Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

East Lancashire Hospitals NHS Trust Board Meeting

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Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD MEETING (OPEN SESSION) AGENDA

10 JULY 2024, 12.30

BOARDROOM, FUSION HOUSE

v = verbal
p = presentation
d = document
✓ = document attached

OPENING MATTERS				
TB/2024/086 **13.30**	**Chairman's Welcome**	Chairman	v	
TB/2024/087 **13.01**	**Apologies** To note apologies.	Chairman	v	
TB/2024/088 **13.02**	**Declarations of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Chairman	d✓	Approval
TB/2024/089 **13.15**	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 15 May 2024.	Chairman	d✓	Approval
TB/2024/090 **13.20**	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2024/091 **13.22**	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2024/092 **13.25**	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2024/093 **13.35**	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information/ Approval
QUALITY AND SAFETY				
TB/2024/094	**Patient Story** To receive and consider the learning from a patient/Staff story.	Chief Nurse	p	Information/ Assurance
TB/2024/095	**Nursing Professional Judgement Review**	Chief Nurse	d✓	Information/ Assurance
TB/2024/096	**Corporate Risk Register Report** To receive an update on the Corporate Risk Register and approve revisions based on the Executive Risk Assurance Group, Committees' and Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Executive Medical Director	d✓	Assurance/ Approval
TB/2024/097	**Board Assurance Framework** To receive an update on the annual review of the Board Assurance Framework and risk appetite and approve the revisions based on the Executive Risk Assurance Group, Committees' and the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Director of Corporate Governance	d✓	Assurance/ Approval

TB/2024/098	**Patient Safety Incident Response Assurance Report** To receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP). This report also includes information on maternity specific serious incidents reporting as required by Ockenden recommendations.	Executive Medical Director	d✓	Information/ Assurance
STRATEGIC ISSUES				
TB/2024/099	**Maternity and Neonatal Services Update** *T Thompson to attend for this item.*	Chief Nurse / Divisional Director of Midwifery and Nursing	d✓	Information/ Assurance
TB/2024/100	**Trust Priorities 2024-25**	Executive Director of Service Development and Improvement	p✓	Information / Approval
TB/2024/101	**Response to Edenfield Report**	Chief Nurse	d✓	Information / Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2024/102	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: **15.15** a) Introduction (Chief Executive) **15.20** b) Safe (Executive Medical Director and Chief Nurse) **15.25** c) Caring (Chief Nurse) **15.30** d) Effective (Executive Medical Director) **15.35** e) Responsive (Chief Operating Officer) **15.40** f) Well-Led (Director of People and Culture and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2023/103	**Freedom to Speak Up Report**	Executive Director of People and Culture	d✓	Information/ Assurance
GOVERNANCE				
TB/2023/104	**Standing Orders and Standing Financial Instructions and Annual Review**	Director of Corporate Governance/ Executive Director of Finance	d✓	Approval
TB/2023/105	**Triple A Reports from Finance and Performance Committee** To note the matters considered by the Committee in discharging its duties. a) May 2024 b) June 2024	Committee Chair	 d✓ d✓	Information

TB/2024/106	**Triple A Reports from Quality Committee** To note the matters considered by the Committee in discharging its duties. a) May 2024 b) June 2024	Committee Chair	 d✓ d✓	Information
TB/2024/107	**Triple A Report from People and Culture Committee** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information
TB/2024/108	**Triple A Report from Audit Committee** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information
TB/2024/109	**Triple A Report from Trust Charitable Funds Committee** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information
TB/2024/110	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2024/111	**Any Other Business**	Chairman	v	
TB/2024/112	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2024/113	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: 1. Have we, as the Board, via the agenda and our discussions fulfilled our objective of supporting our: a. Communities b. Staff c. Stakeholders 2. Have we, as the Board fulfilled our statutory obligations.	Chairman	v	
TB/2024/114	**Date and Time of Next Meeting** Wednesday 11 September 2024, 12.30pm, Venue to be Confirmed.	Chairman	v	

Lancashire and South Cumbria Provider Collaborative

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT | **Item** | **88**

10 July 2024 | **Purpose** | Approval / Information

Title	Declarations of Interests Report

Summary: Section 5 of the Trust's Standing Orders describes the duties and obligations of Board Members in relation to declaring interests. The Register is available for public inspection.

