC Quality Improvement Plan (QIP), there are 31 (57%) recommendations assessed as 'Green' i.e., delivered, 21 (39%) as 'Amber-Green' i.e. ongoing and progress made and 2 (4%) as 'Amber-Red' i.e. not currently delivered and risks with delivery. There are nil currently assessed as 'Red' i.e. not expected to deliver at any point in time.

A Great Place to Work

Over the second half of FY2324, we observed a sustained downward trajectory of agency usage and spend, remaining under NHS England's target of agency spend being no more than 3.7% of the overall pay bill. For the new financial year, the national planning guidance has revised the target to be no more than 3.2% of the overall pay bill, with which we are compliant in M01 (2.6%). We are continuing with ICS rate card reduction plans for nursing and are not seeing any significant risk in relation to fill. There continues to be no off-framework agency usage and no non-clinical agency usage within the organisation, with a complete freeze placed on non-clinical agency requests.

As part of the Trust's Financial Recovery Plan, a revised vacancy factor savings target has been implemented for FY2425 of £12m. Divisions are identifying posts that can be withheld from proactive recruitment for an approved period and will continually consider further posts as they become vacant over the course of the year to realise their allocated vacancy factor savings targets. Further, a robust vacancy control process is in place and the Trust has recently tightened its criteria for recruitment such that there is a vacancy freeze with an executive-led exceptions process for critical patient-safety posts. EQIAs are required for all posts under consideration so that risks are fully considered, and appropriate mitigations put in place. Additional ICB-level vacancy controls also remain in place for some posts. As a result of these controls, we may start to see our vacancy rates increase in our reporting over the coming months.

The Trust's final plan for FY2425 was submitted on 25 April 2024. During Q1, the Trust will continue to develop the detail behind FTE-releasing CIP schemes that have been identified in the plan as opportunities, including a review of risks to full realisation in accordance with original anticipated timelines.

Please note that the Trust has commenced using a new general ledger system with effect from 01 April 2024 which means that, unfortunately, we are delayed in our ability to report a M01 vacancy rate at the time of preparing this report while we transition all workforce and finance systems and realign to new codes. This is to be expected and will not prohibit us from obtaining a M01 value in due course.

A key organisational priority in 2024/5 is to reduce sickness absence levels to alleviate staffing pressures. The sickness absence rate has reduced to below 6% in M01, which is in line with typical seasonal trends. We will imminently be launching our annual health and wellbeing survey to better understand the factors affecting workforce wellbeing and the needs for support.

Delivering Value for Money

Income and Expenditure

The Trust is waiting for final approval of the financial plans and has delivered against plan for month 1, a deficit of £3.7m. The Trust continues to have considerable underlying financial pressures to manage with a financial gap of £58m which requires mitigation.

Capital Position

Capital expenditure in April at £14.1m is c£1.1m less than 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 2024/25 and an approval to access such support will be sought from the Board of Directors at their June meeting.

Cost Improvement Programme

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

In month 1 the Trust delivered £1.6m in the month which is on plan however most of this was non-recurrent. Annually £3.4m has been delivered towards the £58m target which is just under 6%.

Use of Resources

The Trust is in Segment 3.

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

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

The Agency spend in month 1 was £1.2m, 2.7% of pay expenditure. This compares favourably to the agency cap of 3.2% of pay expenditure which has reduced from the cap of 3.7% in 2023/24.

Fit for the Future

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

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

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

Previous consideration

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

Excellent care with compassion

Always Safety First

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Board of Directors

Performance to April 2024

INTRODUCTION

Performance to 30th April 2024

Mission

To provide excellent care with compassion

Strategic Aim

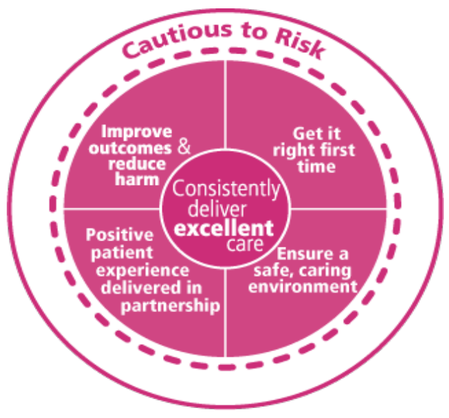
To provide excellent healthcare to our local communities

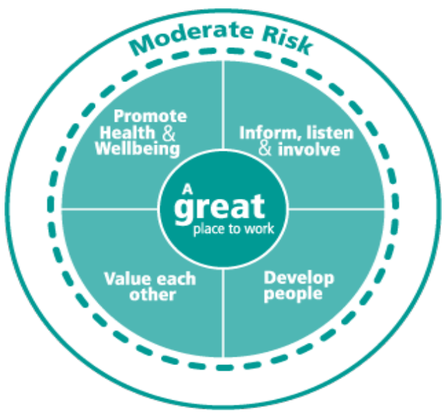
Strategic Aim

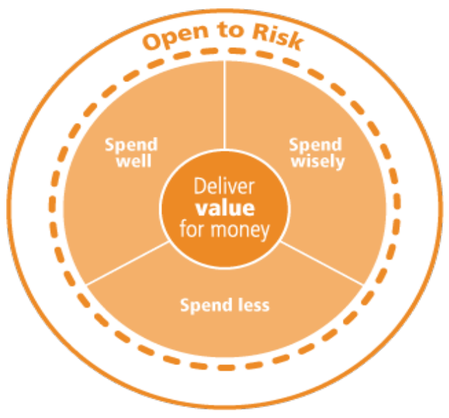
To offer a range of high quality specialist services to patients in Lancashire and South Cumbria

Strategic Aim

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







In order to ensure that the we are continually monitoring delivering against our Big Plan, the metrics within the Integrated performance report for the Board of Directors are aligned to the Big Plan 2021/24 outcomes and provide details of performance against the agreed KPIs. Each of the ambitions upon which our Big Plan is founded is aligned to a board sub committee which will undertake more detailed scrutiny of progress in achieving the identified outcome, understand risk and seek assurance against delivery.

Chief Executive

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Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One – Improve outcomes and prevent harm										
CQC	Big Plan	To achieve a rating of good with one outstanding service	M | T-D-S | TB-SQ | ALL	Yes	Progress towards CQC rating of good is ongoing					
	Sub Metric	Percentage of Must and Should do's completed			-	-	-	-	57.0%	-
Pressure Ulcers	**Key Metric**	**Reduce the number of people developing pressure ulcers by 10% - per 1000 bed days** (Rate per 1000 beddays)	M | T-D-S | TB-SQ | SC	No				1.68	2.11	3.00
	Big Plan	Reduce the number of device related pressure ulcers by 10% - per 1000 bed days (Rate per 1000 beddays)		No				0.21	0.57	0.75
Maternity safety	Big Plan	Maintain compliance with the 10 safety actions for maternity services		No	-	-	-	100.0%	100.0%	March 2024
	Big Plan	Deliver year 1 of the national maternity & neonatal improvement plan		Delivery Plan in place						
Children and Young People safety	Big Plan	Develop 10 safety actions for children and young people and achieve compliance		10 safety actions created for children and Young people, reported through the Divisional Improvement Forum						
Contribute to PLACE Adult and Children CORE20 PLUS 5 strategy	Big Plan	Develop a plan to respond to CORE20 PLUS 5 – Adults and maternity. Deliver year 1 actions		Delivery Plan in place						
	Big Plan	Develop a plan to respond to CORE20 PLUS 5 – CYP. Deliver year 1 actions		Delivery Plan in place						
Segment Two – Get it right first time										
Mortality	**Key Metric**	**Continue to achieve a mortality HSMR figure of <100 (Hospital Standardised Mortality Ratio (56 Basket – Adult)**	M | T-D-S | SQ | GS	No	Lower Than Expected				65.2	-
Access Standards	**Key Metric**	**Achieve the Emergency Department within 4 hours target**	M | T-D | FPC | FB	No				68.7%	68.7%	68.7%
	Key Metric	**Reduction in patients waiting +12 hours in Emergency Department**	M | T-D | FPC | FB	No				10%	10.3%	9.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 15 minutes**	M | T-D | FPC | FB	No				30.0%	27.9%	52.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 30 minutes**	M | T-D | FPC | FB	No				68.0%	68.1%	86.2%
	Key Metric	**Reduction in ambulance turnaround times - 60 minutes**	M | T-D | FPC | FB	No				87.0%	86.5%	96.0%
	Key Metric	**Achieve agreed trajectory for reducing 52 week waiters**	M | T-D-S | FPC | FB	No				2434	2823	3734
	Key Metric	**Eliminate waits over 65 weeks for elective care by March 2024**	M | T-D-S | FPC | FB	No				368	328	1016
	Key Metric	**Eliminate waits over 78 week waiters**	M | T-D-S | FPC | FB	No				0	5	90
	Key Metric	**Achieve Cancer - 28 day FDS**	M | T-D-S | FPC | FB					75%	72.9%	68.7%
	Key Metric	**Cancer treatments started within 2 months of urgent referral**	M | T-D-S | FPC | FB	No				57%	55.2%	41.7%
	Key Metric	**Moving or discharging 5% of outpatient attendances to a PIFU pathway**	M | T-D-S | FPC | FB	No				5%	3.01%	2.21%
	Key Metric	**Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels - @ March 2024**	M | T-D-S | FPC | FB	No				-25%	-13.67%	-1.36%
	Key Metric	**Reduce adult general and acute (G&A) bed occupancy to 92% or below**	M | T-D-S | FPC | FB	No				92%	95%	94%
	Key Metric	**Achieve 5% of patients in hospital who no longer meet the criteria to reside**	M | T-D-S | FPC | FB-SC	No				5.0%	11.0%	8.7%
	Key Metric	**Reduce length of stay to next best quartile**	M | T-D-S | FPC | FB	Approach to this metric under review						
SDEC	Big Plan	Divert 10 ambulances a day from ED (to SDEC or the appropriate service; SAU, MAU AAU, 2hr UEC response) (Target of 1924 ambulance arrivals per month based on a reduction of 10 amulance arrivals per day on 2022/23 actuals)	M | T-D-S | FPC | FB	No				1924	2442	2417
Pre-procedure elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to planned surgery	M | T-D-S | FPC | FB	No				0.15	0.17	0.33
Pre-procedure non-elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to unplanned surgery	M | T-D-S | FPC | FB	No				0.50	0.28	0.66
Elective Inpatient Average length of stay (Spell)	Big Plan	To reduce the average length of stay for patients undergoing planned surgery	M | T-D-S | FPC | FB	No				3.3	2.8	3.1
Cancer	Big Plan	Full implementation of Teledermatology in the suspected skin cancer pathway	M | T-D-S | FPC | FB	No				80%	63.34%	82.45%
	Big Plan	Full implementation of the Best Practice Timed Pathway for prostate cancer	M | T-D-S | FPC | FB	No	No Patients Currently on this Pathway					

Reporting Requirements Key

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

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

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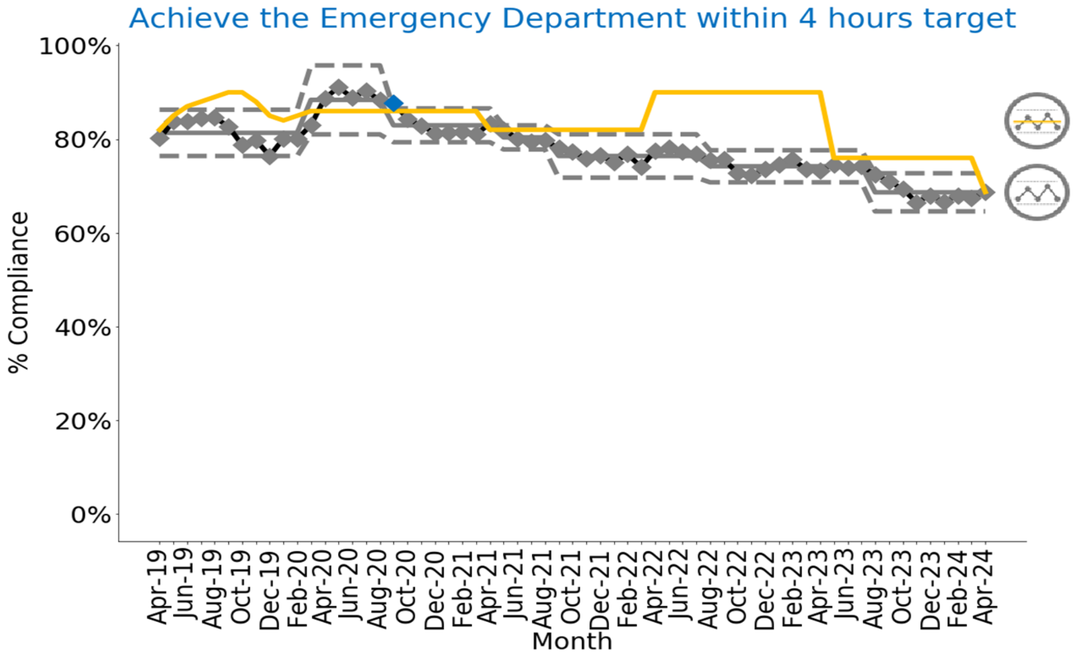
Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment Three – Ensure a safe, caring environment										
Falls	Big Plan	Reduce the number of falls by a further 5% - per 1000 bed days	M | T-D-S | SQ | SC	No	F			3.72	4.53	4.55
Infection	**Key Metric**	**Achieve less than the annual tolerance for C.difficile**	M | T-D-S | SQ | SC-GS	Yes	F		-	10	23	16
	Big Plan	Achieve zero MRSA bacteraemia	M | T-D-S | SQ | SC-GS	No	-	-	-	0	0	Last reported case Sept 2023
Safety	Big Plan	Maintain 90% staff trained in level 1 safety training	M | T-D-S | ETR | NL	No	P		-	90%	98.7%	98.1%
	Big Plan	Achieve 90% executive and senior leaders safety training	M | T-D-S | ETR | NL	No	P		-	90%	94.8%	93.6%
Segment Four – Work in partnership to deliver a positive patient experience										
Complaints	Big Plan	Reduce the number of complaints relating to communication.	M | T-D-S | SQ | SC	No			-	22	23	13
Patient involvement	**Key Metric**	**Achieve a minimum of 90% of patients reporting their experience of good or very good (including neither good/bad)**	B | T-D-S | SQ | SC	No				90%	90.0%	90.7%
Candour	Big Plan	Maintain >90% compliance with duty of candour for all moderate and above harm incidents.	M | T-D-S | SQ | SC-GS	No			-	90%	85.4%	96.0%
Safe Staffing	Big Plan	Maintain Registered Nurse and Midwife fill rates of > 90%	M | T-D-S | SQ | SC-GS	No			-	95%	99.5%	95.8%

Reporting Requirements Key

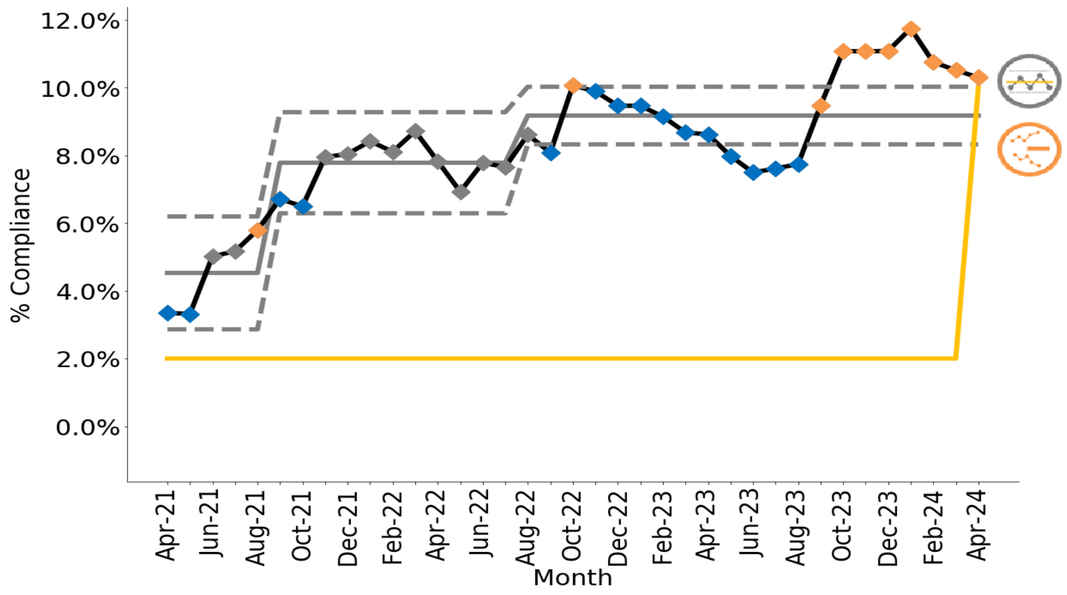
Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
B = Bi-annual	D = Division	W = Workforce Committee	JW = Jonathan Wood	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	FB = Faith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

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

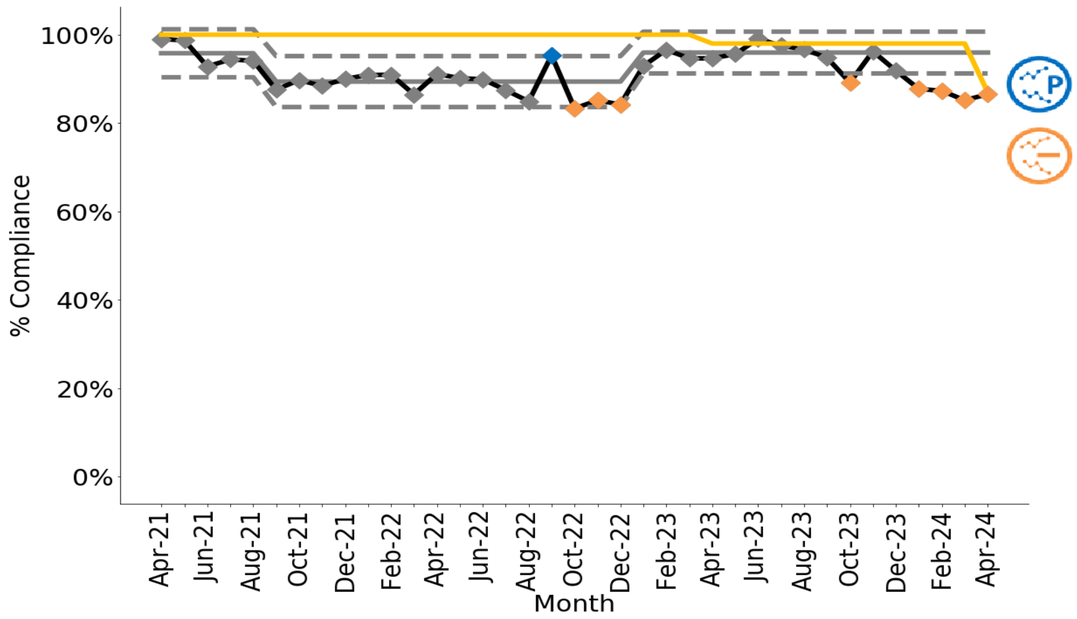
Achieve the Emergency Department within 4 hours target



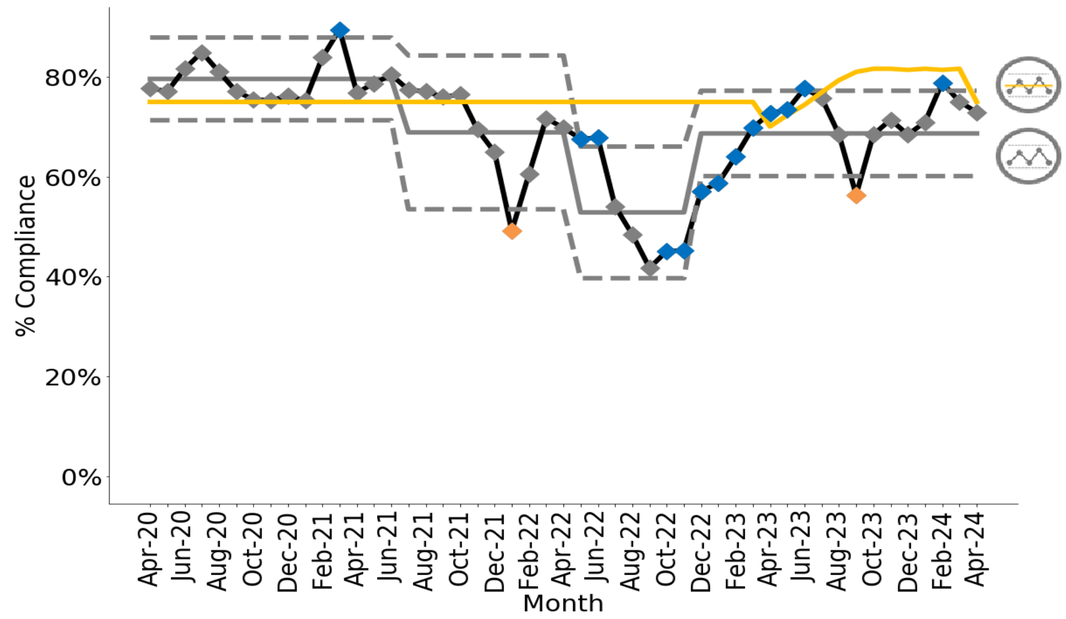
Reduction in patients waiting +12 hours in Emergency Department



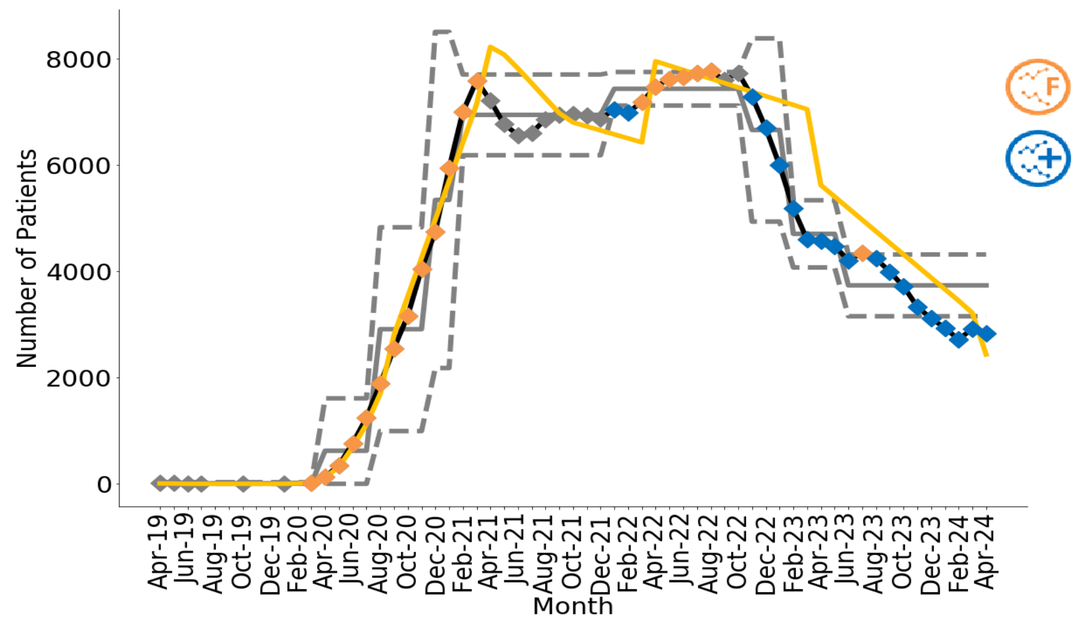
Reduction in ambulance turnaround times - 60 minutes



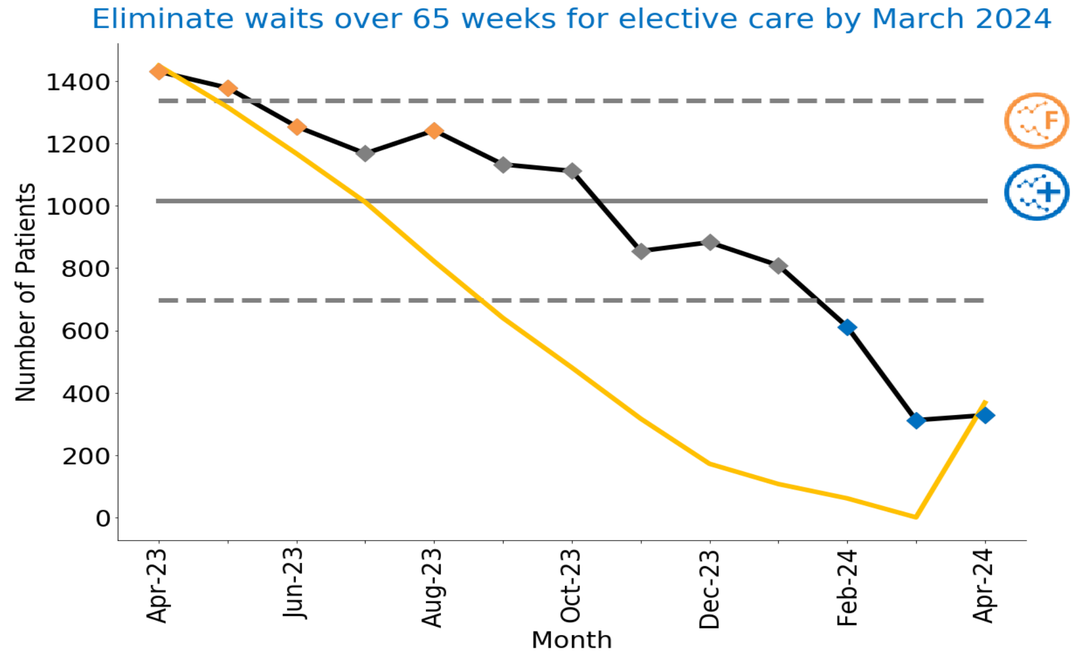
Achieve Cancer - 28 day FDS



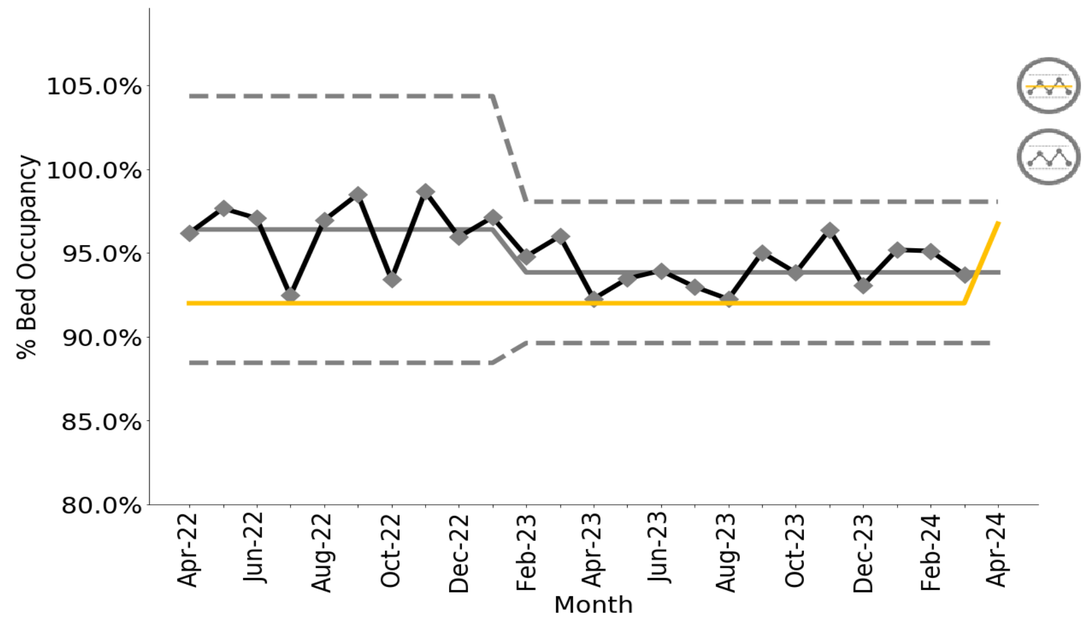
Achieve agreed trajectory for reducing 52 week waiters



Eliminate waits over 65 weeks for elective care by March 2024



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



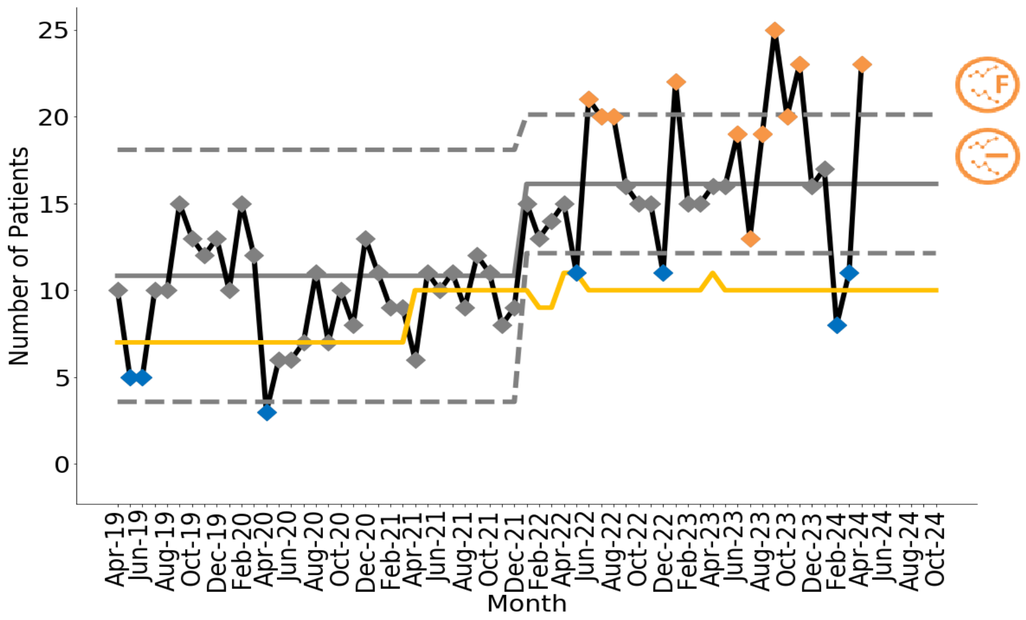
Assurance Icons – How likely are we to hit the set target in future?

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

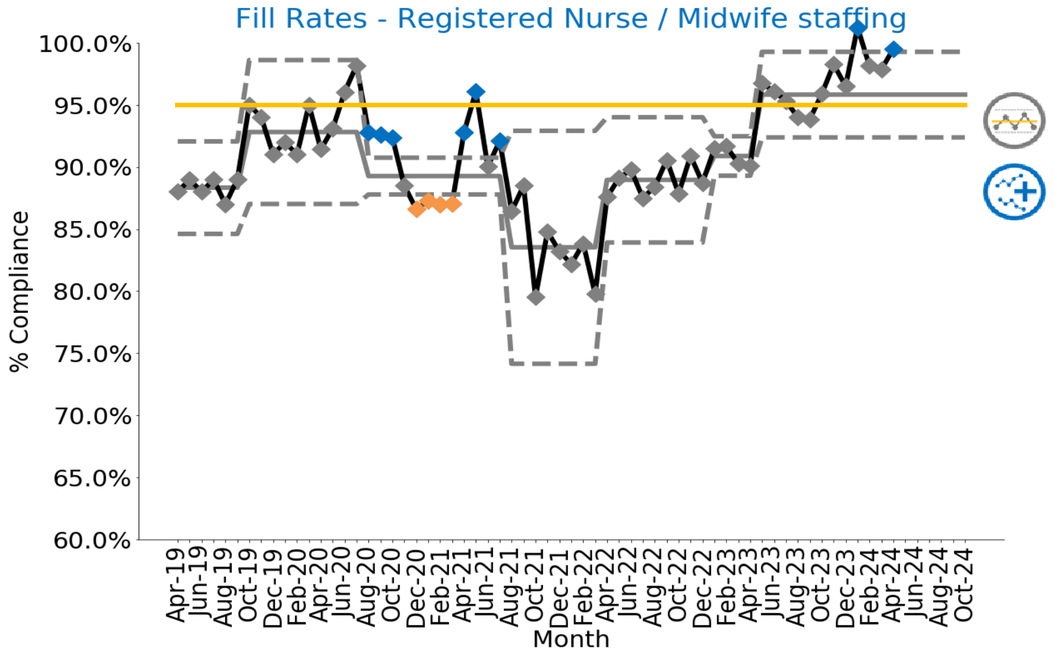
Variation Icons – Is the measure showing signs of change over time?

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

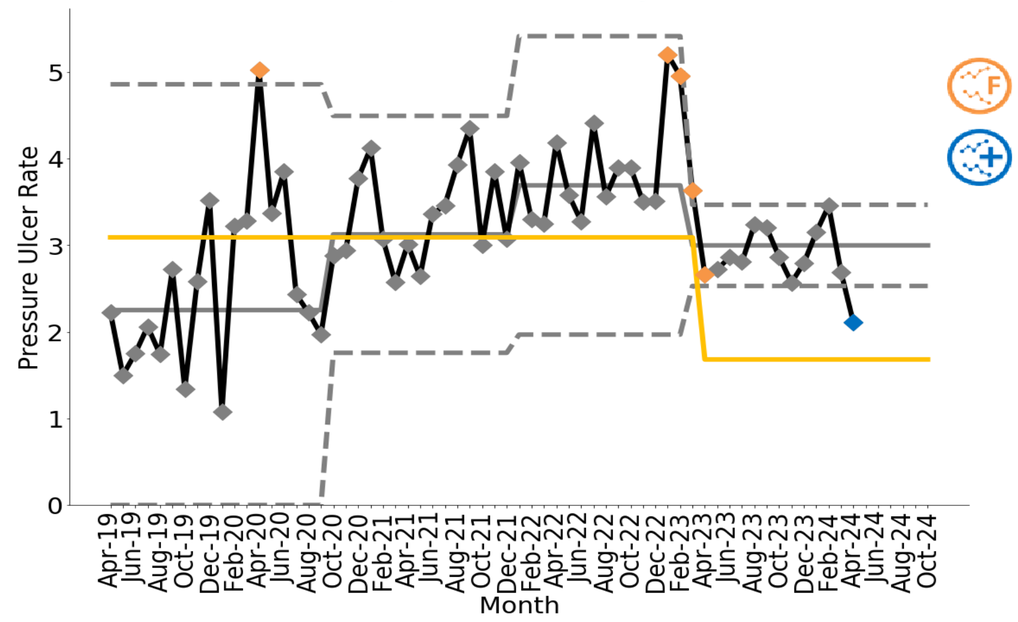
Achieve less than the annual tolerance for C.difficile



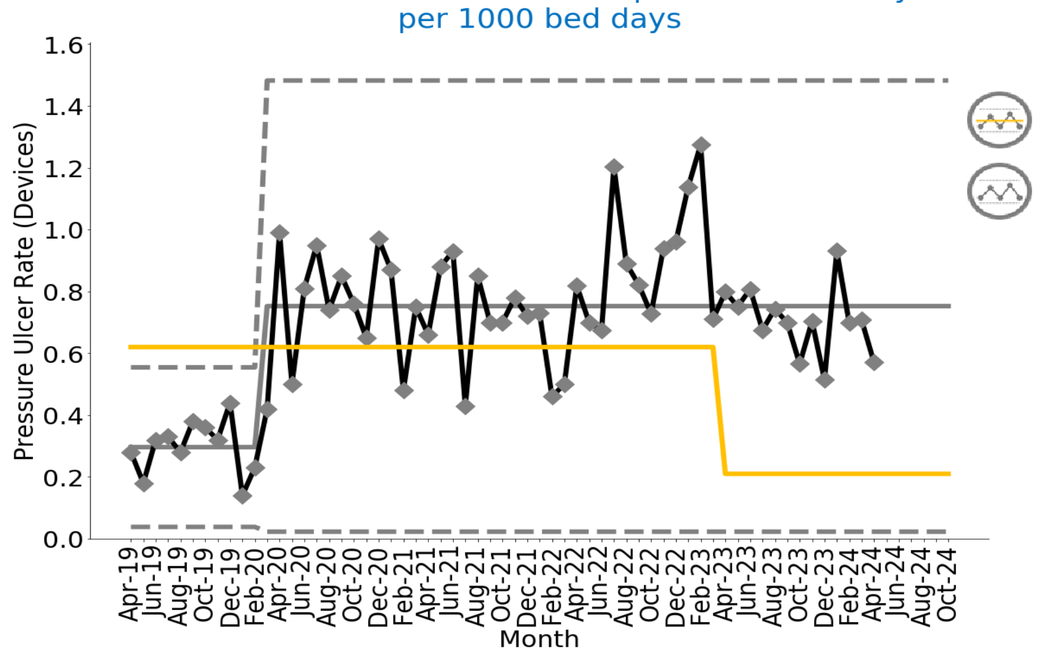
Fill Rates - Registered Nurse / Midwife staffing



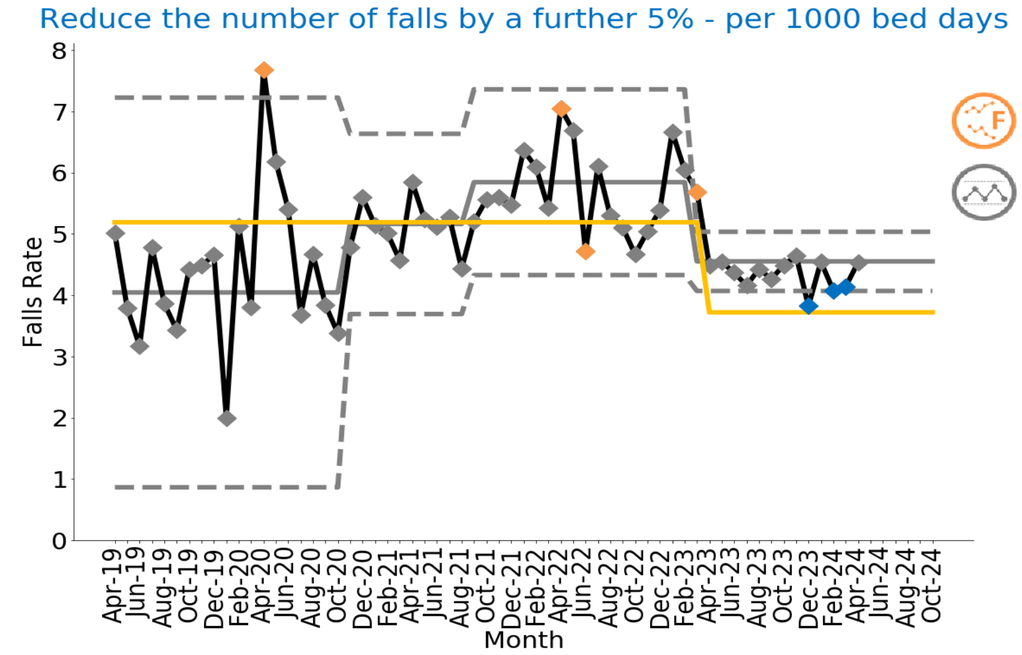
Reduce the number of people developing pressure ulcers by 10% - per 1000 bed days



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



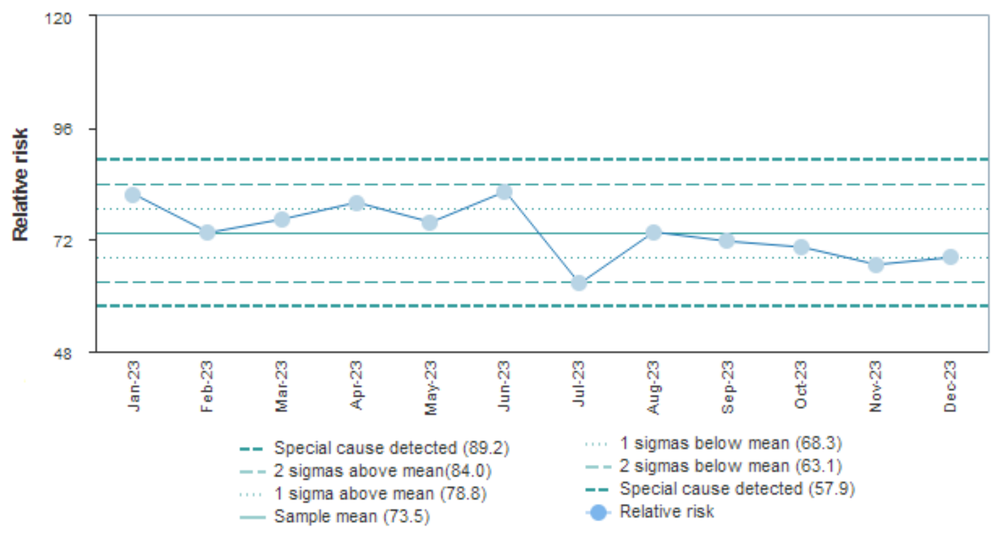
Reduce the number of falls by a further 5% - per 1000 bed days



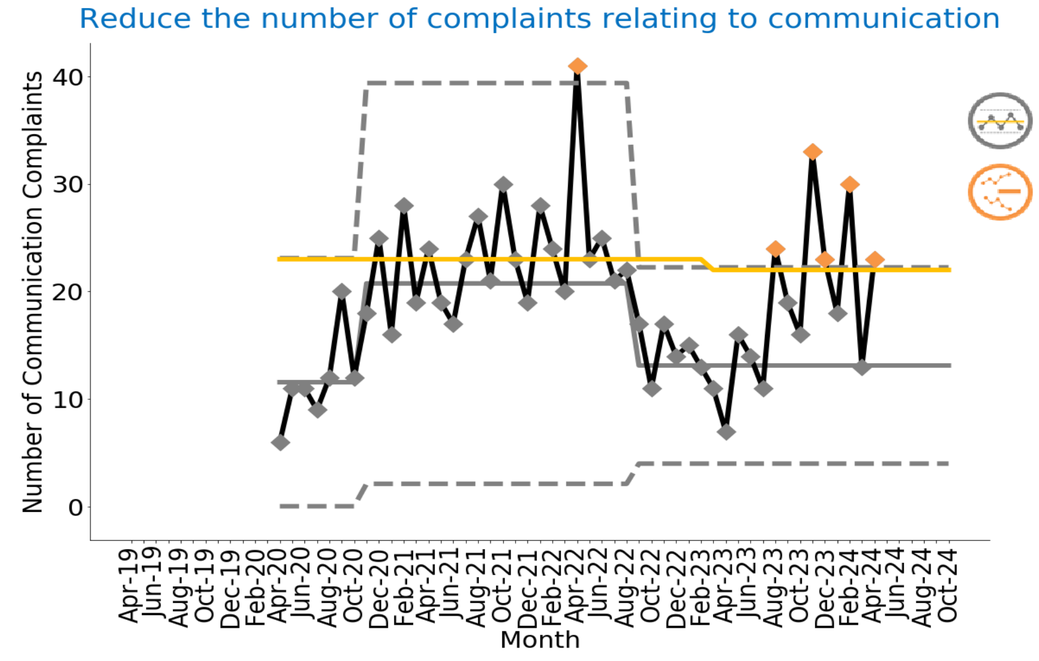
Diagnoses - HSMR | Mortality (in-hospital) | Jan-23 to Dec-23 | Trend (month)

Age (adult/child): 'Adult'

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



Reduce the number of complaints relating to communication



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A GREAT PLACE TO WORK
Reviewed monthly / quarterly

Together

Metric Description		Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Sickness Absence	Reduce overall sickness absence to 5.00% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-	F		-	≤ 5%	5.95 %	6.14 %
	Reduce short-term sickness absence to 1.75% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 1.75%	2.22 %	1.99 %
	Reduce long-term sickness absence to 3.25% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-	F		-	≤ 3.25%	3.73 %	4.16 %
Health & Wellbeing	Reduce average duration of psychological health related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 33.11	41.87	37.07
	Reduce average duration of MSK-related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 20.11	21.99	22.54
	Drive forward zero tolerance of violence and aggression toward staff by reducing the number of incidents by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-	F		-	≤ 73	81	59.00
Develop People									
Turnover	Maintain annual staff turnover between 8% and 11% FTE (annual assessment; ESR in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 0.83%	0.59 %	0.76 %
Vacancies	Reduce the number of vacancies by a further 5% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-	Pending	Pending	-	≤ 6%	Pending (new system)	9.05 %
Appraisals	Maintain 90% HC compliance rate for appraisals	M | T-D-S-C | W | KS	-				≥ 90%	89.36 %	
Mandatory Training	Maintain 90% HC compliance against all core skills training requirements (module compliance reported)	M | T-D-S-C | ETR | KS	-				≥ 90%	93.41 %	
Medical Devices	Achieve 90% HC compliance with medical device training	M | T-D-S-C | ETR | KS	-				≥ 90%	85.48 %	
Inform, Listen and Involve									
Staff Engagement & TED	Increase the number of teams that have undertaken TED by 15% (annual assessment; in-month reported)	M | T-D | W | KS	-	F		-	≥ 17	3	7.92
	Ensure 60% of our staff would recommend us as a place to work	Q | T-D | W | KS	-			-	≥ 60%	59.23 %	61.79 %

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

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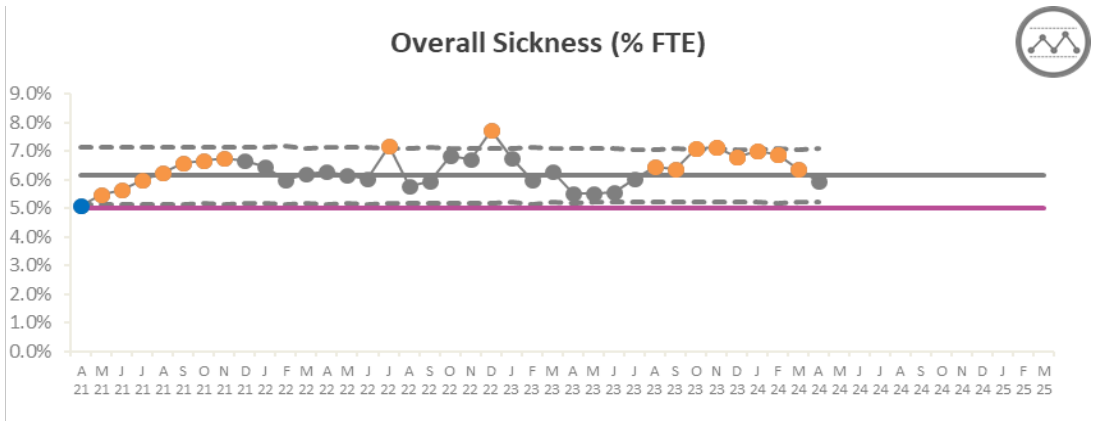
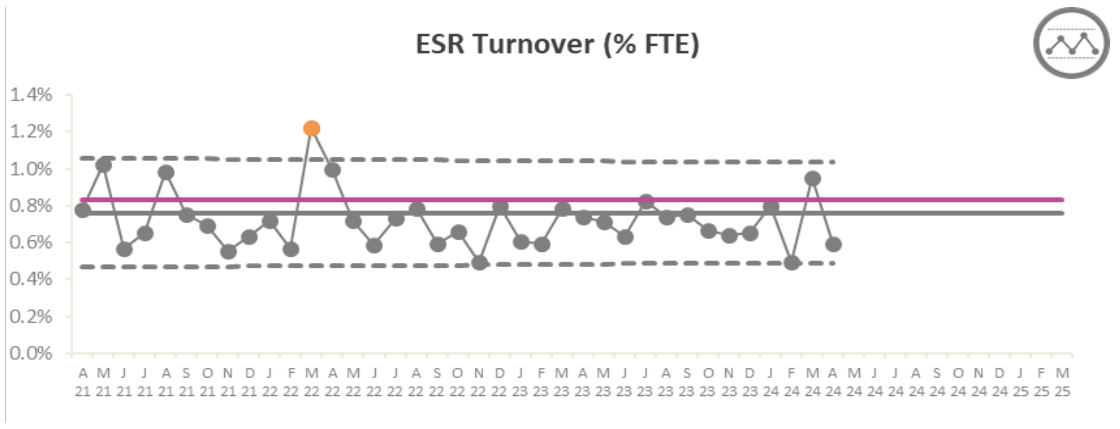
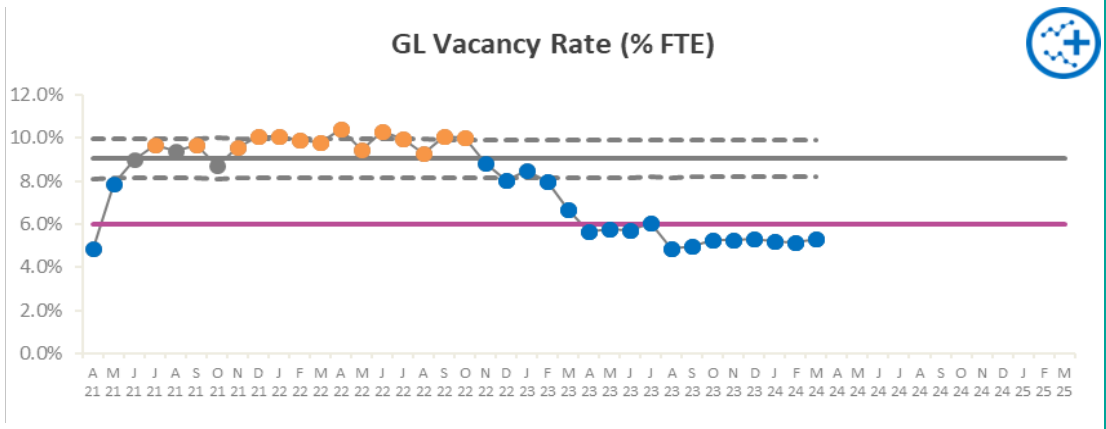
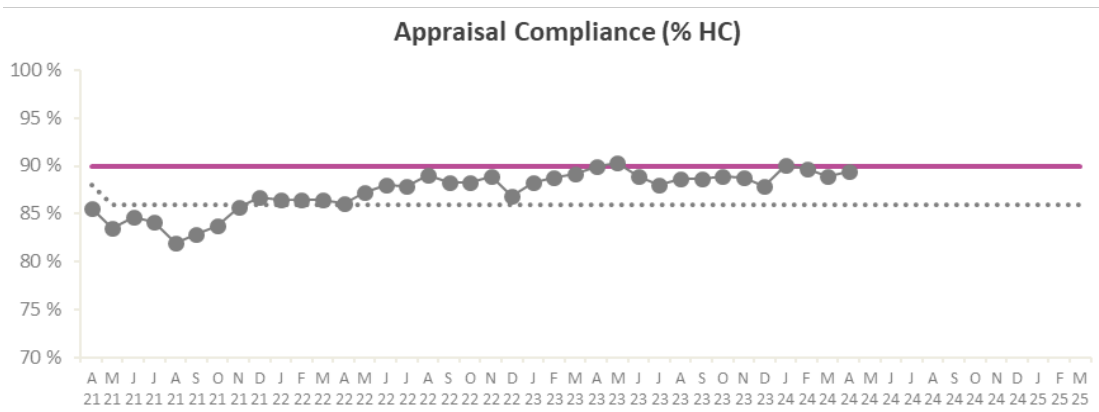
B = Bi-annua	D = Division	ETR = Education, Training & Research Commit	JW = Jonathan Wood
M = Monthly	S = Specialty		All = All Exec Team
Q = Quarterly	C = Cost Centre		

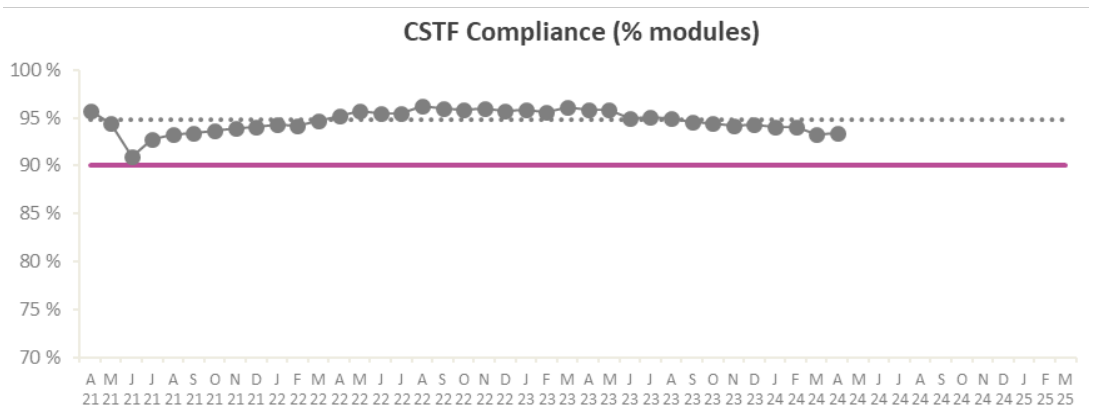
	Metric Description	Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Enivronment	Upgrade a further five local staff rest areas	B | T | W | JW			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