Recommendation: The Board is asked to note the presented Register of Directors' Interests. Board Members are invited to notify the Director of Corporate Governance/Company Secretary of any changes to their interests within 28 days of the change occurring.

Report linkages

Related Trust Goal	-
Related to key risks identified on Board Assurance Framework	-
Related to key risks identified on Corporate Risk Register	-
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	-
Related to ICB Strategic Objective	-

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Name and Title	Interest Declared	Date last updated/ Confirmed
Shazad Sarwar Chairman	• Committee member of Together Housing Group (from 01.09.2021) • Non-Executive Director member of the Greater Manchester Integrated Care Board (from 01.02.2022 to July 2023). • Managing Director of Msingi Research Ltd. (from 01.07.2015) • Member of Prince's Trust Health and Care Advisory Board (until March 2024)	08.07.2024
Martin Hodgson Chief Executive	• Spouse is the Chief Operating Officer at Liverpool University Hospital NHS Foundation Trust.	08.04.2024
Patricia Anderson Non-Executive Director	• Spouse is a retired Consultant Psychiatrist formerly employed at Mersey Care NHS Trust. • Assignment with Knowsley Clinical Commissioning Group, supporting the Accountable Officer for a period of six months (10.05.2019 to 01.10.2019). During this time Mrs Anderson took a leave of absence from the Trust Board at ELHT. • Partnership of East of London Collaborative – Assignment of 1.5 days per month (from 01.12.2020 until 01.02.2021)	15.05.2024

Name and Title	Interest Declared	Date last updated/ Confirmed
Kate Atkinson Executive Director of Service Development and Improvement	• Brother is the Clinical Director of Radiology at the Trust • Sister-in-law is a Trauma and Orthopaedic Consultant at the Trust • Parent Governor at Blacko Primary School (from 01.04.2022 to 31.03.2026)	15.05.2024
Professor Graham Baldwin Non-Executive Director	• Director of Centralan Holdings Limited • Director of UCLan Overseas Limited • Director CY IPS Ltd • Director UCLan Cyprus • Director UCLan Professional Services Ltd • Deputy Chair and Director of UCEA • Chair of Maritime Skills Commission • Member of Universities UK • Chair of MillionPlus • Chair of University Vocational Awards Council • Chair of Lancashire Innovation Board • Member Preston Regeneration Board • Member Burnley Town Board • Member Burnley Economic Recovery Board	23.05.2024

Name and Title	Interest Declared	Date last updated/ Confirmed
Michelle Brown Executive Director of Finance	• Spouse is a paramedic at NWAS • Vice Chair of Governors at St Catherine's RC Primary School, Leyland • Labour Councillor – Clayton West and Cuerden Ward	15.05.2024
Sharon Gilligan Chief Operating Officer and Deputy Chief Executive	• Positive nil declaration	15.05.2024
Melissa Hatch Associate Non-Executive Director (01.12.2023)	• Nil declaration (awaiting confirmation)	15.05.2024
Jawad Husain Executive Medical Director and Deputy Chief Executive	• Spouse is a GP in Oldham	23.04.2024
Tony McDonald Executive Director of Integrated Care, Partnerships and Resilience	• Spouse is an employee of Oxford Health NHS Foundation Trust • Member of Board of Trustees for Age Concern Central Lancashire Charity (to 27.10.2023) • Undertaking the role as Portfolio Director for Community Transformation for Lancashire and South Cumbria Integrated Care Board commencing 1st April 2024 for 12 months in addition to ELHT Executive Director role.	01.04.2024