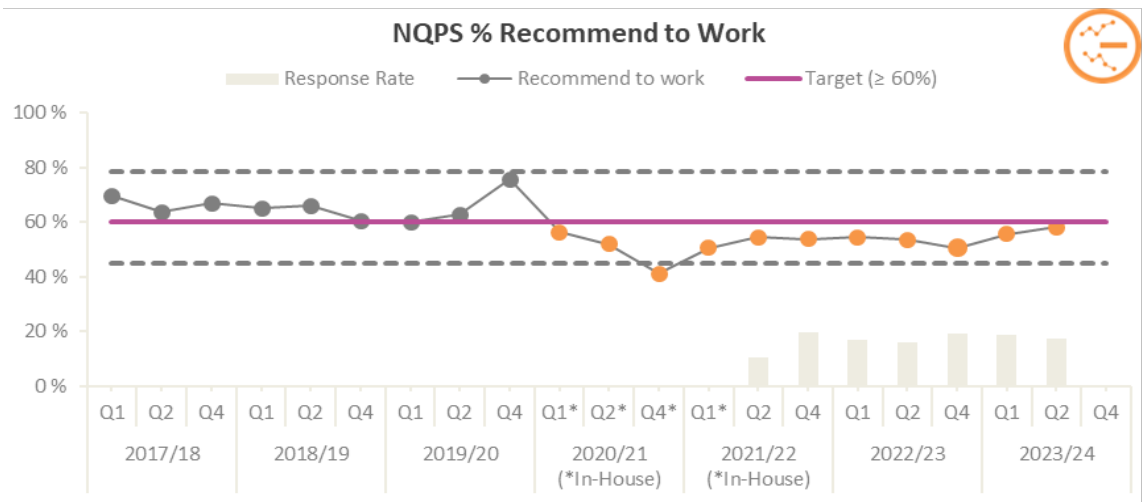

Overall Sickness (% FTE)
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%

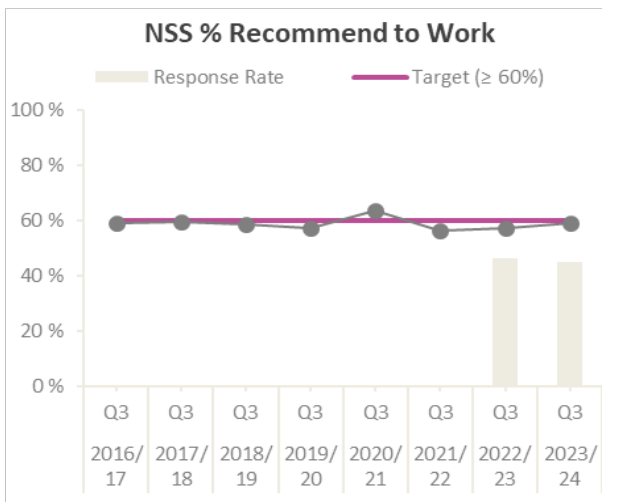

ESR Turnover (% FTE)
1.4%
1.2%
1.0%
0.8%
0.6%
0.4%
0.2%
0.0%


GL Vacancy Rate (% FTE)
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%


Appraisal Compliance (% HC)
100 %
95 %
90 %
85 %
80 %
75 %
70 %


CSTF Compliance (% modules)
100 %
95 %
90 %
85 %
80 %
75 %
70 %


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


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

Deliver Value for Money

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One - Spend Less (Economy)												
Agree revenue and capital financial plan with ICB	**Key Metric**		Deliver 100% of the agreed targeted reduction in our underlying financial deficit	A | T | TB - FPC | JW	This indicator is reported separately agreed at Trust level at budget setting							
Deliver agreed cost improvement delivery target	**Key Metric**		To deliver 100% of agreed cost improvement target	M | T-D-S | FPC | JW	No	-	-	-	1662	1663	-
Segment Two - Spend Well (Efficiency)												
Bed Occupancy Rate (Including Escalations)	Big Plan		Reduce adult general and acute (G&A) bed occupancy rate	M | T-D-S | FPC | FB	No				96.74%	93.7%	93.8%
Theatre Efficiency	Big Plan		RPH - Theatre capped utilisation rates are no lower than 80%	M | T-D-S | FPC | FB	No	-	-	-	80%	82.6%	-
	Big Plan		CDH - Theatre capped utilisation rates are no lower than 85%	M | T-D-S | FPC | FB	No	-	-	-	85%	77.6%	-
GIRFT (Model Hospital)	Big Plan		Achieve 85% day of surgery using BADs Procedures - GIRFT	M | T-D-S | FPC | FB	No			-	85%	87.3%	85.5%
OP Follow Ups	Big Plan		Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels - **March 2024**	M | T-D-S | FPC | FB	No	F			-25%	-13.67%	-1.36%
Supplier payments (BPPC)	Big Plan		To ensure all suppliers are paid in line with national guidance	M | T | FPC | JW	No			-	95%	86.7%	-
Segment Three - Spend wisely (Effectiveness)												
Agency costs	Big Plan		Reduce agency costs to 3.7% of the total pay bill	M | T-D-S | W | SC-GS	No	-	-	-	3.7%	2.55%	-
Delivery of Activity and Revenue Plan	**Key Metric**		To ensure 100% delivery of the Trust's activity and revenue programme	M | T | FPC | JW	No	-	-	-	-3765	-3765	-
Capital	**Key Metric**		To ensure 100% delivery of the Trust's Capital programme	M | T | FPC | JW	No	-	-	-	15233	14120	-

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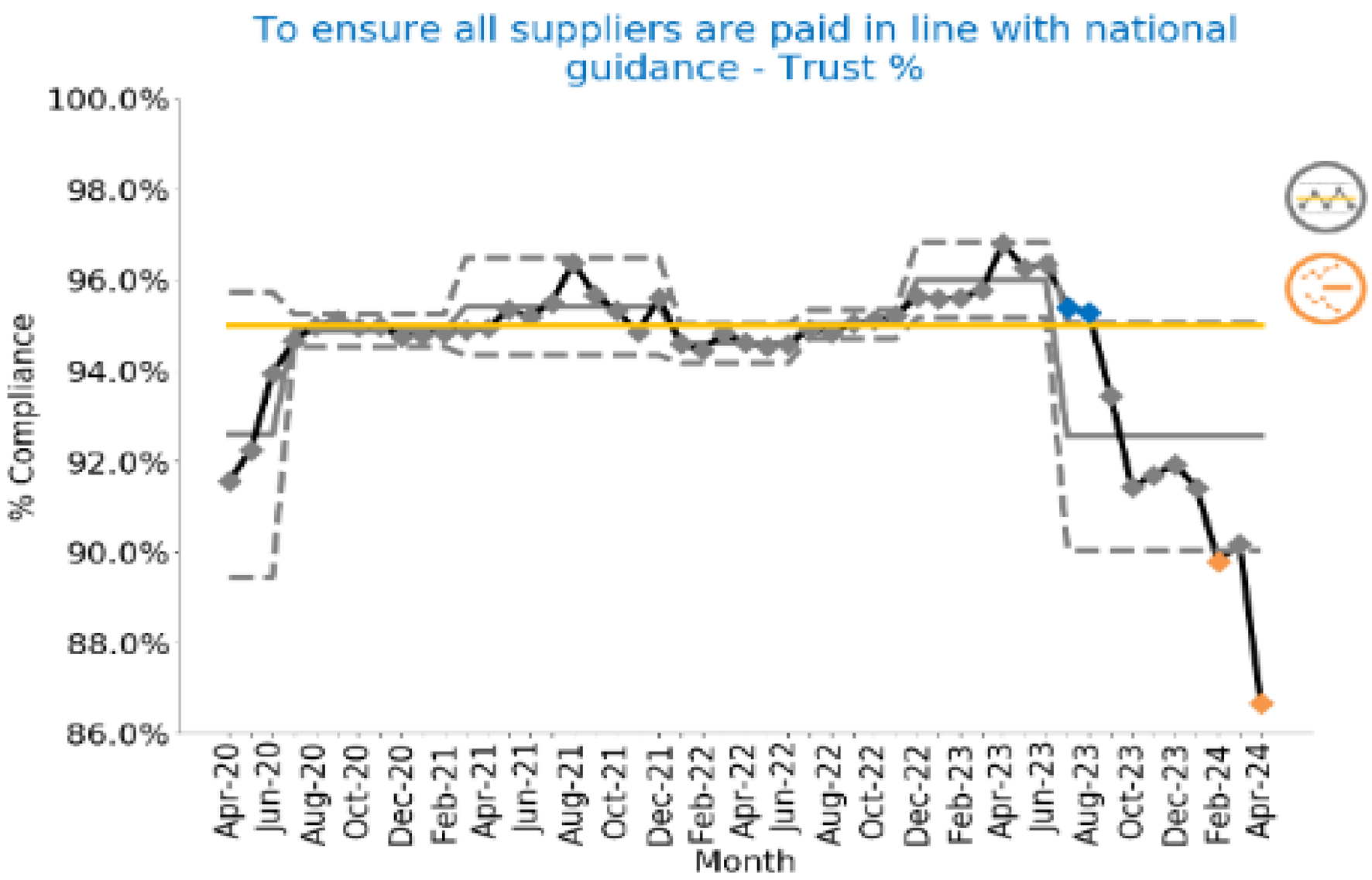

Assurance Icons – How likely are we to hit the set target in future?

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

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

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

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

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

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

Reporting Requirements Key

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

Green Delivering actions and outcomes

Amber On track to recover actions & outcomes

Red Significantly off track with actions & outcomes

Chair's Report to Board		
Chair: T Watkinson	Committee: Audit	
Date(s): 3rd May 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
N/A		None

ALERT

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

No alerts

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The Committee noted the importance of monitoring the actions taken in response to the **Duty of Candour** report. While there was comfort with the actions being taken, the Committee felt it necessary to ensure continuous oversight due to the high-rated recommendations from MIAA.
- The Committee highlighted the need to keep the Board informed about the actions being implemented to address **key financial control issues**. This did not require immediate action but warranted ongoing monitoring to ensure improvements would be effective.
- The Committee advised maintaining a focus on the significant risk around financial sustainability. It was important to ensure that the **VFM conclusion** aligned with the actions and improvements being planned, particularly the emerging three-year plan for SIP, FRP, and CIP. This also included maintaining a balance between safety, quality, and finance.

ASSURE

Assurance received; Matters of positive note.

- Green rating on **counter fraud**; this indicated strong performance in fraud prevention and detection. The Committee approved the Counter Fraud Workplan 2024-25
- Completion of the **internal audit programme**, substantial assurance provided by MIAA. This reflected positively on the effectiveness of the internal audit processes.
- Assurance was provided on the updates to **policy management**. The Committee was satisfied with the improvements and ongoing management of policies.

- The Committee was assured of the significant improvements in **theatre utilisation** to address previous audit findings. This was particularly noteworthy given the ongoing resource pressures in those teams.
- The **internal audit plan** was endorsed, providing a structured approach to audit activities and future assurances.
- There was reassurance provided around the scrutiny of the **VFM risk**, ensuring actions aligned with strategic objectives and financial stability.

Audit Committee

3 May 2024 | 2.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	2.30pm	Verbal	Information	T Watkinson
2.	Apologies for absence	2.31pm	Verbal	Information	T Watkinson
3.	Declaration of interests	2.32pm	Verbal	Information	T Watkinson
4.	Minutes of the previous meeting held on 18 January 2024	2.33pm	✓	Decision	T Watkinson
5.	Matters arising and action log	2.34pm	✓	Decision	T Watkinson
6. INTERNAL AUDIT					
6.1	Internal Audit Progress Report	2.35pm	✓	Assurance	MIAA
6.2	Combined Internal Audit and Anti-Fraud Follow-Up Summary Report		✓	Assurance	MIAA
6.3	Draft Head of Internal Audit Opinion	2.45pm	✓	Assurance	MIAA
6.4	Internal Audit Plan and Fees	2.55pm	✓	Assurance	MIAA
6.5	a) Counter-Fraud Annual Report b) Counter Fraud Work Plan and Fees	3.05pm	✓ ✓	Assurance	MIAA
7. EXTERNAL AUDIT					
7.1	Update on External Audit Plan	3.15pm	✓	Information	KPMG
8. RISK AND ASSURANCE					
8.1	Committee Risk Reviews – *Deliver Value for Money*	3.25pm	✓	Decision	S Regan
8.2	Policy Management Paper (action ref 72/73)	3.35pm	✓	Assurance	C Morris
8.3	Theatre Management Progress Report (action ref: 76/23)	3.45pm	✓	Assurance	I Devji
8.4	Items for escalation to the Board or referral to/from other Committees	3.55pm	Verbal	Information	T Watkinson
8.5	Reflections on the meeting and adherence to the Board Compact	3.58pm	✓	Information	T Watkinson

№	Item	Time	Encl.	Purpose	Presenter
9.	**ITEMS FOR INFORMATION**				
9.1	Strategic Risk Report		✓		
9.2	Technical Update		✓		
9.3	Review of Cycle of Business & Terms of Reference		✓		
9.4	Internal Audit Charter		✓		
9.5	Tender Waivers		✓		
9.6	Losses and Special Payments		✓		
9.7	Clinical Audit Programme Update		✓		
9.8	Annual Report on Gifts and Hospitality		✓		
9.4	MIAA Final Audit Reports a) Assurance Framework Review b) Duty of Candour c) Key Financial Systems d) Mortality Review		✓		
9.5	Date, time and venue of next meeting: *21 June 2024, 10.00am, Microsoft Teams*	4.00pm	Verbal	Information	T Watkinson

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NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors' Report

Board Appointments			
Report to:	Board of Directors	**Date:**	6 June 2024
Report of:	Company Secretary	**Prepared by:**	J Foote

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

Executive Summary:

The purpose of the report is to update the Board on the end of terms of office and subsequent appointments, including seeking a decision of the Board for the appointment of a chair to the board of Lancashire Hospital Services Ltd.

Recommendations

It is recommended that the Board:

i. notes the changes as detailed in the report;
ii. formally records its thanks to Jim Whitaker, Michael Wearden and Peter Wilson for their contribution and commitment in their respective roles at the Trust;
iii. appoints Victoria Crorken as chair of LHS Ltd.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Council of Governors Minute No 79/23 (appointment of Uzair Patel)

1. Introduction

A number of terms of office of non-executive and associate non-executive directors will end shortly. This has required the Chair to consider the current profile of assurance committee chairs and the chair of the board of the wholly owned subsidiary, Lancashire Hospital Services Ltd.

2. Background

Non-Executive Directors

The current term of office of Jim Whitaker will end on 1 July. Jim has served for a total of seven years and has decided not to seek a further term. Jim is currently chair of the Workforce Committee and also Chair of Lancashire Hospital Services Ltd, a wholly owned subsidiary of the Trust.

Associate Non-Executive Directors

The terms of office of Michael Wearden and Peter Wilson end on 9 June and 15 June respectively.

At its meeting in August 2023, Council appointed Uzair Patel as a Non-Executive Director to commence at the next vacancy (with the Board appointing Uzair as an Associate Non-Executive director until the vacancy occurred). Uzair will therefore step up to a full NED role from 2 July for a period of three years.

At this point the Board will not have any current associate NEDs. It is intended that the Board should take the opportunity to review the use and benefits of the associate role, including redefining the purpose and scope for any future appointments.

Assurance Committee Chairs

The Chair has appointed Victoria Crorken to the position of chair of the Workforce Committee. Other Committee Chairs will remain in their current role.

Uzair Patel will continue to be mentored by Tim Watkinson in anticipation of taking on the role of Audit Chair at the end of Tim's final term of office in March 2025.

LHS Ltd

The appointment of the chair of the company board is a reserved matter for the Trust. The Board is therefore asked to approve the appointment of Victoria Crorken to the position of chair of LHS Ltd.

Succession Planning

Further terms of office are due to end throughout 2025 and consideration will need to be given as to how this is managed in a planned and ordered manner to ensure continued stability at Board level.

Jim, Michael and Peter have all given their time and expertise in service of the Board. This paper formally recognises and acknowledges their valued contributions whilst in office.

3. Financial implications

Within budget (with a small saving as a result of the vacant ANED positions).

4. Legal implications

The appointments are as required under the Trust's establishment order and the Articles of Association of LHS Ltd.

5. Risks

The appointments allow for a continuity of leadership at non-executive level with a planned succession for Audit Chair in place.

6. Impact on stakeholders

The new appointees will need to build networks and relationships as part of their role.

7. Recommendations

It is recommended that the Board:

i. notes the changes as detailed in the report;
ii. formally records its thanks to Jim Whitaker, Michael Wearden and Peter Wilson for their contribution and commitment in their respective roles at the Trust;
iii. appoints Victoria Crorken as chair of LHS Ltd.

Chair's Report to Board		
Chair: Peter White	NHP Assurance Committee	
Date: 16 April 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
None allocated due to infancy of the Committee	n/a	No items for recommendation due to infancy of the Committee

ALERT

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

No matters to alert.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

The Trust would be required to sign the NHP Agreement before the submission of the business case. This was not yet in final form and would be closely scrutinised by the Committee before any recommendation is made to the Trust.

ASSURE

Assurance received; Matters of positive note.

The Project Delivery Group which is the executive leadership function within the Trust has been launched.

The NHP land assembly business case has been approved and shared with colleagues at national level.

A review of the governance of the L&SC NHP was undertaken in December 2023 by PA Consulting. This gave a clarity on guidance and reporting/assurance mechanisms for the programme, which was highly complex with multiple agencies involved. Other working groups would be formed as part of the work plan and would include joint working groups from the Trust and ICB.

NHP Assurance Committee

16 April 2024 | 9.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	9.00am	Verbal	Information	P White
2.	Apologies for absence	9.01am	Verbal	Information	P White
3.	Declaration of interests	9.02am	Verbal	Information	P White
4.	Senior Responsible Officer Report	9.05am	Verbal	Discussion	J Wood
5.	NHP Land Assembly Business Case Update	9.15am	Verbal	Information	J Wood
6.	New Hospital Programme Agreement	9.25am	✓	Discussion	J Wood
7.	Resource Aligned to Workplan	9.35am	✓	Discussion	J Wood / R Malin
8.	Programme Governance – PA Consulting Report	10.00am	✓	Discussion	R Malin
9.	Terms of reference and workplan		✓	Information	
10.	Date & time of next meeting: 16 July 2024, 1.00pm – 2.30pm MS Teams	10.10am		Information	

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Infection Prevention and Control Annual Report 2023/2024							
Report to:	Board of Directors			**Date:**	6 June 2024		
Report of:	Chief Nursing Officer			**Prepared by:**	Dr D Orr 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 2023/2024 and update the Board of Directors on the Trust's performance against key areas of Infection Prevention and Control (IPC).

During the period 2023/2024 there has been an increase in subsequent infections including Norovirus, Measles, Xtensively Drug Resistant Pseudomonas, and Influenza with the National Health Service (NHS) operating under significant pressure during the recovery of the COVID-19 pandemic.

In 2023/2024 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 Control and Sarah Marsh providing nursing leadership as the Matron. There is a full complement of IPC nurses providing a 7-day service.
- In the 2023 CQC report there was one infection control should do in RPH Medicine - The service should ensure that staff follow infection prevention control principles. This was delivered with underpinning assurance evidence on the 31.11.23.
- 1 hospital acquired Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteraemia case.
- The Clostridioides difficile (C. *difficile/CDI*) objective was exceeded by 82 cases despite the measures put in place to reduce. There has been a national increase in cases following the COVID-19 pandemic. Faecal testing has been continued to accurately identify the source of infection, identify and isolate C. *difficile* earlier in the patient's journey. Following an NHS England review increased oversight of improvement actions is included in this report. (Appendix 3)
- The CDI risk has been increased to 20 in year to reflect the outcome data and this is escalated to IPC Committee and Trust Board with oversight of mitigations and actions.
- The Trust has met the national CQUIN target prompting switch of intravenous to oral antibiotics for 2023/2024 seeing a reduction in 12-month trend for proportion of IV antibiotic use vs oral.
- The Trust remains compliant with documented indication for antibiotics on prescription charts.
- The Antimicrobial stewardship team work closely with the sepsis lead and a change in Trust guidance for first line antimicrobial options for sepsis of unknown source has supported a reduction in cefuroxime usage (linked to CDI incidence).

- The National cleaning standards (2021) have not been fully implemented across all clinical areas within the Trust. Currently 15 wards are compliant. Further roll out requires investment in domestic services.
- 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.
- The Trust is impacted by high reports of blockages in the single stack sewage system, with an average of 30 blockages reported per month in 2023/2024. An external assessment of the sewage system has been commissioned and report is awaited. There are several preventative measures in place including the launch of the Bin the Wipes Campaign.
- The IPC team are working across the Integrated Care System to share learning using the principles of the Patient Safety Incident Response Framework
- Covid-19 numbers have fallen in year.
- The objective for gram -negative bacteraemia was exceeded by 6 cases.
- The influenza season was sustained over 4 months from December 2023 which reflected the national picture.
- Plans are in place in response to the national measles outbreak with a measles policy in place and communications and simulations making clear the actions required.
- In December 2023 there was an outbreak of extensively drug resistant pseudomonas involving 5 patients on the neuro high care unit. An external review was commissioned and the action plan in response to the recommendations in the report is being overseen at IPC Committee.
- IPC mandatory training is compliant.
- The Trust remains compliant with decontamination HTM01-01 standards, ISO 13485:2016 Quality Management System
- The Trust has a sustainability group, sustainability champions and policies and procedures in place to assist with the Green Plan commitments and sustainability.

The report contains an update on the actions delivered in the 2023/24 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 2023/24 and presents the 2024/2025 IPC plan for approval.

It is recommended that:

- The Board of Directors are asked to receive the contents of the report for information and note the Safety and Quality committee have scrutinised the report and confirmed it is assured of the contents and endorsed the closure of the 2023/24 annual plan and the production of the 2024/25 annual plan.

Appendix 1 – IPC 2023/24 Annual plan
Appendix 2 – IPC 2024/25 Annual plan
Appendix 3 – C. difficile improvement plan
Appendix 4. Infection, Prevention and Control Governance Structure

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	☒
	☒	Deliver Value for Money	☒

To drive health innovation through world class education, teaching and research		Fit For The Future	☒

Previous consideration

Infection Prevention and Control Committee, 17/05/2024
Safety & Quality Committee May 2024

1. Introduction

The purpose of this report is to provide an overview of the progress made against the annual Infection Prevention and Control annual plan for 2023/2024 and update the Board of Directors on the Trust's performance against the annual objectives for Methicillin-Resistant Staphylococcus aureus (MRSA) bloodstream infection and Clostridioides difficile infection (C. difficile/CDI).

Infection Prevention and Control (IPC) remains a key priority for Lancashire Teaching Hospitals (LTHTR). The IPC team continues to work closely with other providers across the health economy. Dr David Orr, a Consultant Microbiologist, currently holds the Director of Infection Prevention and Control (DIPC) role and the Matron for Infection Prevention and Control, Sarah Marsh, is the senior nursing lead. The DIPC is supported by the Deputy Chief Nursing Officer, Catherine Gregory, the IPC specialist nurses, and Microbiologists. The Associate Director of Infection Prevention Control (ADIPC) is currently vacant.

Hospitals across the UK were challenged in 2023/24 due to the significant influx in inpatients stays resulting in overcrowded Emergency Departments, Assessment Units, and boarded patients (the practice of placing patients in temporary or makeshift areas within the hospital when the appropriate beds or wards are unavailable) on inpatient wards, ED and assessment areas and also due to the increase in various infections following the COVID-19 pandemic.

The number of inpatients per year has been steadily increasing with the year 2023/2024 reporting 280,671 inpatient stays, an increase of 13.14% from 2021/2022. LTHTr was particularly challenged due to its poor estate, evidenced by the Trusts participation in the new Hospitals programme, as well as insufficient isolation rooms that do not meet the demands of the patient population. These factors have contributed to the increase in outbreaks and HCAIs' over the last financial year and the risk is captured on the risk register with mitigation and action in place (Risk 1302).

Multidisciplinary Post Infection Reviews (PIRs) continue to be a key strategy for learning and improvement. The PIR process promotes a culture of learning and openness rather than blame. The Trust adopted the Patient Safety Incident Response Framework (PSIRF) in November 2023 which focusses on system learning and advocates that time should be spent on value added improvement actions rather than investigating individual incidents that draw a conclusion of no new learning. For hospital acquired infections, the team have been working with colleagues across the Integrated Care Board (ICB) to share learning and agree a standardised approach for learning responses and in line with PSIRF this approach will be implemented from April 2024 as part of the new way in which hospital acquired infections will be investigated and responded to. In preparation for this an improvement plan for CDI has been produced and is being tracked via IPC Committee and builds on evidence based best practice guidance, learning themes from 85 cases that were reviewed as part of the PIR process between August 2023 and January 2024 and local stakeholder knowledge of processes and issues.

This report presents the details of IPC performance at Lancashire Teaching Hospitals Trust (LTHTR) in 2023/2024 with the focus on key IPC issues and includes the 2023/2024 programme which details the completion of improvement actions in line with the ten domains of the Hygiene Code which accompanies the Health and Social Care Act 2022.

In the 2023 CQC report there was one infection control should do in RPH Medicine - The service should ensure that staff follow infection prevention control principles. This was delivered with underpinning assurance evidence on the 31.11.23.

The Infection Prevention and Control Annual Plan 2023/2024 is attached for information and closure. The 2023/24 IPC Annual Plan was ambitious, and the majority of actions have been delivered, however, as a result of unprecedented demand, financial limitations, multiple infections, and staffing levels there have been some which have been delayed and are carried over to the annual plan 2024/2025. These include:

- To reduce Gram-negative bacteraemia cases and improve continence and bowel care services across the ICB including the promotion of hydration and a reduction in catheter associated urinary tract infections across the ICB
- Review and define the Trust cleaning standards in compliance with the National Cleaning Standards for 2023/2024.

The 2024/2025 Annual Plan is attached for approval. This will expand and build on improvements made in 2023/2024.

2. Discussion

Each clinical division has a monthly IPC divisional meeting / Always Safety-First meeting which reports by chairs escalation into the Trust wide IPC Committee. In addition, there is an Estates and Facilities and clinical partnership board that reports into IPC Committee along with scheduled reports from the Water Safety Group, Decontamination, Sepsis, Surgical Site Infections, and Antimicrobial Stewardship. Appendix 4 - Infection, Prevention and Control Governance Structure

IPC is a standard agenda item on the weekly Nurse, Midwifery and AHP Clinical leaders meeting, weekly Strategic Operational Group (SOG) and fortnightly Clinical Reference Group (CRG) so that updates and any learning can be shared with medical leaders, non-medical clinician leaders and operational leaders on a regular basis, highlighting the importance and emphasis on IPC practice.

3. TRUST PERFORMANCE RELATED TO ORGANISMS OF CONCERN

3.1 MRSA Bacteraemia

Staphylococcus aureus is a bacterium that commonly colonises human skin and mucosa. Most strains of S. *aureus* are sensitive to the more commonly used antibiotics, and infections can be effectively treated. However, some S. *aureus* bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin-resistant S. *aureus* (MRSA). Bacteraemia occurs when bacteria get into the bloodstream.

Infection Prevention and Control continues to be a key priority for the Trust, and the incidence of MRSA is outlined below:

- In 2021-22 there has been 1 incident of hospital onset MRSA bacteraemia and 2 cases of community onset MRSA.

- In 2022-23 there has been 1 incident of hospital onset MRSA bacteraemia and 5 cases of community onset MRSA.
- In 2023-24 there has been 1incident of hospital onset MRSA bacteraemia and 7 cases of community onset MRSA.

Despite an increase in MRSA bacteraemia cases in the community over the past 3 years, the numbers reported as hospital onset have remained consistent with 1 case per annum.

Cases are investigated by a multi-disciplinary team using the national post infection review tool and discussed with the Director of Infection Prevention & Control to identify causes and actions for future prevention. The Hospital associated case identified in September 2023 was reviewed and was determined to be a contaminant. The key contributory factors were a lack of re-screening and further decolonisation after treatment.

3.2 *Clostridioides difficile* Infection

Clostridioides difficile (C. *difficile*) is an anaerobic bacterium that is present in the gut. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of infants). In some instances, strains of *C. difficile* can grow to unusually high levels and attack the intestines, causing mild to severe diarrhoea. Patients who are commonly affected are elderly and/or immunocompromised; exposed to antibiotics and *C. difficile* from spores from within the environment.

NHS England define the report of C. difficile Toxin positive cases into the below grouping:

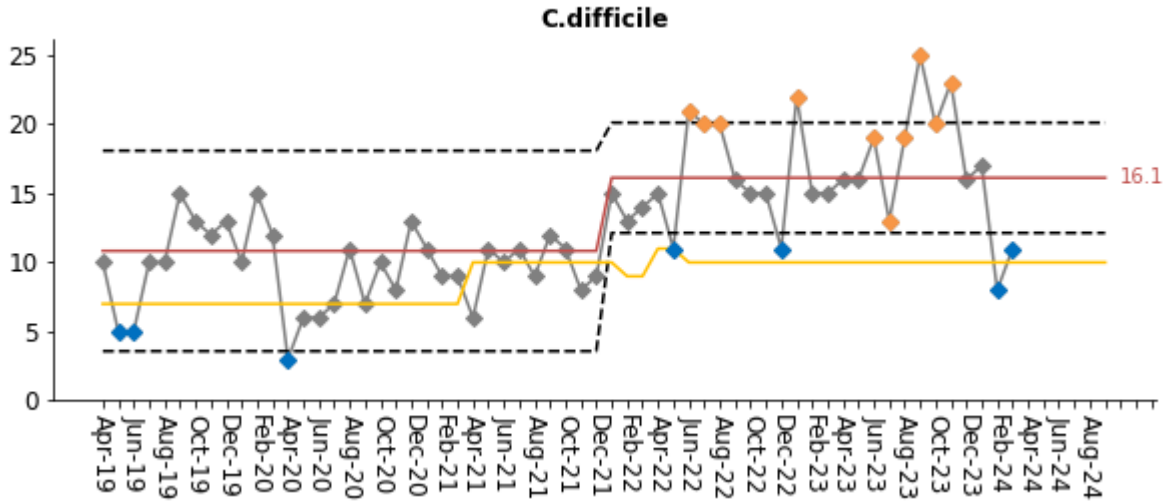
- Hospital Onset Healthcare Associated (HOHA): cases that are detected in the hospital two or
- more days after admission.
- Community Onset Healthcare Associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
- Community Onset Indeterminate Association (COIA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks.
- Community Onset Community Associated (COCA): cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

The national objective set for the Trust accounts for HOHA and COHA cases.

The prevention of C. *difficile* infection remains a key priority for our organisation. In the year 2023/24, the national objective set by NHSE for the trust was to have no more than 122 hospital associated cases. The Trust exceeded the national objective with an increase in hospital associated cases during 2023/2024 in comparison to previous years with a total of 203 cases. This was a 3.6% increase from 2022/2023 which had a total of 196 hospital associated cases.

Although the year 2023/2024 saw an overall higher number of hospital associated cases, the number of HOHA cases decreased compared to 2022/2023 with a reduction of 12 cases.

Figure 1 Hospital Associated C. *difficile* Toxin positive rates per month.



4. The national and regional picture

There has been a national increase in *C. difficile* infection and a significant proportion of Trusts nationally are above trajectory. In the Northwest 12/24 trusts (50%) were over their objectives as reported in February 2023, however, LTHTr ranks highest of major trusts in terms of *C. difficile* rate per 100,000 bed days.

Table 1 C. *difficile* incidence and rate per 100,00 bed days - Northwest hospitals April 2023 – March 2024

Organisation Name	April 2023 to March 2024	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	5	8.8	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	80	30.3	
BOLTON NHS FOUNDATION TRUST	121	55.8	High (0.001)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	77	47.1	High (0.025)
EAST CHESHIRE NHS TRUST	11	10.2	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	101	30.7	Low (0.001)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	203	63.6	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	3	5.6	Low (0.001)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	161	30.8	Low (0.025)
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	275	34.6	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	51	30.8	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	78	36.0	
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	171	35.5	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	40	28.5	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	74	26.9	Low (0.001)
STOCKPORT NHS FOUNDATION TRUST	81	36.4	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	55	36.6	
THE CHRISTIE NHS FOUNDATION TRUST	56	92.9	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	12	36.9	
THE WALTON CENTRE NHS FOUNDATION TRUST	11	24.2	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	85	39.2	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	55	28.5	Low (0.025)
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	109	41.8	High (0.025)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	56	30.8	
North West	1971	33.9	

In July 2023, the Chief Nursing Officer (CNO) initiated weekly (and then bi-weekly) executive oversight meetings with a focus on reducing *C. difficile.* To date these meetings, continue and oversee the PSIRF CDI reduction improvement plan. The actions have been collaboratively driven showing the synergy and effectiveness that can progress when teams work together. The last 2 months data points have shown positive special cause variation and a significant reduction in CDI rate. Whilst it is too early to predict, the actions would indicate a positive effect on outcome data and if sustained would forecast an improved CDI position in the 2024/2025 data. This will continue to be overseen at IPC Committee and reported in monthly to Safety and Quality Committee.

Main initiatives in 2023/24 to reduce CDI (*Clostridioides difficile* infection) included:

1) Removal of cefuroxime for treatment of unexplained sepsis since July 2023 – this is a high-risk antibiotic.
2) Introduction of Tristel jet (sporicidal) for general cleaning on wards since September 2023
3) Introduction of ward staff cleaning checklist for items that require daily and weekly cleaning by ward staff since August 2023. Assurance of this is built into the STAR process.
4) Gradual roll out of national cleaning standards by domestic services (15 wards currently) with a proposal to continue with all inpatient wards, subject to investment.
5) Improvement in Fogging compliance where *C. difficile* cases were detected. This is now tracked via the daily bed capacity meetings and escalation actions recorded where fogging has not been completed within timescale.
6) Reduction in patient transfers on beds to enable beds to remain the property of wards, hence greater assurance of cleaning and mattress checks.
7) Trust wide mattress audit and replacement followed by an increased checking of mattresses (mattress audits) so that damaged mattresses with soiling internally can be removed. With support from the IPC team, Tissue Viability team and mattress provider Medstrom, an audit was conducted on 488 mattresses on inpatient wards and in the bed store. Of these reviewed, 136 were changed due to damage or strike through. The IPC Matron and Tissue Viability Lead also reviewed the process for the cleaning and checking of mattresses on transfer/discharge of patients. The mattress audit on AMaT was also reviewed and updated ensuring all mattresses are checked monthly as a minimum with a separate audit being produced for trolleys in theatres.
8) Improved assurance of IPC/cleaning standards through the “STAR” assurance framework where wards get inspected and given a STAR rating.
9) New flag for estates remedial work requests from wards, if they have an IPC impact, so that they can be managed quickly from August 2023
10) Weekly communication of IPC-flagged estates requests and the time-period to resolution from August 2023
11) Improvements in electronic “Side-room audit” which lists everyone in hospital who is in a side-room and why they were placed in the side-room. To allow more efficient use of side-room capacity. Improvements sustained since July 2023

Initiatives of note from 2022/23 that continued or were enhanced:

1) Expansion in the definition of diarrhoea to include type 5 stools (June 2022) – this resulted in a 50% increase in testing and earlier diagnosis of cases in 2022/23.
2) Introduction of rapid test for *C. difficile* (and 21 other GI pathogens) for use if side-room capacity is limited. If the test is negative, the patient with diarrhoea can remain in a bay.

3) Introduction of a ward "Whiteboard," which is checked 1-2 times per day by ward co-ordinators and flags patients who have diarrhoea from their electronic stool charts.
4) Introduction of a new electronic nursing Kardex which alerts nurses to recent diarrhoea and prompts them to perform a risk assessment for testing and isolation.
5) A "diarrhoea dashboard" that is available to IPC nurses which compiles a list of everyone in hospital with diarrhoea and includes details including – laxative use, recent CDI testing and whether or not they are in a side-room.
6) Implementation of a *C. difficile* Qlikview page which displays all the *C. difficile* cases in hospital, where they were detected and the wards that they passed through in graphical form. To allow for pro-active fogging

However, the IPC team have identified the following weaknesses that remain:

- Lack of capacity in domestic services to fully implement 2021 national cleaning standards in most areas.
- Exceptionally high reports of blockages, with an average of 30 blockages reported per month in 2023/2024, in the sewage system leading to backup into ward areas including sinks, contaminating the ward environment with faecal organisms including *C. difficile.*
    - It is a "single stack" system where water from toilets and macerators enter the same drains as water from wash-hand basins.
    - Over time the main drains have become rusted and narrowed on the inside
    - Non-dispersible wipes used for cleaning, flushed down toilets or placed in macerators inappropriately, are causing high numbers of blockages.
- Insufficient decant facilities for more timely decontamination of the environment ("Fogging") in response to cases of infection.
- Sub-standard estate due to reduced funding for repairs and insufficient decant to perform repairs.
    - Surfaces that are difficult to clean due to their deterioration.
- Insufficient side-room capacity leading to delays in isolation of *C. difficile* diagnosed patients.
- Understaffing within the Domestic Services and Estates, maintenance and service team and its impact on IPC practice
- Overcrowding of patients on hospital sites because of increased demand

The CDI risk was updated in IPC Committee in January 2024 with the risk score increased to 20 and hence it remains escalated to Trust Board.

5. Patient safety incidence response framework (PSIRF)

In 2023, the Chief Nursing Officer, England, and national director of patient safety in England wrote to NHS foundation trusts asking them to move to a new framework for managing patient safety incidents.

PSIRF moves away from a linear 'one-size-fits-all' RCA approach towards the use of a broader system-based learning response toolkit. It also supports organisations to use their incident response resources to maximise improvement rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Implementing the PSIRF across the system is an opportunity to refocus our response to infection and will allow for a deeper understanding of incidents to better understand the system-factors that contributed to the infection; thus, helping identify meaningful improvements to interrupt the chain of infection transmission.

The infection control leads from the ICS met in January 2024 and proposed the following for incident management for 2024/25:

I. Post-infection Reviews would no longer be performed for all individual cases.
II. MDT reviews would be performed in the following circumstances (using forms that are specific to the hospitals and include their data):
    (1) Confirmed transmission from genotyping indicating outbreak.
    (2) Areas of high incidence (based on local judgement in hospitals).
    (3) Hospital associated infection on death certificate.
III. Patient safety incident investigation will be performed when a patient dies within 28 days of a C. *difficile* infection, and it is on the death certificate and
    (1) Where genotyping demonstrates a link to another case strongly suggesting transmission.
    (2) Poor care is identified in the MDT review which likely contributed to the death.

6. Summary

LTHTr has particularly high rates of *C. difficile* infection and risks being singled out regionally and nationally.

The actions for the coming year to reduce *C. difficile* are listed in the annual plan and some require resourcing.

- Co-production of an investment case for extra domestic resource in order to become compliant with 2021 national cleaning standards.
- Continued efforts to reduce inappropriate disposal of non-dispersible wipes in the sewage system and monitoring of the impact in terms of blockage frequency.
- Support the Estates department in the review of the current state of the sewage system and the exploration of the feasibility of improvement.
- Explore a research project with Primel (a company that produces Hand Hygiene and surface decontamination products with long-lasting antimicrobial effects)
- Patient involvement in reduction of hospital associated infections. The patient safety partners are working collaboratively on patient information and innovative ways of empowering patients whilst accessing Trust services.

There will continue to be a focus on the fundamentals including prompt assessment of patients with diarrhoea, sampling, and isolation, as well as hand hygiene (staff and patients), environmental cleanliness and antimicrobial stewardship, as evidenced by audit.

6.1 SARS coronavirus-2 (SARS-CoV-2) - COVID-19

On 31 December 2019, World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus SARS coronavirus-2 (SARS-CoV-2) was subsequently identified. The virus is mainly transmitted by respiratory droplets and aerosols, and by direct or indirect contact with infected secretions. Infection control, which, in large part, relies on segregation of infected from non-infected individuals, is incredibly difficult as one third of infected individuals have no symptoms but are still able to transmit the infection to others.

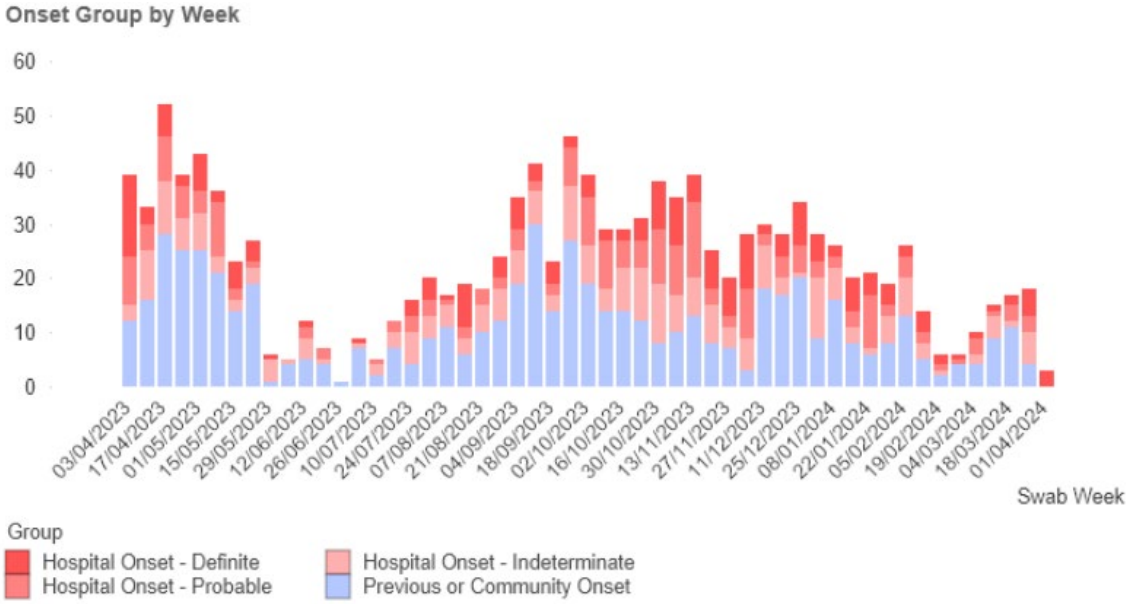
Notable changes in policy in 2023/24 (which mirrored changes in national guidance) included:

- The removal of staff masking except when managing patients with suspected or confirmed infection.
- Reduction in the isolation period for infected patients (5 days if improved and afebrile for 48 hours)

- Removal of routine testing of elective patients prior to admission
- Updated guidance on the timing of surgery after infection
- The change from a molecular approach to testing to an antigen approach (LUMIRA)

Figure 2 shows the impact of COVID-19 on patients in LTHTr in 2023/24.

Figure 2 Hospital Onset versus Community Onset COVID-19 infections



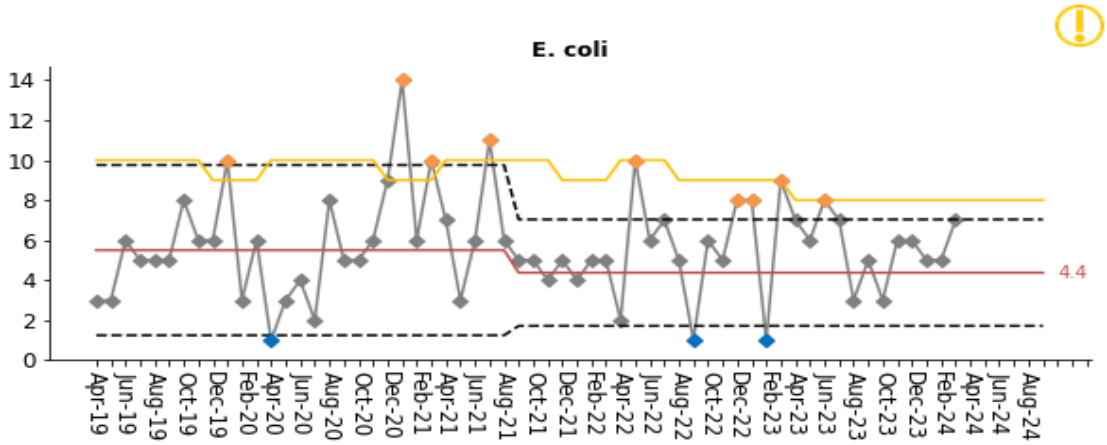
Source: LTHTR data

6.2 Gram-negative bacteraemia

NHSE published objectives for Trusts to reduce Escherichia coli (E. coli), Klebsiella species, and Pseudomonas aeruginosa in 2022/23.

The 2023/24 objective for E. coli bloodstream hospital associated infections was 95. LTHTr ended the year with a total of 101 hospital associated E. coli cases which was 6 cases above objective, however this was a reduction of 7 cases from the previous financial year 2022/2023.

Figure 3 Hospital Associated Escherichia coli positive rates per month.



The 2023/24 objective for *Pseudomonas aeruginosa* bacteraemia bloodstream hospital associated infections was 12. LTHTr ended the year with a total of 17 hospital associated *Pseudomonas aeruginosa* bacteraemia bloodstream cases for 2023/2024, this if 5 cases above objective.

The 2023/24 objective for *Klebsiella* species bloodstream hospital associated infections was 25. LTHTr ended the year with a total of 30 hospital associated Klebsiella species cases for the year 2023/2024, this is 5 cases above objective.

7. OTHER OUTBREAK INVESTIGATIONS IN 2023/24

7.1 Norovirus Outbreaks

The year 2023/2024 saw 18 Norovirus outbreaks: 2 in the summer of 2023, and 16 from February – March 2024. This matched the current national picture with Norovirus being a dominant virus during January 2024 onwards causing many patients within the community coming to emergency and medical assessment units with symptoms of vomiting and diarrhoea.

Historically, Norovirus outbreaks have resulted in closure of entire wards resulting in many trapped beds. The continued use of the rapid intestinal screening test has allowed for early identification of patients with Norovirus and supported the management allowing for early isolation to prevent or contain outbreaks, closing Bays rather than full wards. Unfortunately, with Norovirus being a dominant virus in the community, this has affected staff within LTHTr, which have been the presumed index cases for some of the outbreaks identified.

As a trust there has been increased focus on enhanced cleaning to reduce the bioburden within the environment, IPC precautions to mitigate the risk of spread, and the completion of fogging following the infectious period to mitigate the risk of the transmission of the virus to new patients preventing further waves. Communications were circulated reiterating protocols to staff to ensure that they refrain from work until 48 hours clear of symptoms.

Figure 4 Number of confirmed positive Norovirus Patients April 2023 – March 2024 (excluding patients identified in outbreaks that are likely Norovirus positive but not tested)

Source: LTHTR data

7.2 Influenza

Influenza is an acute viral infection of the respiratory tract that spreads easily from person to person. Influenza viruses cause seasonal epidemics in winter in temperate climates, as in UK. There are 2 groups

of Influenza virus, Influenza A and Influenza B which cause infection in humans. The epidemiology of Influenza is unpredictable as Influenza viruses continually change and evolve, which is why a new vaccine is developed for each season.

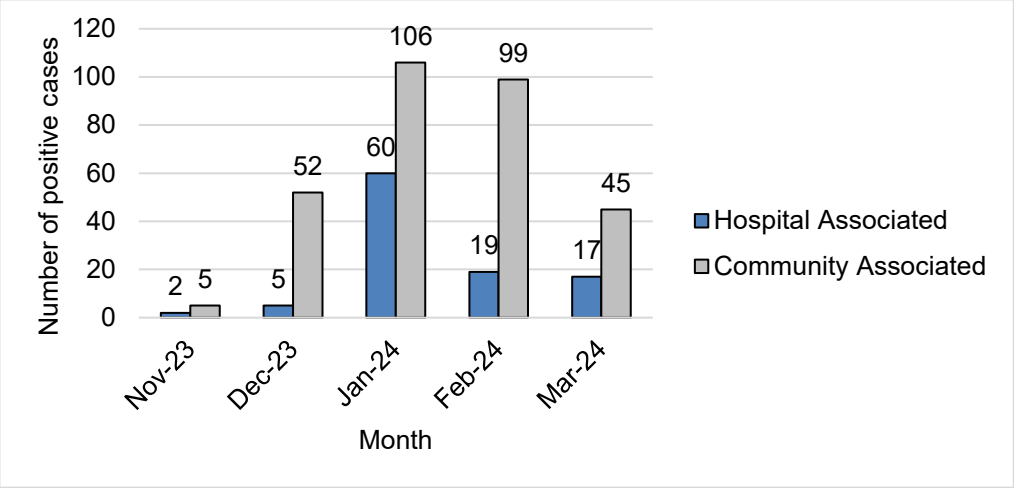
Transmission of Influenza occurs mainly by droplets, which can travel up to 2m through the air and by direct and indirect contact. Aerosol-generating procedures such as bronchoscopy and non-invasive ventilation can produce small particles which can travel further than droplets and remain in the air for longer. Prevention of influenza is by vaccination and basic hygiene including hand hygiene and cough / sneeze etiquette.

Isolation in single rooms and use of appropriate personal protective equipment (PPE) for suspected and confirmed Influenza cases is also key to preventing Influenza transmission in healthcare. When the number of single rooms exceed the single room capacity, cohorting Influenza cases can be implemented by subtype. In temperate climates, the incidence of influenza is seasonal and peaks in winter usually between January and March.

7.3 Influenza season 2023/2024

The Influenza season in LTHTR for 2023/24 started in December 2023 in line with the national pattern and peaked in January and February 2024. The year 2022/2023 saw a noticeable high-volume peak in December 2022. This year, 2023/2024 did not have this significant peak however the Trust saw a sustained increase in cases across a 4-month period which reflected the national pattern. The sustained nature of this Influenza season posed significant challenges for Infection Prevention and Control, and there were a larger proportion of Nosocomial cases. Influenza A was the most predominant strain with a small number of cases of Influenza B.

Figure 5 Influenza positive patients by onset



Source: LTHTR data

7.4 Measles National Outbreak

During 2023, there was a resurgence of measles in England. From 1 January to 31 December 2023 there were 368 laboratory confirmed measles cases, 122 (33%) of these in London and 160 (44%) in the West Midlands, however all Regions have reported cases; while the London cases have remained consistent monthly, the West Midlands cases were extremely low until December 2023.

From October 2023, there has been a rapid escalation of activity. The majority (67%) of these cases are in children under the age of 10, and 24% in young people and adults over the age of 15. Cases have predominantly been in Birmingham with smaller numbers in other West Midlands local authority areas. It is anticipated that cases will continue to increase over the next 4-6 weeks. Most cases are unvaccinated. There is a national awareness campaign ongoing to promote prevention of disease.

At the beginning of January 2024, the IPC formed a Measles response cell at LTHTr to plan for measles cases locally. The current action tracker is in Appendix 4. The risk has been placed on the risk register and is being monitored via IPC Committee with mitigation actions in place.

It is unclear as to the likely local impact on inpatient bed capacity, however, even with a relatively small number of measles cases coming into hospital, the impact could be significant on our services. This is because measles is a highly infectious infection and can cause severe disease, particularly in the immunocompromised patients, pregnant women and infants and these groups need post-exposure prophylaxis if they are exposed and not immune:

- MMR vaccination in some cases
- Intramuscular immunoglobulin
- Intravenous immunoglobulin in some cases

It only takes 15 min in the same room as a patient with measles for exposure to occur, so if a patient with measles goes into the Emergency Department waiting room, for example, as many as 50 contacts can be created that need followed up. Simulation of processes following a patient presenting at adult or children's ED have been conducted to inform practice and processes to be followed have been clearly communicated to ED colleagues.

A LTHTr measles policy was published at the beginning of February and issued with communication to all staff. Occupational health have reviewed the Measles immunity records of all staff in identified 'at risk' roles and departments.

7.5 XDR Pseudomonas

December 2023 saw an outbreak of Xtensively Drug Resistant Pseudomonas (XDR) (isolate is resistant to more than one antimicrobial agent in all the antimicrobial categories, except in two or less). The outbreak occurred due to a patient being de-isolated from a side room into a Bay with Multi-Drug Resistant Pseudomonas as another patient requiring the side room was risk assessed as being a higher priority for isolation. Unfortunately, it was not known at the time that the patient was XDR Pseudomonas, and this was the cause for subsequent cases declaring the outbreak.

Weekly outbreak meetings were held including UKHSA and the ICB IPC team to review the cases and identify areas for learning and development. The Estates and Facilities team were present in the meeting with support from the Consultant Microbiologist, Alison Muir.

External Consultant Medical Microbiologist, Michael Weinbren, completed a review of the unit and compiled a report of recommendations. Following this visit, an action plan was created and is monitored monthly via meetings.

5 patients in total had multidrug resistant pseudomonas; 4 of whom have met the criteria for XDR pseudomonas.

All 5 patients were centred around the Neuro High Care Unit (NHCU). Actions included environmental swabbing of the sinks, water testing, and ribotyping of the positive patients which identified links with two possible modes of transmission:

- Patient-to-patient transmission on hands and other fomites (when patients shared the same space at the same time)
- Patient-sink-patient transmission

Potential Contributory factors that have led to the outbreak:

- Lack of understanding on all of the staff as to what they can use Hand Wash Basins for.
- Placement of patients within the splash-zone from sinks which is 2 metres from sinks, thus resulting in contamination of the patient.
- Lack of side rooms – due to the speciality of care the patients require of NHCU there is limitations regarding isolation which led to one of the XDR patients being nursed in a bay, subsequently leading to another patient getting the XDR Pseudomonas of the same strain.

Learning from this outbreak has been communicated via weekly clinical leaders meeting and there is an ongoing review of processes, led by the IPC Matron and peer colleagues across inpatient areas to reduce risk of future incidents.

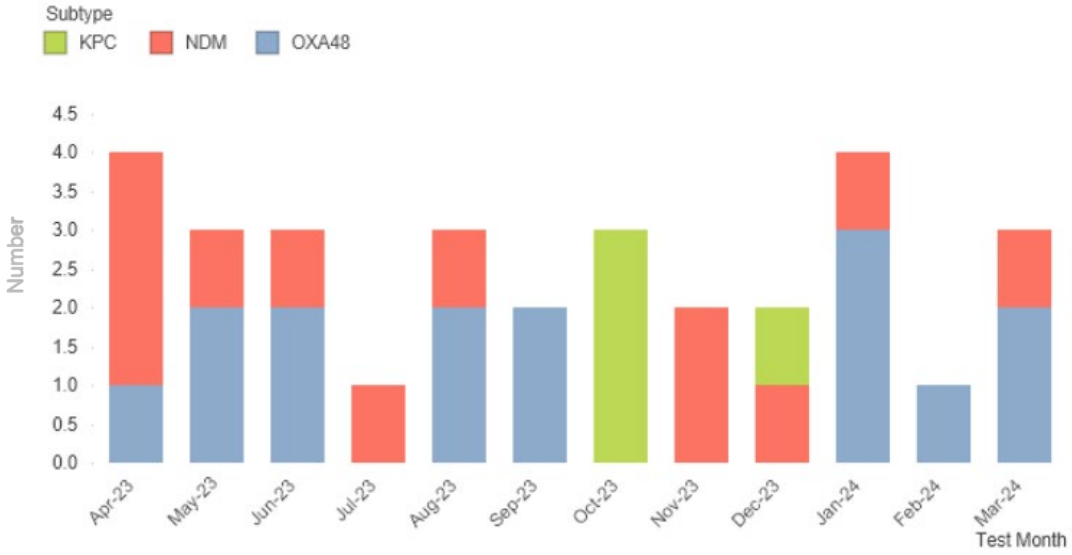
7.6 Carbapenemase-producing Enterobacterales (CPE)

Enterobacterales producing acquired carbapenemases are referred to as CPE. KPC, OXA-48-like, NDM, VIM, and IMP enzymes are the most prevalent enzymes in the UK. Increasing gut colonisation with these resistant bacteria will inevitably lead to an increase in difficult-to-treat infections.

In the year 2023/2024, the Business Intelligence team created a CPE dashboard allowing us to view all CPE positive patients from 2016 to date. The IPC team create an infection alert on Harris Flex to ensure patients are isolated on admission and screened as per policy.

In 2023/2024 the IPC team identified 31 new CPE positive cases; 15 OXA48 positive patients; 12 NDM positive patients, and 4 KPC positive patients. These strains of bacteria are highly resistant and often only treatable with novel, expensive antimicrobials and are often linked with higher mortality rates. At LTHTr, the number of CPE positives remains in single figures per month, and this compares favourably with other Trusts in the Northwest. However, the new Business Intelligence app allows monitoring of this trend closely.

Figure 6 Carbapenemase-producing Enterobacterales Group by month April 2023 – March 2024



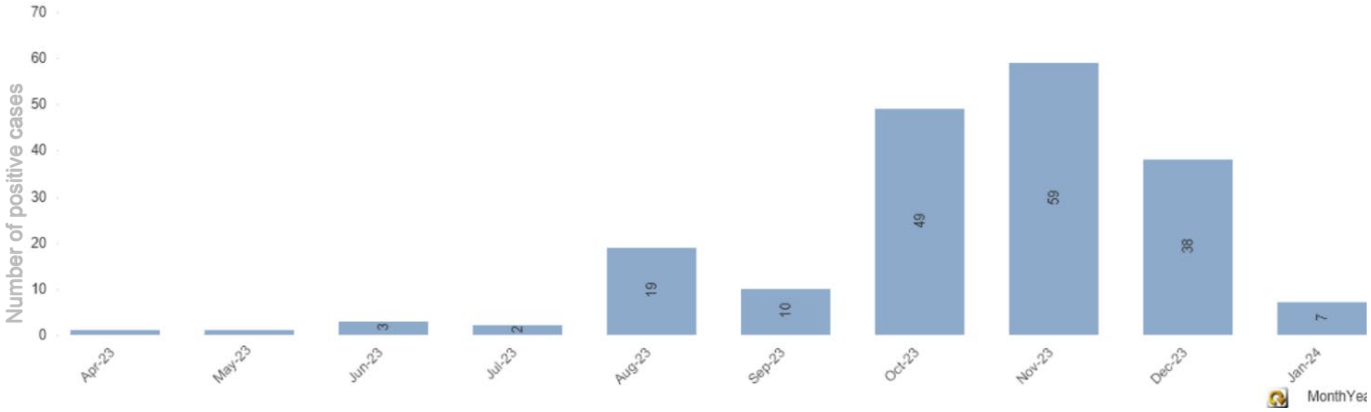
Source: LTHTR data

7.7 Respiratory syncytial virus (RSV)

Respiratory syncytial virus (RSV) is an enveloped RNA virus, in the same family as the human parainfluenza viruses and mumps and measles viruses. RSV is one of the common viruses that cause coughs and colds in winter.

In 2023/2024, winter months, there was a significant increase in RSV compared to the previous year. This had a significant impact on the Children's services.

Figure 7 Volume of Respiratory syncytial virus (RSV) positive cases April 2023 – March 2024



Source: LTHTR data

7.8 Scabies

Scabies is a common, itchy, inflammatory disease of the skin caused by a tiny mite called Sarcoptes scabiei. It is highly contagious, and outbreaks have occurred in hospitals and care homes where both patients/residents and staff have been affected. The condition is recognised by an allergic reaction to the saliva and faecal material excreted by the mite. It is a worldwide disease but is more common where overcrowded conditions prevail. It can affect any individual irrespective of social class or age.

In May 2023, there was an increase of Scabies in Nursing and Care Homes across Lancashire and South Cumbria. Subsequently, we had two Scabies outbreaks in May 2023, and October 2023. As an organisation, we decided a Trust policy for the management of Scabies was required.

Outbreak meetings were scheduled to determine the number of suspected patients and staff contacts and provide effective treatment / prophylaxis. The process was established for how staff would source prophylaxis treatment and the process for suspected patients to have confirmation of diagnosis of scabies.

Issues identified during the outbreak included a need to establish the mechanism for administration of treatment and prophylaxis to staff (the occupational health department could not support in this), and a national shortage for Permethrin. The Trust policy was followed with enhanced cleaning, appropriate linen management, and accurate reporting to mitigate spread to further patients and staff.

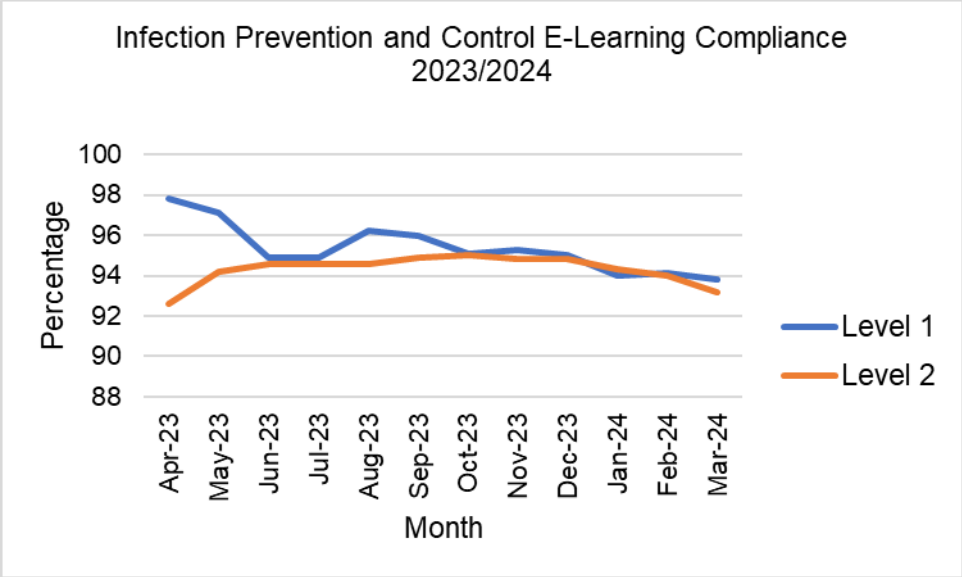
8. KEY INTERVENTIONS TO PREVENT NOSOCOMIAL INFECTION

8.1 Assurance Platform

The IPC committee have identified the need for specific process and outcome data to be available at departmental level. This data fields have been submitted to the Business Intelligence team and there is ongoing collaboration to create a HCAI Assurance Platform triangulating IPC compliance with levels of Hospital Acquired Infections. This work is currently still in progress with the Platform due to be completed early 2024/2025 financial year. The availability of this data will support early escalation, action and prediction of risk and is considered by IPC committee to be an essential action for further reduction in hospital acquired infections. In the interim, data is collected from various sources and presented manually at IPC Committee in a monthly report.

IPC Mandatory training, including ANTT compliance, is reviewed at the divisional IPC / Always Safety-First monthly meetings with oversight at IPCC within the IPC Team report broken down divisionally. Areas that are not over 90% compliant are flagged and escalated negatively to the Safety and Quality Board via Chair's report.

Figure 8 Infection Prevention and Control Level 1 and Level 2 E-learning compliance 2023/2024



The accreditation process STAR audits are also reflected within the IPC Teams report. The Matron for IPC and STAR meet regularly to review the IPC elements of STAR with the compliance of Infection Control being reviewed and audited frequently as part of the mandatory checks.

Figure 9 STAR accreditation compliance for Infection Prevention and Control

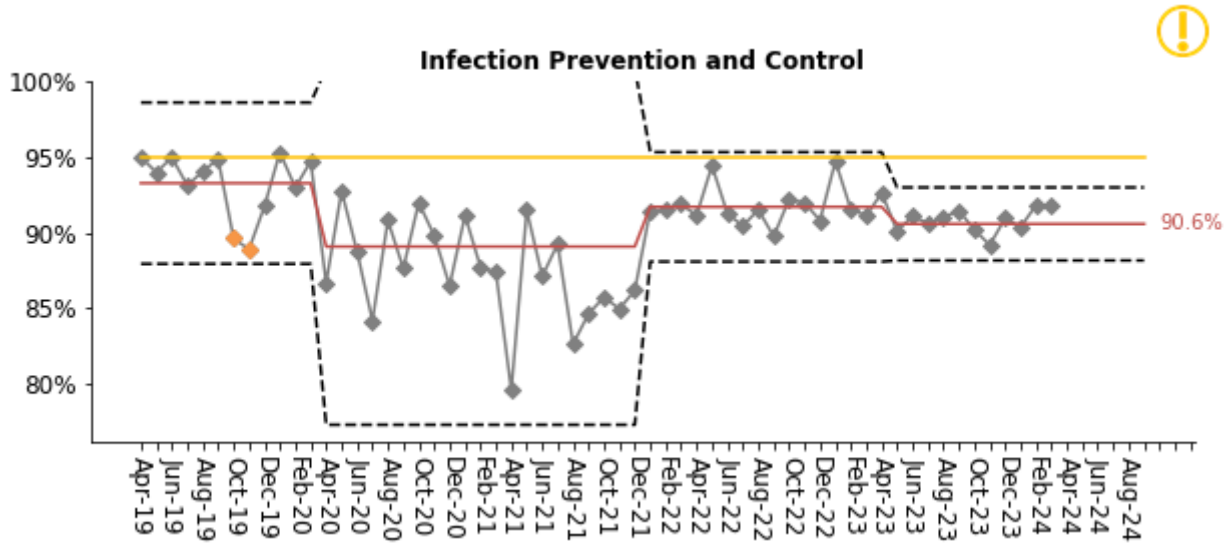
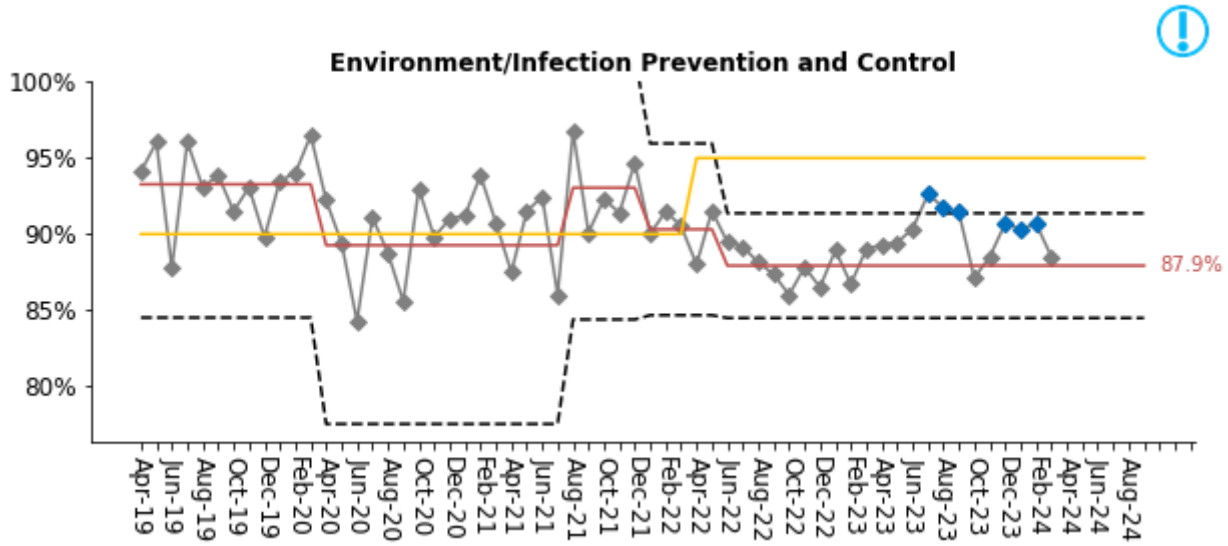


Figure 10 STAR accreditation compliance for Environment/Infection Prevention and Control



8.2 PSIRF Implementation for Hospital Associated Infections

The criteria of investigations triggers for IPC related PSIRF investigations was agreed by the acute trust IPC leads and internally in each separate acute trust at the Lancashire and South Cumbria Integrated Care Board.

For Clostridioides difficile, the routine investigation of all individual cases is no longer required.

Multi-Disciplinary Team (MDT) review (using forms that are specific to the hospitals and include site-specific data) will be performed in cases were:

- Genotyping confirms nosocomial acquisition of infection.
- There are areas of high incidence (based on local judgement and surveillance).
- A Hospital associated infection is listed on a death certificate.
- MRSA bacteraemia cases.
- Cluster review of gram-negative bacteraemia (based on local judgement and surveillance).

Patient Safety Incident Investigation (PSII) will be completed in cases were:

- Nosocomial infection on the death certificate and epidemiology demonstrates likely hospital acquisition.
- Major issues identified in MDT review (above) which contributed to severe harm or death.

It is anticipated that the above criteria will replace all previous RCA/PIR processes from April 1st, 2024.

8.3 Antimicrobial Stewardship

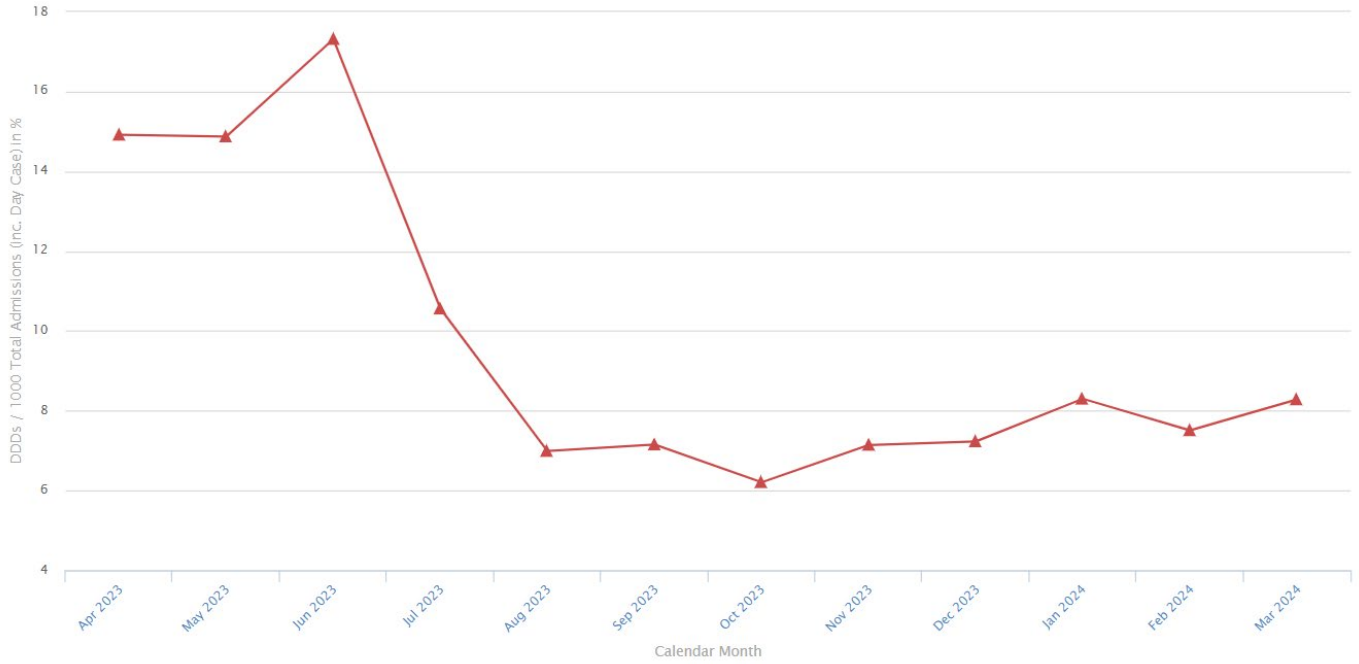
The Trust Antimicrobial Management Group (AMG) meets every two months to review antimicrobial stewardship and includes representation from microbiology, pharmacy in both LTHTR and the Community and the IPCT.

In 2023/2024 the antimicrobial stewardship (AMS) team have continued with a broad range of antimicrobial stewardship activities including guideline updates, antimicrobial ward rounds, audit, and teaching. The AMS team undertakes quarterly antibiotic prescription point prevalence audits to promote good antimicrobial stewardship and safety in the management of antibiotics. The Trust has remained >90% compliant with documented indication on the drug chart, >85% compliant with antimicrobial choice in line with guidelines or recommended by microbiology and >85% compliant with documented review within 72hrs.

In the past year further enhancements of antimicrobial reviews to prompt active review where ‘continue’ is selected and updates to electronic options for antimicrobial indications has been implemented to improve accuracy and efficiency. This year we have observed a sustained compliance of >90% across Q3 and Q4 for documented antimicrobial review within 72hrs. The AMS team is proud that the improvement work behind this success has been accepted for a poster presentation at the European Society of Clinical Microbiology and Infectious Diseases conference 2024.

The AMS Team continues to work closely with the sepsis team. Change in trust guidance for 1st line antimicrobial options for sepsis of unknown source has supported a reduction in Cefuroxime use. This helps limit risk of C. *difficile* infection related to antimicrobial use and has allowed us to come closer to the NHS standard contract target of 10% cumulative reduction in ‘Watch’ and ‘Reserve’ category antibiotics (as defined by the World Health Organisation) from 2017 baseline by end of March 2024.

Figure 11 – Cefuroxime usage Percentage Defined Daily Doses/1000 total admissions.



The national CQUIN 2023/2024 – prompting switch of intravenous to oral antibiotics requested that lower than 40% patients should receive IV antibiotics past the point at which they meet switching criteria. The significant benefits of this have been shared widely across the trust including reduction in patient length of stay and considerable financial savings. The trust has met this target and has seen a reduction in 12-month trend for proportion of IV antibiotic use vs oral.

8.4 Water Safety

The Trust Water Safety Group (WSG) is continuing to meet virtually and reports to the Trust Health and Safety Governance Committee along with providing information to the Infection Prevention and Control Committee in relation to any potential waterborne infection risks. In 2024 The Trust Water Safety Group will be supported with the implementation of an operational Estates Water Safety Meeting which will focus primarily on operational and capital technical issues.

The Trust Water Safety Plan remains in place and capital developments are managed in line with this. 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 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.

The Trust has authorised and commissioned a full legionella risk assessment review of Royal Preston Hospital and Chorley District Hospital. This is a large undertaking from Hydrop and work is currently on-going. The Trust also commissioned a Pseudomonas risk assessment and have received the draft report. The report is currently under review and an action plan will be created and overseen at the water safety group.

Water testing for Pseudomonas aeruginosa (P. aeruginosa) continues in Augmented Care Areas in line with Health technical memoranda (HTM) 04-01 with samples collected every 6 months. If out of range results

occur, then these are dealt with in line with the Water Safety Plan and HTM guidance. Additional water samples are taken following remedial works in response to this.

Legionella sampling regimes was revised in 2022 to strengthen compliance with the HTM and advice received from the Authorising Engineer to ensure both local and systemic contamination may be detected in high-risk areas. The areas have been identified in collaboration with Estates, microbiology, and the Authorising Engineer. The testing regime has been largely increased to sample quarterly. If out of range results occur, then these are dealt with in line with the Water Safety Plan and HTM guidance. Additional water samples are taken following remedial works in response to this.

The Estates team have created a shared monitoring document to action any defects in collaboration with our microbiologist and Infection prevention control team. The Estates team have also worked closely with the trust DIPC to action and mitigate issues regarding drainage and the impact on patient safety.

8.5 Ventilation

The Estates services department continue to implement the relevant guidance to control the risk of airborne particulate transmission. Following a change of structure and management, the operational Estates services work closely with the Estates capital team and independent authorising engineers to ensure new mechanical ventilation systems comply with new HTM guidance.

All workplaces need an adequate supply of fresh air (Minimum of 10 L/sec/Person) that can be provided either by natural ventilation from doors and windows, or by mechanical ventilation. The recommendations and the health care standards HTM 03-01 & associated HBN`s have changed over the time. Therefore, there is a high variety of standards and design specifications regarding mechanical ventilation in use across LTHTR. New HTM guidance is not retrospective to already installed mechanical ventilation systems. A proportion of mechanical ventilation systems throughout LTHTR are in general ageing condition and have reached recommended life cycle. Some of the inpatient areas in Royal Preston Hospital are particularly poorly ventilated in general.

Estates services have engaged a specialist contractor (Medical air Technology) who have carried out all the re-verifications of critical ventilation systems throughout LTHTR in line with Health Technical Memoranda (HTM) guidance which is implemented via the Ventilation Safety Group. The Estates services have written and implemented a ventilation policy which is now available on the trust heritage portal.

Estates services have implemented a Health Technical Memoranda (HTM) compliant training schedule for all mechanical staff working with the mechanical ventilation systems. Authorised person ventilation training is scheduled for the new engineering managers who have recently joined the trust. Competent person training for all mechanical trade operatives was completed in 2023 by the Trust Authorising Engineer.

As funding and access (to retrospectively upgrade Trust mechanical ventilation) is limited there was a need to mitigate the risk of the poorly ventilated areas related to the potential spread of airborne bacterial contamination. To do this the Trust has procured over 100 mobile air purifier machines. These units are capable removing bacteria and viruses from closed areas. Their capacities are limited and cannot be used everywhere, and it should be noted that they re-circulate air inside as opposed to replacing with fresh air. These air purifiers have been deployed in the most at risk inpatients areas including the non-compliant ward bays.

8.6 Decontamination

This annual decontamination report provides a comprehensive overview of the decontamination activities conducted within the Sterile Services department in compliance with HTM01-01 standards throughout the year 2023. It refers to several aspects including maintenance, incident reporting, staff training, production metrics, audit compliance, recruitment, and Datix that are included in this report.

9. Compliance with HTM01-01 Standards

Throughout the reporting period, the Sterile Services department demonstrated diligence in maintaining compliance with the HTM01-01 standards, ISO 13485 :2016 Quality management system. The highest standards of decontamination procedures were upheld by conducting frequent internal audits, and inspections to ensure compliance with the guidelines. By consistently adhering to the HTM01-01 standards, the department is contributing to the overall quality assurance of the Trust and to the patient safety. These standards are implemented to ensure that the department ensures that proper measures are in place to prevent the spread of infections, maintain a clean environment.

10. Incident Reporting

In the year of 2023/2024, no adverse incidents, MHRA Field Safety notice, were reported, which indicates the effectiveness of Trust decontamination protocols and the commitment of staff to always maintain the best practices. The staff are equipped with the knowledge and skills necessary to prevent adverse incidents and ensure the ongoing effectiveness of decontamination procedures.

11. Staff Training

All identified staff members received comprehensive and up to date training on decontamination procedures. During the ISO external audit in February 2024, all training records were reviewed and the QMS audit report confirmed there is no gaps in the training process.

Continuous training and development initiatives were implemented to ensure that our staff remained proficient in their roles and knowledgeable about the latest advancements in decontamination services and best practices. iLearn Decontamination courses from Isopharm were added to the staff training matrix. A total of 307 and 45 training hours and 472 CPD-approved modules have been completed by staff members, with fourteen still in progress.

Table 2 Sterile Services Department (SSD) Total Production

A detailed chart illustrating the total production output of the Sterile Services department throughout 2023/2024 is provided below:

SSD PRODUCTION

YEAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2021 - 2022	11166	11495	12091	11378	10606	11548	11039	12043	10876	10345	10684	12291
2022- 2023	10286	11629	11651	12134	11185	13506	12606	13326	11507	12527	11793	13830
2023 - 2024	12012	12698	13367	12307	12633	13265	13056	14968	11842	13524	12587	12498
2024 - 2025												
2025 - 2026												
2016 - 2027												

12. ISO 13485 Audit Compliance

The Sterile Services department successfully passed the ISO 13485 audit in 2023 with no major or minor non-conformities This achievement demonstrates the Trusts constant commitment to maintaining the highest levels of quality in decontamination procedures and activities.

13. Recruitment

Recruitment is up to date, with all vacant positions within the Sterile Services department successfully filled during the reporting period. One clerical officer and one SSD Technician are joining the team in early 2024.

14. Decontamination Strategy Committee meeting

A new decontamination strategy committee meeting has been formed in March 2023 to discuss the trust wide decontamination activities such as Theatre decontamination, endoscopy decontamination, ENT, pathology. The decontamination manager is responsible for chairing this meeting and acting as a Trust decontamination lead for implementing decontamination strategies, action plans, and conducting this meeting. The decontamination meeting reports via chairs escalation into IPC Committee on a cycle of business with the last update provided in March 2024.

15. Environmental Cleaning /Disinfection and Waste Management

15.1 Waste Management

Over the next year the Trust will be implementing the colour coding system for clinical waste streams across the various sites. This will ensure productivity by not over treating waste, as well as moving to more cost-effective disposal routes.

Our non-clinical waste continues to be recycled or recovered, with zero waste to landfill. Some waste streams continue to be separately recycled including cardboard, plastic bottles, wood, metal waste electrical and electronic equipment, batteries, mattresses, fluorescent tubes, confidential paper waste (following shredding), cooking and engine oils. Food waste is recovered via anaerobic digestion and green waste from

our grounds, is composted. Work is on-going to reduce food waste at source and more accurate production data will be produced as a result of NHS food waste initiatives that will be implemented.

Warp-it, the Trust re-use portal for furniture and equipment continues to grow in membership and not only saves money not having to procure new items, but also saves on disposal costs. Work is on-going on increasing the use of this system both internally and with neighbouring Trusts. The Trust has a local company providing an upholstery service for various types of furniture, allowing more items to be reused rather than disposed of.

The Trust is involved in a Lancashire based partnership addressing the reuse of walking aids, with other Trusts and Local Authorities. This is in the early stages of implementation currently.

A number of our waste reduction initiatives are unfortunately hindered by storage space restrictions including reuse of furniture and equipment and walking aids, but potential solutions for this are being worked on.

More work is required regarding the review of the Trust supplier/provider regarding their sustainability policies and procedures to assist with the Green Plan commitments and sustainability. This will include less reliance on single use products, in particular plastics. In turn all wards and departments are encouraged to make informed purchasing decisions to reduce waste completely, or where this is not possible, ensure that waste can be reused, recycled, or recovered more easily.

The Trust now has a Sustainability Group which continues to meet and produce regular newsletters, as well as an intranet-based Hub providing information to our staff. A number of Sustainability Champions are also in place in some wards and departments, and it is planned to increase these numbers over the next year.

A key element of making changes to the waste management systems will involve raising awareness and staff training, which will be introduced alongside the colour coding changes. This will hopefully encourage staff to think differently about waste and prioritise waste minimisation, reuse, recycling, and recovery over disposal whilst still ensuring compliance with health and safety.

16. Financial implications

There are several schemes identified to reduce C. difficile infection rates. The teams are working to rationalise the overall approach to ensure the most cost-effective approach is proposed whilst addressing the increase rates observed. This includes.

- Co-production of an investment case for extra domestic resource to become compliant with 2021 national cleaning standards – 1.2 million.
- Maintenance of rapid testing approach to ensure isolation capacity continues to be used efficiently.
- Water testing
- Treatment for XDR / CPE – one week treatment may cost approximately £5000.
- Ongoing sewage issues – managing blockages 85-90k per annum.

These will be managed through the Trusts normal processes and where possible include stopping undertaking one activity in place for a more effective and efficient approach.

17. Legal implications

There are no legal implications within this report.

18. Risks

ID	Title	Current Score
1157	Increased C. *difficile* Infection	20
1302	Insufficient side rooms to meet Infection prevention & control requirements & demand	12
1867	Risk of increased infection of Measles	9

19. Impact on stakeholders

Infection control plays a critical role in patient safety and experience outcomes. Infection leads to increase in treatments and length of stay and colleague sickness. Therefore, the prevention of infection plays an important role in the available bed and colleague capacity within the services.

20. Recommendations

It is recommended that:

i. The Board of Directors is asked to receive the contents of the report for information and note the Safety and Quality committee have scrutinised the report and confirmed it is assured of the contents and endorsed the closure of the 2023/24 annual plan and the production of the 2024/25 annual plan.

Appendix 1 – IPC 2022/23 Annual plan
Appendix 2 – IPC 2023/23 Annual plan
Appendix 3 – C. *difficile* improvement plan
Appendix 4 – Infection, Prevention and Control Governance Structure

Infection Prevention and Control (IPC) Annual Programme 2023/2024

The annual programme for 2023/2024 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2022/2023. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of lessons learned,especially following post infection reviews (PIR), is a key strategy to support the Annual Programme. The PIR process introduced in 2017/2018 continues to be strengthened. This PIR process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

The annual programme is based upon SMART principles and has 9 sections, all of which have the relevant Health & Social Care Act Hygiene Code criteria assigned. The 9 sections are as follows: 1) Staffing 2) Education & Development 3) Information sharing and communication 4) Audit & Surveillance 5) Post infection review 6) Environment 7) Antimicrobials 8) Winter preparedness 9) policies and procedures

This annual programme details developments and changes to the IPC service, which will be introduced to improve patient safety, reduce healthcare associated infections and strengthen learning amnd communication.

The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection.These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	1.1.0									
Inter-relations / Wider Community / Strategic working	1.1.1	Standardise working across the ICS	1,2,3,4,5,6,7,8,9	Matron IPC / DIPC	Work collaboratively with the ICS providing IPC strategic working, expertise and driving future changes	Matron IPC / DIPC	Q3	Y		IPC collaborative meetings are held every other month with members of the ICS and NHS England to discuss IPC strategies and workstreams to drive future c hanges. **Appendix 1.1.1 Continence and Bowel care meeting notes. Appendix 1.1.1 LSC-ICB-Agenda**
	1.1.2	Provide consultancy for external charities to support in IPC practice	1,2,3,4,5,6,7,9	Matron IPC	Provide Derian House Children's Hospice with IPC support and Annual Audit	Matron IPC / IPC Team	Q2	Y		The IPC Team have completed an Annual Audit for Derian House Children's Hospice and continue to provide IPC support. **Appendix 1.1.2 Derian House Audit**

Ongoing Task | Milestone

Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	2.1.0									
Education Programme	2.1.1	Ensure that there is a comprehensive education programme that meets the needs of Trust staff	4, 6, 10	Matron IPC	To review and update the mandatory infection prevention and control education delivered to clinical and non-clinical staff	IPC Team / Lead nurse / Blended Learning team	Q3	Y		The IPC team have reviewed the E-learning package and completed draft changes. This is awaiting a live date from Blended Learning.
	2.1.2	Expand IPC education to the bed management team to support operational management in the Trust	4, 6, 10	Matron IPC	Strengthen learning for the bed management team based on best practice guidelines and real life clinical cases	IPC Team	Q2, Q4	Y		The IPC Team work closely with the Bed Management team to assist in the appropriate use of isolation facilities. The isolation room audit is available on Flex for RPH and CDH which identifies which patient is in the isolation room, if they have an infection, and is colour-coded as per the isolation procedure. The Isolation procedure is available to Bed Management with an additional Quick Reference Guide for prioritisation. The IPC Team attend the Bed Management Meetings twice daily and in times of capacity issues, spend the day with the team. The IPC team have daily meetings to review any potential de-isolations within the Trust to support Bed management. **Appendix 2.1.2 IPC Side Room Audit Report. Appendix 2.1.2 Isolation Procedure. Appendix 2.1.2 Removal of Redi-rooms & effective use of side rooms and Rapid tests**
	2.1.3	Continue the Infection Prevention and Control face-to-face study days throughout the Trust to strengthen IPC communication and cascade IPC training for frontline staff	1,2	Lead IPC Nurse	Increase the number of education sessions for IPC across the Trust	IPC Team	Q1,2,3,4	Y		The IPC Team complete audits daily with training sessions being scheduled weekly based on results. Bespoke training is also completed following outbreaks, post infection reviews and if any concerns are raised. IPC Link worker sessions are held quartely with nominated individuals from each area. **Appendix 2.1.3 IPC training session email. Appendix 2.1.3 Link Nurse Agenda 10/05/2023. Appendix 2.1.3 Link Nurse Day MS Teams recording. Appendix 2.1.3 Link Nurse invitation. Appendix 2.1.3 Training Registers. Appendix 2.1.3 Housekeeper IPC Agenda**
	2.1.4	Reduce reoccurring themes and trends identified in post infection reviews and/or outbreak outcomes	1,2,3,4,5,6,7	Matron IPC	Provide bespoke IPC training for departments following post infection reviews or outbreaks	Lead IPC Nurses / IPC Team	Q1, Q3	Y		The IPC Team complete bespoke training following any Post Infection Reviews (PIRs) and Outbreaks. Reoccuring themes are discussed at each PIR and a summary of 'lapses in care' to identify themes and trends from CDI PIRs is submitted quartely to the IPCC through the IPC teams report and bi-annually in the 'lapses in care' report. Following the introduction of the nurse cleaning checklist introduced due to the high level of CDI cases, a specific teaching session was held for Housekeepers. **Appendix 2.1.4 CDI PIR Form example. Appendix 2.1.4 IPC Teams Report. Appendix 2.1.4 Housekeeper agenda. 2.1.4 Sample CDI PII Meeting minutes. 2.1.4 Sample Norovirus Outbreak meeting minutes.**
	2.1.5	Manage isolation rooms accordingly	1,2,6,7,9	Matron IPC	Continue to provide education on the correct use of isolation rooms and audit current usage to support capacity	Bed Management / IPC Team	Q2, Q4	Y		The IPC Team work closely with the Bed Management team to assist in the appropriate use of isolation facilities. The isolation room audit is available on Flex for RPH and CDH which identifies which patient is in the isolation room, if they have an infection, and is colour-coded as per the isolation procedure. The Isolation procedure is available to Bed Management with an additional Quick Reference Guide for prioritisation. The IPC Team attend the Bed Management Meetings twice daily and in times of capacity issues, spend the day with the team. **Appendix 2.1.5 IPC Side Room Audit Report. Appendix 2.1.5 Isolation Procedure. Appendix 2.1.5 Removal of Redi-rooms & effective use of side rooms and Rapid tests**
	2.1.6	Improve compliance with mandatory IPC / ANTT training with Foundation (Junior) Doctors	1,4,6	Educational Supervisor Lead	Create a mandatory IPC / ANTT training plan for Foundation (Junior) Doctors	Educational Supervisor Lead	Q2	Y		Clinical Educators have been providing face-to-face ANTT training sessions with Foundation Doctors. The first session was held on 23/11/2023 and will be repeated on each Doctor intake indcution. Improvements are monitored within the IPC teams report presented at IPCC monthly. **Appendix 2.1.6 ANTT Training register**

					Ongoing Task	Milestone				
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	3.1.0									
Electronic Communications	3.1.1	Enhance communication, education and awareness of IPC issues in the Trust via social media	4,6	Matron IPC	Use the IPC Team Twitter account to communicate to Trust and local community and Health economy including other local acute Trusts about activities and themed events	IPC Team	Q 1,2,3,4	Y		Twitter update regularly
	3.2.0									
Patient Lived Experience	3.2.1	Sharing learning and examples of good practice around IPC within the Trust.	1, 4, 6	Divisional Leads	Divisional leads to share learning and good practice or lessons learnt from Post Infection Reviews, patient lived experience / story, and outbreaks	Divisional Leads	Q 1,2,3,4	Y		Good practice surrounding Post Infection reviews is discussed monthly within the Divisional IPC meetings and is summarised in the Divisional Chair's reports presented at IPCC. During Post Infection reviews and/or outbreak meetings any learning identified is reiterated to future cases and shared to promote good practice and shared learning. **Appendix 3.2.1 IPCC Minutes. Appendix 3.2.1 Medicine IPCC Chairs report**
	3.3.0									
Glove Awareness	3.3.1	To educate all staff across the Trust on the correct use of Gloves	1,9	Matron IPC	Promote a new campaign for Glove awareness across the Trust	IPC Lead Nurses, IPC Team, Divisional Leads	Q 1,2,3,4	Y		Posters have been created as part of the Glove Awareness campaign that appear on screensavers across the Trust. **Appendix 3.3.1 Glove Awareness Campaign. Appendix 3.3.1 NICU Gloves off Campaign**

Ongoing Task Milestone

Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	4.1.0									
Infection Prevention and Control Reports	4.1.1	To communicate the LTHTR performance against mandatory infection objectives in the IPC Team report and Board papers for 2023/2024	1,4	DIPC	Review IPC Team report to reflect changes in mandatory reporting and the objectives for 2023/24	DIPC	Q1	Y		The IPC Team report is reviewed and amended annually to reflect changes in mandatory reporting and objectives. **Appendix 4.1.1 IPC Teams report**
	4.2.0									
Surgical Site Infection	4.2.1	Ensure that LTHTR is compliant with reporting on mandatory surgical site infection surveillance in orthopaedics and completes actions for continuous improvement	1,4	Orthopaedic Directorate	To report collated quarterly data and ongoing actions for improvement to IPCC	Divisional Nursing Director/ Mandatory SSI lead	Q 2,4	Y		The January - March 2023 Surgical Site Infection Surveillance Service Summary Report was shared and presented at July IPCC. **Appendix 4.2.1 Hip SSI report. Appendix 4.2.1 Knee SSI report**
	4.2.2	To reduce vascular device associated bloodstream infections	4,6	Divisions	To report progress biannually to IPCC and quarterly to Divisions	Divisions with support of CVAD team	Q 2,4	Y		**Appendix 4.4.2 CVAT CRSBI report for April 2023. Appendix 4.4.2 CVAT CRBSI report for IPCC October '23**
	4.3.0									
Gram negative bloodstream infection	4.3.1	Improve intelligence about contributory factors for Gram negative bacteraemia in LTHTR	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Focus on improving practice and education identified by the E. coli deep-dive investigation	DIPC / IPC Matron / Lead IPC Nurses	Q4	Y		**Appendix 4.3.1 E.coli Deep Dive - 2023-24**
	4.3.2	To reduce Gram-negative bacteraemia cases and improve continence and bowel care services across the ICB	1,5,6,8	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	A collaborative approach to review continence and bowel care across the ICB to improve services	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	Q3	Ongoing		IPC collaborative meetings are held every other month with members of the ICS and NHS England to discuss IPC stratedgies and workstreams to drive future changes. Due to the increase in CDI Toxin across the region this workstream is of lower priority. Continence and Bowel Care is being discussed within the Trust at divisonal IPC meetings with updates brought via Chair's report to IPCC monthly. The IPC E-Learning package has also been reviewed to include education on catheter care adn the Nursing Kardex has been reviewed and updated to include catheter insert dates and daily care plans. This item will be carried forward to 2024/2025 plan.
	4.3.3	Improve intelligence about contributory factors for Gram negative bacteraemia in LTHTR	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Focus on improving practice and education identified by the E. coli deep-dive investigation	DIPC / IPC Matron / Lead IPC Nurses	Q 2,4	Y		Documentation has been reviewed with updated care plans added to Harris Flex. Work is currently ongoing to review and update the urinary Catheter care E.learning. **Apprendix 4.3.3 Catheter Care on Flex**
	4.3.4	Promote Hydration across the ICB	1,5,6,8	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	Develop a trust strategy to ensure that patients receive appropriate hydration via key stakeholders.	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	Q4	Ongoing		Due to an increase in outbreaks and priorities with CDI and Measles prepardness this has not been completed. For the next Annual Plan, consider support from patient partners, patient safety Matron, and Divisions to promote hydration trustwide. This item will be carried forward to 2024/2025 plan.
	4.3.5	Reduce Catheter associated UTIs across the ICB	1,5,6,8	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	Develop a trust strategy to ensure that urinary catheters are inserted in the correct patients and managed and removed appropriately.	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	Q4	Ongoing		Due to an increase in outbreaks and priorities with CDI and Measles prepardness this has not been completed. For the next Annual Plan, consider support from the ICB, patient partners, patient safety Matron, and Divisions to develop a trust strategy. This item will be carried forward to 2024/2025 plan.
	4.4.0									
	4.4.1	Annual review of what we are auditing and the audit process and ensure cycle complete	1,2	DIPC / Matron IPC / Quality Assurance Matron	IPC Matron and Quality Matron to review and update audits to improve the IPC section of the STAR audit	DIPC / Matron IPC / Quality Assurance Matron	Q4	Y		Appendix 4.4.1 STAR Accreditation Visit Templates

Surviellance	4.4.2	Maintain a collective Trust-wide approach on diarrhoea and isolation compliance	1,2,4,5,7	DIPC / Matron IPC / Quality Assurance Matron	Strengthen the STAR report to monitor usage of IT systems	DIPC / Matron IPC / Quality Assurance Matron	Q3	Y		The IPC Team are reviewing the isolation time for CDI Toxin positive patients which is being presented at the weekly executive oversight meeting and at IPCC monthly. In terms of reviewing isolation as a whole, we do not have the IT facilities to pull this information to include in a report. Therefore, CDI Toxin poistive has been prioritised. STAR do not have the IT capabilities to perform this, the IPC Data Administartor is reviewing and actioning this daily.
	4.4.3	DIPC and Matron to continue Infection Prevention and Control Environmental checks	1,2	DIPC / Deputy Director of Nursing / IPC Team	Review estate and identify any environmental issues	DIPC / Deputy Director of Nursing / IPC Team	Q1,2,3,4	Y		The DIPC, Deputy Director of Nursing, and Matron for IPC complete bi-monthly reviews of the estate highlighting any concerns through the the E&F Partnership Board monthly. When reporting an estates job, the system has been upgraded to allow for prioritisation of IPC risks. **Appendix 4.4.3 EF Chairs report. Appendix 4.4.3 Patnership Board Minutes.**
	4.4.4	Improve CPE surveillance for inpatients in augmented care	1,5,6,7,9	DIPC	Strengthen BI portal by adding CPE inpatient screening data	DIPC / BI team	Q2	Y		CPE inpatient screening is now live on the IPC BI portal **Appendix 4.4.4 CPE inpatient screening data**
	4.5.0									
Sepsis management improvement	4.5.1	To improve sepsis management in LTHTR	4,6	Divisional Nursing Directors / Matron IPC	To present a report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4	Y		The Safety and Quality Trust Sepsis report was shared and presented at June IPCC. **Appendix 4.5.1 Annual Sepsis Report May 2023**

Ongoing Task | Milestone

Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	5.1.0									
Post Infection reviews	5.1.1	To share and embed the learning from Post Infection Reviews (PIRs)	1,4,6	DIPC	Completion of the Action plan from PIRs to be detailed in Divisional IPC reports and presented at Trust IPCC	IPC Team	Q1,2,3,4	Y		Each Division shares the number of CDI cases, good practice, lessons learned, and the progress of actions from PIRs through the divisional Chair's reports into IPCC. The actions of PIRs are uploaded to Datix for monitoring and assurance of completion. **Appendix 5.1.1 IPCC Minutes. Appendix 5.1.1 Medicine IPCC Chairs report**
	5.1.2	Identify and themes and trends and promote learning following CDI Post Infection Reviews	1,4,6	DIPC	Produce a biannual Lapses in Care report	DIPC	Q2, 4	Y		**Appendix 5.1.2 C. difficile Bi-annual Lapses in Care Summary 2023**
	5.1.3	Ensure IPC incidents, complaints, patient feedback and IPC risk register are visible in IPCC	1,4,6	Deputy Nursing, Midwifery & AHP Director	Demonstrate an improvement in the frequency of IPC incidents and complaints	IPC Data Admin	Q1,2,3,4	Y		IPC related incidents and complaints are a standing agenda item for IPCC. The incidents are reviewed and any themes or trends are identified with appropriate actions set for improvements. **Appendix 5.1.3 IPCC Agenda**
	5.1.4	Share learning from Outbreak management to highlight good practice and areas for learning and improvement	1,4,6	Matron IPC	Include any outbreaks and periods of increased incidents within the IPC Team report	IPC Team	Q1,2,3,4	Y		Outbreaks and PII's are included in the monthly IPC Teams reports with a summary of events, actions and learning. **Appendix 5.1.4 IPC Team Report**

Ongoing Task Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	6.1.0									
Water safety	6.1.1	Provide assurance to IPCC in regards to water safety management	2	Assistant Director of Estates	Provide quarterly reports to IPCC and the Trust Health and Safety Governance Group on water safety management including abnormal results and remedial actions	Water Safety Group / Head of Operational Estates	Q1,2,3,4	Y		The Water Safety Group Chairs report was shared and presented at August IPCC. **Appendix 6.1.1 WSG - March 2023**
	6.2.0									
Environmental and Equipment Cleaning	6.2.1	To improve the cleanliness of the environment	2	Assistant Director of Facilities	Review and define the Trust cleaning standards in compliance with National Cleaning standards for 2023/2024	Head of Facilities	Q1, Q4	Ongoing		Weekly meetings have been arranged with the execs, DNDs, and E&F Management with a deadline of 6 weeks for a plan of action. The nursing daily, weekly, and discharge cleaning checklists have been rolled out. Tristel Jet was implemented on 18/09/2023 for all inpatient areas with the IPC team continuing to review compliance. There is currently 9 areas compliant with the National Clenaing Standards which will be increased to 15 areas by January 2024. Finance for the other areas within the Trust will require a business case. **Appendix 6.2.1 SOP for nure cleaning of patient equpiment. Appendix 6.2.1 Training schedule**. This item will be carried forward to 2024/2025 plan.
	6.2.2	To improve the cleanliness of environment	2	Director of Estates & Facilities	Chairs report Estates and Facilities partnership board	IPC Matron	Q1,2,3,4	Y		The Matron for IPC now chairs the Estates and Facilities partnership board monthly. A Chairs report is created and fed through to IPCC. **Appendix 6.2.2 EF Chairs reports**
	6.2.3	Provide assurance of the Trust's environmental cleanliness and report the findings to Divisions on a monthly basis.	2	Director of Estates & Facilities	Monitor progress and compliance and report monthly to IPCC. IPC Matron to support and provide guidance on products.	Hotel Services Manager / IPC Matron	Q1,2,3,4	Y		Facilities provide a monthly report to IPCC including cleaning compliance, patient transfers etc. **Appendix 6.2.3 Facilities Monthly Summary report**
	6.2.4	To ensure all cleaning information is up to date	2	Matron IPC / Associate DIPC	Monitor IT rapid response to fogging and deep cleaning	Domestic Management / IPC Leads. Associate DIPC	Q1,2,3,4	Y		The Domestic Team have a biportal showing the total tasks requests, outstanding tasks, and pending cleans. This information is reported and monitored through the E&F partnership board. **Appendix 6.2.4 Domestic Dashboard**
	6.2.5	Review UV cleaning as an alternative to fogging	2	Assistant Director of Facilities	Provide a report on the findings on the completion of the UV trials	Head of Facilities	Q2	Y		**Appendix 6.2.5 UV Trials Data. Appendix 6.2.5 UV trials report**
	6.3.0									
Decontamination	6.3.1	To provide assurance to the IPCC in regards to Decontamination management	2	Decontamination Lead	Provide quarterly reports to IPCC on Decontamination management including track and trace and remedial actions from findings	Decontamination Lead	Q1,2,3,4	Y		The Decontamination Quarterly Performance Report was shared and presented at July PCC. **Appendix 6.3.1 Decontamination Report. Appendix 6.3.1 Strategic Decontamination Group meeting Feb 2024**
	6.3.2	Identify and report Decontamination audit gaps in standards through divisional IPC.	2	Decontamination Lead	Provide monthly reports to divisional IPC meetings to strengthen the current audit and for feedback and improvement for assurance of current gaps in audits	Decontamination Lead	Q1,2,3,4	Y		The Decontamination Monthly Performance Reports are shared monthly at divisional IPC meetings. **Appendix 6.3.2 IPCC Surgery Chairs Report April 2023.**
	6.4.0									

Ventilation	6.4.1	Review and implement a strategy on air purification and ventilation	1,2	Head of Operational Estates	Maintain assurances for ventilation and update risk register and Trust policy accordingly	Head of Operational Estates	Q2, 4	Y		Quarterly Ventilation Safety Group meetings have been established. **Appendix 6.4.1 Ventilation Safety Group Chairs Report**

				Ongoing Task	Milestone					
Domain	**Reference**	**Aim**	**Hygiene Code Criterion**	**Lead**	**Actions**	**Actioned By**	**Completion due**	**Complete Y/N**	**RAG**	**Embedded Evidence Y/N N/A**
	7.1.0									
Antimicrobial stewardship	7.1.1	Provide assurance of Trust performance against Start Smart and Focus antimicrobial stewardship standards'	3	AMS Lead	Quarterly report on point prevalence audits	AMS Team	Q1, Q2,Q3,Q4	Y		The Antimicrobial Stewardship Report for Quarter 1 was shared and presented at June PCC. **Appendix 7.1.1 Trustwide Antimicrobial Point Prevalance Audits**
	7.1.2	Identify any themes and trends relating to antimicrobial prescribing in CDI cases	3	AMS Lead	Provide a report of antimicrobial use associated with CDI cases	AMS Team	Q2	Y		**Appendix 7.1.2 AMS Team PIR Review**
	7.1.3	New sepsis strategy to reduce the use of Cefuroxime for "unexplained sepsis"	3	AMS Lead	Review guidelines for the treatment of "unexplained sepsis"	AMS Team, DIPC	Q3	Y		First line treatment for sepsis unknown source switched to IV Gentamicin, IV Amoxicillin + PO/IV Metronidazole. The Adult Anitmicrobial Guideline has been updated appropriately.
	7.1.4	Reduce the use of "watch and reserve" antimicrobials	3	AMS Lead	Monitor Antibiotic usage	AMS Team	Q2	Y		The use of Watch and Reserve Antimicrobials are reviewed and monitored at each Antimicrobial Group Meeting.
	7.1.5	Strengthen knowledge and skills of IPC nursing team around antimicrobial stewardship	3	Deputy Nursing, Midwifery & AHP Director	IPC nursing team member to complete non medical prescribing course.	Matron IPC & Lead Nurse	Q2	Y		Helen Leach has been accepted on the non-medical prescribing course which commences on 09/10/2023.