Name and Title	Interest Declared	Date last updated/ Confirmed
Peter Murphy Chief Nurse	• Spouse works at Liverpool University Foundation Trust.	15.05.2024
Kate Quinn Executive Director of People and Culture	• Director at Lancashire Institute of Technology • Governor at Goosnargh Oliverson's Church of England Primary School	15.05.2024
Catherine Randall Non-Executive Director	• Executive Director Derian House Lead for Clinical Services • Independent Chair of the Safeguarding Board • Independent Chair at Blackburn Church of England	15.05.2024
Khalil Rehman Non-Executive Director	• Director at Salix Homes Ltd • Director at Medisina Foundation. • NED at Leeds Community Healthcare Trust • Vice Chair of Seacole Group • TSI Caritas Ltd • NED at UCLan • Interim Director of Finance at Touchstone Support Ltd, Charity with links to the NHS in neighbouring system	31.05.2024

Name and Title	Interest Declared	Date last updated/ Confirmed
Liz Sedgley Non-Executive Director	• Self Employed Accountant Liz Sedgley FCCA Accountancy and Management Consultancy • Governor at Nelson and Colne Colleges Group • Husband is Financial Controller at Select Medical Ltd	29.04.2024
Richard Smyth Non-Executive Director	• Spouse is a Patient and Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary. • Spouse is a Non-Executive Director at Lancashire Teachings Hospitals Foundation Trust as from 04.02.2019. • Chair of Board of Governors at Bury Grammar School as of 27 March 2023.	15.05.2024

Name and Title	Interest Declared	Date last updated/ Confirmed
Shelley Wright Joint Director of Communications and Engagement for East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BFWH)	• Post held jointly with Blackpool Teaching Hospitals NHS Foundation Trust	24.04.2024

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TRUST BOARD REPORT **Item** **89**

10 July 2024 **Purpose** Approval

Title	Minutes of the Previous Meeting
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mr S Sarwar, Chairman
Date Paper Approved by Executive Sponsor	

Summary: The minutes of the previous Trust Board meeting held on 15 May 2024 are presented for approval or amendment as appropriate.

Report linkages

Related Trust Goal	-
Related to key risks identified on Board Assurance Framework	-
Related to key risks identified on Corporate Risk Register	-
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	-
Related to ICB Strategic Objective	-

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

For Trust Board only: Have accessibility checks been completed? Yes

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 13:30, 15 MAY 2024
MINUTES

PRESENT

Mr S Sarwar	Chairman	Chair
Mr M Hodgson	Chief Executive / Accountable Officer	
Mrs P Anderson	Non-Executive Director	
Mrs M Brown	Executive Director of Finance	
Mr J Husain	Executive Medical Director / Deputy Chief Executive	
Mrs C Randall	Non-Executive Director	
Mr K Rehman	Non-Executive Director	
Mr R Smyth	Non-Executive Director	

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement
Mrs M Hatch	Associate Non-Executive Director
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)

IN ATTENDANCE

Mr D Byrne	Corporate Governance Officer	Minutes
Miss K Ingham	Corporate Governance Manager	
Mr M Ireland	Deputy Director of People and Culture	
Mrs M Montague	Interim Deputy Chief Operating Officer	
Mrs J Pemberton	Deputy Chief Nurse	
Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2024/072

APOLOGIES

Professor G Baldwin	Non-Executive Director
Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary

Mrs B Edgar	Interim Director of People and Culture	Observer
Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive	
Mr P Murphy	Chief Nurse	
Mrs K Quinn	Executive Director of People and Culture	
Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council	
Mrs L Sedgley	Non-Executive Director	

TB/2024/057 CHAIRMAN'S WELCOME

Mr Sarwar welcomed Directors and members of the public to the meeting. He stated that it was important to continue to raise the visibility of the Board across East Lancashire and confirmed that future Board meetings would continue to be held in public venues. Mr Sarwar emphasised that the meeting was being held in public, rather than being a public meeting, and requested that any questions for the Board were directed through the appropriate avenues prior to any meetings.

TB/2024/058 APOLOGIES

Apologies were received as recorded above.

TB/2024/059 DECLARATIONS OF INTEREST

There were no changes to the Directors Register of Interests, and no declarations of interest made in relation to any agenda items.