8.0 IPC Preparedness & Resilliance

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	8.1.0									
Norovirus	8.1.1	Improve Norovirus management and knowledge across the organisation	5, 6	Deputy Nursing, Midwifery & AHP Director	Ensure the Norovirus policy is shared within the Divisions and educated to Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q1	Y		The Norovirus Policy was reviewed and updated in 2022 following approval from IPCC. Norovirus is discussed during Link worker days and the actions following the identification of an outbreak are followed as per policy. In an outbreak situation, daily meetings are held with the ward, DIPC, IPC team, Domestics, and Pathology to monitor, contain, and appropriately and safely end the outbreak. **Appendix 8.1.1 Management of Norovrius Policy. Appendix 8.1.1 Sample Norovirus Outbreak Meeting Minutes**
	8.2.0									
Influenza	8.2.1	IPC preparation including POCT for seasonal influenza in place	5, 6	Deputy Nursing, Midwifery & AHP Director	Hold a multidisciplinary meeting led by Operations/Emergency preparedness team and report to IPCC to reinforce management and risk assessment of all patients with suspected influenza	DIPC/Matron IPC	Q1	Y		Meeting held and policy reviewed
	8.3.0									
Emergency Preparedness	8.3.1	Review the emergency preparedness plan	1, 2, 5, 6	Head of EPRR and Patient Flow	Review and update the emergency preparedness plan collaboratively	DIPC / Head of EPRR and Patient Flow / IPC Team	Q1	Y		**Appendix 8.3.1 Pandemic Plan**
	8.3.2	Ensure that we are prepared for any future epidemics and / or pandemics	1, 2, 5, 6	Deputy Nursing, Midwifery & AHP Director	Provide education and updates on recent changes in National Guidance. Update any IPC Trust policies in accordance to changes	Deputy Nursing, Midwifery & AHP Director	Q1,2,3,4	Y		The IPC Policy Tracker is reviewed monthly and shared within the IPC Teams report for IPCC. Any changes in guidance are discussed in the appropriate platforms and information is distributed across the Trust with education available if required. **Appendix 8.3.2 Policy tracker 2023-2024**

				Ongoing Task	Milestone					
Domain	**Reference**	**Aim**	**Hygiene Code Criterion**	**Lead**	**Actions**	**Actioned By**	**Completion due**	**Complete Y/N**	**RAG**	**Embedded Evidence Y/N N/A**
	9.1.0									
Policy and procedure	9.1.1	Provide assurance policies and procedural documents are in date and complete to enable the prevention of infections and education of staff	1,4,9	IPC Matron / DIPC	Provide assurance through the monthly IPC report of the status of policies owned by IPC and that they are in date and reviewed within the required time	IPC Matron / DIPC / IPC Team	Q1, 2, 3, 4	Y		The IPC Policy Tracker is reviewed monthly and shared within the IPC Teams report for IPCC. **Appendix 9.1.1 Policy Tracker 2023-2024**

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	10.1.0									
C. difficile	10.1.1	Improve estates issues in areas with high C. difficile infection rates	1,2,7	Deputy Director of Estates & Facilities	Review priorities of Estate improvement / maintenance / Capital across the Trust	Deputy Director of Estates & Facilities / Matron IPC	Q3	Y		The DIPC, Deputy Director of Nursing, and Matron for IPC complete bi-monthly reviews of the estate highlighting any concerns through the the E&F Partnership Board monthly. When reporting an estates job, the system has been upgraded to allow for prioritisation of IPC risks.
	10.1.2	Timely management of treatment and isolation of patients	1,2,7	IPC Team	Ensure diarrhoea dashboard is reviewed daily and shared with Clinical Leader / Nurse co-ordinator	IPC Team	Q1	Y		The IPC team review the checklist of all inpatient areas when visiting each area. At each PIR the diarrhoea dashboard is discussed and actions are created to ensure its use.
	10.1.3	Prevent cross-infection of CDI	1,2,7	DIPC / IPC Team	Monitor CDI cases for any PIIs / outbreaks and provide bespoke training, education and prioritisation of remedial works	DIPC / IPC Team	Q3	Y		Specific actions are created to celebrate and share good practice and target any areas of concern at each CDI PIR. Outbreaks and PII's are monitored by the IPC Data Analyst with meetings arranged when required. The IPC team schedule training sessions for areas when required alongside an ongoing education rota. There are currenlty discussions around triangulated sewage incidetns with CDI cases.
	10.1.4	Review the current mitigations for the reduction of C. difficile	1,2,7	DIPC	Co-produce and submit business cases for redi-rooms and rapid intestinal PCR testing	DIPC / Matron IPC	Q2	Y		Accepted with non-recurrence funds. Will be reviewed on a yearly basis.
	10.1.5	Review the current mitigations for the reduction of C. difficile	1,2,7	Head of Facilities	Co-produce and submit business case to support U/V decontamination	Head of Facilities / Matron IPC	Q2	Y		**Appendix 10.1.5 UV Report**

Infection Prevention and Control (IPC) Annual Programme 2024/2025

The annual programme for 2024/2025 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2023/2024. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of lessons learned,especially following post infection reviews (PIR), is a key strategy to support the Annual Programme. The PIR process introduced in 2017/2018 continues to be strengthened. This PIR process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

The annual programme is based upon SMART principles and has 9 sections, all of which have the relevant Health & Social Care Act Hygiene Code criteria assigned. The 9 sections are as follows: 1) Staffing 2) Education & Development 3) Information sharing and communication 4) Audit & Surveillance 5) Post infection review 6) Environment 7) Antimicrobials 8) Winter preparedness 9) policies and procedures

This annual programme details developments and changes to the IPC service, which will be introduced to improve patient safety, reduce healthcare associated infections and strengthen learning amnd communication.

The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection.These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Ongoing Task | Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	1.1.0									
Inter-relations / Wider Community / Strategic working	1.1.1	Standardise working across the ICS	1,2,3,4,5,6,7,8,9	Matron IPC / DIPC	Work collaboratively with the ICS providing IPC strategic working, expertise and driving future changes	Matron IPC / DIPC	Q3			
	1.1.2	Provide consultancy for external charities to support in IPC practice	1,2,3,4,5,6,7,9	Matron IPC	Provide Derian House Children's Hospice with IPC support and Annual Audit	Matron IPC / IPC Team	Q2			
	1.1.3	Share learning from incidents across the ICB	1,2,7,9	Matron IPC / IPC Lead Nurse	IPC Lead Nurse and Matron to visit an exemplar NHS Trust to review IPC practices and ways of working for shared leanring on best practice.	Matron IPC / IPC Lead Nurse	Q3			

				Ongoing Task	Milestone					
Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	2.1.0									
Education Programme	2.1.1	Ensure that there is a comprehensive education programme that meets the needs of Trust staff	4, 6, 10	Matron IPC	To review and update the mandatory infection prevention and control education delivered to clinical and non-clinical staff	IPC Team / Lead nurse / Blended Learning team	Q4			
	2.1.2	Expand IPC education to the bed management team to support operational management in the Trust	4, 6, 10	Matron IPC	Strengthen learning for the bed management team based on best practice guidelines and real life clinical cases. Continue to provide education on the correct use of isolation rooms and audit current usage to support capacity	IPC Team	Q2, Q4			
	2.1.3	Continue the Infection Prevention and Control face-to-face study days throughout the Trust to strengthen IPC communication and cascade IPC training for frontline staff	1,2	Lead IPC Nurse	Continue with education sessions for IPC across the Trust	IPC Team	Q1,2,3,4			
	2.1.4	Reduce reoccurring themes and trends identified in MDT reviews and/or outbreaks.	1,2,3,4,5,6,7	Matron IPC	Provide bespoke IPC training for departments following MDT reviews or outbreaks	Lead IPC Nurses / IPC Team	Q1, Q3			
	2.1.5	Improve compliance with mandatory IPC / ANTT training with Foundation (Junior) Doctors	1,4,6	Educational Supervisor Lead / DND's	Create a mandatory IPC / ANTT training plan for Foundation (Junior) Doctors	Educational Supervisor Lead / DND's	Q2			
	2.1.6	Improve patient education on the importance of IPC principles (Hand Hygiene).	1,2,4,9	IPC Team / Patient Saftey Partners	Work with the Patient Safety Partners to develop a patient information package to empower patients who access Trust services	IPC Team / Patient Saftey Partners	Q2			

			Ongoing Task	Milestone						
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	3.1.0									
Electronic Communications	3.1.1	Enhance communication, education and awareness of IPC issues in the Trust via Trust comms, saftey bulletins, and social media	4,6	Matron IPC	Communicate Trust-wide regarding immediate safety and learning concerns, and celebrate good practice.	IPC Team	Q 1,2,3,4			
	3.2.0									
Patient Lived Experience	3.2.1	Sharing learning and examples of good practice around IPC within the Trust.	1, 4, 6	Divisional Leads	Divisional leads to share learning and good practice or lessons learnt from MDT reviews, patient lived experience / story, and outbreaks	Divisional Leads	Q 1,2,3,4			
	3.3.0									
IPC Campaigns	3.3.1	To educate all staff across the Trust on different campaigns including; Glove awareness, Bin the wipes, and the basic principles of IPC.	1,9	Matron IPC	Continue to promote best practice	IPC Lead Nurses, IPC Team, Divisional Leads	Q 1,2,3,4			

Ongoing Task | Milestone

Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	4.1.0									
Infection Prevention and Control Reports	4.1.1	To communicate the LTHTR performance against mandatory infection objectives in the IPC Team report and Board papers for 2024/2025	1,4	DIPC	Review IPC Team report to reflect changes in mandatory reporting and the objectives for 2024/2025	DIPC	Q1			
	4.2.0									
Surgical Site Infection	4.2.1	Ensure that LTHTR is compliant with reporting on mandatory surgical site infection surveillance in orthopaedics and completes actions for continuous improvement	1,4	Orthopaedic Directorate	To report collated quarterly data and ongoing actions for improvement to IPCC	Divisional Nursing Director/ Mandatory SSI lead	Q 2,4			
	4.2.2	To reduce vascular device associated bloodstream infections	4,6	Divisions	To report progress biannually to IPCC and quarterly to Divisions	Divisions with support of CVAD team	Q 2,4			
	4.3.0									
Patient Safety and Health Promotion	4.3.1	Improve intelligence about contributory factors for Gram negative bacteraemia in LTHTR	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Review themes and trends identified through PSIRF	DIPC / IPC Matron / Lead IPC Nurses	Q4			
	4.3.2	Standardise continence and bowel care services across the ICB	1,5,6,8	ICB Quality & Performance Specialist / IPC Leads across the ICB	Prepare a paper outlining how continence and bowel care is delivered across the ICB to highlight any differences in services and support a potential business case to improve patient care.	DIPC / IPC Matron	Q2			
	4.3.4	Promote Hydration within the Trust	1,5,6,8	Divisional Nursing Directors	Divisional leads to report to IPCC in terms of progress on improving hydration. Educational information to be shared with patient partners.	Divisional Nursing Directors	Q2			
	4.3.5	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Policy owner	Contribute to the review of the Urethral Catheterisation Procedure	DIPC / IPC Matron / Policy owner	Q1			
	4.3.6	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Divisional Nursing Directors	Devise a Point Prevalence questionnaire for Divisional Leads to audit. Report findings to IPCC.	DIPC / IPC Matron / Divisional Nursing Directors	Q3			
	4.3.7	Reduce Catheter associated UTIs	1,5,6,8	DIPC / IPC Matron / Divisional Nursing Directors	Devise a list of actions in response to the Point Prevalence audit results which will include key messages to staff through safety bulletins	DIPC / IPC Matron / Divisional Nursing Directors	Q4			
	4.4.0									
	4.4.1	Annual review of IPC audits.	1,2	Matron IPC / Lead Nurses IPC	Review and update audits to reflect current themes and trends identified.	Matron IPC / Lead Nurses IPC	Q4			
	4.4.2	Maintain a collective Trust-wide approach on diarrhoea and isolation compliance	1,2,4,5,7	DIPC / IPC Matron / IPC Data Analyst	Report compliance to IPCC on a monthly basis via IPC Team report	DIPC / IPC Matron / IPC Data Analyst	Q1			

Surviellance	4.4.3	DIPC and Matron to continue Infection Prevention and Control Environmental checks	1,2	DIPC / Deputy Chief Nurse / IPC Team	Review estate and identify any environmental issues thast require urgent maintenance or repair.	DIPC / Deputy Chief Nurse / IPC Team	Q1,2,3,4			
	4.4.4	Ensure IPC standardised signage is visible across the trust.	1,9	Matron IPC / Lead Nurses IPC	Complete an annual audit of IPC signage across the trust; Hand wash, Hand Gel, and outbreak signage.	Matron IPC / Lead Nurses IPC	Q1			
	4.4.5	Create a dashboard to have visibility of IPC compliance and infection rates at ward level.	1 2,6,9	Deputy Chief Nurse / Matron IPC / BI	Establish a data platform with BI which can be broken down departemntally to triangulate IPC compliance with infection rates to allow for priotisation for education and training.	Deputy Chief Nurse / Matron IPC / BI	Q2			
	4.5.0									
Sepsis management improvement	4.5.1	To improve sepsis management in LTHTR	4,6	Divisional Nursing Directors / Matron IPC	To present a report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4			

Ongoing Task Milestone

Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	5.1.0									
Patient Saftey Inccident Reporting Framework	5.1.1	To identify, share and embed themes and trends to promote learning through incidents reported using PSIRF	1,4,6	DIPC	Produce processes for HCAI reporting and incident investigations.	IPC Team	Q1,2,3,4			
	5.1.2	Identify and themes and trends and promote learning following CDI MDT reviews	1,4,6	DIPC	Produce a quartely CDI outcome report identifying themes for learning to be presented at IPCC.	DIPC	Q1,2,3,4			
	5.1.3	Ensure IPC incidents, complaints, patient feedback and IPC risk register are visible in IPCC	1,4,6	Deputy Chief Nuse	Demonstrate an improvement in the frequency of IPC incidents and complaints	IPC Data Admin	Q1,2,3,4			
	5.1.4	Share learning from Outbreak management to highlight good practice and areas for learning and improvement	1,4,6	Matron IPC	Include any outbreaks and periods of increased incidents within the IPC Team report	IPC Team	Q1,2,3,4			

Ongoing Task Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	6.1.0									
Water safety	6.1.1	Provide assurance to IPCC in regards to water safety management	2	Assistant Director of Estates	Provide monthly reports to IPCC and the Trust Health and Safety Governance Group on water safety management including abnormal results and remedial actions	Water Safety Group / Head of Operational Estates	Q1,2,3,4			
	6.2.0									
Environmental and Equipment Cleaning	6.2.1	To improve the cleanliness of the environment	2	Assistant Director of Facilities	To be compliant with the National Cleaning standards of 2021 for 2024/2025	Head of Facilities	Q1, Q4			
	6.2.2	Monitor Estate and Facilities workstreams - Capital, maintenance, and cleanliness	2	Director of Estates & Facilities	Monthly Chairs report from the Estates and Facilities partnership board to be presented at IPCC.	IPC Matron	Q1,2,3,4			
	6.2.3	Provide assurance of the Trust's environmental cleanliness and report the findings to Divisions and IPCC on a monthly basis.	2	Director of Estates & Facilities	Monitor progress and compliance and report monthly to IPCC.	Hotel Services Manager / IPC Matron	Q1,2,3,4			
	6.2.4	To ensure cleaning and fogging is completed following CDI cases.	2	IPC Matron / IPC Data Analyst	Monitor compliance of fogging following CDI cases to reported to IPCC monthly in the IPC Teams report.	IPC Matron / IPC Data Analyst	Q1,2,3,4			
	6.2.5	To ensure any improvement works are reviewed and prioritised from an IPC perspective.	2	IPC Matron / Head of Estates/ Head of Capital / Head of Domestic Services	IPC Matron to complete monthly walkrounds with Estates and Facilities to review the Etstates from an IPC perspective and provide recommendations for best practice.	IPC Matron / Head of Estates/ Head of Capital / Head of Domestic Services	Q1,2,3,4			
	6.3.0									
Decontamination	6.3.1	To provide assurance to the IPCC in regards to Decontamination management	2	DIPC / IPC Matron / Head of Estates/ Departmental Leads / Decontamination Lead	Develop key metrics of data that must be monitored through IPCC relating to decontamination.	DIPC / IPC Matron / Head of Estates/ Departmental Leads / Decontamination Lead	Q1			
	6.3.2	To provide assurance to the IPCC in regards to Decontamination management	2	Decontamination Lead	Provide quarterly reports to IPCC on Decontamination management including track and trace and remedial actions from findings	Decontamination Lead	Q1,2,3,4			
	6.3.3	Identify and report Decontamination audit gaps in standards through divisional IPC.	2	Decontamination Lead	Provide monthly reports to divisional IPC meetings to strengthen the current audit and for feedback and improvement for assurance of current gaps in audits	Decontamination Lead	Q1,2,3,4			

	6.4.0									
Ventilalation	6.4.1	Monitor ventilation across the estate.	1,2	Head of Operational Estates	Maintain assurances for ventilation via the Ventilation Working Group	Head of Operational Estates	Q2, 4			

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	7.1.0									
Antimicrobial stewardship	7.1.1	Provide assurance of Trust performance against Start Smart and Focus antimicrobial stewardship standards'	3	AMS Lead	Quarterly report on point prevalence audits	AMS Team	Q1, Q2,Q3,Q4			
	7.1.2	Reduce the use of IV antimicrobials	3	AMS Lead	Monitor proportion of IV vs Oral antimicrobial use	AMS Team	Q4			
	7.1.4	Reduce the use of "watch and reserve" antimicrobials	3	AMS Lead	Monitor Antibiotic usage	AMS Team	Q4			
	7.1.5	Strengthen knowledge and skills of IPC nursing team around antimicrobial stewardship	3	Deputy Nursing, Midwifery & AHP Director	IPC nursing team member to complete non-medical prescribing course.	Matron IPC & Lead Nurse	Q2			

Ongoing Task | Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	8.1.0									
C. difficile		Reduce Hospital Acquired CDI	1,2,3,4,5,6,7, 8,9	Chief Nurse / Deputy Chief Nurse / DIPC	Monitor progress in the CDI Action Plan monthly at IPCC.	IPC Matron / DND's / Head of Facilities / Head of Estates	Q1,2,3,4			
	8.2.0									
Norovirus	8.2.1	Improve Norovirus management and knowledge across the organisation	5, 6	Deputy Chief Nurse	Ensure the Norovirus policy is shared within the Divisions and educated to Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q2			
	8.3.0									
Influenza	8.3.1	IPC preparation including POCT for seasonal influenza in place	5, 6	Deputy Chief Nurse	Hold a multidisciplinary meeting led by Operations/Emergency preparedness team and report to IPCC to reinforce management and risk assessment of all patients with suspected influenza	DIPC/Matron IPC	Q2			
	8.4.0									
Measles	8.4.1	Ensure processes are in place for the potetnial risk of an epidemic of Measles.	1,2,3,4,5,6,7, 8,9,10	DIPC / Matron IPC / Divisional Nursing Directors / Clinical Directors / Deputy Chief Nurse	Hold regular multi-disciplinary Measles prepardness meetings with relevent actions monitored.	DIPC / Matron IPC / Divisional Nursing Directors / Clinical Directors / Deputy Chief Nurse	Q1,2,3,4			
	8.4.2	Ensure trustwide policy, processes, and procedures are in place to maintain patient safety/	1,2,3,4,5,6,7, 8,9,10	DIPC / Matron IPC	Review and update the Measles policy and risk register accordingly.	DIPC / Matron IPC	Q1,2,3,4			
	8.5.0									
ganisms	8.5.1	Mitigate risk of mulitdrug resitant waterbourne infections.	1,2,3,4,5,6,7, 8,9	DIPC / Head of Estates / Head of Facilities / Augmented Care Leads	Hold regular meetings with Estates and Facilities and Augumented Care Leads to review and action findings identified in the external water expert report.	DIPC / Head of Estates / Head of Facilities / Augmented Care Leads	Q1,2,3,4			

XDR Multidrug resitant or	8.5.2	Mitigate risk of mulitdrug resitant waterbourne infections.	1,2	Matron IPC / Lead Nurses IPC	Review the facilities in inpatient ward areas to ensure best practice is practical.	Matron IPC / Lead Nurses IPC	Q2			
	8.5.3	Mitigate risk of mulitdrug resitant waterbourne infections.	1,2,9	Matron IPC / Lead Nurses IPC	Review the distance between water basins and patient beds across inpatient areas.	Matron IPC / Lead Nurses IPC	Q2			
	8.6.0									
Emergency Preparedness	8.6.1	Review the emergency preparedness plan	1, 2, 5, 6	Head of EPRR and Patient Flow	Review and update the emergency preparedness plan collaboratively	DIPC / Head of EPRR and Patient Flow / IPC Team	Q1,2,3,4			
	8.6.2	Ensure that we are prepared for any future epidemics and / or pandemics	1, 2, 5, 6	DIPC / Matron IPC	Provide education and updates on recent changes in National Guidance. Update any IPC Trust policies in accordance to changes	DIPC / Matron IPC	Q1,2,3,4			

				Ongoing Task	Milestone					
Domain	**Reference**	**Aim**	**Hygiene Code Criterion**	**Lead**	**Actions**	**Actioned By**	**Completion due**	**Complete Y/N**	**RAG**	**Embedded Evidence Y/N N/A**
	9.1.0									
Policies and procedures	9.1.1	Provide assurance policies and procedural documents are in date and complete to enable the prevention of infections and education of staff	1,4,9	IPC Matron / DIPC	Provide assurance through the monthly IPC report of the status of policies owned by IPC and that they are in date and reviewed within the required time	IPC Matron / DIPC / IPC Team	Q1, 2, 3, 4			

Clostridium *difficile* Improvement Plan

Version	Updated by	Date
1	S.Cullen/C. Gregory	29.2.24

Status Key	
1	Not complete
2	Actions on track to deliver within timescale
3	All actions complete but awaiting evidence
4	All actions completed and good supporting evidence provided

Ref	Area for improvement	Key Actions	Lead Executive Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1. Estate						
	Management of the drain blockages	Focused campaign on reducing inappropriate items down the drain.	S. Marsh	30.4.24	Item in progress. Filming complete, signage on display in bathrooms and sluices. Campaign launched April 2024.	
		Need to check adequate disposal is available to reduce risk of wipes being put down toilets/macerators. Audit to be completed	S Marsh/S Fisher	31.5.24	New item identified 10.4.23. S Marsh to link with S Fisher Audit complete and on track	
		Meet with NHS England IPC Lead Rosie Dixon to explore concerns relating to estate and how these can be managed.	D. Orr	14.2.24	Meeting held and agreed next action relating to site survey.	
		Undertake sewage site survey to understand the capital requirements to address the back up of the single sewage stack.	C. Howell	31.3.24	Survey commissioned. Report expected March 24. Update provided to say survey has been completed and report is now expected end of April so will review options on receipt of report.	
		On receipt of survey report (above) consider options for reduction of risk	Estates partnership board	31.5.24	New item added 10.4.24	
	Management of sink blockage and pseudomonas risk	Explore chemical options to reduce risk of pseudomonas.	D. Orr/S. Ashworth	1.2.24	Explore acetic acid and discounted due to health and safety management risk.	
		Arrange expert review through NHS P to review sinks within high risk areas.	D. Orr	16.2.24	Visit completed, report received, and action plan created on recommendations. Regular meetings being held.	

	Insufficient number of side rooms and reliance on redirooms	Identify a solution to address a lack of side rooms.	D. Orr	31.4.23	Point of Care faecal testing solution identified and funded as a cost pressure.	
	Management of IPC related estate issues	Explore an alternative approach to addressing IPC risks in partnership with estates team.	S. Cullen	15.4.24	Discussion to be held following Northampton learning visit.	
	Consistent signage and hand wash – all entrances and sinks	Survey review to be undertaken by hand gel/wash provider and refreshed signage to be built into contract.	S. Marsh	31.5.24	Purell reps supported site survey and review of signage. This will be reviewed yearly and requested ongoing education and training support across all sites. The IPC team will complete a walkaround to review all dispensers and signage as per the IPC Annual Plan 2024/25.	
		Audit question to be included in STAR and assurance of signage compliance to be obtained.	S. Marsh/K. Dickinson	31.5.24	Confirmation received from QA matron that question added, assurance evidence required.	
	Post incident process following sewage leaks	Incorporate a standardized remedial process following sewage leaks	L Taylor/ S Marsh	31.5.24	Training scheduled with plumbers in April 2024.	
2. Cleaning standards						
	The trust is not compliant with national cleaning standards	Implement national domestic and nursing cleaning standards in 15 areas	J. Ashley	31.3.24	Completed in wards: Brindle, RWA, RWB, MAU, CrCu, 2a,20,21,23,24, 25 15,17,18,10 Audit evidence required, display results on entrance.	
		Implement nursing component of national cleaning standards in all areas.	C. Gregory	31.3.24 31.5.24	Completed Assurance evidence outstanding	
		Identify resource required to implement national cleaning standards in wards non-compliant.	J. Ashley	15.2.24	Identified as a risk on the risk register. Identified as a cost pressure for consideration. Options appraisal considered by C FO/CNO – option 2 full compliance with wards and partial in non ward areas (outside of FR1) Value confirmed as £750k.	
		Provide rationale for required resource to implement cleaning standards.	J. Ashley	31.3.24	Following discussion with CFO/CNO rationale to underpin value of implementation costs required.	
	Cleaning product selection	Implement sporicidal based cleaning product (Tristal jet) to replace red sporicidal wipes.	S. Marsh		Tristal jet selected. Now fully implemented in inpatient wards. Require evidence of reduced ordering and assurance if use in all areas.	

		Review approach to medical device cleaning and determine an agreed way forward.	S.Riley/D. Orr	15.2.24	Agreed to use Tristal jet on lowrisk ward based medical devices.	
		Remove the green clinnel wipes from routine practice to promote Tristal jet use in ward areas and reduce the presence of wipes that contribute to drainage issues.	S. Marsh	30.4.24	Green clinell wipes have been reduced in inpatient areas (still required for the cleaning of computers). Safety bulletin prepared and circulated via safety and learning. Tristel Jet use has been extended to include the most frequently used medical devices in Bays e.g., blood pressure machines etc.	
		Consider if ultraviolet light would enable improved compliance with deep cleaning of contaminated environments.	J. Ashley	31.5.24	Case created and costed. To agree with DIPC that UV light is a reasonable approach compared to chlorine and feedback to JA to enable matter to be progressed.	
	The process and oversight for fogging areas requires strengthening.	Process to be reviewed, strengthened and documented.	C. Gregory	31.1.24	App created and access now in place. Evidence of discussion in patient flow meetings.	
		Access to BI app for all Matrons, Trust Operational Officers, Divisional nurse and Midwifery Directors.	C. Gregory	12.2.24	Trust Operational Officer and Matrons have accessed, this has been checked and confirmed.	
		Evidence that the revised process is leading to less delays.	S. Marsh	31.5.24	Fogging compliance report in IPC Team report for IPCC each month tracking compliance and any outstanding areas. Escalation plans with decant facilities being utilized at weekends to ensure fogging is completed within set timescales. Outstanding fogging requests are escalated daily at the Bed management meetings as an agenda item.	
3. Compliance and assurance oversight						
	Strengthened oversight of triangulated IPC metrics.	Agree the key metrics that provide increased assurance on IPC processes.	C. Gregory	30.11.23	Metric agreed. Manual plan in place to take to IPC committee in March.	
		BI solution to the IPC dashboard required.	P. Capps	31.5.24	Request made. Escalated requirement to progress this as a priority. CG communicated need with PC.	
	IPC policy should reflect the strengthened assurance and oversight mechanisms in place for IPC.	IPC policy to be updated to reflect the strengthened arrangements.	D. Orr/C.Gregory	31.5.24		

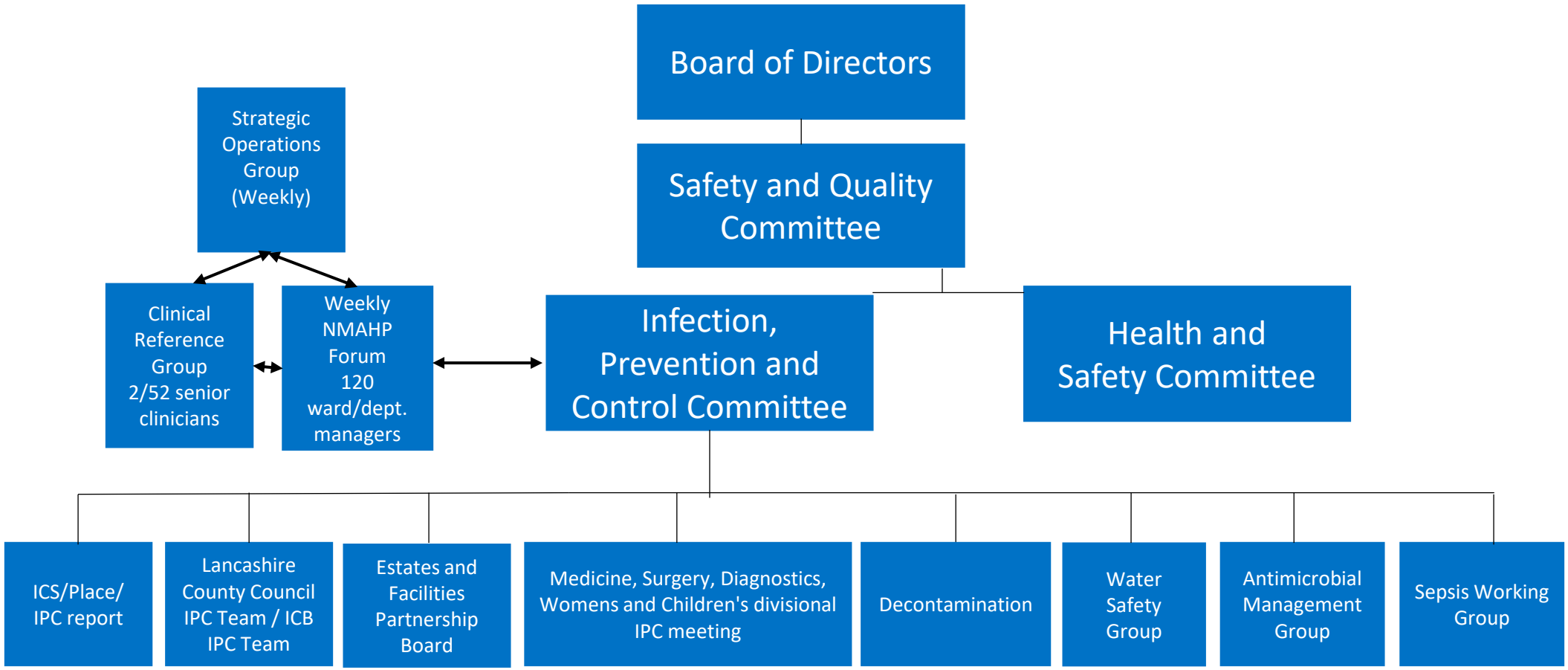
	The C.*difficile* risk should be updated to reflect the enhanced actions taken in response to raised incidence.	The risk should be reviewed and reflect the additional actions taken.	C. Gregory	26.2.24	Completed and recommended risk is escalated to a score of 20 and considered for Board escalation. SQC accepted this and have escalated risk to Board.	
	The assurance data should reflect the dual approach to cleaning standards compliance 2018/2021.	The presentation of compliance data requires revision due to partial implementation of cleaning standards.	C. Gregory	31.5.24	From new 2024/25 performance pack the data will be disaggregated to demonstrate compliance with 2018 and 2021 cleaning standards.	
	Review of STAR metrics and mandatory field	Incorporate cleaning checklist and other standards as mandatory fields	S Marsh/ J Howles	31.5.24	Training with plumbers due to commence. SOP to be developed with clear roles and responsibilities. STAR team are reviewing cleaning and discharge checklists on accreditation visits.	
4. **Training and Education**						
	Strengthen evidence of specific housekeeper training and arrangements for when the housekeepers are absent.	Housekeeping Training Needs Analysis to be created with specific housekeeper training curriculum developed.	S. Marsh	31.1.24	Housekeeper training is completed for all departments across the organization. The IPC team will continue to support this education with HCA's, volunteers and will strengthen patient education as part of the IPC Annual Plan 2024/2025.	
		TNA to be agreed with education and this forms part of the role specific training reports.	S. Marsh /C. Taylor	31.5.24	S Marsh has provided a list of staff members who have completed the training. Awaiting response confirmation tat this has been added to TNA.	
		IPC assurance of training implementation is visible in practice.	S. Marsh	31.3.24	IPC team continue to support wards and departments with bespoke training and revalidation audits.	
	IPC training should reflect the increased vigilance required around C.difficile prevention.	Review of IPC training and confirm it contains the required content for the correct audience.	S. Marsh	31.5.24	The IPC E-learning package has been reviewed and updated, awaiting a live date from the Blended Learning team. The DIPC has reviewed this with IPC Matron and are happy with the content and confirm it is in line with the National IPC framework for education.	
5. Movement around the hospitals						
	The practice of beds being used to push patients around the hospital increases the risk of shedding of spores.	Review the approach to this and communicate expectations to minimize movement of beds unless clinically indicated.	S. Marsh	30.9.24	Communication prepared and completed.	
		Establish an approach to monitoring this.	J. Ashley	31.1.24	Measurement system in place for both CDH and RPH.	
		Establish what expected parameters	J. Ashley		The expected levels of activity should	

		would look like and add to the IPC dashboard.		31.5.24	be articulated, included in the IPC dashboard to ensure activity stays within upper and lower control limits.	
6. Integrity of equipment						
	Mattress integrity is variable when tested. This requires improvement.	Audit approach should be reviewed with training and approach and strengthened.	N. Ross	31.11.24		
		Mattress audit data to be added to the IPC dashboard.	C. Gregory	31.5.24	Requested – awaiting confirmation of live date from BI.	
	Move to white only aprons in pandemic has removed a prompt to change aprons and limits the ability to challenge poor practice.	Return to colour themed aprons.	S. Marsh/J. Ashley	31.5.24	Coloured aprons in circulation across the Trust and being used.	
7. Antimicrobial use						
	Review the use of Cefuroxime due to connection to C.difficile and high consumption noted.	Guidelines to be reviewed to consider alternative.	D. Orr	30.11.24	Antimicrobial guideline reviewed and changed to reduce consumption of Clarithromycin.	
		Review sepsis guideline with specific focus on sepsis of unknown origin.	C. Roberts	31.12.24	Guideline reviewed and focus on sepsis of unknown origin has resulted in a communication campaign to reduce this diagnosis description.	
		Consider how to duplicate effectiveness of antimicrobial prescribing reporting for sepsis. Explore if sepsis prescribing could be included in reporting to lead to areas of improvement being highlighted at specialty level to drive improvement.	C.Roberts/S. Reddy	31.5.24		
8. Patient and family engagement and information						
	Review of information to patients pre, peri and post admission.	Patient Safety Partner to lead this review and make recommendations.	C. Gregory	31.5.24		
	Review of information provided to family regarding infection control on entrance to the hospital start to end of the journey.	Patient Safety Partner to lead this review and make recommendations.	C. Gregory	31.5.24		
9. Learning from previous incidents to improve patient care (PSIRF)						
	Learning from incidents highlights Improvements needed to compliance with hand hygiene audits	Develop IPC dashboard with key metrics. Focus on improvement via Matrons assurance reports and IPC dashboard.	C Gregory DNDS	31.5.24	20 key metrics for IPC dashboard agreed Development underway with business intelligence	
	Learning from incidents highlights improved compliance is needed with documented risk assessments and care plans	As above	C Gregory DNDS	31.5.24		

	Learning from incidents highlights that improve compliance is needed with commode audits	As above	C Gregory DNDS	31.5.24		
	Learning from incidents highlights opportunity to reduce delays in time to isolation	As above	C Gregory DNDS	31.5.24		
	Learning from incidents highlights opportunity to reduce delays in sampling	As above	C Gregory DNDS	31.5.24		
10. Research and innovation						
	Partake in research regarding hand hygiene		D Orr and S Marsh	31.10.2024	Meeting requested following feedback on information received from Primel to discuss next steps.	
End of Action Plan						

Action Plan Sign Off
Name: Sarah Cullen
Date:

Infection, Prevention and Control Governance Structure



Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Maternity Service Bi-annual Staffing Review

Report to:	Board of Directors	**Date:**	6th June 2024
Report of:	Chief Nursing Officer	**Prepared by:**	Jo Lambert
Part I	✓	**Part II**	

Purpose of Report

For Assurance		**For decision**		**For information**	**x**

Executive Summary:

The purpose of this report is to inform the Board of Directors of the findings of the Lancashire Teaching Hospitals NHS Foundation Trust bi-annual maternity staffing review. The report is the first of two staffing reports in 2024 which details the actions taken and the scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated with workforce information, patient experience and clinical effectiveness indicators to provide assurance of safe staffing levels.

In determining staffing requirements for maternity services: the BirthRate plus (BR+) midwifery acuity tool continues to be utilised to define the appropriate and required staffing levels. A summary of obstetric, neonatal nursing and neonatal medical staffing levels and quality indicators is also included in the report because of the associate impact on maternity provision.

The findings of the most recent Birth Rate Plus assessment undertaken at the end of 2022 confirmed that uplift to the funded establishment of 29.7 WTE (Midwives and Support Workers) at a cost of £1,576,043 is required to meet the recommended safe staffing requirements. Given the significant financial investment required an the current Registered Midwife vacancy level, a decision to take a phased approach has been agreed. Phase one includes the specialist midwifery and support worker elements and phase two includes Registered Midwifery staffing uplift and is detailed in Table 1.

The service confirms that phase 1 of the BR+ requirements have been approved by the Board in April 2024 and this has been transacted into the midwifery budget.

The establishment tracker continues to monitor current midwifery staffing levels and the overall projected position. The established vacancies and maternity leave Whole Time Equivalent (WTE) vacancy is current 12.41.

Key performance related to antenatal booking by 9+6 and 12+6-weeks' gestation has been variable for more than 12 months. Staffing pressures from Quarter 2 into Quarter 3 and 4 because of midwifery vacancies, long-term sickness absence (WTE) and rising maternity leave have had a detrimental impact on the ability to achieve and sustain performance. However, following a test of change to introduce a first point of contact booking process, early indicators suggest an improving position.

The service confirms that the current level of midwifery continuity of carer (MCoC) can continue to be delivered safely without impacting on one-to-one care in labour. However, with the projected staffing establishment gap there will be no further expansion of CoC at this time.

Overall compliance rates for Practical Obstetric Multi-Professional (PROMPT) and fetal monitoring training continues to be monitored and tracked monthly. The compliance remains over 90% within each speciality group for fetal monitoring training and a breakdown of the March training data has been included in Appendix 6.

Within this reporting period, there have been no whistleblowing CQC enquiries relating to staffing levels and several listening events lead by the Divisional Midwifery and Nursing Director and Occupational Development team have been undertaken to gain a wider understanding of culture with an overall aim to influence features of safety. Purposeful investment in training (community skills drills, consent and enhanced care), improving clinical escalation, and the TRIM (trauma informed support) programme based on service priorities and learning from incidents has been arranged and deepen the skillsets of the workforce improving outcomes and staff resilience.

Highest red flags reporting includes those associated with delay in time critical activity, delay in obstetric review, delay in augmentation of labour and deferred community visits. This reflects the known pressure points within the service. The trend in reporting is consistent with reduced staffing levels in midwifery and funding gaps in the obstetric workforce and the highest categories should be prioritised as an early warning system for closer review or action.

Analysis of the perinatal quality surveillance tables (PQST) (Appendix 5) has not demonstrated significant safety concerns or causal harm; however, areas of the service continue to report red flags which are associated with areas of staffing pressures staffing pressures in midwifery and neonatal staffing levels. This is evident on several indicators such as fill rates and deflection of inductions, rescheduled community visits and neonatal closures and transitional care capacity.

The times when the service is required to use local escalation procedures to divert women or babies to maintain safety in the unit are captured with the perinatal quality surveillance tables for oversight of diverted activity.

It is recommended the Board of Directors:

i. Receives the biannual maternity safe staffing review for information.
ii. Note the report has received scrutiny and was endorsed at the safety and quality committee.
iii. Note the approval of phase 1 of the Birth Rate plus funding was approved by the Board in April 2024, recognising once recruitment to registered midwives has progressed there will be a further requirement to consider the registered midwife component of the safe staffing recommendation.

Appendices attached:
Appendix 1 Detailed review of new BirthRate Plus summary
Appendix 2 Breakdown of Specialist Midwife Portfolio
Appendix 3 Workforce Action Plan
Appendix 4 Maternity Red Flag data
Appendix 5 Perinatal Quality Surveillance Pack
Appendix 6 Safety Champion Action Log

Appendix 7 CNST MIS Year 6 Training figures.			
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 & Quality Committee April 2024.			

1.0 INTRODUCTION

The report details the findings of the Lancashire Teaching Hospitals NHS Foundation Trust, April 2024 bi-annual maternity staffing review. The review triangulates workforce information with safety, patient experience, and clinical effectiveness indicators to provide assurance of safe staffing levels within the maternity service.

The report fulfils the requirement outlined in the National Quality Board (NQB) staffing guidance for maternity services (NQB 2018) and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). The Incentive Scheme guidance (CNST 2024 Year 6) recommends maternity services should undertake a bi-annual safe staffing review to demonstrate that there is an effective system of midwifery workforce planning.

The bi-annual review continues to be collated using the three National Quality Board expectations for safe, sustainable, and productive staffing levels adapted for maternity services namely right staff, right skills and right place and time. Additional local measures are included in Table 1 to illustrate the other people plan and well led elements.

Table 1: National Quality Board's expectations for safe, sustainable, and productive staffing (2016) adapted for maternity settings.

Right Staff (5.0)	**Right Skills (6.0)**	**Right place and time (7.0)**	**Monitor and Learn (8.0)**
Evidence-based workforce planning Appropriate skill mix Review staffing using the BR+ workforce planning tool annually and with a midpoint review.	Multiprofessional mandatory training development and education Working as a multi-professional team Recruitment and retention	Productive working Efficient deployment and flexibility including robust escalation. Workplace national drivers.	Leadership oversight and assurance Safety Culture Service User Listening to feedback

2.0 SCOPE

This report details includes the arrangements for midwifery staffing provision across all inpatients, community, and specialist midwifery services and is the first bi-annual report of 2024.

It is acknowledged that a safe and effective workforce planning for maternity services must include core medical services. Some detail will be provided in relation to medical and neonatal staffing within the report for triangulation and evidence of the continued effective co-production and forward planning and sustainability of the midwifery, obstetric and neonatal workforce as a continuum.

3.0 METHODOLOGY

A triangulated approach to the planned safe staffing reviews is undertaken by the Chief Nursing Officer, Divisional Midwifery and Nursing Director, Finance Business Partner and Midwifery Matrons. Findings of each review continue to be driven by the requirements of Birth Rate Plus (BR+) and are cross checked using professional judgement, clinical indicators, and safety intelligence.

The review also considers national guidance relating to the provision of safe staffing levels within maternity services; Royal College of Obstetrician and Gynaecologists (RCOG) 2021), National Institute for Clinical Excellence (NICE) 2016, national reviews such as the Single Delivery Plan (2023) and maternity and neonatal safety bundles.

4.0 MATERNITY SPECIFIC SAFETY AND QUALITY METRICS

Maternity staffing metrics are displayed on the perinatal quality surveillance table (PQST) each month as part of the safe staffing report submitted to Safety and Quality Committee for oversight which is also shared with the Executive Trust Board. The PQST (Appendix 5, A, B, C, D, E) tracks performance over time in relation to key safety indicators.

In determining safe staffing requirements, services should hold a helicopter view of safety data and intelligence which must be used as an early warning system or a call to action for safety critical staffing decisions. Approaches to determining appropriate staffing levels in maternity services must be flexible and use the full range of intelligence to include Maternity and Newborn Safety Investigations (NMSI), CQC enquiry, thematic learning from Patient Safety Incident Response Framework (PSIRF), the national Perinatal Mortality Review Tool (PMRT), low, moderate harm incidents, safe staffing fill rates for midwifery and obstetric acute cover, coronal regulation 28 cases and safety champion's oversight.

It was requested the Safety and Quality Committee that the report talks to harm levels that are associated with safe staffing as a measure of assurance. However, this continues to be difficult to define, due to complex variables. Acknowledging that the rational for this request is so the committee can understand safety critical key intelligence, the work to update the PQST is progressing. It is intended to present the data in statistical process control format detailing the service performance against local and national maternity system mean averages where available. It is anticipated that this new format will define areas of focus more clearly and be introduced by June 2024.

5.0 RIGHT STAFF

Maternity teams must have sufficient and appropriate staffing capacity and capability to ensure safe, high quality and cost-effective care for women and their babies always. Staffing decisions must be aligned to operational and strategic planning and must be able to demonstrate sufficient flexibility, capacity and workforce planning to meet demand safety. This includes having effective leadership- from floor to board, a clear governance framework, a positive safety culture of learning and transparency with a model of care that promotes choice of place of birth, and which continues to, when possible, prioritise continuity of carer.

5.1 BIRTH RATE PLUS - EVIDENCE BASED WORKFORCE PLANNING

The Three-Year Delivery Plan for Maternity and Neonatal services (March 2023) states that services should undertake regular workforce planning reviews and where they do not meet the staffing establishment levels set by BR+ do so as soon as possible no later than by 2027/2028.

BR+ looks not only at the midwife-to-birth ratio but considers acuity and complexity, making it maternity-unit specific. This is significant because although the birth rate has remained stable for Lancashire Teaching Hospitals (4,200-4,400), a significant change in the case mix, with an increase of 10/11% in Category IV and V has been demonstrated since 2022. More complicated cases such as elective caesarean section; pre-term births; low Apgar and birth weight in category IV and in category V (those who require a very high degree of

support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery) have led to an increasing requirement for additional care hours in midwifery, obstetrics and as a consequence neonatal workforce.

In addition, a slight increase in number of women (43) giving birth on the Delivery Suite, an increase in the number of outpatient clinics, additional staffing requirements for Maternity Assessment (Triage), additional safeguarding built into the community and continuity staffing requirements for the Homebirth team have led to additional staffing requirements.

The latest BR+ assessment undertaken in 2022, recommended an uplift to 190.10 WTE. To align the workforce to a 90/10 skill mix split for postnatal and community work, 171.09 WTE Registered Midwives and 19.01WTE Midwifery Support Workers (MSW) are required. Specifically, 16.67 WTE registered midwives, 5.93 WTE Midwifery Support Workers and 5.53 WTE Health Care Assistants (HCA) would be needed at a total cost of £1,576,043. The findings and uplift have been reviewed and accepted as correct and were approved by the Board of Directors in August 2023 and endorsed by the Integrated Care Board (ICB) Chief Nurse.

Although the recommendations to meet BR+ are understood, a financial solution to fulfil all of requirements has not, until recently been possible. Recognising the significant financial investment required, a phased approach to funding has now been agreed by the Trust and Integrated Care Board. Phase 1 (April 2024) will focus on the specialist midwifery portfolio and the maternity support staff. Phase 2 will be presented in the second bi-annual report to be considered in the 24/25 financial planning round. A breakdown of the requirements of each phase is detailed in table 2.

Table 2 Phased approach to achievement of BR+

Phase 1 April 2024	**WTE required**	**Costs**
MSW (Band 3)	4.6 (already funded) +1.33	£62,533
HCA (Band 2)	5.53	£248,358
Specialist Midwives (Band 7) (Mon-Fri 9-5)	2.31	£176,903
Total		£487,794
Phase 2 October 2024	WTE required	Costs
Midwives (Band 6)	10.16	£770,480
Staffing uplift of 25% for midwives (Band 6)	4.20	£317,769
Total		£1,088,249
Overall Total		1,576,043

5.2 CONTINUITY OF CARER

In accordance with the three-year single delivery plan for maternity and neonatal services. The service continues to monitor their ability to offer Midwifery Continuity of Carer (MCoC). Taking into account the principles of safe staffing, the Divisional Midwifery and Nursing Director and leadership team regularly reviews the service provision. They confirm that three continuity models can be continued without impacting on the safety of the

service. This is because the impact of suspension of specialist diabetes care and home birth services would have a detrimental effect on service organisation and provision without a wide positive effect on fill rates.

The service also continues to seek innovative ways to expand the provision of MCoC so that priority can be given to those most likely to experience poorer outcomes first, including women from Black, Asian and mixed ethnicity backgrounds and those living in the lowest decile of deprivation. At this time, work is ongoing with the NHS Race and Health Observatory to understand how clinical indicators can be disaggregated to plan care based on individual rather than universal risk. Once the BR+ requirements are achieved, and all vacancies are filled, the service will use this information and recommendations to develop an enhanced team for women from Black and Asian groups.

5.3 APPROPRIATE SKILL MIX

BR + advises that any additional specialist workforce should equate to approximately 10% of the funded clinical midwifery establishment to support for the provision of a safe service. The comparator data from the 2019 BR+ is detailed along with the updated breakdown for 2022 of WTE specialist midwives required and the distribution of the speciality clinical midwives is detailed in table 3. 19.01 WTE meets the 90/10 requirements.

Table 3 Specialist Midwife Ratio's in current establishment and recommended by BR+ 2022.

Current Funded Establishment (Specialist Midwives) 2019	Birth Rate Plus Recommendation (10%) 2022	Variance WTE
16.06	19.01	-2.95 (Phase 1)

5.3 FILL RATES

Lower fill rates for registered midwives (RM) below 85-90% due to ongoing vacancy in the establishment has been consistently below target for over 12 months. The current registered midwifery vacancy rate is 12.41 WTE (vacancy and maternity leave). The midwifery establishment trajectory tracker monitors vacancy and recruitment into and backfill to maternity leave for midwives and support workers continues to be supported by the Trust Board. Targeted action and innovative recruitment continues, and a profiling exercise is ongoing to trend the data related to recruitment conversion from interview to appointment, maternity leave, sickness and turnover to enable more efficient workforce planning.

To maintain safe staffing, all shifts are initially offered as bank and are then converted to agency after 2 weeks of not being filled. This demonstrates the commitment of the service to fill all vacant shifts. Consistently the service fills between 50-60% of all unfilled shifts that are converted to agency shifts. The impact of temporary staffing on budget control, on wellbeing of substantive staff and service user experience should be acknowledged and although agency fill is an essential component of safe staffing, the commitment to substantively recruit is a must do action.

5.4 NEONATAL NURSE STAFFING (The British Association of Perinatal Medicine BAPM) FILL RATES

The Northwest Neonatal Network monitor staffing levels against BAPM standards using the Clinical Reference Group neonatal nurse calculator. Compliance with the standard is presented within the Activity Capacity Demand (ACD) report and for 2022/23 reporting period compliance was achieved based on the average activity for the previous 3 years. However, at times high acuity intensive care cot days and sickness absence has affected the ability to maintain BAPM compliance, despite having a zero percent vacancy rate and that this has resulted in increasing neonatal closures. Performance continues to be tracked via the PQST (Appendix 5) and neonatal dashboard monthly and high-level actions to improve sickness absence rates (15% in March 2024) are ongoing

by the Divisional with workforce partners. The safety and Quality committee receive a monthly safe staffing reported allowing detailed focus on neonatal outcomes and the safe staffing assessment was included in the 2023 annual safe staffing review presented to the Board of Directors in April 2024.

5.5 MEDICAL WORKFORCE REQUIREMENTS

Providing high quality and safe care is critical and requires a sustainable, engaged workforce who are responsible for ensuring safe medical staffing for both elective and emergency work. RCOG and RCoA promote the principle that standards of care must be maintained by having the appropriate workforce with the necessary skills in the right place at the right time.

5.6 OBSTETRIC WORKFORCE

Since the last report the service can confirm the appointment of a new Clinical Director and successful recruitment to 2 new consultants within the speciality of obstetrics. The ability to move to 96-hour cover requires 2 further WTE consultants to provide cover on a 1:12 weekend on call system. There is currently an ambulatory care consultant out to advert which will have an obstetric element, therefore once this post is filled, this gap will reduce to 1. In addition, a workforce review of the middle grade rota is ongoing to scope the establishment and work towards a 2-tier roster system and an update will be shared in due course.

5.7 NEONATAL MEDICAL WORKFORCE

A local workforce review of the neonatal medical staffing requirement to achieve British Association of BAPM standards was undertaken in 2023. Table 4 details the ongoing workforce requirements. As of March 2024, there is a 1.4 WTE gap in the tier 2 roster. Ongoing actions to achieve full compliance are ongoing, including recruitment via the ORDER programme.

Table 4 BAPM Medical workforce compliance

Medical Staffing	March 2024	RAG
Consultant n=9	9/9	
Tier 2 n=7	4.6/7	
Tier 1 n=7	7/7	

6.0 RIGHT SKILLS

Organisations must have robust mandatory training, development, and education programmes for multidisciplinary teams. Boards must assure themselves that sufficient staff have attended such training and are competent to deliver safe maternity care. Staffing establishments must allow for staff to be released to undertake the required training and development. Table 5 details the core national, regional and local priorities for training and progress against the work plans for committee oversight.

6.1 TRAINING- NATIONAL, REGIONAL AND LOCAL PRIORITIES

Table 5 National, regional and local priorities for training

Training Requirement	Standard	Actions and update	RAG
Core Competency Framework V2	**CNST Year 6** To deliver additional taught study day, titled saving babies' lives	On track with TNA requirements.	On track
		BR+ uplift of 4.2 WTE required in phase 2 for additional required study day to be funded.	No agreed solution
CNST Year 6 TNA- PROMPT fetal monitoring, neonatal resuscitation	**CNST Year 6** 90% Compliance for all relevant staff groups for PROMPT fetal monitoring, neonatal resuscitation	Action on track. See appendix for latest compliance.	On track
Baby Friendly Initiative	**Three-year plan Priority LMNS Target/ WHO requirement**	At risk. There is a risk to achievement of stage 2 accreditation linked to delays in training plan due to midwifery staffing. Risk has been added to the risk register and an action plan is ongoing	Action plan in place
Baby Life Line Community Drills NEW 2024	**Local target** agreed to ensure appropriately skilled work force	On track 25 places for stand-alone birth centre and home birth teams	On track
TRIM Training (Trauma informed Support for staff) PMA NEW 2024	National review 3-year plan **priority**	Local target set to ensure appropriate restorative support for staff following traumatic or complex cases.	On track
Professional Midwifery Advocacy (PMA)	**Three-year plan Priority**	Plan to prioritise further places for either the PMA conversion or PMA course from CPD in 2024.	On track
Enhance Critical Care NEW 2024	**Maternal Medicine**	4 places for Critical care course funded by maternal medicine network. System LMNS response requested and awaited.	On track
		36 Place for the baby life line enhanced care training ring fenced from CPD for 2024.	On track
Delivery Suite Coordinator Programme awaited	**Three Year Plan Priority**	System level approach with LMNS ongoing	Action plan in place
Bereavement training 2023/2024	**Three Year Plan Priority/SANDS**	On track	On track

6.2 RESTORATIVE SUPERVISION

Since the relaunch of the Professional Midwifery Advocate role in 2020 deliver the Advocating for Education and Quality Improvement (A-EQUIP) model of restorative support for registered midwifery staff, a progressive increase in the number of PMA's has been demonstrated. The service has now trained 14 midwives. Although the recommended ratio of one PMA to every 20 registered staff is achieved, additional places for the course will be facilitated in 2024 to strengthen the restorative offer considering the increasing complexity of case mix that is being experienced. A reset of the core PMA offer is planned in the next few months with the regional Deputy Chief Midwife/PMA team to ensure that restoration and support is well managed and best placed in the service.

6.3 BEREAVEMENT

In the last few months, the provision for early pregnancy, maternity and neonatal bereavement has been aligned and incorporated into the wider corporate bereavement team to provide a joint service and system approach. Acknowledging the nature of the role, this transition will enable wider shared oversight, clinical supervision and restoration pathways to be incorporated into group supervision sessions in house. Working in this way builds a pathway of professional support and a network of expertise across the Trust and has been received positively across the teams.

6.8 ENHANCED SUPPORT MIDWIFERY TEAM SAFEGUARDING

Safeguarding supervision continues to be facilitated by the enhanced support midwifery team to the maternity and corporate specialities. Regular supervision sessions for midwifery staff are provided as part of planned team meetings, daily safety huddles and during 1:1's. The number of sessions has reduced, in the last few months, due to the increasing pressures due to increasingly complex safeguarding cases and sickness absence. However, the team continue to be visible in the maternity unit and provide ongoing supervision during evolving cases daily during safety huddle and during floor walks.

6.9 WORKFORCE PLANNING- RECRUITMENT AND RETENTION

The overarching work force plan for 2023/24 continues to make progress. The plan collated by the service in collaboration with the workforce business partners details the actions taken to mitigate the ongoing staffing risk (Appendix 3). National pump prime funding continues to support specific work streams within midwifery and obstetrics and includes recruitment and retention, bereavement, maternity support and leadership PAs for Clinical Directors.

The Divisional People Plan recognises the benefit of having a skilled workforce and the service is in the process of developing a multi-professional leadership day for band 7 leaders/managers, band 8 matrons and consultant obstetricians.

A professional recruitment video has also been commissioned for the maternity service and is currently in development. It is anticipated that the video will represent all areas of the service and raise the profile of Lancashire Teaching hospitals as a valued work place.

6.10 SICKNESS ABSENCE

The sickness levels within the service have been significantly above the Trust target of 4% for well over 12 months. Several interventions by the division and work force partners as well as a review of long-term sickness management strategies within the division has been effective in reducing absence. In the month of March 2024, the sickness absence rate was 4.1%. This is the 4th consecutive month where a steady reduction in sickness in the cohort of maternity has been demonstrated. When comparing this quarter to the last quarter there has been improved position of 2.6%. Staff engagement and investment such as strengthened leadership, core roles, reward and recognition activity, raising the profile and offering Continuous Professional Development (CPD) across the workforce groups has also shifted the landscape.

7.0 RIGHT PLACE AND TIME

7.1 RED FLAGS

Midwifery red flags highlight potential areas of staffing concern within the service. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing levels.

The service continues to report red flag incidents. The breakdown by category is provided in appendix 4. The highest reported category related to delayed community postnatal visits, delay in review for more than 30 minutes for obstetric review in triage and delay in time critical activity and the red flags continue to be monitored are added to the associated risks on the register for additional oversight by the division.

Reporting triangulates to known pressures within the service and consideration of the high reporting red flag indicators should be used to noted and used as a lever for phase 2 of BR+ funding as required.

7.2 CLINICAL ESCALATION UNIT DIVERT

Maternity diverts are not currently classified as a national red flag event; however, the service continues to monitor capacity issues that have resulted in a request to divert.) There have been no maternity diverts for 7 months, with the last divert being September 2023 where the unit was diverted on 2 occasions over one weekend for a duration of 8 hours each time.

The service also collates data related to inability to accept intrauterine transfers. The decision to decline Northwest Connect requests for a level 3 neonatal cot is undertaken using a multi-disciplinary approach, recognising the financial and family impact of a declined admission. The on-call consultant, delivery suite coordinator and maternity matrons (in hours) and neonatal team review the unit acuity, induction of labour activity, delays, planned elective work and staffing levels and confirm whether the Intra uterine transfers (IUT) can be accepted or declined.

To provide wider triangulation of operational pressures on the maternity and neonatal service, the PQST Appendix 5 also includes a separate breakdown of all (IUT's) declined by maternity and those declined by the neonatal unit. It also details instances when antenatal IUT's are requested because of staffing, capacity, or closure of the neonatal unit. Mutual aid within the Local Maternity and Neonatal System to accept cases of induction of labour from the service during times of pressure is also tracked and recorded.

Both the maternity and neonatal service data indicates that the service continues to be under intermittent times of pressure associated with obstetric, midwifery and neonatal staffing which must be closely monitored but acknowledge an appropriate escalation response.

7.3 SUPERNUMERARY STATUS

The requirement for standard 5 of the Clinical Negligence Scheme for Trust (CNST) Maternity Information system (MIS) has changed in relation to the supernumerary coordinator requirements following the publication of the year 6 standards. In year 5 the standard confirmed:

CNST year 5 Standard 5 Element C *The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.*

This has been replaced by:

CNST year 6 Standard 5 Element C *The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.*

This provides wider flexibility for the service to safely manage unplanned gaps in the roster. However, it is the intention to maintain the current arrangement to manage the supernumerary status of the coordinator. Having a delivery suite coordinator and second band 7 as unit coordinator, based on and in the delivery suite numbers is an effective safety netting model. However, the consequence of the recurrent vacancy means that they are almost always taking a clinical caseload and the wider oversight function that they should take is reduced. Performance will continue to be monitored monthly and the service reports that 100% compliance is consistently achieved.

7.4 ONE TO ONE CARE

The ability to provide one to one care in labour is monitored each month and provides a reference point from which safe staffing levels can be confirmed. Since October 2024, the service has been able to report 100% compliance with one-to-one care for all women across 4 places of birth. The ability to maintain this performance requires that the matron of the day and delivery suite coordinator review, risk assess and move staff around the service to maintain appropriate staffing levels. Whilst this is the accepted and agreed process, the impact of moves around the service on staff and on experience of care should not be under- estimated and can affect overall resilience.

7.5 ROYAL COLLEGE OBSTETRICS AND GYNAECOLOGISTS ATTENDENCE

Ongoing monitoring of compliance related to consultant attendance for the clinical situations listed in the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document: ‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’ continues. This is an important metric to sense check the system pressures and track the clinical impact of gaps within the obstetric workforce.

Acute obstetric unit medical staffing and consultant availability (daytime labour ward cover and out of hours/on call) is monitored via the PQST. The data submission reflects the actual medical staffing for the acute obstetric service in relation to the planned staffing levels. The provision of acute obstetrics takes priority over all other planned medical obstetric and benign gynaecology workload. Since August 2022 (when the data collection commenced) 100% cover has consistently been achieved for all tiers of the acute obstetric rota (consultant, middle grade, and junior tier).

It is important to note that in prioritising the acute setting, which is non-negotiable, there are unintended consequence on the planned work; including the ability to review women attending the Early Pregnancy, Gynaecology Assessment Unit EPGAU and timely review in maternity triage when trainees and consultants are diverted to cover rota gaps. The workforce review and peer comparison of the middle grade rota to scope the establishment and work towards a 2-tier roster system will provide a platform for future sustainability planning.

The service also monitoring/effectiveness tool contained within the ‘RCOG guidance on the engagement of short and long-term locums in maternity’ to audit their compliance with the recommendations for locum doctors and

have a plan to address any shortfalls in compliance. A monitoring process is in place to ensure that the standards are met, and the last audit confirmed 100% compliance.

7.6 MATERNITY TRIAGE

Compliance to the Birmingham Specific Obstetric Triage System (BSOTS standard) and (NICE Guidance for triage review within 30 minutes) continue to be audited and monitored by the service monthly. Over the last 12 months, over 90% of women were reviewed within the NICE 30-minute target range. The stretch target to meet the 15-minute standard set by BSOTS for women seen by a midwife is between 86% and 94%.

The service has also collated a response to Royal College of Obstetricians and Gynaecologists (RCOG) Good Practice Paper providing recommendations for maternity triage operational structure and pathways. A benchmarking exercise against the new standards indicates compliance with 24/28 actions (86%). This position compared variable to peers with the LMNS. The areas of current non-compliance are detailed below and an action plan to monitor the progress against the outstanding requirements is ongoing.

- Patient telephone calls not being answered outside of the MAS environment.
- We do not dedicate one midwife to be the “call handler” per shift.
- We do not have a dedicated white board to display those women currently in MAS.

Mitigating Actions

Call management- Specific actions related to call handling, identified during the Care Quality Commission must do requirements are ongoing. A local audit of dropped calls is undertaken daily by the maternity support workers and the project work to introduce the contact centre call handling system is in progress.

Whiteboard- Work to review the current whiteboard arrangements moving to an electronic version is also being considered. Although it would be best practice to implement the electronic monitoring of women through the service, the current arrangement is functional.

7.7 STAFFING RELATED RISKS

Detailed below (Table 6) are the open risks on the women’s health register that are associated with the ability to maintain safe staffing levels for information.

Table 6 Staffing related risks. Maternity

Risk ID	Title	Current risk rating
581	Maternity staffing deficit	15 (Active risk)
1592	Delays in induction of labour process	15 (Active risk)
1292	Inability to accept intra-uterine transfers from other organisations	15 (Active risk)
569	Elective caesarean sections list over running	15 (Active risk)
1708	Deferring and rearranging planned consultations in midwifery led services	15 (Active risk)
1688	Maternity Assessment Suite (MAS) – partial implementation of the Birmingham symptom specific obstetric triage (BSOTS) system.	12 (Active risk)
1535	Delay in implementing a maternal medicine centre for Lancashire and South Cumbria	10 (Active Risk)
1762	Inability of the maternity service to achieve BFI full level 3 accreditation by 2024	10 (Active Risk)
1743	Lack of a multiple pregnancy midwife in post (Phase 1 will now be funded)	10 (Active Risk)

All high risks associated with staffing are reviewed by owners and handlers and jointly within the maternity safety and quality committee. Each risk is considered for status, current rating and assurances and gaps in controls. This ensures that risks are prioritised and managed effectively. The highest risk ratings also triangulate to the areas of pressure within the service which are reflected in red flag reporting. (Maternity staffing deficit, delays in induction of labour process, deferring and rearranging planned consultations in midwifery led services). The oversight of highest reporting provides key intelligence by which the service and executive board will act and plan for a safe sustainable service in the future.

Delays in induction of labour process risk 1592.

Delays in induction of labour continue to be monitored as part of daily safety huddles and consultant board rounds and are captured as part of red flag reporting and linked to the register. Timing for admission for induction is overseen by the capacity and flow manager and when delays occur the on-call team are asked to review risk and plan care in partnership with the woman. A wider work education work stream to utilise the induction of labour tab in BadgerNet is ongoing and changes to the format have been requested to enable a unit report to be generated and used to track and monitor delays more robustly.

The LMNS Gold call provides a platform for mutual aid in times of high acuity to offer care in one of the other system providers.

7.8 SAFE STAFFING MITIGATING ACTIONS

The Northwest Maternity Escalation Policy including Maternity Operational Pressures Escalation Levels (OPEL) has unified the procedures for the Northwest region to manage significant surges in demand. The escalation policy enables standardised oversight of the maternity status at Trust and regional level to be operationalised. In addition, the daily GOLD call provides prompt system response and mutual aid in the event of high activity, or the requirement for deflection of work or emergency divert.

Daily staffing figures and acuity levels within the maternity intrapartum areas are captured in an electronic Birth Rate Plus acuity tool and weekly a summary of compliance is reported and shared. The app-based Birth Rate Plus acuity tool is utilised across all 4 local maternity and Neonatal system (LMNS) providers to give greater oversight of the intrapartum areas to enable more efficient management of workload and staffing. The ward-based BR + acuity tool is currently being rolled out to track and monitor activity and staffing acuity on the maternity wards. This will enable wider oversight of capacity and demand and indicate the safe staffing requirement in a wider more systematic way.

A review of all staffing levels is also undertaken at twice daily huddle meetings and any actions taken to redeploy staff are documented for future reference. Oversight of acuity and demand is undertaken by the Matron (Matron of the Day) during working hours and the Delivery Suite Co-ordinator out of hours. The PQST now includes decisions to divert and transfers out due to capacity for induction of labour to ensure the broader context and experiences of women and families is understood. In addition, work is ongoing to track and monitor delays in the induction pathway. It is anticipated that this will also be included in the PQST once changes to Badger Net functionality and documentation have been enacted.

8.0 LEADERSHIP

The Divisional Midwifery and Nursing Director (DMND) is the senior lead within the midwifery team, reporting professionally to the Chief Nursing Officer and provides clinical leadership and strategic direction to the maternity service in addition to the Breast, Gynaecology and Sexual Assault Forensic Examination (SAFE)/Sexual Assault

Referral Centre (SARC) Services. The DMND is part of a divisional leadership QUAD that includes a Divisional Director, Medical Director and Divisional Nurse Director for Children and Neonates. The service is supported by 2 safety champions to include executive and non-executive members of the Board.

8.1 BOARD SAFETY CHAMPIONS

The executive safety champions visit the service monthly to provide an opportunity for staff to see and speak with members of the Board and for them to explore whether safety intelligence presented at Trust Board triangulates with the 'work as done' in practice. The Maternity and Neonatal Board Safety Champions also continue to support the perinatal quadrumvirate in their work focusing on positive cultures within the services. In addition to the Safety Champions meetings, the Board Safety Champion(s) Perinatal 'Quad' leadership team meetings have now been established are prioritised and part of the cycle of business.

8.2 QUAD SAFETY CHAMPIONS

In addition, the divisional QUAD with support from the executive Safety Champions are ongoing with national Perinatal Culture and Leadership Programme. As part of this programme, maternity and neonatal specialities are undertaking work to meaningfully understand the culture of their services. As part of this work, the SCORE culture survey is in progress and will be completed on the 21 April 2024.

8.3 SYSTEM OVERSIGHT AND ASSURANCE

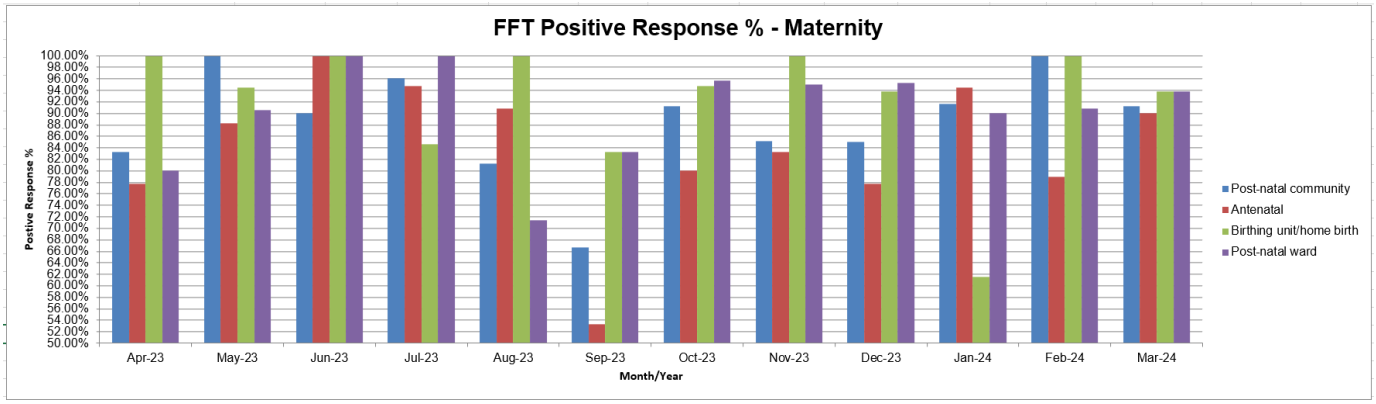
Local Maternity and Neonatal system and Integrated Care Board level continue to be jointly responsible with providers for implementation, monitoring and oversight of progress against national agenda, independent reviews, safety initiatives and care bundles to ensure that maternity and neonatal care is safer, more personalised, and more equitable for women, babies, and families.

Quarterly assurance and improvement visits with the Local Maternity and Neonatal System, have been scheduled to review progress against the 10 CNST year 6 safety standards. In addition, further assurance visits in relation to perinatal quality and safety, priorities set out in the 23/24-Priorities and Operational Planning Guidance (england.nhs.uk), and the Three-year delivery plan for maternity and neonatal services will be undertaken throughout 2024. Feedback from these visits will be shared in due course.

10.0 PATIENT EXPERIENCE

The maternity service continues to actively seek feedback from service users to continuously improve the experience of women and families. The maternity CQC survey, complaints triangulation, lived experience feedback, maternity and neonatal voices partnership and the friends and family response rates provide a wide platform of intelligence in relation to how we are performing. Table 7 details the maternity friends and family survey finding from April 2023 to March 2024.

Table 7: Maternity friends and family survey responses April 2023 to March 2024.



The Friends and Family feedback test for the Royal Preston site has seen variable in performance overall. It is highly possible that the impact of midwifery establishment gaps have contributed to the reduced performance over time and the phase 1 investment to reach BR+ 2022 requirements will go some way to improve experience of care throughout the maternity continuum.

10.1 MATERNITY SURVEY

The last CQC maternity survey and the service was published in 2023. The Trust was ranked 18th out of the 61 participating Trusts. Compared to the 2022 survey results, the Trust ranked 19th out of 65 Trusts surveyed by Picker. The response rate for the 2023 survey was unfortunately 39% compared to the 2022 survey response rate of 44%.

Analysis identified two areas where the Trust scored significantly better when compared to the 2022 survey. There were no areas identified where the Trust score was significantly worse than the 2022 survey. Overall women reported that they were treated with kindness and compassion during labour and birth (98%), they had confidence and trust in staff during labour and birth (97%) and felt midwives and doctors were aware of their medical history during labour and birth (84%).

Within the bottom five scores, issues were identified in relation to information regarding infant feeding choices, review of health records by midwives and doctors, and induction of labour. The survey results triangulate with safety intelligence and patient feedback data already known to the maternity service. An action plan for improvement is ongoing.

10.2 MATERNITY AND NEONATAL VOICE PARTNERSHIP

The maternity service remains committed to listening and learning from service user feedback to continuously improve services for women and families utilising various platforms to engage and co-produce provision of care. The service has an independent MNVP lead and a joint work plan for 2024/25 has been collated and approved to align priorities to the Three-Year Delivery Plan for maternity and neonatal services. 15 steps walk round is planned in the next few months and several health watch view and enter visits were undertaken across the service in March 2024. Once the feedback is received this will be shared.

The MNVP chair attends both maternity and neonatal safety and quality committee and is a quorate member of the safety champions to co-produce and contribute to responsive service delivery. This is essential and has been received positively by the service to receive direct level feedback.

10.3 COMPLAINTS

Learning from patient experience is a divisional priority and the maternity service, along with the rest of the division, meets with the corporate patient experience team on a weekly basis to ensure that there is early identification of learning from complaints, and that a timely response is provided to families. When wider learning is identified from patient experience, the maternity service is shared this not only within the organisation but also at system level at the LMNS serious incident group.

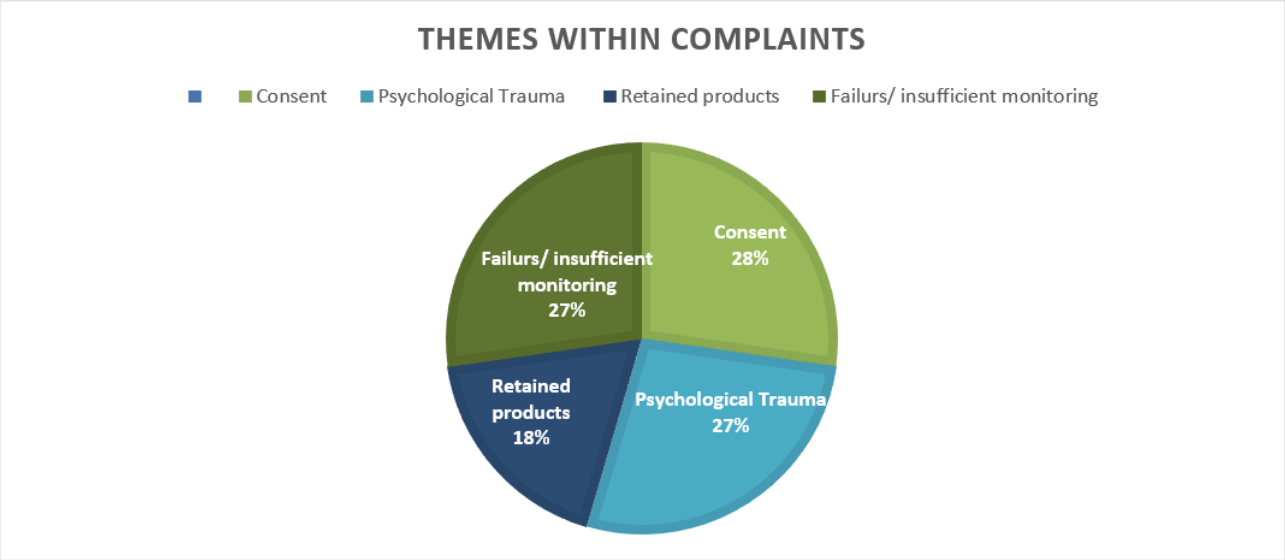
Triangulation of claims, the claims score card, complaints and patient safety incidents is key to learn and improve clinical practice and systems. The maternity service continues to monitor claims, StEIS investigation findings and complaints, and will report to the maternity safety and quality committee on a quarterly basis to ensure dissemination of learning to the clinical teams.

Quarterly thematic analysis of all complaints is undertaken by the Matron for Safety and Quality to identify trends and actions to be undertaken. The number of complaints as well as clinical themes are reviewed to aid further triangulation of experience against clinical outcome measures. Table 8 details the number of complaints received from January 2023- March 2024.

Table 8: Number of complaints received from January 2023- March 2024

The latest thematic analysis undertaken in quarter 3 of 2023 provides a snapshot of the trend analysis.

Graph 1 Themes from complaints received from September to December 2023.



One of the main themes related to conversations related to consent and unfortunately similar themes and trends were identified across the LMNS. In response the LMNS have commissioned external consent training to be delivered by Baby Lifeline, the Trust has a requested 35 places. The places will be prioritised for obstetric consultants, obstetric trainees and the delivery suite band coordinator team.

It was noted that psychological distress, identified in 27% of complaints, was also identified within 50% of the StEIS reported incidents concluded within the quarter, 50% of the complaints received within the quarter and when the claims scorecard was filtered by low value and high-volume claims - cause and injury, psychiatric/ psychological damage was listed. The maternity service currently provides a birth afterthought listening service to support women following their birth experiences and women requiring additional support can be referred to the reproductive trauma service. Education and training on trauma informed care is also be delivered to all midwives and support workers on the maternity public health mandatory study day throughout 2024.

12.0 STAFF ENGAGEMENT

There have been no whistleblowing internal or external activity within maternity and neonatal service in the last 6 months. As discussed, Monthly maternity and neonatal engagement forum are held by the Divisional Midwifery and Nursing Director, the Chief Nursing Officer and the Non-Executive Director who all hold a responsibility as named Safety Champions. This forum is held both virtually and face to face and provides valuable opportunity for staff to escalate any concerns impacting upon the maternity team or service and receive feedback actions taken in response their concerns. The ongoing action tracker is included in the bi monthly maternity and neonatal service board reports and in appendix 6 for information.

13.0 CELEBRATING SUCCESS

A successful workforce, which is derived on the principles of continuous improvement is a key enabler to safer maternity care. The NHS Long Term Plan recognises creating a high performing system is dependent on our people and our workforce. The team is encouraged to contribute and celebrate when things go well and connecting and networking is instrumental in midwifery leadership.

The service continues to engage and contribute to national maternity and neonatal agenda at local regional and national events. Several study days have been hosted by the service including the National Bereavement Care Pathway North West event, bespoke study days designed by SANDs following the peer review undertaken in 2023 and a full day maternal medicine centre conference. An Action on Pre-eclampsia's study day has also been arranged as part of raising awareness of complex pregnancy and the NHS Race Observatory project will host the national learning set 2-day continuous improvement project days later in the year.

The Diabetes team leader has also presented the work of continuity of care at a regional event, where the service was able to share good and best practice for Midwifery Continuity of Care. (MCoC) as an example of exemplar practice.

14.0 CONCLUSION

This report details the findings of the Lancashire Teaching Hospitals NHS Foundation Trust first bi-annual maternity staffing review of 2024 to provide triangulated information to the Safety and Quality committee that staffing requirements are monitored, reviewed and understood to maintain safety.

The Safety and Quality Committee and the Board receives a bi monthly update report on national safety programmes, safe staffing, clinical indicators and experience which enables the Board to consider and align

safety intelligence to their operational and strategic planning processes. The Divisional Midwifery and Nurse Director attends Safety and Quality Committee and The Board of Directors to ensure the profile of maternity and neonatal services is high within the organisation.

The maternity service continues to experience increases in acuity and staffing vacancies that at times are affecting the ability to sustain delivery of services. Colleagues work flexibly across several areas as required to ensure safety is maintained. Deflection and divert procedures are utilised to maintain safety in line with the Regional Escalation Policy. The impact on families continues to be acknowledged and prioritised.

Positive steps are being taken in response to increase midwifery staffing and to explore several new strategies to improve midwifery staffing. This includes work force profile mapping to ensure a sustainable, high functioning workforce is available to women and families.

The vacancy rate of 12.4 WTE increase in the delays in induction and request for mutual aid provision during within the Local Maternity and Neonatal System to maintain safety.

The outcome of the most recent Birth Rate Plus assessment and phase 1 of the funding has been welcomed by the service and a further overall investment of £1,088,249 is required in the next planning round.

It should be noted that in line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Divisional Midwifery and Nursing Director and the Chief Nursing Officer confirms that they are satisfied with the outcome of the bi-annual safe staffing assessment.

15.0 RECOMMENDATIONS

It is recommended the It is recommended the Board of Directors:

i. Receives the biannual maternity safe staffing review for information.
ii. Note the report has received scrutiny and was endorsed at the safety and quality committee.
iii. Note the approval of phase 1 of the Birth Rate plus funding was approved by the Board in April 2024. recognising once recruitment to registered midwives has progressed there will be a further requirement to consider the registered midwife component of the safe staffing recommendation.

APPENDIX 1 BIRTH RATE PLUS
Assessment undertaken November 2022

Birthrate Plus® Staffing: inclusive of 23% uplift

Clinical WTE required	
Delivery Suite: • Births • A/N cases • Postnatal Readmissions • Non-viable pregnancies • Induction of labour	45.90wte RMs
Triage - BSOTS Model	14.69wte RMs
Preston Birth Centre • Births & postnatal care • Births only • Transfers to Delivery Suite	21.36wte RMs
Antenatal Ward • A/N Admissions • Inductions of Labour Postnatal Ward • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions • Postnatal ward attenders	11.02wte RMs *min staffing 2 RMs per shift)* *38.38wte* *(Includes B3 MSWs for postnatal care)*
Outpatients Services • midwife led clinics • Obstetric/Specialist clinics • Fetal medicine • CDH clinics • Maternity Day Care Unit	11.43wte RMs 1.84wte MWs
Community Services: • Home births • Community cases • Attrition • Additional safeguarding	37.44wte RMs and B3 MSWs *(Includes 6.00wte for Homebirth Team, and MSWs -postnatal care)*
Chorley Birth Centre • Births/Triage cases	8.04wte RMs
Total Clinical WTE	**190.10wte RMs & PN MSWs**

APPENDIX 2 – SPECIALIST ROLES BREAKDOWN

Specialist Midwifery Roles (Current funded establishment 16.70 WTE)	WTE	Clinical WTE	Non clinical WTE
Consultant Midwife	1.0	0.2	0.8
Antenatal & Newborn Screening Lead Band 7	1.0	0.8	0.2
Newborn Screening/Fetal Medicine Lead	1.0	0.8	0.2
Digital Midwife Band 7	1.0	-	1.0
Capacity and Flow Coordinator	1.0	0.8	0.2
Named Midwife for Safeguarding Band 8a	1.0	-	1.0
Safeguarding Lead Band 7	1.0	-	1.0
Specialist Perinatal Mental Health – Band 7	1.0	0.5	0.5
Infant Feeding Coordinator Band 7	0.8	0.2	0.6
Specialist Diabetes Band 7	1.0	0.6	0.4
Public Health Midwife Band 7	1.0	0.6	0.4
Practice Education and Development Midwife Band 7	0.8	-	0.8
Bereavement Specialist Midwife Band 7	0.8	0.6	0.2
Bereavement Midwife Band 6	0.4	0.4	-
Service Improvement Midwife Band 7 corporate team	1.0	-	1.0
Information Technology Midwife Band 6	1.0	-	1.0
Clinical Audit Midwife Band 6	1.0	-	1.0
Governance and Risk Midwife – Band 7	1.0	-	1.0
Fetal Monitoring Lead Midwife Band 7	0.6	-	0.6
External Funded Posts			
Preceptorship Lead Midwife(Funded by NHS E)**	0.8	-	0.8
Maternal Medicine	1.0	1.0	-
Pelvic Health Midwife	0.5	0.5	-
Bereavement midwife	0.8	0.4	
Total overall (WTE)	**18.5**	**7.4**	**12.7**
Adjusted figure	**15.4**	**5.5**	**11.9**

APPENDIX 3 WORKFORCE PLAN

RAG	Key
Action outstanding	
Action on track but not yet delivered	
Action delivered	
Action delivered and assurance evidence collated	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	**Review temporary staffing solutions.**	Introduce Thursday 11am weekly operational planning meeting between the ward managers and matrons. Sickness absence should also be discussed during the meetings.	Matrons	~~01.05.2023~~ ~~01.06.2023~~ ~~01.08.2023~~ ~~1.12.2023~~ 20.04.2024	24.04.2023 To commence week beginning 15.05. 2023.First meeting planned. 03.07.2023 First meeting held. Template to be revised and the regular meetings to be set up. 18.09.2023 Action ongoing. 13.11.2023 Action continues to be explored and monthly finance and workforce meetings continue. 20.04.2024 Operational matrons meeting set up to oversee workforce planning. Matron of the day introduced to manage day to day issues. Action closed.	
		Develop a midwifery staffing team's channel.	Matron for complex midwifery care	01.05.2023	24.04.2023 JG to provide MR with a list of people to be added to the team's channel. 15.05.23 List collated and teams' channel open. 18.09.2023 Action completed.	

		Develop a weekly staffing meeting template to record meetings and actions.	Matron for complex midwifery care	~~01.05.2023~~ ~~07.07.23~~ ~~01.08.2023~~ 1.12.2023	24.04.2023 Draft template to be updated by MR 03.07.2023 Template trialled and to be revised. 18.09.2023 Action ongoing. 13.11.2023 Action stood down as not longer applicable.	
		Consideration of an on-call system for the unit.	Matrons	~~30.06.2023~~ 01.09.2023	24.04.2023 Offer on-call shifts as a volunteer temporary arrangement to staff. Draft an expression of interest for staff. Considered and excluded	
		Consult summer leavers to understand if they will consider deferring end date.	Matron for midwifery led services	30.06.2023	24.04.2023 Staff have been consulted and majority are going to new positions. Action closed.	
		Request 10WTE agency midwives block booking for 6-month period.	Chief Nursing Officer	06.07.23	03.07.23 - Request made through temporary staffing and agency recruitment for block booking ongoing based on unfilled shifts through top October 2023. 18.09.2023 Options reviewed and agency booked when possible. Agency fill rates included in the perinatal Surveillance table. Action Closed	
		Explore use of registered Nurses from critical care within maternity services.	Chief Nursing Officer	31.07.23	03.07.23 -Request made of critical care team for nursing staff to support when appropriate and in line with “Safe practice principles for adult nurses working as part of multidisciplinary teams (MDT) in Maternity Services” published by NHS England on 25th May 2023. Options for other nurse roles	

					within maternity services to be explored. 18/09/2023 continuous review of alternative bookings via nursing and critical care. Action closed	
		Publicise bank shifts within and external to the unit	Recruitment team	06.07.23	03.07.23 -Request made of recruitment. 18/09/2023 Action completed	
		Additional shifts created for band 2 and 3 shifts to provide support on reduced fill rate shifts.	Deputy Midwifery and Nursing Director	ongoing	03.07.23 - In place. 18/09/2023 Action completed	
		Bank midwifery advert agreed with Chief Nursing Officer	Chief Nursing Officer	ongoing	3.07.2023 Advert for bank midwives published.	
2	**Utilisation next 3 months**	Review Newly Qualified Midwife (NQM) preceptorship clinical rotation plan to identify any possible rotations which could be better utilised within the service.	Team leaders	~~30.04.2023~~ 31.05.2023	24.04.2023 Shifts have potentially been identified in ANC – assessment to be completed to identify prioritisation of the clinical areas to receive the additional staffing. 15.05.2023 Scoping of hours undertaken. Unable to progress at this time as movement of NQM from ANC will potentially impact on essential planned work re-organisation. Action closed.	
		Review of the birth centre staffing models because of the current birth rates within midwifery led services.	Matron for midwifery led services	30.06.2023	24.04.2023 review is ongoing. Potential for the third person to be a “floating midwife”. 15.05.2023- Matron for MLS reviewed percentage of births in co-located birth centre. Plan to reduce staffing to 2 per shift from 3 per shift from the 10th of June 2023. Action closed.	

		Identify and consider potential withdrawal of non-essential services.	Divisional midwifery and nursing director.	30.05.2023	24.04.2023 identify the non-essential services. 15.05.2023 Unable to identify any non-essential services at present. Non-viable option. Action closed.	
		Identify areas of the service that could be distributed to other staff groups.	Public Health Midwife	~~30.06.2023~~ ~~31.07.23.~~ 1.11.2023	15.05.2023 To explore vaccination services. Potential for a nurse to administer vaccines. Public health midwife liaising with LMNS to consider wider system options. 18/09/2023 Action ongoing. 13.11.2023 Options continue to be reviewed by LMNS. No further options at present stood down	
		Telephone consultation/ virtual services for differed visits.	Matron for midwifery led services	30.05.2023	24.04.2023 Scoped whether there is appetite for a leaver to stay and complete hybrid virtual working. Non-viable option. Action closed.	
		Determine which specialist midwives can be utilised to work clinical shifts during anticipated summer pressures.	Senior management team	~~30.04.2023~~ 30.05.2023	24.04.2023 Specialist midwives identified: screening midwives, midwifery practice educator, preceptorship and retention lead, public health midwife, infant feeding and potentially service development midwife. 15.05.2023 8 specialists will contribute 1 day a week to ANC, Maternity A, B and DS from the 10.06.2023 Action Closed.	

		Consult specialist midwives regarding the preferrable pattern of clinical working (i.e.) 2 days per week or one block week.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting 25.04.2023. 15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	
		All managers to have time to lead reduced to days per week during anticipated summer pressures.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting. 15.05.2023. All managers and team leaders to increase clinical shifts from 1 day per week to 2 days per week from 10.06.2023.	
		Consult team leaders and ward managers regarding the preferrable pattern of clinical working.	Matrons	30.06.2023	15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	
		Consider rationalisation of meeting schedule.	Deputy DMND	~~30.06.2023~~ ~~01.08.2023~~ ~~1.12.2023~~ 5/01/2024	15.05.2023 Review speciality meetings to consider rationalisation and defined attendance over months of June, July, August and September 23. 18/09/2023 Action ongoing.13.11.2023 Action deadline extended to reflect ongoing action. 19.12.2023 Rationalisation exercise undertaken, and action completed.	
3	**Birth rate plus data utilisation**	Review the latest birth rate plus data and complete a paper for board.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 Paper to be shared with chief nurse and then presented to board for review.	

					15.05.2023 Paper to be presented as part of bi-annual staffing review in May 2023 26.05.23 Biannual staffing report presented to S&Q. Action closed	
		Trust Board to share findings of BR+ assessment with ICB	Chief Nursing Officer	~~1.12.2023~~ ~~1.02.2024~~ ~~31.3.2024~~ 31.3.2025	18.09.2023 Br+ Paper approved for sharing and consideration with the ICB and LMNS. 13.11.2023 Action ongoing deadline extended. 19/12/023 Awaiting outcome from ICB discussion action ongoing. Deadline date added. 20.04.2024 Phase 1 of BR+ approved by Board and transacted into the budget for recruitment. Phase 2 to be proposed as part of the second bi-annual report. Action date extended to reflect ongoing work.	
		PWR data review to be undertaken to ensure accurate midwifery staffing establishment reported to NHSE.	Divisional midwifery and nursing director	1.11.2023	25.08.2023 PWR Data review meeting arranged, and discrepancies noted with national data published. Escalated to national team via Regional Associate lead Midwife. Awaiting update. 13.11.2023 Action Completed	
		Complete the training for the ward acuity tool.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.23	24.04.2023 date agreed for training with the external providers. Staff to attend currently being agreed. 15.05.2023 Ward managers assigned to attend, and additional staff released	

					if possible. Session will be recorded for use later. App not working at this time action paused	
		Launch the acuity tool across the ward areas.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.2023	24.04.2023 to be launched in June 2023 following completion of training. Action paused as above.	
4	**Roster management**	Meet with the health roster term to specify supernumerary tiles which will not be included in the unfilled rate.	Matron for complex midwifery care	30.06.2023	24.04.2023 MR has met with health roster team. Health roster team to review request and feedback. 15.05.2023 Email request for speciality meeting. 30.06.2023 Supernumerary tiles now in place. Action closed	
		Matron review of roster templates to ensure that templates reflect the establishment for each area.	Matrons	01.07.2023	15.05.23 Meeting to be arranged with e-roster team to confirm templates reflect staffing requirements. Awaiting update that all areas reviewed. Action completed.	
		Meet with team leaders/ ward managers regarding summer annual leave planning. Reiteration that maximum allowance is 17%.	Matron for complex midwifery care	30.04.2023	24.04.2023 MR has pulled the roster reports and confirmed that the annual leave is booked and does not exceed the maximum requirement. Action closed	
		Creating a new cost centre for preceptees or team midwives	Finance BP	~~31.07.23~~ 1.12.2023	15.05.2023 Finance BP to create new cost centre. Update awaited. 18/09/2023 Action ongoing. 13.11.2023 Cost Centre created. Action completed	

		Unused roster hours to be reviewed by the matrons at sign off.	Matrons	30.04.2023	24.04.2023 Healthroster to be reviewed as part of monthly sign off with each area to utilise un-filled shifts. Action closed	
		Maternity ward B roster to be reviewed for balance. Review MSW staffing ratios across day and night.	Matron for complex midwifery care	30.05.2023	24.04.2023 MR to discuss with HA. 15.05.2023 Staffing gaps have been reviewed to reflect the service requirement. Action closed	
		Consider options for assessing and balancing staff numbers across whole service and develop plan for June-October 2023.	Matrons	30.05.2023	15.05.2023 Matrons to meet to review establishments and confirm plan for distribution of staff across the areas with highest establishment gaps. 03.07.23 – This is now done on a weekly basis. Action closed	
5	**Recruitment**	Continuation of the preceptorship lead midwife post for further 11 months.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 awaiting confirmation from finance. JG has completed the workforce form for the extension. Action closed	
		Recruit up to 16 international recruits.	Preceptorship and retention leader midwife	~~30.07.2023~~ 31.12.2023	24.04.2023 – 3 currently in post, 2 coming to the testing centre in May 2023. Awaiting further information. Recruitment ongoing. 15.05.2023 Deadline date extended to reflect ongoing recruitment plan. 01.07.23 – 4 RM in post. Action ongoing. 18.09.2023 Local recruitment for international recruitment in house commenced.	

					13.11.2023 Paper collated to consider continued funding for international recruitment. 20.04.2024 International recruitment closed, and no further funding allocated in 2024. Alternative options for apprenticeship scheme being considered. Action closed	
		Undertake a workforce profile of maternity leave, sickness and conversion rate from interview to recruitment to consider over offering	Divisional Midwifery and Nursing Director	30.06.2024	20.04.2024 NEW Position paper to be collated with finance and HR to scope workforce profile and request over offering to improve conversion rates.	
		Vacancy and maternity leave tracker to be overseen workforce committee.	Matrons	~~30.05.2023~~ 30.06.23	24.04.2023 – two external recruits successfully made week commencing 17.04.2023. 15.05.2023 Deadline date extended to reflect ongoing and continuous monitoring of vacancies. 30.06.2023 Item to be added to workforce committee in July 2023. Workforce action tracker in place. Action closed.	
		Recruitment to delivery suite core team.	Matron for complex midwifery care	30.05.2023	24.04.2023 – shortlisting has been completed awaiting date for interview. 15.05.2023 Core team recruited. Action closed	
		Recruitment to the birth centre core team.	Matron for midwifery led services.	30.05.2023	24.04.2023 – successfully completed	

		Recruitment to the Mat A/B ward core team.	Matron for midwifery led services.	31.08.23	01.07.23 - Advert out currently. Action closed	
		Recruitment to the caesarean section team as core (1.6 WTE).	Matron for complex midwifery care	~~30.05.2023~~ 30.06.2023	24.04.2023 – advert for the team has been completed and approved by EA. Advert to go to vacancy control this week. 15.05.2023 Shortlisting outcome awaited. Deadline extended. 01.7.23 – recruited to successfully.	
		Associate leader positions to be considered.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – stand down as non-viable at present time.	
		Band 5 advertisement to be released.	Matron for midwifery led services	~~30.04.2023~~ ~~30.06.2023~~ 01.09.2023	24.04.2023 – advert has been approved by EA and RC. Currently with vacancy control anticipated release 28.04.2023. 15.05.2023 Shortlisting in progress. Deadline extended. 01.07.23 – continuous adverts out. Action closed	
		Recruitment open day for band 5 midwives.	Matrons	~~30.05.2023~~ ~~31.07.2023~~ 1.12.2023	24.04.2023 – to be organised once the vacancy is released. 15.05.2023 Consider whether open day or engagement of new starters required. 01.07.23 – ongoing next recruitment event to be confirmed.18.09.2023 events ongoing.	

		Consider recruitment to the band 4 practice development post once the funding becomes available.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ ~~1.12.2023~~ 20.05.2024	24.04.2023 – awaiting outcome of funding. 15.05.2023 Update awaited. 01.07.23 – paper to LMNS submitted and awaiting final approval to recruit. 18.09.2023 funding awaited Awaiting outcome of funding overall. 13.11.2023 Notification of funding confirmed by LMNS awaited. 20.04.2024 MSW for practice development now released and post out to advert.	
		Band 3 allocation to be reviewed across the service.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ ~~1.12.2023~~ 31.1.20234	24.04.2023 – needs finance review. Long term funding of the roles needs to be reviewed. 01.07.23 – Birth rate plus report taken to Board May 2023. 18.9.2023 Additional band 3 recruitment undertaken for MAS. Funded 4.6 WTE Action closed	
		Increase consultant obstetricians by 3 WTE to support demand and capacity and increase in complexity	Divisional Director and Deputy Medical Director	~~01.01.2024~~ 30.06.2024	03.07.23 Demand and capacity assessment has taken place and business case has been created to discuss with finance. Business case will support 98 hours obstetric cover, antenatal clinics, caesarean section list, induction of labour and maternity triage. 18.9.2023 action ongoing.13.11.2023 Paper taken to F&P to seek funding. 20.04.24 Funding and recruitment ongoing. 1 consultant out to advert and 1 further is required to achieve 96	

					hours. Action ongoing and deadline date extended.	
6	**Retention** **Flexible working**	Line manager to have conversations with all staff about flexible working opportunities. Flexible Working Toolkit available	All Managers	1.11.2023	30.06.2023 Flexible working conversations to be included in appraisals and as part of team meetings. Action completed	
7	**Retention Seeking Feedback**	To seek feedback from staff via TED surveys, listening events, team meetings	All Managers	~~31.09.2023~~ 31.01.2023	30.06.2023 All areas to undertake a TED survey and develop local ways to seek feedback from teams. 18.09.2023 Awaiting confirmation that all areas have signed up to TED. 13.11.2023 Part of the W&C people plan deadline extended. 20.04.2024 Score Survey ongoing to seek feedback across the maternity and neonatal continuum. 20.04.2024 Midwifery and trainee listening events undertaken and joint presentation and action plan ongoing in line with the people plan. Action closed	
8	**Retention Retain, Reward and Recognise – Staff Satisfaction**	Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.03.2023	30.06.2023 Monthly thank you awards nominated by the band 5 team for a team member who offering supportive mentorship and professional support.	
		Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.10.2023	17.04.2023 Shining Star award. A monthly award for outstanding kindness and team work continues	
		Engage in Microsystems Coaching Programme via CI team.	Divisional midwifery and nursing director	31.10.2023	17.04.2023 Divisional Engagement with flow and micro coaching programmes. 18.9.2023 Staff identified to complete flow coaching. Action ongoing. 13.11.2023 Leaders identified	

					to attend coaching programme. Action Closed	
		Opportunities for development and career progression available via CPD funding work streams	Divisional midwifery and nursing director	31.10.2023	30.03.2023 CPD requests submitted. HDU courses, NIPE, PMA, Fetal monitoring speciality training, maternal medicine. ANNB ARC. Action complete	
9	**Retention Engagement**	Alternate month mobile coffee catch up with leadership team visiting clinical areas scheduled for 12 months.	Leadership Team	31.03.2024	30.06.2023 Mobile coffee catch up sessions ongoing.	
10	**Retention of Students**	Link with the LMNS 2-day course to be facilitated by university to link with colleges for perspective midwives.	Divisional midwifery and nursing director	~~30.06.2023~~ ~~01.01.2024~~ 30.06.2024	24.04.2023 – awaiting further information. 15.05.2023 Action ongoing. 18.09.2023 Actions continue. 13.11.2023 Meeting arranged with LMNS workforce committee and UCLAN 16.11.2023. 20.04.2024 Schedule of students sessions being developed with education team. Action ongoing.	
					20.04.2024 NEW Student profiling with Cumbria and Edge Hill universities to offer 3rd year students who live in PR postcode elective placements at LTHTR.	

		Explore continuation of funding for midwifery clinical placement facilitator.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – awaiting further information to meet. 15.05.2023 Meeting arranged for 19.05.23 to discuss PEF funding. 03.07.23 – Meeting held and funding continued for PEF with other funding streams being explored therefore action closed	
11	**Retention Health and wellbeing**	Maternity conference to be organised for 15/06/2023 for current midwives and maternity support workers.	Matron for midwifery led care	30.06.2023	24.04.2023 – progressing well. Agenda in development. 15.05.2023 Planning on track 15.06.2023 – Maternity conference delivered as planned	
		Establish and agree the PMA offer.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ ~~1.01.2023~~ 30.06.2024	24.04.2023 – date to meet with PMA's to be arranged. 15.05.2023- Meeting with DMND to be confirmed. 01.07.23 – Trust structure agreed for PNA/PMAs. 5 PMA trained. Staffing limiting activity. To remain on workplan and meeting to be arranged with PMAs to agree development of this service. 1.09.2023 Additional £11,00 funding agreed via a bid for backfill for establishing PMA's 13.11.2023 Action ongoing. 19/12/2023. 2 further places with funding confirmed. Total PMA's – 13. Deadline extended. 20.04.2024 Re- launch planning meeting arranged for 22.04.2024.	

					meeting to be arrange with the regional midwife to support planning. Action extended	
		International day of the midwife – cups and biscuits for the clinical areas/ teams.	Deputy divisional nursing and midwifery director.	30.05.2023	24.04.2023 – Cup designs have been developed and order placed. 15.05.2023 Mugs and biscuits distributed to all areas. Celebrated IDM 2023. Action closed	
		Expansion of the unit coordinator role to include ward and area managers.	Matrons	~~30.05.2023~~ 30.06.2023	24.04.2023 – to discuss with ward managers. Action deadline extended. No further progress. Action stood down	
		Introduce de-brief tool to support hot de-briefing.	S&Q matron	~~30.05.2023~~ ~~31.08.2023~~ ~~1.12.2023~~ 31.3.2023	24.04.2023 – EH to explore hot debrief tool and feedback at the next meeting. 15.05.2023- Options for debrief ongoing. Deadline extended.18.09.2023 13.11.2023 Action ongoing. 19/12/2023 Hot and cold debrief training and core offer discussed and escalated at LMNS serious incident panel for wider collaboration and discussion of training for midwifery staff. March on stress via NWAS also to be considered. Action extended. 20.04.2024 TRIM training funded for trauma informed support and plans to train 25 PMA teams ongoing. Date extended.	
		OD department to develop division wide action plan with ideas for action which are specific to each area	OD leads	~~01.09.2023~~ 1.12.2023	03.07.23 – Meeting held with OD lead for division and area action plans to be developed. 18.09.2023 Draft action	

					plan in place and awaiting confirmation. Action ongoing13.11.2023 Divisional People Plan developed. Action closed.	
12	**Correlation between staffing and safety intelligence**	Monitor safety data daily, including red flags, BR plus acuity, coordinator feedback at safety huddles, PALS, service user feedback, governance systems.	Divisional midwifery and nursing director	Ongoing	Systems in place. Daily monitoring	
		Monthly oversight of safety and quality metrics through the maternity safety dashboard to safety and Quality group in division and Board.	Divisional midwifery and nursing director	Ongoing	Systems in place	
13	**Well Led**	Trust development programme based on ward manager and matron handbook to develop leadership capability and capacity.	Chief Nursing Officer	~~30.09.23~~ ~~1.1.2023~~ ~~31.3.2023~~ 30.06.2024	Chief Nurse leading.18.09.2023 awaiting update of plan.13.11.2023 Action ongoing. 19/12/2023 work ongoing to consider actions required. Date extended. 20.04.2024 in house leadership day being planned with OD. Draft content developed. Action extended.	
		To undertake a training needs analysis of the leaders and managers within the Division, understanding who has completed which development programme, where additional tailored support can be provided and who may need performance management intervention.	OD and Divisional Board to commit & enable attendance	~~1.11.2023~~ ~~31.12.2023~~ ~~31.3.2024~~ 30.09.2024	30.06.2023 Scoping work to understanding of level of capability and confidence in department. What development support is needed, how expectations are communicated and reinforced to improve management effectiveness across the Division. 18.09.23 Action ongoing.	