RESOLVED: Directors noted the position of the Directors' Register of Interests.

TB/2024/060 MINUTES OF THE PREVIOUS MEETING

Mr Hodgson requested a minor amendment to the minutes of the previous meeting, specifically that the wording around the 100 additional beds on page 19 was revised to make it clearer that this would allow the Trust to meet current demand, rather than enabling it to return to pre-pandemic activity levels.

Directors, having had the opportunity to review the minutes of the previous meeting, otherwise approved them as a true and accurate record.

RESOLVED: The minutes of the meeting held on 13 March 2024 were approved as a true and accurate record, pending the requested amendment.

TB/2024/061 MATTERS ARISING

Mr Sarwar informed Directors that the Minister of State in the Department for Health and Social Care of the United Kingdom, Helen Whately, had visited the Trust the previous week who had been able to witness the pressures that the Trust was currently experiencing. He added that the Trust had treated a total of 22,000 patients in February 2024, and had seen an average of 75 more patients per day in April 2024 than at the same time the previous year. Mr Sarwar noted that the visit by Mrs Whately had been a good opportunity for the Trust to outline the various challenges that it was facing, including the rise in patient acuity and the significant financial requirements being placed on it for 2024-25. He stressed the importance of recognising the efforts of Trust staff in managing the pressures being seen but acknowledged that many were experiencing varying degrees of moral injury as a result.

Mr Hodgson praised the interest and support from local Members of Parliament in facilitating the visit from Mrs Whately. He referred to the ongoing activity around Martha's Rule and confirmed that the Trust had launched its own internal Call for Concern initiative to enable anyone to raise any concerns that they may have regarding a patient's condition.

Mr Sarwar stated that it was important to recognise the effort that the Trust had already put into this area, as it had acted to implement this initiative long before it would have been required to do so as part of Martha's Rule.

Mrs Pemberton reported that the Call for Concern service had already received nine calls since it was implemented and confirmed that appropriate actions had been taken to resolve the issues raised.

TB/2024/062 ACTION MATRIX

Directors noted that all items on the action matrix were reported as complete, had been updated via the action matrix report or were to be presented as agenda items at this, or at subsequent meetings. The following updates were provided:

TB/2024/039: Patient Safety Incident Response Assurance Report – Mr Husain informed Directors that the Trust had implemented a monthly Trust Wide Quality Governance Committee which, among other things, was intended to triangulate incidents and the learning from them. He added that the Patient Safety Group was another workstream in which all divisions were able to coordinate the learning from any incidents and that updates on Patient Safety Incident Investigations were disseminated throughout the Trust via quarterly bulletins.

RESOLVED: **Directors noted the position of the action matrix.**

TB/2024/063 CHAIRMAN'S REPORT

Mr Sarwar reiterated his thanks to all Trust staff for their ongoing efforts in managing the significant pressures being placed on the organisation and in helping to achieve a range of crucial operational performance targets for 2023-24, including the four-hour A&E waiting time target. Mr Sarwar referred to the rise in instances of care being provided on corridors and stressed that while the Board recognised that this was far from ideal, similar issues were being seen at many other NHS organisations across the country. He reaffirmed the Trust's commitment to ensuring that all patients were treated in the right place in the organisation and received safe, personal and effective care.

Mr Sarwar went on to provide a summary of his activities to Directors since the previous meeting. He confirmed that he had continued to attend North West system leaders' meetings and indicated that there was an ongoing focus on financial challenges and operational performance. Mr Sarwar added that another significant area of focus would be ensuring that all Trusts were able to continue to deliver at pace and on productivity.

Mr Sarwar referred to the recent stepping down of David Flory as Chair of the Integrated Care Board (ICB) and extended his thanks on behalf of the Board for his leadership in bringing providers across the system together. He explained that the ONE LSC programme remained at the forefront of the Joint Committee of the Provider Collaboration Board's (JCPCBs) considerations, as well as the clinical configuration and financial challenges of the system. Mr Sarwar stressed that the Trust had a statutory responsibility to live within its means but pointed out that some aspects were not within its gift to control and would continue to have an impact on it and the population of East Lancashire.