					13.11.2023 Actions ongoing with divisional people plan. Date extended. 20.04.2024 Wide corporate band 7 leadership programme being developed. Action extended	
		To set up a Band 7 Action Learning set where leaders come together monthly to have the headspace, facilitated support, consultancy support to identify how to make improvements in team engagement and staff satisfaction, enabling them to develop actions plans which improve colleague experience	OD and Divisional Board to commit & enable attendance	~~31.10.2023~~ ~~31.03.2024~~ 30.06.2024	30.06.2023 Action Learning groups to be set up from October 2023 after new recruits in post. 18.09.2023 Action ongoing. 13.11.2023 Deadline extended. 19/12/2023 As part of the RGOG escalation project culture workshops to commence in 2024 to include Band 7 coordinators. Action ongoing. 20.04.2024 in house leadership day being planned with OD. Draft content developed. Action extended.	
		Based on the findings of the training needs analysis consider the delivery of a series of bespoke leadership 'away days.	OD and Divisional Board to commit & enable attendance	~~30.09.2023~~ ~~31.03.2024~~ 30.06.2024	30.06.2023 Agree bespoke series of meetings following review of leadership TNA and from listening to feedback from the team. 18.09.2023 Action ongoing. 13.11.2023 Deadline extended. 20.04.2024 in house leadership day being planned with OD. Draft content developed. Action extended.	

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

APPENDIX 4 PERINATAL QUALITY SURVIELLENCE BREAKDOWN PACK- RED FLAGS

Red flag Reporting Metrics	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Delay in time critical activity	13	54	22	17	17	50	43	34	38	23	10	28	51	38
Missed or delayed care> 60 mins in washing or suturing	0	1	0	0	1	2	0	0	0	0	1	1	0	1
Failure for women to receive the medication required.	0	1	0	0	0	0	0	0	0	1	0	0	0	0
>30-minute wait for pain relief.	0	1	0	0	0	3	2	3	0	1	0	1	1	0
Lack of full examination when woman presents in labour.	0	1	0	0	0	0	1	1	1	1	0	1	0	1
>2-hour delay in induction?	0	10	1	6	4	30	10	16	10	7	0	23	9	18
Delay in recognition of and action of abnormal signs.	0	2	2	0	0	0	2	0	0	4	0	1	0	1
Inability to provide one to one care in labour?	0	2	0	0	0	7*	0	1	0	0	0	0	0	0
>30-minute delay for assessment by a midwife when presenting in labour. Replaced by BSOTS														
>15 minute delay following presentation for BSOTS midwife assessment. (New parameter August 2023)							5	21	18	13	1	12	18	29
>30-minute wait for obstetric triage.	1	40	15	15	15	29	29	25	11	10	5	9	15	12
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)	0	0	0	0	0	1	0	0	0	1	0	4	1	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation? (New parameter Oct 22)	0	7	3	5	3	24	5	15	8	19	0	23	18	12
Was there a delay in transfer once labour was established? (New parameter Oct 22)	0	1	0	0	1	3	1	1	1	1	0	2	1	2
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)	0	0	0	0	0	0	1	0	0	1	0	0	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)	0	0	0	1	0	0	1	0	0	1	0	0	0	0
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)	0	2	0	1	0	7	1	3	1	1	0	0	1	1
Has there been any cancelled or delayed community work? (New parameter Oct 22)	1	4	1	27	177	31	4	85	14	5	0	28	38	28
Did redeployment of staff to other services/ sites/ wards occur? (New Parameter December 2023)											0	19	18	2
Total numbers of red flags	**15**	**126**	**44**	**72**	**218**	**187**	**105**	**205**	**103**	**90**	**17**	**156**	**170**	**146**

APPENDIX 5 PERINATAL QUALITY SURVIELLENCE BREAKDOWN (A-E)

Table A Clinical Safety Indicators April 2023 to March 2024

Metric	Red flag		Green flag		April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
CNST 10 Key safety actions (Year 5 scheme)					100%	100%	40%	40%	60%	60%	80%	90%	100%	100%	100%	100%
CQC Rating Overall					Good	Good	Good	Good	Good	Good	Good	RI	RI	RI	RI	RI
Births					298	339	371	362	369	352	344	327	315	377	334	333
Total stillbirths represented as a number. New Dec 23												3	1	0	0	1
Total stillbirth rate (per 1,000 births)	>	4.9	≤	4.9	3.4	2.9	0.0	2.8	5.4	2.8	2.9	9.2	3.2	0	0	3.0
Stillbirth rate excluding termination for fetal abnormality					3.4	2.9	0.0	2.8	5.4	2.8	2.9	9.2	3.2	0	0	3.0
Neonatal Death within 7 days New																2
Examination of the newborn completed within 72 hours	<	95%	≥	95%	95.6%	96.2%	95.7%	96.7%	96.5%	92.6%	95.1%	93.5%	95.2%	95.8%	96.4%	95.8%
Breastfeeding initiation	<	70%	≥	70%	79.8%	76.3%	77.6%	79.8%	77.9%	76.1%	78.4%	74.7%	80.3%	76.4%	77.8%	81.6%
Booked by 9+6	<	50%	≥	50%	42.2%	51.5%	51.3%+	47.4%	48%	30.3%	32.5%	35.1%	52%	48.4%	55.6%	55.2%
Booked by 12+6	<	90%	≥	90%	83.3%	92.7%	90.3%	48%	85.5%	81.5%	83.1%	87.3%	92.3%	90.3%	90.2%	89.9%
Women giving birth in a midwife-led setting	<				16.6%	14.2%	15.8%	15.2%	14.2%	12.5%	14.8%	16.3%	11.9%	14.4%	12.8%	17.2%
Home birth	<				3.7%	3.2%	2.4%	2.5%	3.3%	2.3%	2.9%	3.7%	1.6%	1.6%	2.1%	2.7%
Incidence of severe tears grade 3 and above	≥	2.4 %	<	2.4%	2.3%	1.5%	2.7%	2.6%	1.8%	2.9%	3.0%	4.6%	1.1%	4.0%	2.1%	4.5%

Table A (i) incidents breakdown- neonatal death

Classification	Narrative and Action
Neonatal Death	Term infant - 41+5 weeks gestation admitted with reduced fetal movements to MAS on the day of planned induction of labour. Terminal bradycardia on admission, transferred to theatre for category one caesarean section, baby born in poor condition. Resuscitated and transferred to NICU where cooling was commenced however decision to reorientate the care to palliative, death was certified as severe Hypoxic-ischemic encephalopathy (HIE). Case has been referred to Maternity Neonatal Safety Investigation (MNSI) and early notification and has been accepted for investigation. Duty of Candour (DOC) has been provided to the family.

Neonatal Death	27 weeks gestation placental abruption, entrapment of the after coming head of the breech. Cervical incision required to release the head. Baby born admitted to NICU and sadly died on day 2 postnatal. After action review arranged and PMRT process commenced. PMRT duty of candour has been provided.

Table B Perinatal Quality Experience and Regulation April 2023-March 2024 (MIS Standard 9)

Metric	Red flag	Green flag	April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Incidents of moderate harm and above	--	--	0	0	3	0	3	2	3	6	3	1	2	4
Maternity and Newborn Safety Investigations Programme (Formally HSIB referrals opened.	--	--	0	0	0	0	0	2	2	1	0	1	1	1
Complaints	--	--	2	2	2	1	2	2	3	3	1	2	2	1
Prevention of future deaths regulation 28	--	--	0	0	0	0	0	0	0	0	0	0	0	0
CQC Enquiries	--	--	0	0	0	0	0	0	2	1	0	0	0	0
Maternal Death	> 1	<1	0	2	0	0	0	0	0	0	0	0	0	0

Table B (i) incidents breakdown

Classification	Narrative and Action
Severe Harm	Placental abruption at 35 weeks gestation resulting in category one caesarean section. Baby born in poor condition, resuscitated and admitted to NICU. Decision to cool baby, post cooling MRI has demonstrated severe Hypoxic-ischemic encephalopathy (HIE). Referral criteria to MNSI and early notification not met due to gestation. After Action review (AAR) has been completed and a learning response is being developed. Duty of candour has been provided to the family.
Moderate Harm	Assisted birth with Neville Barnes forceps resulting in a significant fourth degree perineal tear. After Action Review (AAR) performed which identified that the OASI care bundle was not applied at birth. A learning response is being developed. Duty of candour has been provided to the family.
Moderate Harm	Cooling in a term infant resulting in a neonatal death at 24 hours of age. 41+5 weeks gestation admitted with reduced fetal movements to MAS on the day of planned induction of labour. Terminal bradycardia on admission, transferred to theatre for category one caesarean section, baby born in poor condition. Resuscitated and transferred to NICU where cooling was commenced however decision to reorientate the care to palliative, death was certified as severe Hypoxic-ischemic encephalopathy (HIE). Case has been referred to MNSI and early notification and has been accepted for investigation. Duty of candour has been provided to the family.

Table B (ii) incidents breakdown

Classification	Narrative and Action
Closed	One MNSI investigation concluded in March 2024, this was a case of cooling of a term infant born in September 2023. The baby was born by category one caesarean section following a failed attempt at instrumental vaginal birth with sequential instruments. The mother had had spontaneous onset of labour at 40 weeks and 6 days gestation and was transferred to the delivery suite from the alongside birth centre following a delay in the second stage of labour. The baby was born in poor condition, was resuscitated, stabilised and transferred to the neonatal intensive care unit. Cerebral function monitoring (CFM) was commenced and following confirmation that the cooling criteria had been met, therapeutic cooling treatment was initiated by the neonatal team within six hours of age. The baby was cooled for 72 hours and then re-warmed. The post cooling magnetic resonance imaging (MRI) scan subsequently revealed no features to suggest moderate or severe hypoxic ischaemic encephalopathy. The baby was also diagnosed with a subgaleal haemorrhage and has subsequently received a blood transfusion. MNSI did not issue the Trust with any safety recommendations, however, there is an ongoing safety learning action plan which has been developed in response to the incident.

Table C Safe Staffing April 2023-March 2024 (MIS Standard 5)

Metric	Red flag		Green flag		April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
One-to-one care in labour in Delivery Suite.	<	100 %	=	100%	99.2%	97.6%	100%	100%	100%	99.5%	100%	100%	100%	100%	100%	100%
One-to-one care in labour in Preston Birth Centre	<	95%	=	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
One-to-one care in labour in Chorley Birth Centre	<	95%	=	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
HDU trained per shift.	<	89%	=	90%		99.57%	99.57%	100%	100%	98%	98%	98%	97%	100%	100%	99%
Supernumerary status of DS coordinator	<	95%	=	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Births per Funded Clinical Midwife WTE	>28		≤26		21	23	24	26	25	24	23	23	21	25	24	22

Neonatal Nurse Staffing compliance to BAPM (Badger Net report)	<90%	>90%				90%	98%	65%	69%	93%	77%	97%	74%	47%
Unable to provide TC Nurse NEW														5
Staff sickness rate	4%	4%	7.9%	8.47%	8.6%	8.7%	8.8%	8.6%	9.0%	9.2%	6.9%	6.3%	5.9%	4.1%
Fill rate RM Day	<85%	>85%	82%	NA	93%	95%	91%	74%	79%	84%	84%	87%	86%	86%
Fill rate MSW Day	<85%	>85%	73%	NA	93%	90%	86%	76%	74%	79%	71%	77%	75%	80%
Fill rate RM Night	<85%	>85%	97%	92%	90%	84%	82%	82%	81%	87%	87%	89%	87%	88%
Fill rate MSW Night	<85%	>85%	100%	94%	89%	91%	100%	94%	98%	100%	98%	98%	95%	94%
Registered Midwife shifts sent to agency per month.	--	--	107	110	110	127	127	146	146	151	152	121	142	155
Registered Midwife Agency hour fill rate percentage.	--	--	51%	46%	45%	39%	49%	42%	42%	52%	51%	64%	54%	57%
Maternity Triage BSOT standard (15min)			94%	90%	91%	93%	89%	91%	92.4%	89.4%	94.6%	89%	93%	87%
Maternity Triage NICE standard (30 min)			99%	98%	98%	98%	98%	97%	97%	97%	100%	95.7%	99%	92.5 %

Table D Obstetric Medical Staffing April 23- March 2024 MIS Standard 4

Metric	Red flag	Green flag	April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Number of Consultant hours on obstetric unit	<70 hrs	=/> 96.5hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs
RCOG obstetric benchmarking compliance	<100%	100%	100%	100%	100%	91%	100%	100%	100%	91%	98.4%	100%	100%	100%
24-hour acute obstetric medical staffing fill rate	<95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table E Clinical Escalation April 23- March 2024

Metric	Red flag	Green flag	April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	
Maternity Diverts	> 1	<1	0	0	0	1	0	2	0	0	0	0	0	0
Women who transfer to an alternative provider during induction of labour (New Jan 24) Internal mutual aid.	--	--											2	4
In- utero transfers declined to accept from other units (maternity)	--	--	0	2	5	4	5	5	5	3	2	2	2	0
In- utero transfers declined to accept from other units (NICU)	--	--	2	1	1	2	0	4	10	4	4	3	2	0
In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal)	--	--	0	10	0	0	1	1	0	0	0	0	2	0
NICU Closure	> 1	<1	5	13	1	1	0	1	2	0	2	1	6	5

APPENDIX 5 SAFETY CHAMPION ACTION LOG

Date	Decision/action agreed	Forum	Action Owner	Actions	RAG
Carried over	Charitable bid to be submitted for PBC, delivery suite and main corridor in SGU for staff rest areas.	Safety Champions Walk round	Area Leads and Matrons	17.8.2023 PBC delivery suite and main corridor bids approved. Work awaiting start dates. 21.12.2023 Delivery suite rest area completed, 12.1.24 Ground Floor ongoing and dates awaited early January 24 from D&G PBC work to commence. 14.2.24 Action completed. Works agreed for all rest areas.	
8/8/2023	Neonatal Safety Champion to contact network to consider whether additional clinical SBAR can be provided when IUT is requested to aid decision making.	Safety Champions forum	Neonatal Safety Champion	9.8.2023 Email sent and plans in place to review process. 21.12.2023 Feedback provided to the Northwest Connect Team. Action closed	
8/8/2023	Consider whether training budget can train core midwives on maternity B and Birth centres to support capacity and flow	Safety Champions forum	Matron for Safety and Quality	17.08.2023 Training budget to be reviewed with practice educator. Applications to be submitted for maternity B. Email to Birth centre managers to confirm names from midwifery led services. 21.12.2023 Core staff allocated funding to undertake NIPE training. Action closed.	
8/8/2023	Review arrangement for postnatal wellbeing checks for women whose baby is on NICU or for women in Bowland house	Safety Champions forum	Matron for Complex Care	17.8.2023 Meeting to be arranged to consider relocation of postnatal appointments to day unit once service has been relocated. 21.12.2023 Postnatal clinics relocated to ANC. Action completed.	
8/8/2023	Documentation key themes learning template to be generated by the audit midwives to ensure key information is documented in the right place within the EPR	Safety Champions forum	Matron for Safety and Quality	17.8.2023 Matron for Safety and Quality to liaise with specialty audit and IT to create a PowerPoint and learning template for sharing with obstetric and midwifery teams. 12.1.2024 Work ongoing with Digital team to create update user guides for documentation and a working party will be convened to agree a plan	
8/8/2023	Training for Badger| Net and key themes to be added to agenda for clinical audit.	Safety Champions forum	Matron for Safety and Quality	17.8.2023 Matron for Safety and Quality to liaise with specialty audit and IT to create a power point and learning template for sharing with obstetric and midwifery teams. 21/12/2023- Completion of Badger Net process mapping to update operational guides to improve consistency of documentation and any inaccuracies are being flagged to system C.	
8/8/2023	ANC clinic templates to be reviewed with CD to consider type of clinic allocated	Safety Champions forum	Clinical Director and Matron for Complex care	17.8.2023 Email to CD detailing action sent. To review whether clinic organisation can be reviewed. 21.12.2023 Wider actions in relation to ANC templates ongoing with CD and consultant team. Action extended. 12.1.24 ANC to be considered for MCA programme. 14.2.2024 Outpatient staffing and template review to be considered.	
20/02/24	Face to face visit to EPGAU. Weekend staffing discussed in view of the increasing demand for services at weekend	Executive Safety Champion	1.06.2024	Weekend staffing of the EPGAU to be considered as part of the annual staffing review planned for March 24. Paper being prepared by Chief Nursing Officer	
20/02/24	Finishing touches to EPGAU to be signed off by Charity to ensure environment is reflective of service needs.	Matron for Gynaecology and Baby Beat lead	31.03.2024	20/02/24 Confirmed that Additional baby beat bid had been signed off	

20/02/24	Challenges to ability to ring fence dedicated space for women who require care following baby loss.	Clinical Business Manager	31.03.2024	20.2.24 Paper to be prepared and presented to SOG to request 2 dedicated side room for responsive provision of private care following pregnancy loss. 20.04.2024 Paper presented to SOG to ringfence 2 side rooms on Gynaecology for early pregnancy loss.	
21/3/23	Virtual Session with midwives	Executive Safety Champion	31.05.2024	Virtual session held as open feedback session	

Appendix 6: CNST MIS YEAR 6 TRAINING COMPLIANCE

Compliance by Staff Group 01/04/2024 (March figures)

	MIDWIVES	CONSULTANTS	DOCTORS	COMPLIANCE PERCENTAGE OVERALL
CTG update **(Delivered as part of PROMPT or attendance at CTG meeting)**	**93 %** *169 compliant out of 182*	**93%** *13 compliant out of 14*	**100%** *19 compliant out of 19*	**93%** (Decrease 2%) *201 compliant out of 215*
Fetal Monitoring training **Attendance at full day fetal monitoring training**	**99 %** *175 compliant out of 177*	**100%** *14 compliant out of 14*	**100%** *19 compliant out of 19*	**99%** (Decrease 1%) *208 compliant out of 210*
CTG Equipment	**99 %** *175 compliant out of 177*	**100%** *14 compliant out of 14*	**100%** *19 compliant out of 19*	***99%*** (Decrease 1%) *208 compliant out of 210*
GAP/GROW	**92%** *168 out of 182*	**93%** *13 out of 14*	**100%** *19 out of 19*	**93%** (Increase 3%) *200 compliant out of 215*
Human Factors **(attended PROMPT or fetal monitoring)**	**100%** *182 out of 182*	**100%** *14 out of 14*	**92%** *24 out of 26*	**99%** (Increase 1%) *220 compliant out of 222*

	MIDWIVES	CONSULTANT	DOCTORS	ANAESTHETISTS	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES **(PROMPT) Includes Neonatal Basic Life Support**	**94%** 171 out of 182	**93%** 13 out of 14	**92%** 24 out of 26	**96%** 24 out of 25	**92%** 45 out of 49	**94%** (Same) *277 compliant out of 296*
Pool Evacuation	**99%** *180 out of 182*	**93%** *13 out of 14*	**92%** *24 out of 26*	**96%** 24 out of 25	**90%** 44 out of 49	**96%** (Increase 4%) 285 out of 296

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Patient Experience Annual Report 2023/2024			
Report to:	Board of Directors	**Date:**	6th June 2024
Report of:	Chief Nursing Officer	**Prepared by:**	John 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 assurance to Board of Directors that the outcomes associated with the Patient Experience and Involvement Strategy 2022 to 2025, at the end of year 2, are progressing in line with the plan. The report with detailed plan has been scrutinised by the Safety and Quality committee.

This report also will provide assurance on the Trust position in relation to key performance indicators relevant to patient experience and involvement such as complaints, response rates, friends and family indicators, patient surveys and compliments.

The report demonstrates the following patient experience and involvement activity over the 12 month reporting period:

- During 2023/24 a total of 2,664 compliments were received.
- Complaints performance has risen from 50% in April through to 79% in March and an average for the year at 75% compliance.
- Friends and Family Test response rates have improved compared to 2022/23 with11,359 more valuable pieces of feedback collected in 2023/24. This equates to an increase of 22.19%.
- Friends and Family ratings for adults have remained above 90% recommendation for outpatients and day case. Maternity and Adult/Children inpatients are not yet achieving consistent performance of greater than 90% recommended.
- The number of complaints has reduced by 132 when comparing 2022/23 to 2023/24 equating to 27.1% reduction.
- National Picker surveys demonstrate improvements in the Emergency Department (Royal Preston) survey, sustained high performance in maternity and cancer and a below average performance in adult In-Patients.
- There have been 10 Parliamentary Health Service Ombudsman (PHSO) referrals in the last 12 months, 3 have been partly upheld the other 7 cases remain under investigation.
- Patient experience is a key component of continuous improvement (CI) methodology and the CI strategy.
- The Trust is participating in the patient experience research led by Imperial College Healthcare NHS Foundation Trust
- The Trust has recruited 3 patient safety partners in year and a maternity neonatal voices partnership chair.
- There are over 170 patient experience champions established across wards and areas.
- There are 16 forums or groups involving different patients, advocacy services, charities, 3rd Sector and Trust colleagues working collaboratively.

- Volunteers are supporting patient experience and hospital guide roles.
- An eLearning training package regarding the Patient Advice and Liaison Service (PALS) concerns and local resolution has been developed and is now live.
- There is increased training for staff in basic British sign language (BSL).
- The development of LTHTR proud awards now enables patients to be nominate staff, team or services in recognition of the care provided, this has been adopted as part of the learning from magnet4Europe study.
- Personalised Stratified Follow-Up (PSFU) and health and wellbeing workshops and initiatives have started across various specialities.
- 19 second letter from complaints were received and responded to and learning from this has been discussed to prevent this from happening less often in future.
- The top theme for complaints is communication, confidentiality and consent and this is being separated out for the next reporting period to allow more focussed actions.
- The backlog of complaints responses from Covid-19 has reduced from 64 to 0.
- Finney House has completed its first year, with 1665 fewer patients spending longer than necessary in a hospital setting leading to a the provision of rehabilitation for patients who are more likely to leave Finney house returning to their baseline, avoiding long term care placements.

Implementing a successful patient experience and involvement strategy requires a multi-faceted approach, sustained commitment and regular refinement based on feedback and evolving healthcare. By placing patients and their families at the heart of every decision, LTH can significantly improve quality of care and patient outcomes.

It is recommended that Board of Directors:

- Receives the update on year two of the Patient Experience and Involvement Strategy 2023-2024, noting the scrutiny completed through safety and quality committee.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Safety and Quality Committee May 2024

1. Introduction

1.1. The Patient Experience and Involvement Strategy 2022 to 2025 was developed and co-produced with patients, families, carers, governors and staff and is now entering the final year. This annual report provides assurance to Safety and Quality Committee that the ambitious strategy is an active document that has been progressed in line with the plan that was set. Implicit within the report are people's lived experience of accessing the healthcare provided by the Trust and these are a powerful tool to understand and then improve existing services and meet the patients' holistic needs. This report will demonstrate how the patient voice and their involvement has been used to develop pathways and improve experiences within the organisation.

1.2. This report will provide assurance on the Trust position in relation to key performance indicators relevant to patient experience and involvement such as complaints, response rates, friends and family indicators, patient surveys and compliments.

2. Discussion

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

The strategy is divided into 3 sections:

1. Insight - improving our understanding of patient experience and involvement by listening and drawing insights from multiple sources of information.
2. Involvement - equip patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.
3. Improvement - design and support improvement programmes that deliver effective and sustainable change.

3. Year 2 Strategy Review

3.1 The ambition of the strategy is to involve our patients and communities to co-produce and deliver services that have been formed collaboratively as equal partners whilst also improving patient satisfaction, experience and enhancing clinical outcomes. Year 2 of the strategy has continued to build on the firm foundations established in year 1 and raise the profile of the patient voice further as demonstrated in the sections below which summarises and celebrates the successes achieved.

Insight

- Patient Experience is a key component to the Continuous Improvement (CI) methodology and strategy that the Trust has embraced such as the Microsystem Coaching Academy (MCA) and the Flow Coaching Academy (FCA).

- The Trust is participating in the patient experience research led by Imperial College Healthcare NHS Foundation Trust.
- There are quarterly deep dive reports reviewed allowing for emerging themes to be identified.
- Friends and family feedback has increased by 22.19%.
- Complaints have reduced by 27.1%.
- National Picker surveys demonstrate improvements in the Emergency Department (Royal Preston) survey, sustained high performance in maternity and cancer and a below average performance in adult In-Patients.
- Governors and Integrated Care board colleagues are involved with STAR accreditation visits and these have demonstrated an increase in compliance on patient feedback.
- Established links with underrepresented groups such as the '*Sahara Centre'.*

Involvement

- The recruitment of 3 Patient Safety Partners and a maternity voices partnership chair has been completed in year 2.
- There are over 170 patient experience champions established across wards and areas.
- Volunteers are supporting patient experience and hospital guide roles.
- There are 16 forums or groups involving different patients, advocacy services, charities, 3rd Sector and Trust colleagues working collaboratively.
- The development of an eLearning training package regarding the Patient Advice and Liaison Service (PALS) concerns and local resolution has been achieved.
- There are increased number of Flow Coach Academy (FCA) big rooms and MCA projects.
- There is increased training for staff in basic British sign language (BSL).
- The development of LTHTR proud awards now enables patients to be nominate staff, team or services in recognition of the care provided, this has been adopted as part of the learning from magnet4Europe study.
- Personalised Stratified Follow-Up (PSFU) and health and wellbeing workshops and initiatives have started across various specialities.

Improvement

- PLACE visits have recommenced.
- All wards with 2 ward managers have demonstrated an improved STAR position.
- The digitised food ordered with increased diverse options i.e. Vegan.
- Rebuilt Gynae and women's assessment unit in response to patient feedback and experience.
- There has been successful recruitment to a full-time bereavement lead for Gynaecology services.
- Emergency department redesign and creation of Acute Assessment Unit.
- Day case surgery for children on CDH site is improving patient experience.
- There are multi-disciplinary CARING rounds for patients at end of life.
- There are 7-day bereavement services.
- The refurbishment of ward 8 parent room has occurred.
- There is a new Garden of Remembrance to honour organ donors and those who lost their life during the pandemic.
- There is increased satisfaction of patients attending radiotherapy.

- Finney House has completed its first year, with 1665 fewer patients spending longer than necessary in a hospital setting leading to a the provision of rehabilitation for patients who are more likely to leave Finney house returning to their baseline, avoiding long term care placements.

4. Patient Experience and Involvement Group

4.1 In the last 12 months the Patient Experience and Involvement group has continued to develop and grow. The group is well represented by all divisions, patient's, 3rd sector partners, charities, governors and advocacy groups. The meeting is now separated into two-parts Part A and Part B. Part A focuses on patients, families and carers feedback and stories are presented and heard from each division which enables learning.

4.2 Part B enables the group to understand the data and metrics. Quarterly reports from each division gives an oversight of all aspects of patient experience across the hospitals.

4.3 In the last 12 months a review of the terms of reference and cycle of business has been carried out allowing for clarity of expectations for this group to ensure that it fits with the strategy and action plan. The aim of the group is to have full representation from people who have a protected characteristic. This is continuing to improve and it is expected that within the next 12 months there will be representation from all equality groups. A focus of this is to be more inclusive specifically from people from an ethnic or BAME origin and this is an area of development through greater publicity in Trust forums and Equality Diversity and Inclusion (EDI) group.

5. Patient Feedback

5.1 The following information considers the ways in which the Trust can demonstrate progress with patient experience and considers responses from a range of sources, including:

- Friends and Family Test (FFT) data
- Complaints and concerns raised by patients and family members.
- Care Opinion website.
- Information received from cases referred to The Parliamentary Health Service Ombudsman (PHSO)
- Compliments and Thank You messages.
- National patient survey results

5.2 The Trust Patient Experience and Patient Advice and Liaison Service (PALS) teamwork alongside staff, patients/carers and other stakeholders in a responsive way. The team do this by:

- Providing information to patients, relatives and carers.
- Resolving problems and concerns before they escalate to become complaints.
- Providing data about the experiences of patients, their relatives, and carers to inform improvements in the quality of services.
- Informing people about the complaints procedure and how it can be accessed.
- Acting as an early warning system for the Trust.
- Identify opportunities for learning from the experiences of patients, relatives, and carers;
- Working in partnership with the teams of other healthcare providers and partner organisations.

6. Improvements in the Patient Experience and PALS team during 2023/2024

6.1 The following have been developed in the reporting period:

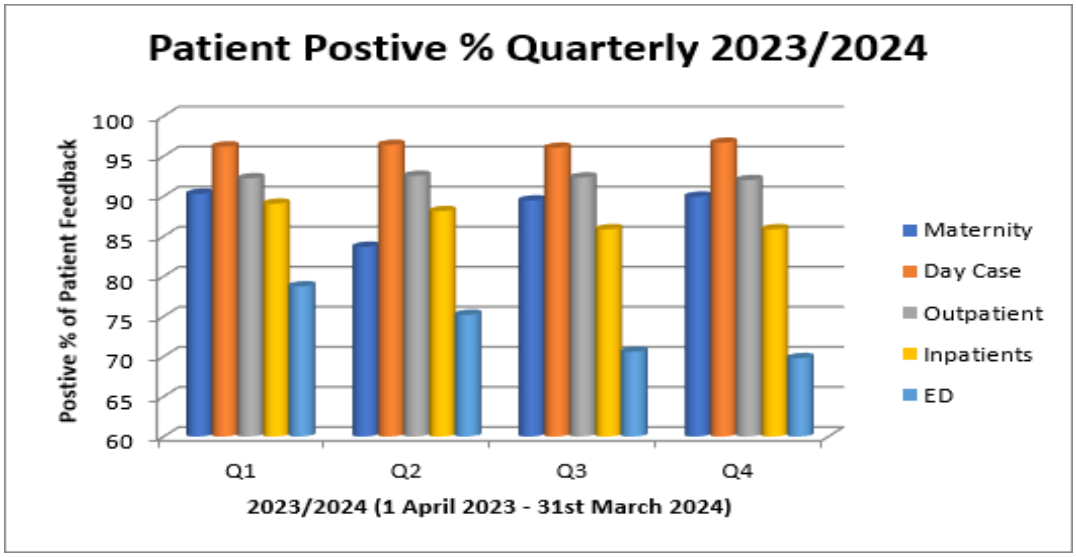
- The introduction of a new eLearning package which focuses on local resolution and an awareness of the Patient Advice and Liaison function to provide a better patient experience. 218 members of staff have completed this and a communications plan is in place to promote this further.
- Team participation with the TED tool which has demonstrated positive results and improvement regarding the Patient Experience and PALS team following the initial TED in 2022.
- A clear recovery from the COVID-19 pandemic in relation to reducing the backlog of complaints that were not responded to timely. There were 64 cases as part of the backlog and this was reduced to 0.
- Continued commitment to meeting with the Divisions weekly to monitor complaint compliance.
- A reduction in the number of PALS cases open and meeting the internal measures of from 76% to 86%.
- Consistency of striving to achieve complaints compliance of 90%, through divisional meetings.
- The Friends and Family feedback has seen a month on month increase and an overall satisfaction score of 90%.
- 100% compliance achieved with appraisal and mandatory training across the whole team.
- Work with maternity and gynaecology as a result of complaints in relation to miscarriage has led to some of the changes in practice and the development of a new and improved service within that area, with the aims of improving experience, learning and reducing the complaint/concerns.

7. Friends and Family Feedback

7.1 The Friends and Family Test (FFT) is used as a national measure to identify whether patients would or would not recommend the services of our hospitals to their friends and family. The national requirement is to report on the following areas:

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

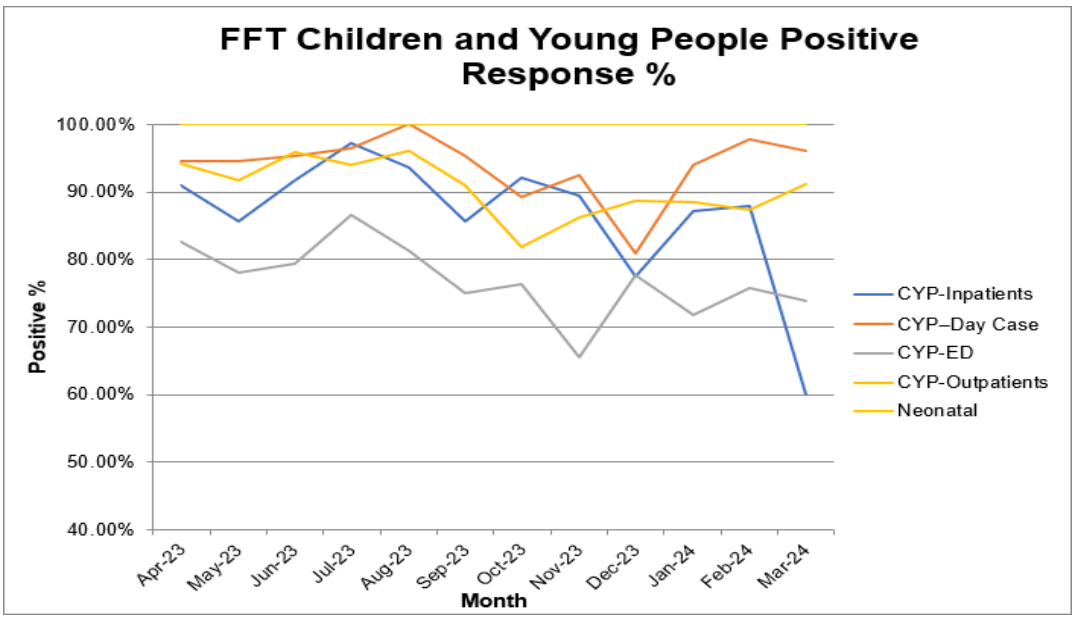
Graph 1 – Quarterly percentage of positive responses Friends and Family by Division



Source: FFT data CIVICA

7.2 A target of 90% is set for patients who would recommend services to friends and family in four of the areas, with a target of 85% in the Emergency Department. Maternity has achieved this in Q1 and Q4, Day case and Outpatients have consistently achieved more than 90% in all four quarters, Inpatients and the Emergency Department are under the target percentage in all four quarters. The Emergency department remains overcrowded alongside inpatient wards at times being 'boarded' it is vital we understand the patient experience and have plans in place to improve this. The PALS team are supporting by visiting these areas to gain real time feedback from patients as are Healthwatch. Further development of Patient Champions is planned for summer 2025 and the plans to produce ward-based data to share at the monthly patient champions update will challenge areas to improve the friends and family uptake.

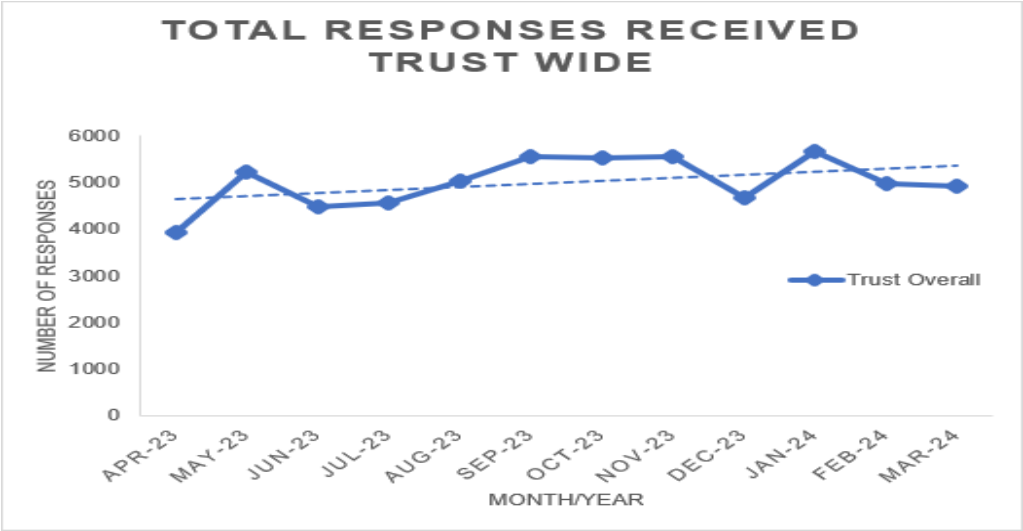
Graph 2 – Children and Young People (CYP) Quarterly percentage of positive responses (FFT)



Source: FFT data CIVICA

7.3 Although not a national requirement, the Trust undertakes surveys in Children and Young People's Services to ensure an equitable approach to measurement of experience. Children and Young People using the Urgent and Emergency pathways are reporting less favourable experiences. The day case and outpatient departments are demonstrating positive performance. The neonatal service has maintained a sustained performance of 100%.

Graph 3 Friends and Family % Response



Source: FFT data CIVICA

7.3.1 The data above demonstrates an overall increase in responses and an increase in usage of the various methods of collection.

8. Friends and Family response rate

8.1 Expanding the methods used to collect feedback is important in order to understand what matters to patients. The response rate is an area we set out to improve and the data below demonstrates this has been achieved with a total of 11,359 more valuable pieces of feedback than what was collected in 2022/23.

8.2 It is not yet possible to view this feedback through the lens of protected characteristics and deprivation, however work is underway to capture this.

Year	QR codes/online surveys	Paper surveys	Telephone surveys	SMS text surveys	Total
2021-2022	1,468	2,829	3,684	36,128	44,109
2022-2023	2,905	6,788	4,421	37,070	51,184
2023-2024	3,016	10,944	2,112	46,471	62,543

8.3 In the year 2023-2024 there has been a positive increase in the response rates overall of 22.19% on the previous year. Increases have been realised with Quick Response (QR) codes/online surveys, paper surveys and Short Message Service (SMS) test surveys. There has been a reduction in the telephone surveys which in part may be due to an increase in online and mobile preferences for service users.

8.4 Training is provided for colleagues on how to use the system and departmental patient experience boards are kept updated with the "You said, we did" posters and various reports that can be downloaded using

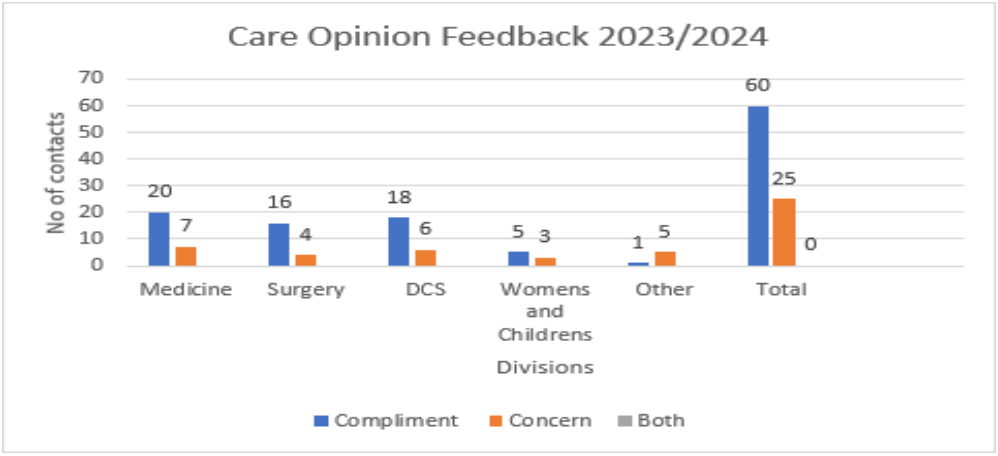
CIVICA. Managers and Leaders are actively seeking to make improvements with the Friends and Family test and this is measured through the Safety and Quality Committee. Monthly reports are sent to all governance and divisional leads to ensure the results are reviewed and acted upon and shared throughout the Trust.

8.5 Please note appendix 1 for positive and negative patient comments from Friends and family.

9. Care Opinion Website

9.1 During the past financial year there have been a total of 85 reviews posted on the Care Opinion website relating to care and treatment at Lancashire Teaching Hospitals NHS Foundation Trust. These have consisted of 60 compliments and 25 concerns.

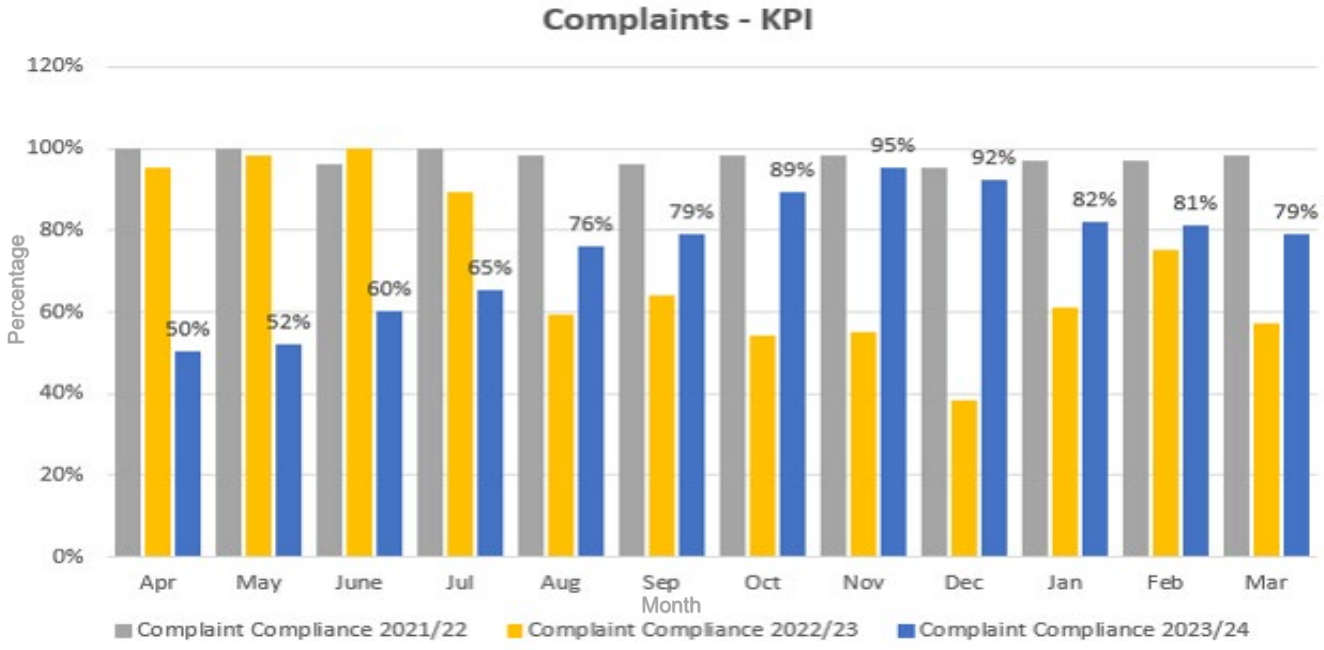
Graph 4 – Care Opinion feedback



10. Complaints

10.1 During 2023/2024 the Trust received 355 formal complaints, a decrease of 132 from 2022/2023. In this year the backlog of complaints from the COVID-19 pandemic was addressed as all are now closed. The complaint performance has been monitored through the year and patients receiving a response within 35 or 60 days has risen from 50 % in April through to 79% in March and an average for the year at 75% compliance. It is the intention of the team to return and maintain the trust target of 90% in 2024-25 and this will require timely responses from specialty teams. Learning from complaints and providing a single point of contact and keeping complainants updated on progress is a key component of the Patient Safety Incident Response Framework (PSIRF).

Graph 5



Comparator data for Complaints 2021 to 2024

Year	Complaints received	Increase/reduction
2021-22	580	+219
2022-23	487	-93
2023-24	355	-132

Source: LTHTR Datix

10.2 During 2023/2024 the Trust received 355 formal complaints, a decrease of 132 from 2022/2023. The decrease represents a percentage of 27.1%. This continues to follow the trend from the previous year where there was also a reduction. Whilst there has been a reduction the complaints received into the organisation are more complex that previously. The trend in the ratio of complaints to patient contacts over the past three years is detailed in the table below:

Trend of ratio of complaints per patient contact 2020 to 2023

Year	No of complaints	Total episodes (inpatient/outpatient)	Ratio of complaints to patient contacts
2021-22	580	821,526	1:1,416
2022-23	487	849,328	1:1,744
2023-24	355	871,231	1:2,454

Source: LTHTR Datix

10.3 Of the 355 complaints received between April 2023 to March 2024, 285 (80%) related to care or services provided at the Royal Preston Hospital (RPH), 65 (18%) to care or services provided at Chorley and South Ribble Hospital (CDH), 1 (0.2%) to care or services provided by Preston Business Centre, and 4 (1.8%) to care and services provided at Finney House Community Healthcare Hub. There were no cases which were outside of the 12 months' timescale set out under the NHS Complaints Procedure.

Number of Complaints by Division – April 2023 to March 2024

Division	Number (%)	Division	Number (%)
Medicine	150 (42%)	Women and Children's Services	43 (12%)
Surgery	129 (36%)	Diagnostics and Clinical Support	27 (8%)
Estates and Facilities	1 (0.5%)	Corporate Services	5 (1.5%)

Source: LTHTR Datix

10.4 During this financial year there were 334 cases due to be closed. The outcome of these can be broken down into the following outcomes 17 (5.9%) of the complaints had been upheld. 180 (53.89%) were partly upheld and 127 (38.02%) were not upheld. 10 cases currently remain open at the end of the year.

10.5 The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 87% of complainants received an acknowledgement within that timescale where complaints were received into the Patient Experience and PALS team. Whilst 100% of patients receive an acknowledgement via email or verbally on the telephone. The 87% figure reflects when the case is opened on the Datix Governance system and the case manager contacts the complainant.

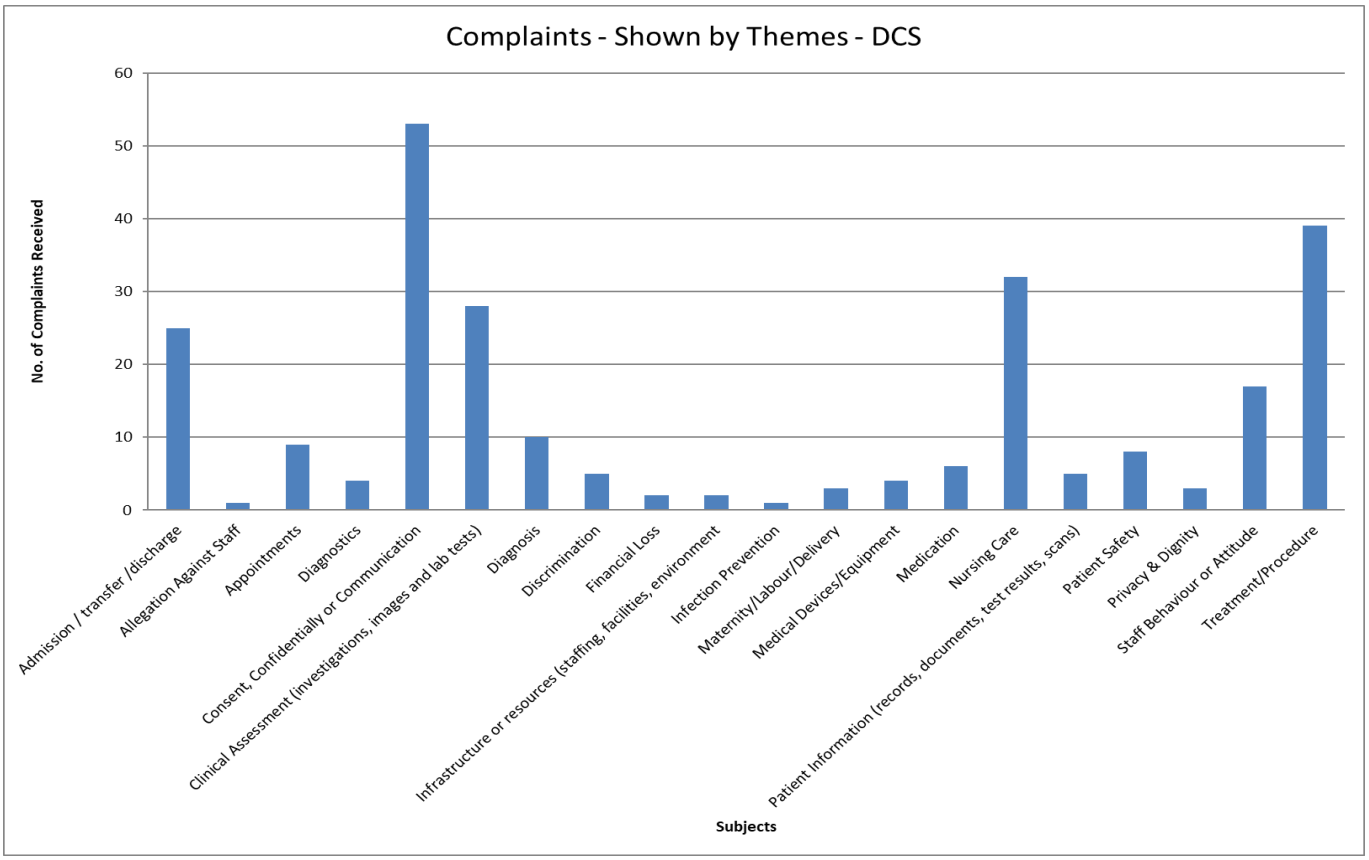
10.6 Second letters may be received because of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the period between April 2023 and March 2024 the Trust received 19 second letters.

10.7 During the period 1st April 2023 to 31st March 2024 249 complaints were closed. 75% of complaints received in 2023/24 were closed within the 35-day or 60-day timescale. This is reported to Safety & Quality Committee monthly. Of note the organisation is not mandated to respond within 35 days, however the standard set is to ensure that complainants receive timely responses to provide a better patient experience. The Patient Experience and PALS Team have dealt with a total of 2,325 concerns and 2,741 enquiries.

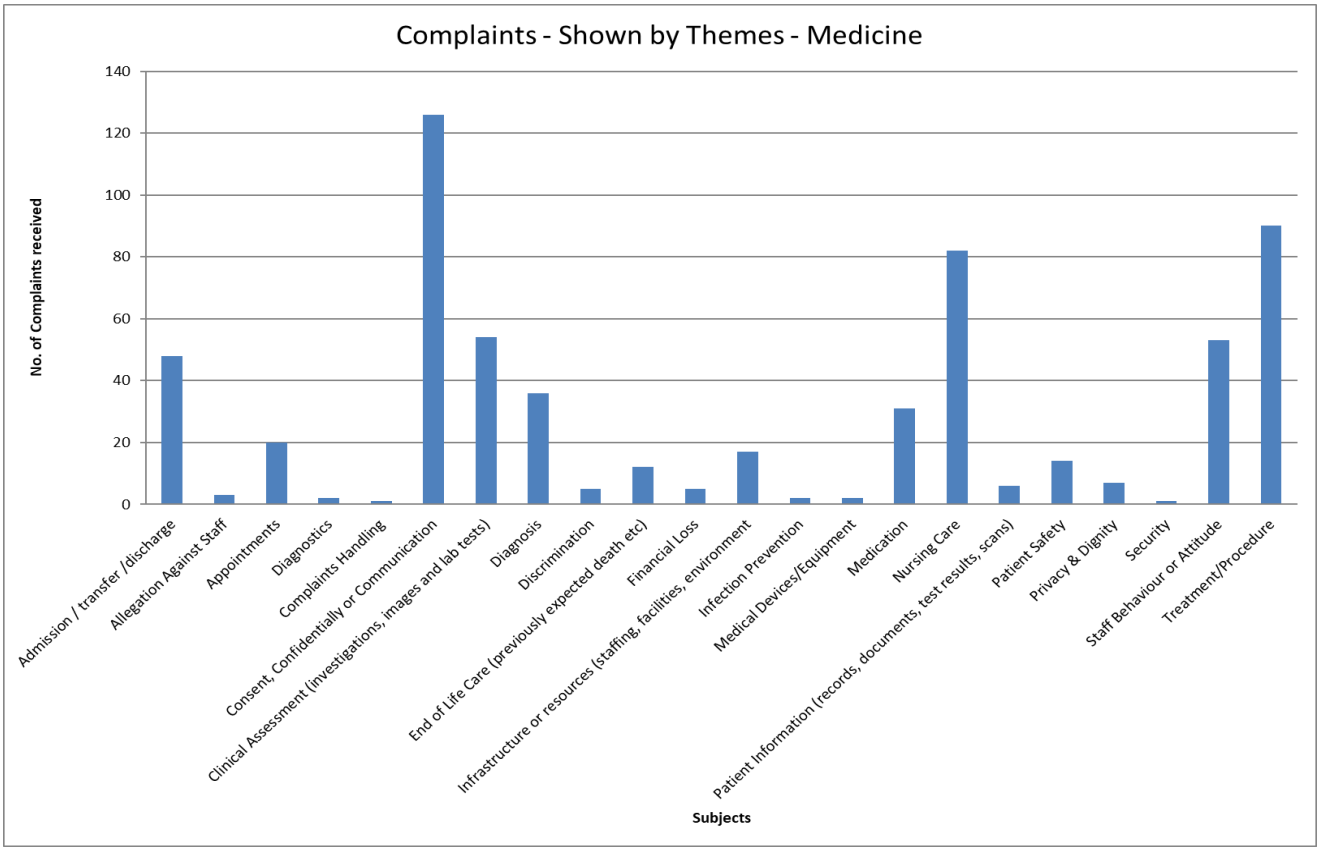
11. Top Themes Complaints and Concerns by Division

11.1 The following bar charts provide the top themes based on the number of complaints made in each area for each division for the period April 2023 to March 2024. The top theme is consent, confidentiality and communication. In 2024/2025 this category is being amended so the 3 aspects will be individually reported as a theme in order to drill into the specific items for improvement.

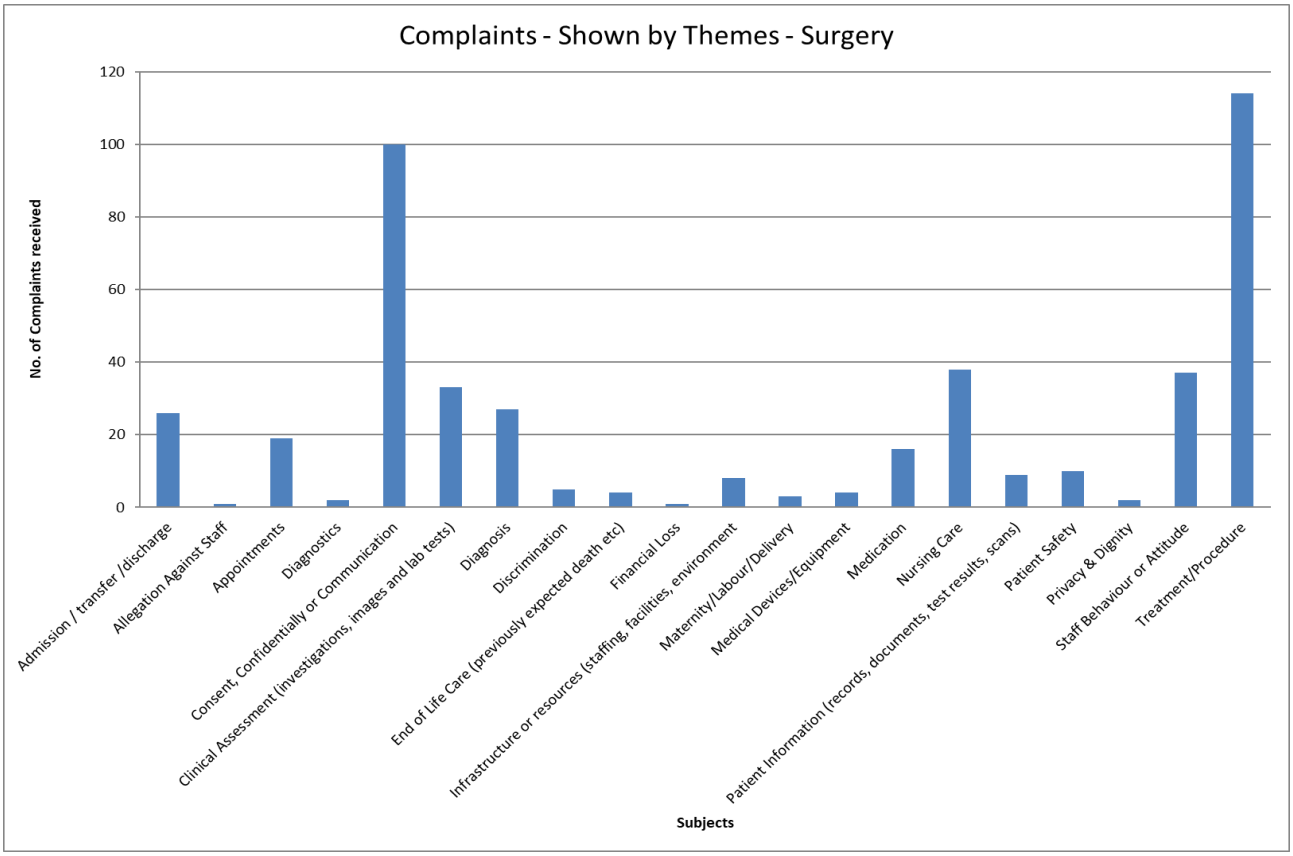
Graph 6 – Diagnostic Clinical Support



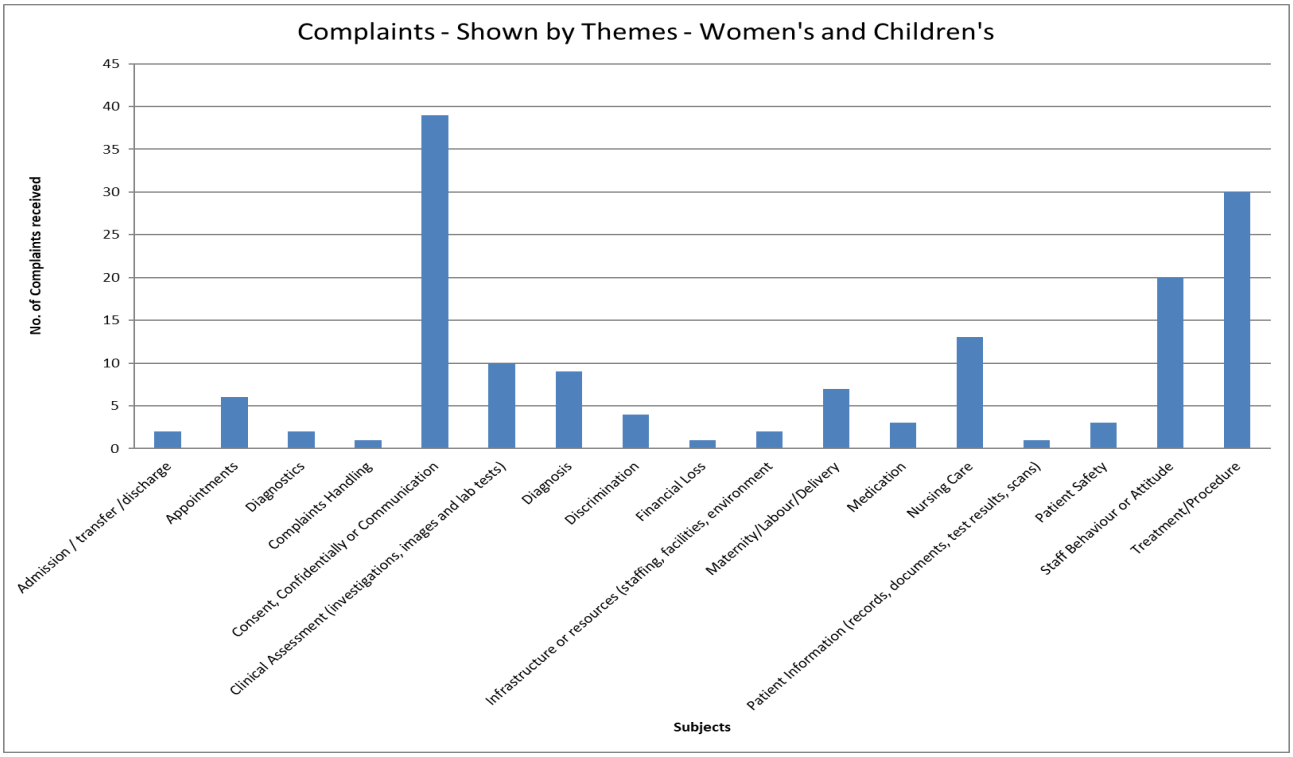
Graph 7 – Medicine



Graph 8 – Surgery



Graph 9 – Women and Childrens



11.2 Top 3 themes from complaints by division:

Division	Themes
Diagnostic and Clinical Support	1. Confidentiality or communication 2. Treatment/Procedure 3. Nursing care
Women and Children	1. Confidentiality or communication 2. Treatment/procedure 3. Staff Behavior or Attitude
Medicine	1. Confidentiality or communication 2. Treatment/procedure 3. Nursing care
Surgery	1. Treatment/Procedure 2. Confidentiality or communication 3. Nursing care

12. Complaint Themes

12.1 Whilst there are many more compliments than complaints, complaints are an important source of feedback. There are a number of key complaints themes that run across all divisions. These are communication, consent, confidentiality, Treatment and Procedure and Nursing care. To note there are no complaints regarding consent and a review of all subject headings and sub subjects will be completed for 2024/25.

12.2 To capture the learning from complaints a quarterly deep dive is undertaken and presented originally through the Patient Experience and Involvement group and is also noted in individual divisional reports to this group. It is important to understand the divisional challenges and importantly the actions taken to support resolving concerns and complaints.

13. **Communication, confidentiality and consent**

13.1 This is a theme which has been noted for some time, there is evidence the divisions are developing plans to support the improvement, for example:

The patient has stated – ***'the inappropriate use of language used during in baby loss, why use the word products?', the environment where you are sat with pregnant mothers and those who are miscarrying is difficult'***.

Action - The women's and children's division met this family. This led to working with the Trust charity to upgrade the environment, recruitment to a research bereavement role and training from a charity focussing on communication with all staff.

The patient/family has stated - '*I understand that it is a medical decision to place a DNAR on a patient and am accepting that this is now in place, but dad is a very poorly man and I worry that this could be dad's final impression of coming to hospital. This has caused undue stress on our family at what is already a difficult time and along with the constant badgering dad has endured from this doctor I feel this is a very sensitive issue that should be discussed in private rather than whilst family were visiting and in front of a ward full of other patients.'*

Action – A review of the DNAR policy was completed and discussed with patients, families and carers who are represented in the Patient Experience and Involvement group to ensure how we communicate and is delivered with compassion. The commencement of CARING round in a multi-disciplinary way has enabled colleagues to give feedback and support patient, families and carers with decision making.

14. **Treatment and Procedure**

14.1 This is an increasing theme particularly in relation to the continued pressure to deliver elective surgery and delay in diagnostics alongside procedure results. It is also noted delays in treatment throughout the emergency pathway as a result of continued system pressures.

The patient has stated – '*patient during their assessment who expressed anxieties in relation to her upcoming admission and treatment following a previous poor experience'.*

Action - pre-operative team to explore if the ward area at Chorley could accommodate the patient's assistance dog to help alleviate her anxiety and therefore support recovery. Sellers ward immediately investigated this and were soon able to confirm that they could support this request. This resulted in a positive patient experience, both patient and Dexter the dog attended Sellers and required an overnight stay. This is a good example of why it is important to treat each of patients as individuals and why 'thinking outside the box' and using a 'can-do' approach is important.

The patient has stated – '*I waited over 5 months for a referral with the renal team at Royal Preston Hospital you have stage 3 CKD, and you'll need dialysis in 5 years' time. No explanation, he didn't want to answer questions, didn't have time to explain anything, I was being told this for the first time!.*

Action - The Kidney Care big room is a multi-professional enhanced supportive clinic that champions shared decision making, ensuring patients have the opportunity to participate in advanced care planning and address their needs before hospitalisation. The clinics aims to improve symptoms over time for patients receiving conservative management and honours the preferred place of care and providing good palliative and end of life care for patients and support for relatives.

15. **Nursing Care**

15.1 In relation to the nursing care theme, it is again reflective across all divisions with particular focus on care delivery issues, internal delays i.e. scans and also discharge arrangements. This again is a reflection of significant system challenges across the system with teams and departments delivering the best possible care despite this. It is evident that the increased pressure has led to the care delivery of patients in settings that are not always in the best interest of patients and has inevitably resulted in issues with nursing care.

Patient stated - *There seemed to be minimal to no effort to get my father out of bed and moving, a couple of times a physio did visit but that was it, in the 4+ weeks, so he was in bed almost all the time'.*

Action - To improve patient experience for patients within elderly medicine day room activities are being re-established and encouraged on Rookwood A and ward 17 promoting use of activities for patients who are living with dementia by music therapy, games and group sessions where families and carers are encouraged to attend. Relatives are also encouraged to bring items from home to make patients feel secure with recognisable possessions.

Patient Stated – *why did I have to wait so long for my diagnosis and treatment plan, it was cancer.*

Action - In acute and specialist surgery, Upper GI patients have access to pre-habilitation (prehab), which means getting ready for cancer treatment in whatever time you have before it starts. It is a programme of support and advice that some NHS hospitals are using. This is co-designed with patients and aims to provide a one stop service to help prepare patients pre-operatively in informing them of what to expect before and after surgery. The Colorectal Advanced practitioners: 'Tell People Quickly that They Don't Have Cancer' initiative was Highly Commended at the HSJ Patient Safety Awards. This project has significantly reduced the length of time patients are waiting for outcomes from referrals.

At multiple points around the organisation, on desktop Personal Computer's and on the intranet and internet, information is provided to patients, carers, service users and to staff about how to make a complaint using patient information leaflets, pull up banners across the organisation at entrances and on each floor of the ward blocks. In addition, the team now feature on the hospital radio across both sites, providing patients with valuable information on the service provided by Patient Experience and PALS. The team have also produced a film to raise staff awareness, and a presentation has been delivered to senior leaders through the Nursing, Midwifery and AHP meetings and locally through Divisional Governance team meetings. Work is currently underway to promote local resolution to prevent complaints and provide a better experience for patients in our hospitals.

16. The Parliamentary Health Service Ombudsman (PHSO)

16.1 Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1st April 2023 to 31st March 2024 there were 10 cases referred to the PHSO; 3 were partly upheld and 7 are ongoing. During this period, the PHSO sent final reports for 3 cases which were opened prior to April 2023 and the outcome of these were that 2 were not upheld and 1 was partly upheld. There is one further case referred to the PHSO prior to April 2022, which is still under investigation by the PHSO, and a final decision is yet to be reached. This compares to 4 cases being referred to the PHSO in 2022 to 2023.

17. Compliments

17.1 The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2023/24 a total of 3,871 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office and documented on Datix, although it is recognised that there will be far more compliments that are not documented. There has been a 45% increase in the number of compliments received this year. Departments are being encouraged to actively log compliments on the Datix system which has its own module for this purpose. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and divisions. A new Trust campaign has been implemented to encourage recording of compliments recognising value our teams place on the recognition they receive from patients and families. From April 2024 league tables will be published to enable teams to benchmark against one another.

18. National Surveys

18.1 Maternity Survey

18.1.1 The Maternity survey is based on a sample of maternity service users who had a live birth between 1st March 2023 – 31st March 2023. In the 2023 survey the Trust was ranked 18th out of the 61 participating Trusts. Compared to the 2022 survey results, the Trust ranked 19th out of 65 Trusts surveyed by Picker. The response rate for the 2023 survey was 39% compared to the 2022 survey response rate of 44%.

18.1.2 Analysis identified two areas where the Trust scored significantly better when compared to the 2022 survey. There were no areas identified where the Trust score was significantly worse than the 2022 survey. Overall women reported that they were treated with kindness and compassion during labour and birth (98%), they had confidence and trust in staff during labour and birth (97%) and felt midwives and doctors were aware of their medical history during labour and birth (84%).

18.1.3 Within the bottom five scores, issues were identified in relation to information regarding infant feeding choices, review of health records by midwives and doctors, and induction of labour. The survey results triangulate with safety intelligence and patient feedback data already known to the maternity service. Action plans are in place to respond to this feedback with the aim of improving experience for women, birthing people and families.

18.2 National Inpatient Survey

18.2.1 Compared to the national inpatient survey in 2021, Lancashire Teaching Hospitals remains in the same position, with no areas identified as significantly better or significantly worse in 2022. Lancashire Teaching Hospitals is now ranked 50th out of the 70 Trusts surveyed by Picker. This compared to the 2021 survey where the Trust was ranked 55th out of 73 Trusts surveyed. This shows a slightly improved position in the overall positive score of 2 points, however, does not represent the improvement ambition the organisation is aspiring to. Adult inpatient experience is a priority area of action for the Patient Experience and Involvement strategy and progress against the strategies deployment will continue to be overseen by the Safety and Quality committee.

18.3 Emergency And Urgent Care Survey

18.3.1 The National Picker Adult and Urgent & Emergency Care Survey 2022 was for patients attending the Royal Preston Hospital Emergency Department and Chorley District General Hospital.

18.3.2 The Urgent and Emergency Care Survey is carried out every 2 years. The previous survey was undertaken in 2020. The purpose of the survey is to understand what patients think of the care they have received within a Type 1 Emergency department.

18.3.3 The results demonstrated an improved position for the Emergency Department compared to the last National Picker survey in 2022. LTHTR is ranked 18th out of 62 trusts nationally. This is compared to the 2020 survey, where the Trust was ranked 34th out of 66 Trusts surveyed.

18.4 Children's and Young Peoples Survey

18.4.1 There have not been any Picker survey results in this reporting period for Children and Young People. The survey will be undertaken between March and May 2024.

18.5 Cancer Survey

18.5.1 The survey results were published July 2023. The overall score for care at the Trust was 9 out of 10, which is higher than previous years. There were 61 questions in total and 14 questions were in the higher-than-expected range with no responses in the lower-than-expected range which is a significant improvement on the previous years.

18.5.2 Common themes that require improvement across the range of cancer services include:

- Hospital care confidence in staff particularly within Head & Neck (H&N) Gynae and Upper GI.
- Discussions with patients about research.
- Support and communication from primary care and cancer care reviews in primary care.
- Emotional support from voluntary services in the community.
- Information regarding immunotherapy.

18.5.3 Areas where LTH has scored positively are:

- Head and Neck team scored highest with an overall rating of 9.5.
- Teams scoring above an overall rating of 9 were Lung 9.4, Prostate 9.3, Sarcoma 9.3, Upper GI 9.2, Colorectal 9.2
- All teams scored highly for privacy when receiving results. H&N, lung, prostate and sarcoma all scored 100%.
- All teams scored highly regarding support from main contact, UGI, Skin and Colorectal teams scored 100%.
- All teams scored highly for review of care plans with patients, Upper GI, skin, colorectal and H&N scored 100%.
- All teams scored highly in the Treatment section.

19 Conclusion

19.1 Implementing a successful patient experience and involvement strategy requires a multi-faceted approach, sustained commitment and regular refinement based on feedback and evolving healthcare. By placing patients and their families at the heart of every decision, LTH can significantly improve quality of care and patient outcomes.

19.2 As the strategy closes, engagement will commence to agree and co-produce the next iteration of the plan. This will involve:

- defining a clear goal and defining the objectives.
- engaging stakeholders and seeking out new methods of engagement
- using feedback.
- developing policies that cater to the diverse needs of the patient population, including those with disabilities and those where English is not the first language.
- developing protocols for clear, honest and timely communication.
- provide patients with easily understandable information.
- implement training and development plans.
- use digital platforms and technology effectively.
- monitor performance, evaluate and adapt.
- ensure strong leadership and role modelling of patient centred values.
- develop recognition and reward schemes.
- collaborate with community and patient advocacy groups.

20 Financial implications

20.1 Whilst no direct costs have been applied to this annual report, it is recognised that patient experience directly links with improved outcomes, and improved efficiency and therefore getting this right provides a direct contribution to the efficient and productive running of the organisation.

21 Legal implications

21.1 None

22 Risks

22.1 Inpatient experience is the most significant area within the organisation that requires improvement. This is predominantly because of flow and communication. Both topics have strategies and improvement plans aimed at resolving the challenges and associated risk assessments.

23 Impact on stakeholder

23.1 The continued drive to engage and listen to our patients and work in partnership in regard to their lived experience is clearly evident. There is evidence of increased engagement this year as the organisation recovers from the pandemic. A reduction in complaints, increased friends and family recommendations and increase in improvement work aims to continue to address feedback received from patients and families and in year 3 improvements will be prioritised around the emergency pathways across all specialties.

24 Closing year 2 and moving to year 3

24.1 The strategy identifies the actions that will be taken in year 3, due to the requirement to prioritise focus, a number of year 2 strategies will be carried over to be delivered also. From the year 2 strategy the delivery of a training package for leaders to understand local resolution, as well as how to provide appropriate responses to complaints. There will be further development of PCCN, continue the gynae road map and improving STAR will be a key focus of delivery. The continued work and expansion of forums to be more diverse and be used to influence Trust policy, pathways across the organisation with be a key driver in change and delivery.

24.2 Working alongside the new PSIRF principles of engagement and using patient safety partners as a voice in our key improvement strategies will lead to continued delivery of the strategy. This will also lead to the development of another wholly inclusive strategy for the next 3 years.

25 Equality, Diversity and Inclusion

25.1 The Equality, Diversity and Inclusion strategy is the golden thread that runs through the Patient Experience and Involvement Strategy. It is vitally important that as part of this strategy we are always consciously inclusive in everything we do. As part of being wholly inclusive and diverse we need to ensure we gather as much information from the patient voices of those who are seldom heard, so a real focus on those with protected characteristics whilst using Friends and Family feedback, Datix and PSIRF as well as working alongside our health inequalities agenda. This will enable us to really understand the true diverse voices of the patients.

25.2 The requirement to continue to understand experience by each protected characteristic group and considering deprivation is developing and will form a large part of the focus on data for year 3 of the strategy.

26 Recommendations

It is recommended that Board of Directors:

- Receives the update on year two of the Patient Experience and Involvement Strategy 2023-2024, noting the scrutiny completed through safety and quality committee.

Appendix 1

OUR PATIENTS' COMMENTS – April 2023 – March 2024

We have received over 60,000 responses in 2023 from our patients with an overall positive response of 90.39%

All the staff were delightful. They kept me informed of what was happening to me (treatment/test wise). They were very attentive & responded well to my requests (Ward 20)

Friendly, professional delivery of care with empathy. Good communication on next steps and wait times. Calm management of a busy waiting room observed. (A&E)

All staff extremely friendly & helpful at all times of the day (Ward 8)

Appointment on time and very pleasant and helpful staff. (CT scan)

Personal care delivered to the highest standards with respect for the patient and their best interest provided for at all times and by each and every member of the NHS Team (Oncology)

The professional treatment from all staff was excellent. However, in addition, the communication, explanations and responses from the nursing staff was superb.I felt a real part of my recovery. (Leyland Ward)

I was overwhelmed but everyone took time to listen to me, to explain what was going on, and most importantly to reassure me. (Theatre Day case)

Just been looked after really well Really nice staff on the ward! Enjoyed my stay, going to miss the place Now I'm better time to go home Thank you! (Cardiac Unit)

Mum has dementia with dysphagia - she is non verbal and receiving palliative care with end of life meds. Family have been consulted at every stage and have been included in all decisions and medical plans with informative guidance THANK YOU ALL! 5* + (Ward 23)

The staff made me feel welcome, put me at ease and more relaxed about the procedure. They were very kind and patient. (Endoscopy)

Very attentive and caring, showing empathy when looking after me before the operation. (Gynae)

Staff are caring and no how to handle all situations in calm manner! They care for the babies + parents and they are respectful + poliet and listen to your concerns. (NNU)

Friendly staff

Reception staff welcoming nursing staff welcoming on arrival at the clinic. Information on wait times displayed Appointment on time, consultation thorough. (Immunology)

Treated as a human being, with respect, very friendly & attentive - superb care, couldn't do enough for me - very happy. (Ashton)

All amazing

Everyone was polite and helpful

OUR PATIENTS' COMMENTS – April 2023 – March 2024

We have received over 60,000 responses in 2023 from our patients with an overall negative response of 5.50%

It was a long wait at Preston I was told to go for 12'oclock I wasn't seen till 3 so it was an awful long wait especially for people who taken me there. Apart from that I think everything was alright thank you. (Ward 4)

I have waited over a year and a half for the operation, arrived on time and waited another 6.5 hours only to be told the surgeons don't have the correct instruments to carry out the operation and was sent home. I tried to empathise, though it's hard to understand how they can be without equipment for a planned procedure.Both me and my dad took holiday days and to top it off, had to pay for parking on exit. (Day case Theatres)

Even though there I was the only one in the waiting room, I had to wait an extra 30mins to be called in to see the consultant, hence seeing the consultant in total 45mins after by appointment time. If this continues people will just arrive late in the future. (Endocrinology)

The was only one toilet and I ten was filthy with urine all over the seat and floor. (Gynae)

I was waiting for hours in MAU waiting room and felt I was admitted unnecessarily.Doctor assessed me at 5am and told me he would contact neurology only to be told by consultant there is no neurology department.What a wasted exercise. There was no choice offered at meal time.You got what was available which wasn't edible.The staff were friendly but felt I was left to my own devices for hours.

Waiting time really bad, huge backlog but the staff are brilliant, even offer brews, sandwiches, very apologetic. Not their fault. Corrupt Government need to sort nhs! And protect our nurses. (Gastro Surgery)

Waited 7hrs in accident emergency was told id have to wait till morning to see a doctor so i went home

Takes too long for buzzer to be answered. Feels things haven't been explained to him.Very pleasant staff (Meadow)

Too busy no time to do one thing at once ask for something you have to wait hope they don't forget (Cuerden Ward)

Had day surgery. No aftercare advice given or even spoken to about what had taken place during surgery. Had to ring from home on 3 occasions to try and get some answers, before speaking to a dr who was arrogant and disregarded my concerns. Given the surgery was for a 'cancer scare' I have been left unsupported and feeling let down tbh.

Mine and my daughters bloods went missing leading to my daughter needing to have 4 blood test at less than 24 hours old, doctor on shift at night couldn't give a detailed answer why this was, therefore we had to wait until the doctor on shift the following day came to see us

The staff were lovely. Very reassuring & made us feel safe and welcome but cubicle 39 is too close to the nurses station & the door doesn't close, it was too noisy for baby to sleep most of the time. Door needs sorting. (PAU)

Board of Directors

PSIRF Update and Annual Report of Incidents reported to the Strategic Executive Information System (StEIS)

Report to:	Board of Directors	**Date:**	6th June 2024
Report of:	Chief Nursing Officer	**Prepared by:**	H Hodgson
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

The purpose of this paper is to provide an update on the implementation of the Patient Safety Incident Response Framework (PSIRF) and to provide an annual overview of incidents reported to the Strategic Executive Information System (StEIS) between 1st April 2023 – 31st March 2024 inclusive.

- During 2023/24, the Trust has successfully transitioned from the Serious Incident Framework (SIF) to PSIRF with partial implementation on 6th November 2023 and full implementation on 25th March 2024. This has been supported by:
  - The development of a PSIRF Policy and PSIRF Plan, endorsed by the Trust Safety and Quality Committee, the Board of Directors and by the ICB.
  - ICB Community of Practice Meetings to ensure oversight of Trust PSIRF progress.
  - Identification of local and national priorities.
  - Appointment of 3 Patient Safety Partners and a maternity neonatal voices partnership chair to ensure the voice of the patient is heard.
  - A roll out of PSIRF training with a Training Needs Analysis (TNA) for appropriate staff. Although accessibility of this training has been challenging.
  - Configuration of the Trust's Incident and Risk Management System to support the PSIRF roll out.
  - A review of PSIRF governance arrangements and new meetings structures.
  - Joint working with other trusts across Lancashire and South Cumbria.

- The Trust successfully transitioned from the National Reporting and Learning System (NRLS) to the Learning from Patient Safety Events (LFPSE) system, a new national centralised system for the recording and analysis of patient safety events in health and care services in September 2023, making the Trust compliant with the national requirement deadline.

- In 2023/24, the combined number of incidents reported to StEIS was 89. In comparison to the previous year, this represents a decrease against the 2022/23 reported figure of 111. 81 of these incidents were

reported under the SIF and 8 of these incidents have been reported under PSIRF. The reduction in incidents reported to StEIS in the last quarter compared to the previous is due to the criteria for StEIS no longer being based on harm level but rather based on national and local priorities. This a significant shift in management of serious incidents and should therefore be considered when making comparisons to numbers of incidents reported to StEIS prior to the 6th November 2023 and previous years going forward.

- The most common type of incidents reported to StEIS in 2023/24 under the SIF and PSIRF criterion were pressure ulcers (24), slips, trips and falls (15), treatment delay (10), maternity incidents (8), suboptimal care of a deteriorating patient (6).

- During 2023/24, the Trust reported 3 Never Events to StEIS. This is a decrease in the number of Never Events which were reported by the Trust in 2022/23 (4). All Never Events reported in 2023/24 have occurred within the Surgical Division. 2 occurred within the category of Wrong Site Surgery (wrong side lumbar decompression and wrong side injection) and 1 within the category of incorrect naso-gastro tube placement.

- During the reporting period, there have been 3 incidents that have met the Patient Safety Incident Investigation (PSII) criteria. 1 was under the national priority of Death thought more likely than not due to problems in care and 2 under the Never Events criteria.

- During the reporting period of 2023/24, there have been 10 cases reported which are also subject to a claim, 12 cases which have been subject to a formal complaint and 10 cases with the outcome of Death reported within this year are also subject to inquest.

- The Trust has received one Regulation 28 in the reporting period. Details have been previously provided to the Safety and Quality Committee, learning focused on management of obesity and VTE risk and patient and carer involvement with learning disability and mental health presentations.

- Whilst the Trust has successfully transitioned to PSIRF, there are a volume of historical incidents under the SIF that are not StEIS reportable that remain open. These are being tracked and monitored at PSIRF Oversight Panel to ensure these are demonstrating a downward trajectory.

- As the Trust only formally went live with all learning responses on 25th March 2024, trends and themes of learning are still emerging. Whilst responding to individual incidents at Lancashire Teaching Hospitals is proportionate based on the Trust wide triage system, for those incidents where the understanding of why an incident repeatedly occurs is well established and further look back is unlikely to bring about new information or learning, time is being invested in taking action to address improvements in the safety profile by developing safety improvement plans. This work is still maturing and so further updates will be provided in future reports.

- Although timely Duty of Candour (DOC) has been applied for all cases reported to StEIS unless there was a justifiable reason, data reported to the Trust Safety and Quality Committee and a recent review by Mersey Internal Audit Agency (MIAA) have identified some room for improvements in applying DOC in a timelier manner. The findings of the MIAA review have been shared with clinical teams, a focus group has been held to understand barriers and solutions to applying timely DOC and this is informing a refresh of the trust policy which is due to be completed in the next few weeks.

It is recommended that the Board of Directors:

i. Receive the report for information, noting it has been scrutinised at safety and quality committee.

Appendix 1 – Charts and Graphs
Appendix 2 – Learning Summaries from Never Events in 2023/24
Appendix 3 – Summary of Maternity Cases Reported to StEIS in 2023/2024

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 2024.

1. Introduction

1.1 The purpose of this paper is to provide an update on the implementation of the Patient Safety Incident Response Framework (PSIRF) and to provide an annual overview of incidents reported to the Strategic Executive Information System (StEIS) between 1st April 2023 – 31st March 2024 inclusive.

1.2 The paper also informs the Safety and Quality Committee of any:

- Themes and trends for incidents reported to StEIS in the reporting period 2023/24.
- Common system and process contributory factors, frequency and types of incidents causing harm and any changes in reporting patterns.
- Any patient pathways or clinical areas / specialities of concern.
- Information on common actions, relevant work streams and safety improvement projects.
- Cumulative data to provide an accurate picture of emerging trends, issues or concerns.

2. Discussion

2.1 Implementation of PSIRF

2.1.1 On the 6th November 2023, after an intensive period of preparatory work, the Trust transitioned from the Serious Incident Framework (SIF) to PSIRF with full implementation on 25th March 2024.

2.1.2 The PSIRF represents a significant shift in the way the NHS responds to patient safety incidents. It supports the development and maintenance of an effective patient safety response system that integrates a considered and proportionate response to patient safety incidents, compassionate engagement, and involvement of those affected by them. It also supports the application of system-based approaches to learning and a supportive oversight focussed on strengthening system functioning and improvement.

2.1.3 The implementation of PSIRF has been supported by the implementation of a PSIRF Policy and development of a PSIRF Plan which was endorsed by the Safety and Quality Committee, Board of Directors and Integrated Care Board (ICB).

2.2 PSIRF Governance arrangements

2.2.1 In February 2024, the Trust formally adopted a new governance meeting structure to support the management of patient safety incidents under PSIRF, replacing Safety and Learning Group (SLG). The new structure includes the following:

PSIRF Level 2 Triage meeting	All patient safety incidents are triaged within the Divisions (Level 1 Triage) each working day and any incidents which potentially meet local or national reporting priorities (see section 2.3.7 and 2.3.8) are escalated to a weekly Corporate led PSIRF Level 2 Triage meeting. Cases are discussed at the PSIRF Level 2 Triage meeting for oversight and consideration of a Patient Safety Incident Investigation (PSII), if appropriate.

PSIRF Oversight Panel (Occurring weekly)	This meeting is Executive led and serves to oversee and approve PSII Terms of Reference (TOR), agree investigation and engagement Leads and confirm investigation deadlines at the point of commissioning a PSII. The panel is also responsible for overseeing and approving completed PSII reports, and any Level 3/StEIS investigations during the period of transition. A representative from the ICB is part of the core membership of the PSIRF Oversight Panel.
Always Safety First Learning and Improvement Group (ASFLIG) (Occurring fortnightly)	This meeting has multi-disciplinary membership from all Divisions provides oversight and assurance that the learning and improvements identified from PSIRF are monitored and sustained evidencing a reduction in patient safety risk and improved quality of patient experience. This is achieved by overseeing learning and improvements identified from PSIIs and other learning responses in line with PSIRF standards in a way that allows the Trust to demonstrate improvement, rather than compliance with prescriptive, centrally mandated measures. The meeting is also monitoring the progress of the Trust's Always Safety First (ASF) Strategy and ensures all work undertaken on patient safety aligns to the Trust's Organisational objectives and Trust values.

2.2.2 A number of Trusts across the Lancashire and South Cumbria region have attended or requested to attend the PSIRF Level 2 Triage and PSIRF Oversight meetings, to observe our meeting format and structure, with a view to adopt these principles locally.

2.3 Themes and Trends for Incidents Reported in 2023/24

2.3.1 ***Chart 1 in Appendix 1*** provides a summary of overall incident reporting in 2023/24 compared to previous years. This demonstrates that across all levels of harm, incident reporting overall broadly continues to track trust activity.

2.3.2 ***Chart 2 in Appendix 1*** provides a breakdown of reported incidents to the StEIS from Quarter 1 2017/2018 up to and including Quarter 4 2023/24. Due to the implementation of PSIRF, reporting to StEIS now sits within the lower control limits with a significant reduction in the number of incidents reported to StEIS in Quarter 4 2023/24.

2.3.3 In 2023/24, the combined number of incidents reported to StEIS was 89. In comparison to the previous year, this represents a decrease against the 2022/23 reported figure of 111. 81 of these incidents were reported under the SIF and 8 of these incidents have been reported under PSIRF

2.3.4 The reduction in incidents reported to StEIS in the last quarter when compared to the previous quarter is due to the criteria for StEIS no longer being based on harm level but rather based on national and local priorities. This a significant shift in management of serious incidents and should therefore be considered when making comparisons to numbers of incidents reported to StEIS prior to the 6th November 2023 and previous years going forward.

2.3.5 The criteria for reporting to StEIS under SIF were serious incidents including acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in

serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

2.3.6 The criteria for reporting to StEIS under PSIRF are patient safety events that meet the national or local priorities.

2.3.7 National priority criteria are as below:

1. Deaths thought more likely than not due to problems in care.
2. Deaths of patients detained under the Mental Health Act (1983) or where the Mental Health Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care.
3. Incidents meeting the Never Events criteria.
4. Mental health-related homicides.
5. Child deaths.
6. Maternity and neonatal incidents meeting the Health Services Safety Investigations Body (HSSIB) or Maternity and Neonatal Safety Investigation (MNSI) criteria.
7. Deaths of a person with learning disabilities.
8. Safeguarding incidents meeting criteria.
9. Incidents in NHS screening programmes.
10. Deaths in patient's custody/prison/probation.
11. Domestic homicide.

2.3.8 The Trust's local priority criteria are as below:

1. Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women).
2. Delayed, missed or incorrect cancer diagnosis.
3. Prescribing or administration error or near miss of anticoagulation medication.
4. Adverse discharge due to gaps in communication or misinformation.
5. Delay in responding to a critical pathology finding.

2.3.9 At present, it is difficult to determine how Lancashire Teaching Hospitals incident reporting data compares to national incident reporting. This is due to the transition from the National Reporting and Learning System (NRLS) to the Learning from Patient Safety Events (LFPSE) system, a new national centralised system for the recording and analysis of patient safety events in health and care services.

2.3.10 At Lancashire Teaching Hospitals, LFPSE implementation was completed on 30th September 2023, making the Trust compliant with the national requirement deadline. However, not all organisations have been able to meet the national deadline impacting availability of data to inform LFPSE national reports and benchmark reporting rates. Once rolled out fully, the new LFPSE system is expected to offer support for staff from all health and care sectors to record safety events, providing greater insight and analysis to aid national and local safety improvement.

2.3.11 ***Chart 3 in Appendix 1*** shows the numbers of StEIS incidents reported during each Quarter of 2023/24 per Division. Key points of note are as follows:

- The ***Division of Surgery*** reported 24 incidents in 2022/23, which is an increase on the previous year's total (22).
- The ***Division of DCS*** reported 8 incidents in 2023/24, which is an increase on the previous year's total (7).
- The ***Division of Medicine*** reported 36 incidents in 2023/24 This is a decrease to the previous year's total (54).
- The ***Division of Women and Children*** reported 15 incidents in 2022/23 with 8 being reported under the category of Maternity. This is a decrease to the previous year's total (22). These reporting figures are in part attributable to the requirement to StEIS report all incidents which meet Maternity and Newborn Safety Investigations (MNSI) (previously HSSIB) criteria in terms of unexpected outcome and does not necessarily indicate poor care.
- The ***Corporate Division*** reported 5 incidents in 2023/24. This is an increase on the previous year's figures (4).
- The ***Estates and Facilities Division*** has reported 1 incident in 2023/24 which is a decrease to the previous year's figures (2).

2.3.12 ***Table 4 in Appendix 1*** shows the types of incidents reported to StEIS in 2023/24 under the SIF and PSIRF criterion. The top incident types by numbers reported are:

- Pressure Ulcers (24)
- Slips, trips, and falls (15)
- Treatment delay (10)
  - When broken down further, 2 of these are related to the thrombectomy service, other incidents are related to treatment delays with respect to other services or conditions i.e. eating disorders, delays on discharge, delays in initiating treatment for hyperkalaemia, delays in management of venous thromboembolism, delays in management of necrotising fasciitis, delays with acting on scan results, cancer tracking delays.
- Maternity Incidents (including 2 reported under national priority which meets MNSI criteria) (8) that met maternity triggers – see section 2.9.
- Sub optimal care of the deteriorating patient (6)

2.4 Never Events

2.4.1 During 2023/24, the Trust reported 3 Never Events to StEIS. This is a decrease in the number of Never Events which were reported by the Trust in 2022/23 (4).

2.4.2 All Never Events reported this year have occurred within the Surgical Division. 2 occurred within the category of Wrong Site Surgery (wrong side lumbar decompression and wrong side injection) and 1 within the category of incorrect naso-gastro tube placement.

StEIS ref	Datix ID	Incident Date	StEIS Reported Date	Division	Location of Incident	Category	Level of Harm
2023/ 11484	123788	07/06/23	12/06/23 under SIF	Surgery	Theatre 3 (CDGH)	Wrong site surgery	Moderate Level 3 investigation completed
2024/ 2222	149449	31/01/24	23/02/24 Under PSIRF	Surgery	Lancashire Eye Centre, (CDGH)	Wrong site surgery	Low PSII under-way
2024/ 2223	149503	01/02/24	23/02/24 Under PSIRF	Surgery	Ward 14, Ortho-paedics (RPH)	Incorrect Naso-gastro tube placement	No Harm AAR completed but reported under PSII criteria as agreed with ICB

2.4.3 Detail of the Never Event cases and the learning from the investigations is listed in ***Appendix 2.***

2.5 Level 3 / StEIS incidents with outcome of death

2.5.1 For the period of 2023/24, a total of 17 incidents were reported to StEIS with the criteria of unexpected/potentially avoidable death. This reflects a decrease from the 20 cases reported the previous year. It should be noted that the term outcome of death is used to identify all incidents where a patient has sadly passed away subject to investigation or inquest where acts or omissions in care were a contributory factor, or where the death is unexpected and required further investigation to establish events leading to the death.

2.5.2 A summary of these cases and the associated learning have been included in quarterly reports to Safety and Quality Committee throughout 2023/24.

2.5.3 2 of the 17 cases relate to unexpected/potentially avoidable deaths reported within Maternity and Neonatal services, which is a decrease in comparison to the previous year (5). Learning from the 2 cases has identified missed opportunities to consider a holistic review of pregnancy and assurance that triage assessment guidance is embedded into practice. There were no cases of maternal death reported this year.

2.6 Types of Investigations based on severity of harm

2.6.1 Under SIF, the level of harm attributed to an incident determined the level of investigation with all incidents confirmed as severe harm or death subject to a serious in-depth incident investigation and incidents confirmed as moderate harm subject to a Situation, Background, Analysis and Recommendation (SBAR) investigation.

2.6.2 PSIRF no longer mandates that the most in-depth investigations are undertaken based on levels of harm, with the focus being on the opportunity for learning instead. However, there is an

acknowledgment that some level of due diligence is given to those incidents that are moderate or above and harm. At Lancashire Teaching Hospitals, all patient safety incidents are triaged within the Divisions (Level 1 Triage) each working day and any incidents which potentially meet local or national reporting priorities are escalated to a weekly Corporate led PSIRF Level 2 Triage Meeting alongside any cases regardless of harm which require escalation, support, further scrutiny or where organisational learning may be indicated.

2.6.3 During the reporting period, there have been 3 incidents that have met the PSII criteria:

- National priority criteria of Death thought more likely than not due to problems in care (1)

A medical examiner review reported an incident in relation to a 52-year-old gentleman with Type 2 diabetes, advanced kidney injury (AKI) and urosepsis, for which the patient was noted to have received the appropriate treatment; however, following a cardiac arrest, it was identified that the patient's blood glucose levels had been omitted to have been monitored following the administration of a variable rate insulin infusion.

On the 8th of November 2023, the patient had required a variable rate insulin infusion for raised blood glucose level. The cannula was inserted at 22:35 and the patient's blood glucose checked via the Point of Care Test (PoCT) device at the time reported a result of 17.7, and the infusion was started at 6 units of insulin per hour. The incident highlighted that the patient's blood glucose was not checked again following the commencement of the insulin infusion. The patient was viewed by a Health Care Assistant (HCA) a midnight, 02:00 and again at 03:35, where it is documented on the Essentials of Care Intervention Chart that the patient appeared to be sleeping. At approximately 04:36 on the 9th of November 2023, a cardiac arrest bleep was activated, and the resuscitation team promptly attended. The resuscitation team identified that the patient had been receiving an insulin infusion for high blood glucose levels, and upon checking, the patient's blood glucose was noted at that time to have been 1.1 mmol. Cardiopulmonary resuscitation (CPR) commenced for 30 minutes, where the team noted that the patient's arrest rhythm was asystole throughout. The resuscitation was unsuccessful, and the team decided to stop CPR after 30 minutes. The patient sadly passed away at 05:10 on the 9th of November 2023.

The incident reported was subject to Level 2 Triage, where a Rapid Incident Review (RIR) was requested and held on the 22nd of November 2023. The conclusion of the review was for consideration of a PSII. A Section 42 notification has been sent to the Local Authority, detailing the events of the incident. Early review from the RIR identified that on the balance of probabilities, the lack of monitoring the patient's blood glucose was the main contributory factor for the patient's cardiac arrest and that an investigation should commence.

The case was discussed at Safety and Learning Group (SLG) on 7th December 2023 (prior to the change in PSIRF governance meeting structures) and a PSII was commissioned. The patient's family have been involved in developing terms of reference for the investigation, which is due for completion in June 2024.

- National priority of Never Event (2)

Further details on these 2 Never Event cases are included in section 2.4.2 and ***Appendix 2*** – See cases 2024/2222 and 2024/2223 for further information.

2.6.4 It should be noted that whilst there were only 3 PSIIs commissioned under PSIRF during 2023/24, there were 8 incidents declared to StEIS (***see Table 4, Appendix 1***). This is due to guidance from the ICB that the Trust were required to report those incidents that met the national criteria but did not require a PSII as they would be investigated via other agencies e.g. Child deaths investigated via the Child Death Overview Panel despite not being due to any problems in our care. The reporting of incidents to StEIS that meet the national priorities but do not require a PSII may be subject to change as we move forward.

2.6.5 All other patient safety events are considered for an alternative type of alternative learning response. The other learning responses under PSIRF are as follows:

- After Action Reviews (AAR) – An AAR is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.
- PSIRF SWARM Huddle - Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.
- Multi-Disciplinary (MDT) Review - The MDT review supports teams to identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.
- Thematic Review - A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative rather than quantitative data to identify safety themes and issues.

2.6.6 Observations from the new PSIRF governance meetings has been that the use of other learning responses has led to shorter and timelier investigations in some instances, resulting in identification of early learning and feedback to patients, families and carers and agreement that commissioning of a PSII may not be necessary if no further learning can be extracted.

2.7 Open incidents under SIF

2.7.1 As of 14th May 2024, 8 Level 3 investigations remain open under SIF. 1 of these investigations is subject to MNSI review. The 7 remaining investigations are subject to extensions agreed by the ICB.

2.7.2 Whilst the Trust has successfully transitioned to PSIRF, there are a volume of historical incidents under the SIF that are not StEIS reportable that remain open. These are being tracked and monitored at PSIRF Oversight Panel to ensure these are demonstrating a downward trajectory.

2.8 Closed incidents during 2023/24

2.8.1 Summary of closed cases in Quarter 1, 2, 3 and 4 2023/24 have been provided on a quarterly basis to the Safey and Quality Committee.

2.9 Maternity Incidents reported to StEIS

2.9.1 In 2023/24, the maternity service reported ten incidents to StEIS, eight of the cases were reported under maternity triggers (see section 2.3.12) and two were reported under non-maternity triggers. Of the non-maternity triggers one incident was reported under the category of treatment delay (venous thromboembolism) and one under the category of adverse medical coverage of public concern about the organisation or wider NHS. In October 2023, the Maternity Newborn Safety Investigation (MNSI) team were established to undertake maternity investigations referred to the Healthcare Safey Investigation Branch (HSIB). All cases referred to HSIB and MNSI in 2023/2024 were reported to StEIS in accordance with Trust process.

2.9.2 A summary of the cases, their current status alongside any learning and actions are detailed in ***Appendix 3.***

2.10 Common or emerging incident themes

2.10.1 As the Trust only formally went live with all learning responses on 25th March 2024, trends and themes of learning are still emerging. Any themes and trends at Divisional level continue to be shared at Divisional Safety and Quality and Always Safety First Meetings with divisional quality improvements identified, risks raised on the risk register for management or themes developed into safety improvement actions.

2.10.2 To mature our organisational learning, from Quarter 2 2024/2025 each division will be required to present themes and trends from Divisional learning responses, safety improvements completed or currently being implemented at the Trust's Always Safety First Learning and Improvement Group to support wider sharing of learning to ensure improvement in patient/staff safety across the trust. Outputs from this will be shared in future updates to the Trust Safety and Quality Committee.

2.10.3 In the meantime, some common and emerging incidents and themes from the last 12 months and actions being taken are detailed below.

Thrombectomy	The Trust has seen a theme of incidents linked to gaps in thrombectomy service position. The Trust is commissioned to deliver a 7-day Thrombectomy service 8am - 6pm but due to workforce limitations, a 5-day service was provided. In September 2023, the Trust commenced a weekend Thrombectomy service, increasing service provision from Monday- Friday 8am-6pm (receiving the last patient at 4pm). However, following the commencement of the weekend Thrombectomy service, the Trust has been unable to agree and mutually beneficial job plan arrangement for the weekends, which is

	consistent with other centres providing the same service. Until an agreement is reached, a decision has been made to stand down the weekend service until further notice. The Trust continues to apply mitigating controls where possible, which include the request to transfer patients to other service providers for treatment, to offer Thrombolysis as appropriate and to provide 24/7 Consultant Nurse cover. The safety and quality committee are monitoring progress against the plan. Incidents where patients are considered to have suffered an adverse outcome as a result of the limitations to the Thrombectomy service are reviewed via the Stroke Panel. Any incidents of concern are also escalated to the weekly PSIRF Level 2 Triage Meeting.
Venous Thromboembolism (VTE) anti-coagulation	Whilst VTE risk assessment compliance has improved and been sustained above 90%, the Trust has seen a theme of incidents related to the prescribing and management of anti-coagulation medication and thromboprophylaxis and some instances of omission of VTE assessment completion. Although these incidents fall under one of the Trust's local priorities for PSII, it is not appropriate to undertake a PSII for every incident. Terms of Reference for a thematic review of incidents were agreed at the Trust's inaugural VTE meeting in February 2024, in addition to the VTE lead Pharmacist undertaking a review of current VTE guidance and to perform a gap analysis against practice. An improvement plan focusing on increased compliance with VTE guidance is being developed and will be presented to the PSIRF Oversight Panel in the next quarter.
TTO/Adverse discharge	A theme concerning the confirmation of and locking down of To Take Out (TTO) medications prior to patient's discharges has been identified via the PSIRF Level 2 Triage Meetings. Initially, a thematic review of cases was suggested, however development work is underway for the Trust's Single Improvement Plan and the Trust's Chief Pharmacist has ensured that the metrics relating to the medicines management element of discharge have been included. Performance of these metrics will be tracked via the Divisional Improvement Forums (DIF).

Missed diagnosis of cancer/Lost to follow up during cancer pathways	There is a risk that there may be a delay, or missed diagnosis in patients with cancer and this may lead to patient harm. There is also the possibility that patients who are already on a cancer tracking pathway, may be inadvertently removed, or 'lost' from the pathway. These incidents are also linked to a current active risk relating to a lack of a robust and consistent processes for the requesting, reporting, alerting, and acting on Radiology investigations within the Trust. The Trust's Lead Nurse for cancer services is developing a Cancer Tracking Improvement plan which will be monitored via the Always Safety First Learning and Improvement Group. Controls in assurance currently include the use of surveillance pathways and daily review of the patient tracking list by the Cancer Tracking team.

2.11 Development of Improvement Plans

2.11.1 PSIRF emphasises that learning and improvement should be undertaken using a system-based approach. Whilst responding to individual incidents at Lancashire Teaching Hospitals is proportionate based on the Trust wide triage system, where the understanding of why an incident repeatedly occurs is well established and further look back is unlikely to bring about new information or learning, time is being invested in taking action to address improvements in the safety profile by developing safety improvement plans. This is to ensure that true learning has taken place with some examples of these listed in Section 2.10.3.

2.11.2 This is a maturing piece of work that is being overseen by the Trust's Always Safety First Learning and Improvement Group with work being undertaken in a phased approach to inform the development of themed improvement plans by:

- Reviewing previous incidents associated with a safety theme to establish recommendations for improvement (Safety I).
- Reviewing evidence based best practice and peer review of those organisations who are achieving better results to learn from what they are doing well, as well as an internal organisational review to learn from those clinical areas performing well (Safety II).
- Incorporating local system knowledge and practice, adherence to policy and understanding what is happening and what improvement are needed based on the views of those colleagues who are patient facing.
- Ensuring the involvement of patient safety partners, patient advocacy groups or patients who have been affected by an adverse safety incident.

2.11.3 Where improvement plans have been developed, each have a Senior Responsible Officer (SRO) and a project group of key stakeholders who are responsible for oversight of the delivery of the plan. In some instances, the improvement plan is attributed to an existing group working on improvements, for example a Big Room who will incorporate this into their driver diagram and measurement strategy. Each improvement plan is expected to have process and outcome measures that will be tracked for improvement with a plan for the SRO or nominated deputy to report progress to the Trust Always Safety First Learning and Improvement Group on a cycle of business.