Mr Sarwar confirmed that he continued to represent Lancashire provider organisations on the local Place-based Partnership and advised that their recent focus had been on community services, redesigning intermediate care and addressing inequity in primary care settings.

Mr Sarwar went on to provide a summary of highlights at Trust level, including a recent series of meetings to focus on Equality, Diversity and Inclusion objective setting for senior leaders and a delivery of toys to the Trust's children's ward by a local charity, 'Share a Smile'. He advised that he had also recently visited the Trust's Family Care service and extended his

thanks to the Family Care senior leadership team and staff for continuing to deliver high quality care to mothers and their families.

Mr Sarwar informed Directors that both he and Mr Hodgson had recently had the opportunity to meet students from the Blessed Trinity Roman Catholic College and Sir John Thursby Community College and listen to their feedback regarding the Trust's services. He added that several local younger people had participated in interviews for Trust clinicians and stated that this was a good example of how the organisation was involving its service users more in its day-to-day activities. Mr Sarwar highlighted that he had also recently met with the Trust's Armed Forces Veteran Advocate team, as part of a two-year programme to support veterans across East Lancashire, and with colleagues from the Together Housing Group to discuss potential joint opportunities over the coming years.

Mr Sarwar concluded his update by highlighting that the Trust was one of the first organisations in the system to commit to become an intentionally anti-racist organisation. He explained that the Trust's plan had been developed in conjunction with colleagues from across the organisation and confirmed that a submission had recently been made to the North West Black, Asian and Minority Ethnic (BAME) Assembly.

RESOLVED: **Directors received and noted the update provided.**

TB/2024/064 **CHIEF EXECUTIVE'S REPORT**

Mr Hodgson referred to the previously circulated report and provided a summary of national, regional and Trust specific headlines to Directors.

Mr Hodgson advised that a national Leadership Event had taken place on the 1 May 2024 with the NHS England (NHSE) Executive team. He reported that there had been clear recognition of the ongoing effects from COVID-19 on the NHS, as well as the challenging financial environment, and the impacts from both on recovery. Mr Hodgson advised that the improvements to ambulance handover times and four-hour A&E waiting time performance seen across the country had been praised. He added that the Trust was performing relatively well in this area, achieving 78% for 2023-24 and that a letter of thanks had been received from the NHSE National Director of Urgent and Emergency Care and Deputy Chief Operating Officer, Sarah-Jane Marsh. Mr Hodgson acknowledged that, despite these achievements, too many patients were still having to be treated on corridors while waiting for a bed.

Mr Hodgson referred to the recent visit to the Trust from Helen Whately and explained that it had been a good opportunity to demonstrate the pressures that colleagues were working under and how Same Day Emergency Care and community services were being used to mitigate these. He informed Directors that a subsequent roundtable event with Mrs Whately and local MPs would be taking place later in the month and confirmed that he would report back on the outcomes from this at a later date.

Mr Hodgson went on to refer to the information in the report regarding a recent fire in the surgical day case units at Royal Blackburn Teaching Hospital (RBTH) and paid testament to the efforts of Trust colleagues in minimising the damage caused. He highlighted that the Trust's response had also been praised by the Lancashire Fire and Rescue Service (LFRS) and confirmed that there had been no impact on patient activity.

Mr Hodgson informed Directors that several developments had taken place at a LSC system level, including the recent transfer of Blackburn with Darwen (BwD) 0-19 Healthy Child Programme services into the Trust. He clarified that around 100 colleagues would be transferred as part of this process and advised that early intelligence indicated that they felt very welcome and were happy to be part of the organisation.

Mr Hodgson explained that other work was taking place to consider how Lancashire and South Cumbria (LSC) could move to more coherent and resilient configuration to deliver better outcomes for the local population. He informed Directors that a business case had recently been approved by three Boards, including the ICB, which would result in the transfer of adult community services into the Trust. Mr Hodgson added that the Trust would also take on running Albion Mill, an intermediate care facility in Blackburn.

Mr Hodgson referred to the ongoing development of the ONE LSC programme and reported that a number of appointments had been made to several key senior leadership roles, including Chief Procurement Officer, Chief Estates and Facilities Officer and Chief People Officer.

Mr Hodgson went on to provide a summary of other developments taking place at Trust level. He highlighted that a new Heart Care Unit at the RBTH site was due to be formally opened over the coming weeks and that the Trust's endoscopy service had recently achieved accreditation from the Joint Advisory Group (JAG). Directors noted that the Trust had also achieved reaccreditation as a Veteran Aware Trust, which recognises its ongoing commitment to the armed forces community. Mr Hodgson advised that a range of other events had taken

place over recent weeks to recognise the achievements of colleagues and to celebrate Holy Week and Eid.

Mr Hodgson concluded his update by presenting Directors with the list of wards applying for SILVER status as part of the Safe, Personal and Effective Care award process. These were: the Burnley West District Nursing team, wards C14a and C14b, the Surgical Ambulatory Emergency Care Unit and the Ophthalmology Theatre. He advised that SPEC status had also recently been removed from the Trust's Postnatal ward following a rating of amber at their most recent inspection. Mr Hodgson explained that although this would undoubtedly be a disappointment to the colleagues working on the ward, it was also evidence that the SPEC process was working effectively. He confirmed that the ward would be supported in its efforts to regain its green SPEC status rating.
Directors confirmed that they were content for SILVER status to be awarded to the areas listed above.

Mr Sarwar commented that the series of service moves both in and out of the Trust were decisions made in the best interest of patients and were also intended to reduce historical access issues and remover variation. He noted that they also tied into productivity and ensuring that organisations were able to get the best from their workforce.

RESOLVED: **Directors received the report and noted its contents.**
Mr Hodgson will update Board members on the outcomes from the roundtable exercise with Helen Whately and local MPs at a later date.

TB/2024/065 PATIENT STORY

Mrs Pemberton provided a brief introduction to the patient story. She explained that it had been provided by a local Councillor, Manzar Iqbal, and detailed his experiences of using the Trust's Long Covid Service.

The patient story can be viewed here.

Mr Sarwar commented that the story had been a learning experience in terms of the range of potential COVID-19 symptoms and their impact on the lives of patients. He requested

clarification on how well used the Long Covid Service had been during and since the COVID-19 pandemic.

Mr Husain explained that most of the patients had been referred to the service by primary care colleagues during the pandemic and that as a result it was difficult to report the exact number. He added that it would take several years for the real long-term effects of long COVID on individuals to become clearer.

Mr McDonald clarified that the Long Covid Service was a multi-professional one but emphasised that therapist colleagues had been particularly instrumental in its development and establishment. He stated that the importance of a holistic approach, both from a physical and mental health perspective, had been clear in the story presented.

Mrs Atkinson pointed out that the Long Covid Service was just one of several services developed during the pandemic. She noted that the patient story had also made clear the importance of educating patients and empowering them to manage their own symptoms.

Mrs Anderson commented that it was clear the debilitating effects from COVID-19 could be long-term, potentially even life long, and that the Trust was likely to see more and more cases like Mr Iqbal's over the coming years.

Mr Hodgson agreed that out of hospital and community provisions would play a pivotal role going forward, particularly in relation to reducing the extreme demand on the Trust's urgent and emergency care pathways. He added that the patient story had been a good example of this approach.

Mr Sarwar agreed with the points raised by Mrs Atkinson around empowering individuals and noted that there were significant opportunities for the Trust to work more closely with colleagues from the education sector around this.

In response to a query from Mr Rehman regarding the reduced emphasis on COVID-19 and the subsequent reduction in funding for services like the Long Covid Service, Mr McDonald confirmed that sufficient funding was available for the system for 2024-25 but indicated that further discussions were needed around how this work could be progressed in future years. He added that it would also be crucial to consider how the array of services across community

and hospital sites could be linked together more closely to better respond to the future health needs of the local population.