2.11.4 To date the following improvement plans have been developed in line with the PSIRF Improvement Plan process with others in development as identified in Section 2.9.3:

Clostridioides difficile (C.difficile)	Due to an increase in cases of C difficile across the organisation, Executive oversight meetings led by the Chief Nursing Officer with attendance of Divisional, Estates and Facilities and Health and Safety teams are in place, to identify several areas of improvement which has resulted in the creation of the Trust C Difficile Improvement Plan. This plan includes several areas of focus including improvements to the Trust's estate. Issues include management of the site's waste facilities and discouraging the use of non-biodegradable wipes. Policies and procedures have been updated to include the adequate provision of side rooms with ensuite facilities when configuring ward areas. Signage and handwashing facilities across the Trust have been reviewed, along with cleaning standards. Infection control data has been made available for staff to view and therefore triangulate any infection with practices.
Pressure Ulcers	Pressure ulcers have been the highest reported incidents to StEIS in 2023/24. The reason for this is multifaceted and includes the complexity and frailty of patients admitted to the Trust, increased number of patients admitted to hospital, increase in length of stay within the Emergency Department (ED) and increased bed capacity of the Trust. In response to the high numbers of pressure ulcers, the Trust has launched a Pressure Ulcer Improvement Group focusing on developing a pressure ulcer reduction improvement plan. The group have focussed on incorporating the new national wound care strategy programme recommendations. testing new ways to reduce harm, implementing Trust-wide training, focussing patient and family engagement, and consistently implementing evidence-based standards across the Trust. The group are focussing on changing the approach to making a difference by using data and an improvement measurement plan, taking learning from previous incidents, research evidence and using a Safety II approach to build upon what has worked well from previous improvement projects. Whilst pressure ulcers have seen a reduction, this is yet to achieve the target reduction.
Falls	Slips/trips and falls incidents were the second highest reported incidents to StEIS in 2023/24. In this reporting period improvements have included commencement of a Falls Prevention Big Room using the continuous improvement methodology, developed through the Flow Coaching Academy and

	Falls Prevention Champion role for teams to drive improvements in falls prevention within the Divisions. Falls prevention continues to be a key priority for improvement with a target to achieve a year on year 5% reduction in fall and whilst falls have seen a reduction, this is yet to achieve the target reduction. Therefore from 2024 onward, falls prevention will be included within the Single Improvement Plan.

2.12 Safety Improvement

2.12.1 Examples of other safety improvement work is highlighted in the Trust's Quality Account which is due to be presented to the Safety and Quality Committee in May 2024.

2.12.2 Some examples are provided below:

- Themed analysis to determine improvement priority workstreams include deteriorating patients, reducing violence and aggression, ED exit block and patient flow, rapid tranquilisation and mental health with outputs aligned to Big Rooms.
- An annual report has been presented to enable understanding of reporting incident culture. Analysis of this has been undertaken and presented to clinical divisions for oversight.
- Thematic analysis is now an embedded technique to obtain learning outcomes.
- The ED safety surveillance system has been completed and rolled out which enables the identification of real time organisational safety risks with plans to embed further.
- A Deteriorating Patient Dashboard has been created which gives the Critical Care outreach team the ability to undertake proactive reviews of patients at risk of deterioration.
- Safety surveillance systems are embedded within all adult inpatient acute and general wards.
- Medicines safety improvement work has focussed on missed doses. As at end of March 2024 the data demonstrates consistent performance of 2% for missed doses of critical medicines.
- The pharmacy team are revising the process for medicines reconciliation to include the separation of the drug taking history process for use by the multidisciplinary team which will include consideration of the multiple route's patients receive medication in the community.
- The orthopaedic service is working with the Regional Spinal Network to develop guideline for neurological observations and examinations based on expert consensus, in the absence of national guidance.
- Orthopaedic surgeons are implementing the sterile cockpit principle in theatre to improve situational awareness and also provide a civil way to ask for quiet time during key parts of a procedure.
- In June 2023, a new process was implemented where all incidents of self-harm by patients in hospital are reviewed by a Matron. The Matron review assess if key care interventions took place in accordance with NICE (NG225) guidance. This includes referrals to the Mental Health Liaison Team.
- An ED self-harm policy was published in September 2023 and provides guidance for staff on how to assess and mange risks for patients presenting following self-harm.
- Matrons share with security colleagues each day patients assessed to be at high risk of harm to self who are currently being treated as an inpatient.

- Improved laryngectomy framework and policy.
- Alert added on to Harris-Flex for all patients with a high-output stoma to trigger an automatic referral to the Stoma Nurses and nutrition team to enable regular remote review and support for this patient group.
- Radiology Alert is being rolled out for scan reporting
- A quarterly deep dive of the World Health Organisation/Safer Surgery Checklist audit in theatres is being undertaken.
- Focussed pieces of work on nutrition and fluid balance is being undertaken.
- The Patient Experience and Involvement Strategy and Learning Disability and Autism Plan have been co-designed with people.
- Development of a critical care delivery group focused on improving outcomes for patients in critical and enhanced care environments. The group is overseeing working towards compliance of the perioperative care standards in enhanced care settings .
- There have been ongoing discussions through the weekly mental health “big room” on learning form incidents together with the Mental Health Liaison Team employed by Lancashire and South Cumbria NHS Foundation Trust.
- The Do Not Attempt Cardiopulmonary Resuscitation Big Room (DNACPR) has led to a reduction of incidents from 10 in 2022 to 2 in 2023 for inappropriate resuscitation attempts where a valid DNACPR decision was in place.
- An adverse discharge improvement plan has been developed overseen by the Safeguarding Board.
- The Trust has been successful in being identified for the first phase of the introduction of Martha’s Rule which aims to improve the identification of a deteriorating patient.
- A focussed piece of work has been undertaken to improve local resolution resulting in timelier response to patients, families and carers and improved experience.
- Work has been undertaken to improve overnight response rates with the hospital at night.
- A trauma informed approach to violence and aggression incidents across the organisation is being adopted.
- A review of security training at an organisational level has been undertaken.
- Work is being undertaken with the Race & Health Observatory & Institute for Healthcare Improvement Learning Action Network on post-partum haemorrhage.
- Focussed work has been done in maternity in relation to third and fourth degree tears and with women who do not have English as their first language.
- Enhanced support and guidance for staff who are caring patients displaying challenging or dysregulated behaviour.
- Gynaecological Assessment Unit improvement plan developed focussing on patient experience relating to care provision where patients experience pregnancy loss.
- Gynaecology improvement plan developed focussing on Termination of Pregnancy through an Early Pregnancy working group.
- Breast improvement plan developed in relation to clinical assessment and triage of patients and building protocols to support clinical management of patients during diagnostic process for cancer clinical management.

2.12.3 In addition to the above, further work is being undertaken to review existing improvement work in line with the PSIRF approach as outlined above. Outputs from this will also be shared in future updates to the Trust Safety and Quality Committee.

2.13 Development of a learning strategy

2.13.1 The Always Safety First Learning Improvement Group has identified an ideas list to build and generate our Trust wide learning strategy whilst evolving and evidencing the move towards a learning organisation. A working group has convened to develop this thinking further with a plan to develop an organisational wide learning strategy in 2024/25.

2.14 Cases subject to other forms of investigation

2.14.1 During the reporting period of 2023/24 there have been 10 cases reported which are also ***subject to a claim.*** This is a decrease compared to the number of claims received linked to serious incidents during 2023/24 (22). Matters of concern include pressure ulcer care, inpatient falls, delays in cancer diagnosis, management of maternity and postnatal care.

2.14.2 There have also been 12 cases which have been ***subject to a formal complaint.*** The complaints cover a variety of issues including the management of deteriorating patients, maternity care, inpatient falls, unexpected patient deaths and adverse discharge.

2.14.3 10 cases with the outcome of death reported within this year are also ***subject to inquest,*** 5 of which have been heard by the Coroner. Of the remaining 5, 4 cases are due to be listed, and progression of one case to a full inquest, will depend on completion of the Trust's PSII.

2.14.4 In the majority of cases learning evidenced in the Trust investigation reports are shared with the Coroner and bereaved families ahead of the inquest. However, in some cases the Coroner and families provide further challenge and feedback during the course of the inquest which provide valuable opportunities for further learning. In the case of family feedback this is often softer learning in relation to their own experiences and views on care.

2.14.5 Bereaved families attending inquests have provided valuable feedback both on the care of their relative and on their own experiences. Feedback is shared with Divisions for consideration at their Safety and Quality meetings and are formally reported through the Mortality and Learning from Deaths Annual and Bi-Annual reports.

2.15 Regulation 28

2.15.1 The Trust has received one Regulation 28 in the reporting period. This was issued by HM Coroner for South Manchester in January 2024 following the inquest of a 20 year old patient with a mental health condition and autism who died from a pulmonary embolus shortly after having been discharged from the Neurosurgery Unit having undergone spinal surgery.

2.15.2 An action plan was developed in response which was shared with the Coroner, the ICB and the CQC. This is subject to ongoing monitoring for completion and evidence of embedding of actions.

2.15.3 A paper providing full details has been previously shared with the Safety and Quality Committee. Learning focused on management of obesity and VTE risk and patient and carer involvement with learning disability and mental health presentations. Key actions have included modifications to the Anti Embolism Stocking (AES) care plan, the creation of specific VTE guidance for spinal

patients and the creation of a VTE patient information leaflet, development of a VTE improvement plan, review of the neurosurgery staffing model, improvements in the communication between clinical and nursing teams, review of the communication, documentation and holistic care of neuro divergent patients, updates to learning disabilities and autism plan and amendments to the reasonable adjustments tab.

2.16 Duty of Candour (DOC)

2.16.1 DOC has been applied for all cases reported to StEIS unless a justifiable exclusion has been identified. Examples of justifiable exclusions can be where a patient and/or family do not want to receive DOC or the Trust despite best efforts is unable to locate an address for patient and/or family.

2.16.2 Although timely DOC has been applied for all cases reported to StEIS, data reported to the Trust Safety and Quality Committee and a recent review by Mersey Internal Audit Agency (MIAA) have identified some room for improvements in applying DOC in a timelier manner. The findings of the MIAA review have been shared with clinical teams, a focus group has been held to understand barriers and solutions to applying timely DOC and this is informing a refresh of the trust policy which is due to be completed in the next few weeks.

2.17 PSIRF Training Requirements

2.17.1 Specific knowledge and experience are required for those leading learning responses and those in oversight roles. This includes knowledge of systems thinking and system-based approaches to learning.

2.17.2 A Training Needs Analysis (TNA) was undertaken to identify the cohorts of staff who require PSIRF training, and at which level, dependant on their current role, and potential responsibilities in undertaking PSIIs and learning responses.

2.17.3 However, availability of nationally led accredited PSIRF training has been challenging (i.e. PSIRF Oversight, PSIRF Systems Approach, PSIRF Engagement. Whilst training has been commissioned by the Health Service Safety Investigation (HSSIB) and a small number of other Human Factors Specialist companies, session availability has been significantly limited.

2.17.4 As such, in April 2024, a decision was made to revisit the current requirements of TNA to accurately reflect training availability and colleagues' roles and responsibilities under PSIRF. The change in TNA is expected to be reflected in training compliance reports from June 2024.

2.18 Current PSIRF Training Compliance

2.18.1 As of 16th May 2024, Trust compliance with Patient Safety Training is as follows:

Topic	Attended Within Target Audience	Attended Outside Target Audience	Compliance (Within Target Audience)
Level 1 – Essentials of Patient Safety for all staff	9684	617	98.8%

Topic	Attended Within Target Audience	Attended Outside Target Audience	Compliance (Within Target Audience)
Level 1 – Essentials for Patient Safety for boards and senior leadership teams	1179	164	95.2%
Level 2 – Patient Safety Access to Practice	999	160	80.7%

2.18.2 As of 16th May 2024, the following numbers of staff have completed PSIRF nationally accredited training which is additional role specific training either for those in oversight roles, for those who are learning response leads, or those who are nominated engagement leads.

Topic	Numbers of people who have completed training
PSIRF – Oversight	43
PSIRF – Systems Approach	101
PSIRF – Engagement	201

2.19 Lancashire and South Cumbria PSIRF Community of Practice and Training

2.19.1 To help embed and further improve incident management and investigations under PSIRF across Lancashire and South Cumbria, a Community of Practice Group has been initiated to identify ways of improving patient safety and provide support with the implementation of PSIRF across the region. The group meet monthly, with facilitation provided by Health Innovation Northwest.

2.19.2 Main areas of focus are the standardisation of practice across the region and the development of joint investigation guidance for investigations involving 2 or more Trusts, to ensure key stakeholder engagement, timely completing and shared learning.

2.19.3 In addition to this, members of the Community of Practice have also established a working group, focusing on the development of in-house PSIRF training which can be shared and accessed by Trusts across the Lancashire and South Cumbria region. This has partly been in response due to the limited availability of nationally accredited training but also feedback from staff who have attended the national training that further training on patient safety response skills for all learning responses is required. The bespoke training package is intended to cover human factors, family/patient engagement when things go wrong, duty of candour and patient safety response skills.

2.20 Patient Safety Partners

2.20.1 The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across healthcare in the UK and is part of the new PSIRF.

2.20.2 PSPs are patients, relative carers or other members of the public who want to support and contribute to the Trust's governance and management processes for patient safety.

2.20.3 The Trust has appointed 3 PSPs who commenced their induction and orientation to the Trust in November 2023.The PSPs are core members of the Trust's Always Safety Learning and Improvement Group, PSIRF Oversight Panel and Patient Experience and Involvement Group on a 3-month rotational basis. In addition to attendance at these committees, the PSPs are aligned to identified project streams, including Pressure Ulcer Improvement, Medication Safety, Falls Improvement and involved in recruitment for patient safety roles.

2.20.4 In their roles, the PSPs have been:

- Supporting us in promoting openness and transparency
- Supporting us to consider how processes appear and feel to patients.
- Helping us know what is important to our patients.
- Helping us identify risk by hearing what feels unsafe to patients.
- Supporting the prioritisation of risks that need to be addressed and subsequent improvement programmes.

2.21 Support for patients, families and carers involved in the investigation process

2.21.1 Alongside PSIRF Engagement Training, to support patients, families and carers involved in the investigation process, the Trust has developed a PSIRF Patient Information Leaflet. This outlines what patients can expect if they are involved in a patient safety incident investigation and includes advice on where they can seek support.

2.22 Support for staff involved in the investigation process

2.22.1 Aligned with the patient engagement, PSIRF promotes the compassionate engagement of those staff also with the success of PSIRF reliant on the establishment of a just and restorative culture throughout the process.

2.22.2 A just and restorative culture ensures that individuals feel safe to report incidents without fear of blame or retribution, fostering an environment of learning and improvement. Organisations that prioritise a just and restorative culture are more likely to effectively implement the framework and achieve its intended outcomes. The Trust's Organisational Development team are assisting with the creation of a guide for leaders, to promote principles of just and restorative culture whilst undertaking learning responses. A blame-free environment reduces stress and anxiety among staff and promotes psychological safety, which is crucial for staff well-being and job satisfaction. By integrating just and restorative culture principles into the learning response process, a culture will be created that encourages learning, innovation, and continuous improvement while maintaining a focus on patient safety.

3. Financial implications

3.1 None.

4. Legal implications

4.1 The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute healthcare providers.

4.2 There are some incidents that are subject to claims and the Trust has received a Regulation 28 regarding 1 incident.

4.3 Lack of timely Duty of Candour may lead to CQC enforcement action.

5. Risks

5.1 As described in section 2.9.3 regarding emerging incidents of concern, there are two high risks recorded which relate to the provision of services (stroke and neuro-interventional radiology) that are impacted by the inability to provider a 24/7 neuro-interventional service. There are two active significant risks related to potential missed cancer diagnoses and the inconsistent pathways for monitoring and actioning radiology reports resulting in delayed diagnosis and patient harm.

5.2 Following full transition to PSIRF, there is a risk that the Trust will not effectively embed the new PSIRF Incident Management Processes. This is due to the number of historic incidents remaining under investigation under the SIF framework, causing the Trust to be managing incidents under 2 frameworks, and a lack of accredited and accessible training for staff to complete to understand the PSIRF principles, impacting on a delay to the change in incident management culture potentially affecting management of incidents whilst dual processes are in place and may also impact on the rate at which PSIRF becomes embedded.

5.3 As detailed within section 2.14, non-compliance with DOC processes poses a risk to the Trust.

5.4 Despite reporting 3 Never Events during 2023/24, the Trust aim is to have zero Never Events reported.

5.5 All risks have been reviewed within the appropriate timeframe and have actions ongoing with key risks summarised below.

Risk ID	Risk Title	Score
584	Risk of patient harm due to limited provision of the Neurointervention service	20
1264	Deterioration in the Trust's Sentinel Stroke National Audit Programme (SSNAP)	16
1960	Risk of missed diagnosis in cancer	12
1044	Inconsistent pathways for monitoring and actioning radiology reports resulting in delayed diagnosis / patient harm.	15
1969	Duty of Candour not consistently applied within Trust targets	12
1970	Trust’s ability to robustly embed the PSIRF Incident Management Processes	12
803	Never Events	8

6. Impact on stakeholders

6.1 There may be a negative impact on patients, families and staff who are affected by serious incidents. The findings of investigations together with the recommended corrective actions are always offered to be shared with the patient and family. Staff are also supported following the incident, during the investigation and after the investigation as concluded, should this be required.

7. Summary

7.1 During 2023/24, the Trust has successfully transitioned from the SIF to PSIRF with partial implementation on 6th November 2023 and full implementation on 25th March 2024. This has been supported by:

- The development of a PSIRF Policy and PSIRF Plan, endorsed by the Trust Safety and Quality Committee, the Board of Directors and by the ICB.
- ICB Community of Practice Meetings to ensure oversight of Trust PSIRF progress.
- Identification of local and national priorities.
- Appointment of 3 Patient Safety Partners to ensure the voice of the patient is heard.
- A roll out of PSIRF training with a TNA for appropriate staff. Although accessibility of this training has been challenging.
- Configuration of the Trust's Incident and Risk Management System to support the PSIRF roll out.
- A review of PSIRF governance arrangements and new meetings structures.
- Joint working with other trusts across Lancashire and South Cumbria.

7.2 The Trust successfully transitioned from the National Reporting and Learning System (NRLS) to the Learning from Patient Safety Events (LFPSE) system, a new national centralised system for the recording and analysis of patient safety events in health and care services in September 2023, making the Trust compliant with the national requirement deadline.

7.3 In 2023/24, the combined number of incidents reported to StEIS was 89. In comparison to the previous year, this represents a decrease against the 2022/23 reported figure of 111. 81 of these incidents were reported under the SIF and 8 of these incidents have been reported under PSIRF. The reduction in incidents reported to StEIS in the last quarter compared to the previous is due to the criteria for StEIS no longer being based on harm level but rather based on national and local priorities. This a significant shift in management of serious incidents and should therefore be considered when making comparisons to numbers of incidents reported to StEIS prior to the 6th November 2023 and previous years going forward.

7.4 The most common type of incidents reported to StEIS in 2023/24 under the SIF and PSIRF criterion were pressure ulcers (24), slips, trips and falls (15), treatment delay (10), maternity incidents (8), suboptimal care of a deteriorating patient (6).

7.5 During 2023/24, the Trust reported 3 Never Events to StEIS. This is a decrease in the number of Never Events which were reported by the Trust in 2022/23 (4). All Never Events reported this year have occurred within the Surgical Division. 2 occurred within the category of Wrong Site Surgery (wrong side lumbar decompression and wrong side injection) and 1 within the category of incorrect naso-gastro tube placement.

7.6 During the reporting period, there have been 3 incidents that have met the PSII criteria. 1 was under the national priority of Death thought more likely than not due to problems in care and 2 under the Never Events criteria.

7.7 During the reporting period of 2023/24, there have been 10 cases reported which are also subject to a claim, 12 cases which have been subject to a formal complaint and 10 cases with the outcome of Death reported within this year are also subject to inquest.

7.8 The Trust has received one Regulation 28 in the reporting period. Details have been previously provided to the Safety and Quality Committee, learning focused on management of obesity and VTE risk and patient and carer involvement with learning disability and mental health presentations.

7.9 Whilst the Trust has successfully transitioned to PSIRF, there are a volume of historical incidents under the SIF that are not StEIS reportable that remain open. These are being tracked and monitored at PSIRF Oversight Panel to ensure these are demonstrating a downward trajectory.

7.10 As the Trust only formally went live with all learning responses on 25th March 2024, trends and themes of learning are still emerging. Whilst responding to individual incidents at Lancashire Teaching Hospitals is proportionate based on the Trust wide triage system, for those incidents where the understanding of why an incident repeatedly occurs is well established and further look back is unlikely to bring about new information or learning, time is being invested in taking action to address improvements in the safety profile by developing safety improvement plans. This work is still maturing and so further updates will be provided in future reports.

7.11 Although timely DOC has been applied for all cases reported to StEIS unless there was a justifiable reason, data reported to the Trust Safety and Quality Committee and a recent review by MIAA have identified some room for improvements in applying DOC in a timelier manner. The findings of the MIAA review have been shared with clinical teams, a focus group has been held to understand barriers and solutions to applying timely DOC and this is informing a refresh of the trust policy which is due to be completed in the next few weeks.

8. Recommendations

It is recommended that the Board of Directors:

i. Receive the report for information, noting it has been scrutinised at safety and quality committee.

Appendix 1 - Charts and Graphs

Chart 1: Overall Incident Reporting in comparison with Trust Activity

Quarter	LTHTR activity	Overall incident reporting	Percentage of incidents against overall activity
Quarter 1 2020/2021	122,622	4420	3.6%
Quarter 2 2020/2021	169,003	5249	3.1%
Quarter 3 2020/2021	172,539	6373	3.6%
Quarter 4 2020/2021	179,855	6723	3.7%
Quarter 1 2021/2022	207,826	6604	3.1%
Quarter 2 2021/2022	204,906	9395	4.5%
Quarter 3 2021/2022	206,928	7546	3.6%
Quarter 4 2021/2022	201,785	7399	3.6%
Quarter 1 2022/2023	208,824	7954	3.8%
Quarter 2 2022/2023	213,458	7540	3.5%
Quarter 3 2022/2023	215,487	8669	4.0%
Quarter 4 2022/2023	215,729	8662	4.0%
Quarter 1 2023/24	208 326	8566	4.0%
Quarter 2 2023/24	208,214	9350	4.5%
Quarter 3 2023/24	212,164	8261	3.8%
Quarter 4 2023/24	214,123	8368	3.9%

Chart 2: Number of reported Serious Incidents to StEIS

Q1 2017/18 – Q4 2023/24 SPC Chart

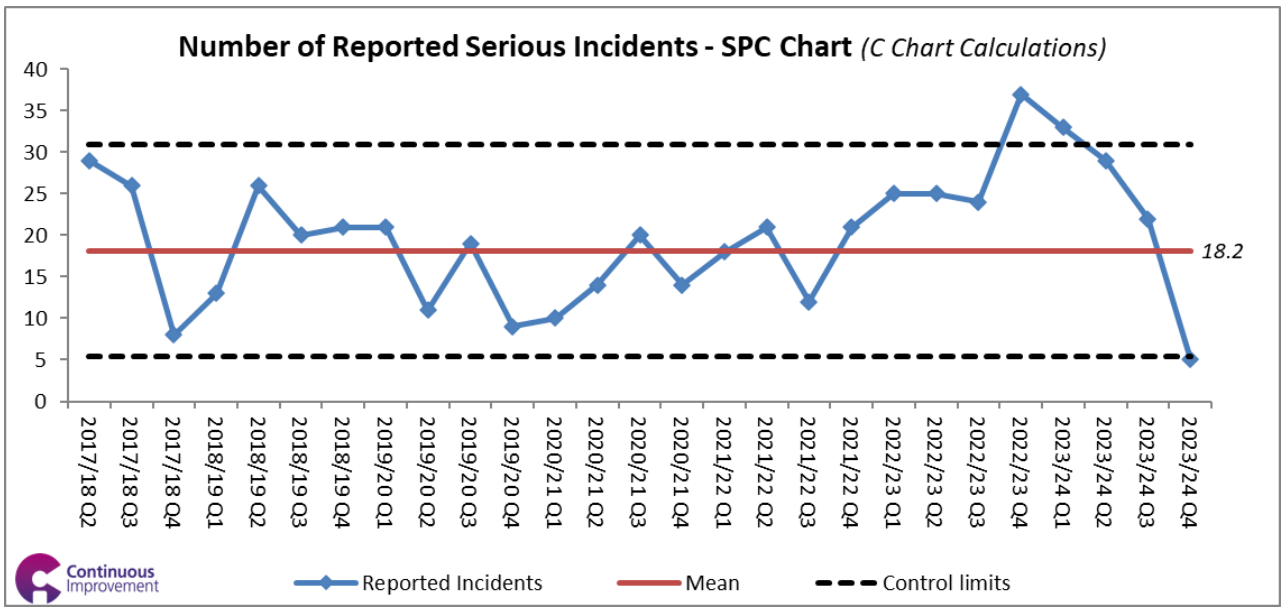


Chart 3: Number of incidents reported to StEIS by Division by quarter during 2023/24

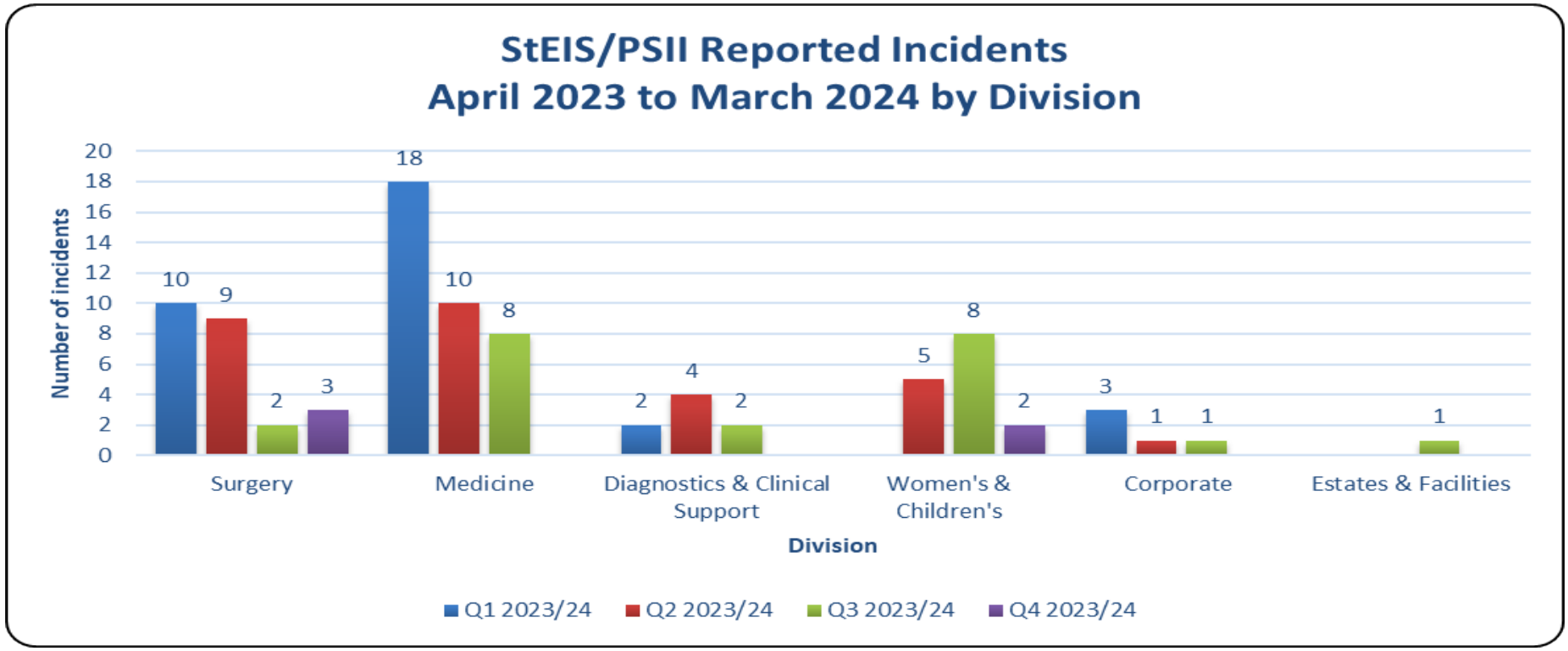


Table 4: Number/type of incidents reported to StEIS each month 2023/24

		Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Total
SIF	Pressure Ulcer	5	3	6	2	1	4	1	2					**24**
	Suboptimal care of the deteriorating patient	1	3		1					1				**6**
	Treatment delay	1	1	2	2	1		1	2					**10**
	Adverse media coverage/public concern about the organisation or wider NHS					1								**1**
	Abuse/alleged abuse of a patient by staff				1									**1**
	HCAI/Infection control incident					3								**3**
	Accident	1												**1**
	Self-Harm		1											**1**
	Diagnostic incident including delay			1				2						**3**
	Slips/Trips/Falls	2		2	1	6	1	2	1					**15**
	Surgical/Invasive procedure incident			1							1			**2**
	Maternity Incident					2		3	1					**6**
	Medication incident					1								**1**
	Abuse/alleged abuse of child patient by third party				1									**1**
	Blood Product/Transfusion incident													**0**
	VTE				1									**1**
	Treatment not available/not completed		1	1										**2**
	Nutrition/Hydration			1										**1**
	Abuse/alleged abuse of child patient by staff							1						**1**
	Incident threatening organisation's ability to continue to deliver an acceptable quality of healthcare services							1						**1**
PSIRF	National Priority - Child Death (NB these are not due to problems in care and have been referred externally)								2	1				**3**
	National Priority - Death thought more likely than not due to problems in care (meets PSII criteria)									1				**1**
	National Priority - Meeting Maternity & Newborn Safety Investigations (MNSI) criteria (referred to MNSI for review)										1	1		**2**
	National Priority - Never Event (meets PSII criteria)											2		**2**
	Overall total by month	**10**	**9**	**14**	**9**	**15**	**5**	**11**	**8**	**3**	**2**	**3**	**0**	**89**

Appendix 2 – Details and Learning from Never Events reported in 2023/24

Never Event Case Number	Details of Incident
StEIS Ref 2023/11484 Never Event – Wrong Site Surgery (Level 3 Investigation Concluded)	A 61-year-old male patient was listed for a left L4/5 decompression in February 2023 following an Orthopaedic clinic appointment. The patient attended for his elective procedure on the 7th June 2023 at Chorley District General Hospital. Prior to surgery, the site was marked correctly on the patient and consent was discussed confirming the procedure: a left L4/5 microscopic central and subarticular decompression which matched the listing letter, the OPERA waiting list entry, previous imaging and the Theatre list for that day. The patient was taken to theatre in the afternoon for his procedure. The Sign In and Time Out as per the World Health Organization (WHO) checklist were completed correctly with the Theatre Team confirming that the patient was to undergo a left L4/5 decompression. The surgical site marking was obscured when the patient was draped. Whilst closure was taking place, it was realised that the decompression had been performed on the incorrect side and a left sided decompression was performed during the same session. The incident was presented at the Trust's Safety and Learning Group on the 6th July 2023 and confirmed that this met the criteria for a Never Event – Wrong Site Surgery. The incident has highlighted the importance of robust challenge, the importance of surgical site marking being visible, the impact of human factors and for all the Surgical Team to stop and verbally reconfirm the procedure in minimising the likelihood of a wrong site surgery occurring. Actions from the investigation included exploring the possibility of changing when Time Out occurs to after staff have scrubbed up and prior to knife-to-skin by way of a working group with a Nursing and Medical Lead and for the spinal orthopaedic surgeons to implement the sterile cockpit principle in theatre to improve situational awareness and also provide a civil way to ask for quiet time during key parts of a procedure.
StEIS Ref 2024/2222 Never Event – Wrong Site Surgery (PSII Underway)	A 72-year-old female attended clinic for an Eylea injection to the left eye for treatment of diabetic macular oedema on 30th January 2024; however, the right eye was injected instead. An AAR was held on the 2nd February 2024 which identified multiple system factors for learning. The Evolve system was not working when the Ophthalmology Nurse Practitioner was conducting pre-clinic checks. This meant that the patient's injection request could not accurately be cross-checked to confirm laterality. The patient was listed for an injection in the right eye by the ophthalmology doctor on Harris Flex. The last follow-up letter did not specify which eye was to be injected. Medisight is a new system and only some Ophthalmology specialties are using the system. The software is not familiar with all staff. Listing laterality

	involves pressing '1' or '2' on the keyboard to indicate left or right. As these buttons are next to each other on a keyboard, this could easily be mistyped leading to incorrect listing. The only computer available for checks in the injection room is for control by the assistant, preventing the injector from viewing clinic software in real-time. The patient had had issues with both eyes and had a history of injections bilaterally. She therefore did not raise any concern when she was informed that her right eye was to be injected. The incident was discussed at the PSIRF Oversight Panel on 22nd February 2024 where the Chief Nursing Officer and Chief Medical Officer were present. It was agreed that due to the opportunities for learning around the appropriate checking of patient notes, prior to any procedure, that this incident met the criteria of a Never Event under the category of Wrong Site Surgery and a Patient Safety Incident Investigation (PSII) has commenced.
StEIS Ref 2024/2223 Never Event - Misplaced naso or oro-gastric tubes (AAR concluded but reported as PSII as agreed with ICB)	A 93-year-old female was initial admitted on the 5th December 2023 for an elective spinal decompression and discharged on the 9th December 2023. On the 16th December 2023, the patient was readmitted with a large post operative haematoma, significant compression of the thecal sack and severe cauda equina compression. Neurological assessments showed that the power in both legs was 2/5. The patient was subsequently taken to theatre for a lumbar wound exploration, haematoma evacuation and duroplasty and was later treated for a deep surgical site infection. On 12th January 2024, a Naso-Gastric (NG) tube was successfully passed with assistance of the Nutrition Team. The aim was to increase the patient's likelihood of survival by increasing her nutritional intake, as this was very poor orally. It was believed that NG feeding could help to improve the patient's consumption and therefore nutritional value. It was hoped this would then impact her ability to recover from her current health problems and frailty. Between 12th January 2024 and 28th January 2024, the patient pulled out her NG tube several times. On 28th January 2024, when the NG tube was reinserted, light bleeding was noted, and the NG tube was left out pending a medical review. On the 29th January 2024, no concerns were noted by the medical team and therefore an NG tube was passed with a bridle. An aspirate of 3.5 was obtained and the NG tube was deemed safe for use. On 30 January 2024 and 31 January 2024, enteral feeding sheets were completed detailing an aspirate of 4.0 and 5.5. On 1st February 2024, the patient became acutely unwell. Chest x-rays showed that the NG tube was in the left bronchus with what appears to be food in the lung. An AAR took place on the 12th February 2024 which concluded that there was good practice overall in the management and care of the NG tube by ward staff. It was also highlighted that the Nutritional Team managed the NG appropriately. All checks were completed within guidance, feeds were only given when a pH of 5.5 or less was obtained and the placement of the NG tube was indicated to give the patient the best chance of survival. The incident does not appear

	to have impacted on the patient's outcome. The patient has been repatriated to Royal Lancaster Infirmary for ongoing care. The incident was discussed at the PSIRF Oversight Panel on the 22nd February 2024 where the Chief Nursing Officer and Chief Medical Officer were present. It was agreed that the incident does meet the criteria of a Never Event under the category of misplaced naso or oro-gastric tubes. However, the circumstances around this incident are rare, in that all appropriate checks were completed before use of the NG tube and all normal safety barriers were in place. The panel agreed that further investigation is unlikely to yield any new learning. The pH reading taken prior to use of the NG tube is within the threshold advised within national guidance and it was noted that there is a recognised 98% false positive rate for pH testing. The incident was reported onto to the StEIS system and relevant commissioners and regulators including the Care Quality Commission (CQC) and ICB were informed. A request was made to the ICB to feedback learning from this case to the national team to reflect that under the current Never Events criteria there does not appear to be any systems factors that have contributed to the patients misplaced NG tube and this incident did not occur due to any problems in care. However, this incident has resulted in a Never Event being attributed to the Trust. It is hoped that sharing learning from this case can contribute to a review of the misplaced NG tube Never Events criteria as part of the Never Events consultation which is currently underway. In the spirit of PSIRF a caveat was applied in this instance to not undertake a PSII but to still report this incident under the PSII category. The rationale for this is that an AAR learning response has been undertaken and a PSII is unlikely to identify any new learning. DOC was applied by the patient's consultant, the ward manager and nutrition team on the day of the incident with a letter given to the patient's family on the 14th February 2024.

Appendix 3 – Summary of Maternity Cases Reported to StEIS in 2023/2024

(noting 8 incidents reported under maternity triggers and 2 reported under non-maternity triggers).

The cases, and their current status, are displayed in the below

Quarter 23/24	StEIS and incident reference.	Incident description	Status of investigation
2	2023/16976 - 133914	Term baby admitted to NNU for therapeutic cooling treatment	Final report received by Trust from HSIB. Incident awaiting closure by ICB
2	2023/16150 - 123343	Post partum haemorrhage > 1500ml	Investigation closed December 2023
2	2023/15924 - 124537	Treatment Delay (venous thromboembolism)	Investigation closed October 2023
2	2023/15488 - 128820	Adverse media coverage of public concern about the organisation or wider NHS	Investigation closed February 2024
3	2023/18512 - 136440	Term baby admitted to NNU	Final report received by Trust from HSIB. Incident awaiting closure by ICB
3	2023/19375 - 138212	Neonatal Death	Final report received by Trust from MNSI. Investigation closed May 2024.
3	2023/19688 - 138783	Neonatal Death	Family declined consent for MNSI Investigation. StEIS investigation ongoing.
3	2023/20653 - 140413	Term baby admitted to NNU for therapeutic cooling treatment	Final report received by Trust from MNSI. Incident awaiting closure by ICB.
4	2024/918 - 147628	Term baby admitted to NNU for therapeutic cooling treatment	Investigation ongoing by MNSI
4	2024/2199 – 151097	Term baby admitted to NNU for therapeutic cooling treatment	Investigation ongoing by MNSI

The cases are summarised below.

HSIB investigation – StEIS 2023 16976, MI-024639	This was a case of therapeutic cooling treatment in a term infant. A mother attended the alongside birth centre in established labour. Labour progressed well and the baby was born at 02:20 in an unexpectedly poor condition. The neonatal team arrived at 02:22 and took over management of the resuscitation. The baby as stabilised and transferred to the neonatal unit for

	ongoing management. A decision was made to cool the baby and the baby was cooled for 72 hours. The post cooling MRI scan showed a moderate/severe hypoxic ischemic encephalopathy (HIE). HSIB issues the trust three safety recommendations which included, the Trust to ensure there is a holistic review of mothers, taking into account cumulative risk factors when assessing suitability for the birth centre, to enable mothers to make informed decisions about their care. The Trust to ensure that staff are supported to do intermittent auscultation in line with guidance to ensure timely escalation of care when needed. The Trust to ensure that staff are supported to transfer mothers from the birth centre to the labour ward when blood-stained liquor is identified.
StEIS level three investigation – StEIS 2023/ 16150	This was a case of postpartum haemorrhage at the freestanding birth centre requiring emergency ambulance transfer to the delivery suite. Following arrival at the obstetric unit, intravenous access was secured, and fluid resuscitation was commenced. The mother was stabilised and transferred theatre for surgical control of the bleeding, the total blood loss was 2500mls. The mother required a 2-unit blood transfusion. The investigation found that birthplace discussions were not revisited with the mother when a Group B strep positive result was received antenatally. The mother was not aware that she had group B strep at the onset of labour and had she been aware, she would have opted for birth at the consultant unit and accepted intravenous antibiotics in labour. A second midwife had been requested to attend the freestanding birth centre to support care in the second stage of labour. Due to the current operational processes regarding on-call duties for midwifery staff, the midwife who was called as a second midwife, and who provided intrapartum care for this mother, had worked a full day shift before being called into the freestanding birth centre to assist. The investigation also identified that intravenous access and fluids were not commenced prior to the arrival at the obstetric unit.
StEIS level three investigation – StEIS 2023/15924	This was a case of postnatal cerebral venous thrombosis (CVT). Following the diagnosis of the CVT the mother suffered a significant deterioration in mental wellbeing requiring admission to Ribblemere mother and baby from February 2023 until August 2023. The investigation team requested a specialist opinion regarding the CVT formation. The investigation team were advised that the CVT was likely to have formed on day 5 postnatal when the mother first experienced neurological symptoms. Given the mother was receiving Low Molecular Weight Heparin (LMWH) at the time of thrombus formation, antenatal LMWH was unlikely to have prevented thrombus formation however, a 6-week course would have reduced the clot burden and ultimately the mother's symptoms. Learning was identified for the service in relation to VTE risk assessments during pregnancy and following postnatal readmission.
StEIS level three investigation – StEIS 2023/15488	Following a court judgement, a decision was made to retrospectively StEIS report a historic incident. This was a case of neonatal cooling of a term infant, the incident occurred prior to the introduction of HSIB. A StEIS level three investigation was completed, and an external review of the incident has also been performed by the Local Maternity and Neonatal System (LMNS)

	midwife. The incident has also been discussed with the regional chief and deputy midwife. As this was a historic case, the learning associated with incident has already been implemented into clinical practice. Learning related to standards of clinical documentation and roles and responsibilities of the second midwife attending a birth.
HSIB investigation – StEIS 2023/18512	This was a case of therapeutic cooling treatment in a term infant. A live infant was born by category one caesarean section following a failed attempt at instrumental vaginal birth. The mother had had spontaneous onset of labour at 40 weeks and 6 days gestation. At birth, the baby was noted to be pale and floppy with no respiratory effort. The baby was successfully intubated by the consultant neonatologist and following stabilisation the baby was transferred to the neonatal unit where therapeutic cooling treatment was initiated by the neonatal team. The baby was cooled for 72 hours and then re-warmed. The post cooling magnetic resonance imaging (MRI) scan subsequently revealed no features to suggest moderate or severe hypoxic ischaemic encephalopathy. The baby was also diagnosed with a subgaleal haemorrhage and received a blood transfusion. HSIB did not issue the Trust with any safety recommendations, however, there is an ongoing safety learning action plan which has been developed in response to the incident
MNSI investigation MI-035266 StEIS 2023/19375	This was a case of therapeutic cooling treatment in a term infant resulting in a neonatal death. The mother attended the maternity assessment suite (MAS) with vaginal bleeding at 37 weeks and 4 days gestation. Following arrival in MAS the mother experienced spontaneous rupture of membranes and significant vaginal bleeding was identified. The mother was transferred to the delivery suite and following confirmation by the consultant obstetrician of the presence of a bradycardic fetal heart on ultrasound scan, the mother was transferred to theatre for delivery by category one caesarean section. At birth, a vasa praevia was diagnosed and baby was born in poor condition. The baby was successfully intubated by the consultant neonatologist and following stabilisation, the baby was transferred to the neonatal unit where therapeutic cooling treatment was initiated by the neonatal team. After the initiation of cooling treatment, a decision was made to compassionately reorientate care to palliative and baby died. MNSI did not issue the Trust with any safety recommendations, however, there is an ongoing safety learning action plan which has been developed in response to the incident.
StEIS level three investigation – StEIS 2023/19688	This was a case of therapeutic cooling treatment in a term infant resulting in a neonatal death. The mother was admitted to the delivery suite at 38 weeks and 1 day gestation, by ambulance, after previously taking her own discharge from the antenatal ward against medical advice. The mother was known to have prolonged ruptured membranes >24 hours and had self- discharged following admission for induction of labour. On admission the fetal heart rate pattern was abnormal, and the mother declined consent for caesarean section. After counselling by two consultant obstetricians the mother later agreed to caesarean section and baby was born in poor condition. The baby was successfully intubated by the consultant neonatologist and following stabilisation, the baby was transferred to the neonatal where therapeutic cooling treatment was initiated by the neonatal

	team. After the initiation of cooling treatment, a decision was made to compassionately reorientate care to palliative and baby died. The case was referred to MNSI for investigation however, the mother declined consent for investigation therefore a StEIS level three investigation is ongoing. The case was referred to the police and his Majesty's coroner, the case was also considered for child safeguarding practice review (CSPR). CSPR was not approved, however, multiagency learning was identified by the review panel and there is an ongoing safety learning action plan which has been developed in response to the incident.
MNSI investigation MI-036455, StEIS 2023/20653	This was a case of therapeutic cooling treatment in a term infant. The mother was admitted to the antenatal ward for induction of labour as planned. The induction of labour was successful, and labour established, however, there was a delay in the first stage of labour and a decision was made for delivery by caesarean section. At caesarean section, a Bandals ring was identified and there was an impacted fetal head. The baby was born in poor condition and resuscitation was commenced by the neonatal team. The baby was successfully intubated by the consultant neonatologist and following stabilisation, the baby was transferred to the neonatal unit where therapeutic cooling treatment was initiated by the neonatal team. The baby was cooled for 72 hours, and a post cooling magnetic resonance imaging scan (MRI) was performed which demonstrated findings consistent with a diagnosis of a moderate hypoxic ischemic encephalopathy (HIE). MNSI did not issue the Trust with any safety recommendations, however, there is an ongoing safety learning action plan which has been developed in response to the incident.
MNSI investigation MI-03675, StEIS 2024/918	This was a case of therapeutic cooling treatment in a term infant. The mother attended MAS with reduced fetal movements in the latent phase of labour. Fetal heart rate monitoring was abnormal on admission and the mother was transferred to the delivery suite for ongoing care. Following admission to the delivery suite a decision was made for birth by caesarean section. The baby was born in poor condition and resuscitation was commenced by the neonatal team. The baby was successfully intubated by the consultant neonatologist and following stabilisation, the baby was transferred to the neonatal unit where therapeutic cooling treatment was initiated by the neonatal team. The baby was cooled for 72 hours, and a post cooling magnetic resonance imaging scan (MRI) was performed which demonstrated findings consistent with a diagnosis of a moderate hypoxic ischemic encephalopathy (HIE). The MNSI investigation for this incident is currently ongoing.
MNSI investigation StEIS 2024/2199	This was a case of therapeutic cooling treatment in a term infant. The mother attended MAS with a history of vaginal bleeding and labour. Following assessment in MAS the mother was transferred to the delivery suite for ongoing labour care. As labour progressed the fetal heart rate pattern deteriorated, and a decision was made for birth by caesarean section. The baby was born in poor condition and resuscitation was commenced by the neonatal team. The baby was successfully intubated by the consultant neonatologist and following stabilisation, the baby was transferred to the neonatal unit where therapeutic cooling treatment was initiated by the

	neonatal team. After the initiation of cooling treatment, a decision was made to compassionately reorientate care to palliative and baby died. The MNSI investigation for this incident is currently ongoing.

Learning and actions from the maternity incidents

Thematic analysis of all incidents has been undertaken as part of the maternity and neonatal safety improvement programme (MatNeoSIP). Themes in relation to timely escalation of care have been identified and the service is currently implementing a safety improvement plan utilising continuous improvement methodology. The work is concentrating on implementing the Royal College of Obstetricians and Gynaecologists (RCOG) escalation toolkit which focuses on the use of safety critical language and improving the culture for clinical escalation. The maternity service has also recently completed the national SCORE survey with the results awaited. The SCORE survey is an internationally recognised way of measuring and understanding the culture that exists within organisations and teams. It is an anonymous tool that teams can use to assess their culture with the debriefing of the results of the survey to staff by the patient safety collaborative. Once the results of the SCORE survey are received by the service, a safety improvement action plan will be developed.

Learning from incidents and patient experience provides the maternity service with the opportunity to reduce risk and improve the quality and safety of maternity care. The maternity service recognises the importance of system working and learning from the incidents of neighbouring organisations. The maternity service attends the bi-monthly LMNS serious incident overview panel and following publication of the Core Competency Framework version two (CCFv2) in December 2023, the maternity service has undertaken a benchmarking exercise against the recommendations and has updated the local training plan for implementation of version two of the core competency framework from January 2024. Using the “how to guide” published by NHS England, the training plan has been developed with the chair of the local maternity and neonatal voices partnership (MNVP) and agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS. The training plan upholds the four key principles of CCFv2 with service user involvement in the development and delivery of training, with training based on learning from local findings from incidents, audit, service user feedback, and national and other organisations investigation reports, reinforcing learning from care and learning from excellence in practice. The training plan promotes learning as a multidisciplinary team and shared learning across the local maternity and neonatal system (LMNS).

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

New Hospitals Programme Quarter 4 Board Report

Report to:	Board of Directors	**Date:**	6 June 2024
Report of:	Finance Director / Deputy Chief Executive (LTHTr NHP SRO)	**Prepared by:**	R Malin, Programme Director
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

The purpose of this report is to provide an update on the Lancashire Teaching Hospitals (LTHTR), New Hospital Project for the Quarter 4 period: January to March 2024.

Following a review of governance and agreed revised framework, this quarterly report will be the last received by the Trust Board of Directors. The Q1 report onwards the be presented to the newly established LTHTR NHP Assurance Committee.

The Q4 period has largely been focused on land assembly and acquisition and the preparation towards associated public engagement along with implementing the revised governance framework.

It is recommended the Board:

- Note the progress undertaken in Quarter 4.
- Note the activities planned for the next period.
- Note future reports will be presented to the LTHTR NHP Assurance Committee.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

N/a

LANCASHIRE TEACHING HOSPITALS,
NEW HOSPITAL PROJECT, Q4 BOARD REPORT

1. Introduction

1.1 This report is the 2023/24 Quarter 4 update from the Lancashire and South Cumbria New Hospitals Programme (L&SC NHP) on the progress of the Lancashire Teaching Hospitals, New Hospital Project.

2 Background

2.1 Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) were included in the Government's Health Infrastructure Plan in 2019 (renamed to New Hospital Programme [NHP] in 2021). The Lancashire and South Cumbria NHP is part of cohort 4 of the Government's New Hospital Programme for England.

2.2 The L&SC NHP offers a once-in-a-generation opportunity to develop cutting-edge facilities, offering the absolute best in modern healthcare. The New Hospitals Programme aims to address significant problems with our ageing hospitals in Preston (Royal Preston Hospital) and Lancaster (Royal Lancaster Infirmary). We also need to invest in Furness General Hospital's infrastructure in the context of its strategic importance and geographically remote location. This will provide patients with high-quality, next generation hospital facilities and technologies. Hospital buildings will be designed in a way to meet demand, while remaining flexible and sustainable for future generations. The aim is to support local communities, bringing jobs, skills and contracts to Lancashire and South Cumbria businesses and residents.

2.3 On 25 May 2023 the Government announced a record investment of more than £20 billion, ring-fenced for the next phase of the national New Hospital Programme, which brings proposals for new cutting-edge hospital facilities for Lancashire and South Cumbria a step closer. Following the May 2023 statement to the House of Commons from the Secretary of State for Health and Social Care, the local NHS was delighted to welcome the announcement of two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital as part of a rolling programme of national investment in capital infrastructure beyond 2030. This will also include investment in improvements to Furness General Hospital.

3 National New Hospital Programme

3.0 During Quarter 4, the national New Hospital Programme team have released the Hospital 2.0 library to all schemes with useful context, technical documentation and details of future releases. The L&SC NHP team have continued to support the national team in development of several work streams and take on

early adoption projects. Throughout 2024/25, the national Programme team will finalise and release H2.0 documentation enabling schemes to apply this at a local level. This is an exciting step forwards and will allow each scheme to bring hospital designs to life. This period, the national Programme has also continued to progress the overarching Programme Business Case within central government. The L&SC NHP looks forward to receiving the outcome of this important step**.**

4 New Royal Preston Hospital Project - progress against plan (for the period January to March 2024)

4.0 **Governance** – the L&SC NHP Team has continued to embed the recommendations of the governance review undertaken in December 2023. The Board of Directors approved the establishment of a new governance structure including an Assurance Committee (sub-committee of the Board) and a Project Delivery Group, both had their inaugural meetings in March/April and will continue to evolve over the next period.

4.1 **Potential new sites** – advisors have completed due diligence on the viability of potential new sites for Royal Preston Hospital including technical, valuation and legal. The L&SC NHP team has concluded the development of an enabling works business case focused on land assembly. The Programme continues to work closely with the national New Hospital Programme team regarding the next steps towards land acquisition. In parallel, the L&SC NHP team continues to consider and assess any further sites put forward against the existing criteria.

4.2 **Public consultation planning** – the L&SC NHP team have worked with the ICB and Trust Communications and Engagement colleagues to further develop the tasks and resource required for future pre-consultation engagement and public consultation. This includes the overarching approach to consultation, a communications and engagement strategy, and consultation and pre-consultation engagement plans. The timeline for such consultations will ultimately be determined by the critical dependencies including site acquisition and model of care.

5 Next period – Q1 2024/25

5.0 **Model of care –** the greatest focus for the L&SC NHP team in Q1 will be the development and engagement on a draft urgent and emergency model of care ahead of the clinical senate.

5.1 **Site/land business case** – the team will continue to work with the national New Hospital Programme team to deliver the business case for site assembly and subsequent preparations for engagement.

6 Conclusion

6.0 This paper is a summary of progress on the Lancashire Teaching Hospitals, New Hospital Project throughout Quarter 4 of 2023/24. This will be the final report to the Board of Directors in this format, future reporting will be through the Trust's NHP Assurance Committee. The reporting to the other Trust Boards across L&SC will also cease.

7 Recommendations

7.0 The Board is requested to:

- Note the progress undertaken in Quarter 4.
- Note the activities planned for the next period.
- Note future reports will be presented to the LTHTR NHP Assurance Committee.

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