RESOLVED: **Directors received the Patient Story and noted its content.**

TB/2024/066 **CORPORATE RISK REGISTER (CRR) AND RISK PERFORMANCE REPORT**

Mr Husain referred Directors to the previously circulated report and provided a summary of key highlights. He reported that there were currently 17 risks on the CRR, three of which were new additions (10082 - Failure to meet internal & external financial targets for 2024-25, risk ID and 10086 - missed or delayed diagnosis if no solution for storage and transfer of echocardiogram (ECHO) images cannot be found and 9581 - lack of standardisation of clinical documentation processes and recording in Cerner). Directors noted that five risks (9771 - failure to meet internal & external financial targets for 2023-24, 9570 - no capacity for the storage of legacy ECHO images, 9367 - ECHO Images transfer, 9705 - inability to provide a robust hepatobiliary (HPB) on call service and 9557 - patient, staff and reputational harm as a result of the Trust not being registered for mental health provision) had been removed from the previous iteration of the CRR and that another (8725 - lack of senior clinical decision making and inconsistent medical cover for Community and Integrated Care services) was due to be removed in the near future, due to the efficient mitigation of the risks and subsequent reductions in risk scores. Mr Husain confirmed that the scores assigned to risks 8839 (failure to achieve elective recovery targets) and 8061 (management of harm from the holding list) had been restored to 16 following discussions at the Executive Risk Assurance Group.

Mr Husain highlighted that there had been a reduction in the number of open risks by 60% from quarter 4 in 2021-22 to quarter 4 in 2023-24. Directors noted that there had also been significant reductions in the proportion of significant, moderate, and open risks over the same period. Mr Husain confirmed that scrutiny of all risks on the CRR continued via the ERAG and that a further update on the Trust's processes in relation to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) would be provided at the next meeting of the Board in July 2024.

In response to a request for clarification from Mrs Anderson regarding the references in the report to the competence of managers and risk training, Mr Husain explained that this was related specifically to the management and updating of risks on the CRR, as there was

currently a degree of variation across different areas. It was confirmed that work was ongoing to support managers with risk management processes.

Mr Hodgson stated that healthcare was by definition a risk-based business and highlighted that the reductions in overdue and open risks outlined in the report were clear signs that good progress was being made in this area.

Mr Sarwar suggested that consideration should be given to making RIDDOR a formal part of the Trust's internal audit plan for 2024-25 to provide further assurance.

Responding to a query from Mr Sarwar regarding the progress in resolving the issues around ECHO imaging, Mr Husain confirmed that a solution was almost ready to be deployed. He added that there had been a slight delay to ensure that ICB colleagues could be involved in the procurement of a suitable system and to ensure that it was stable and able to deliver everything that would be required.

RESOLVED: **Directors received the update and assurance about the work being undertaken in relation to the management of risks.**
Discussions to take place regarding the addition of RIDDOR incidents to the Trust's internal audit plan for 2024-25.

TB/2024/067 BOARD ASSURANCE FRAMEWORK (BAF)

Mrs Bosnjak-Szekeres advised that the BAF was currently undergoing the annual review process, with Executive Directors and other senior leadership colleagues working to review their risks and ensure that they were aligned to Trust and system strategic objectives and improvement programmes. She indicated that a revised version of the BAF would be presented for consideration at the next meeting of the ERAG and would be discussed in detail at a subsequent BAF Board Workshop on the 6 June 2024. Mrs Bosnjak-Szekeres confirmed that the revised BAF would then be presented to the June round of Board sub-committees and to the Trust Board meeting in July.

RESOLVED: **Directors noted the update provided.**

TB/2024/068 PATIENT SAFETY INCIDENT RESPONSE ASSURANCE REPORT

Mr Husain requested that the report be taken as read and presented a summary of the salient points to Directors. He advised that a 'Never Event' incident that had occurred in maternity

had taken place to recently to be included in the report. Mr Husain confirmed that no harm had come to the patient involved and that a roundtable exercise had been carried out since the incident had occurred to discuss the contributing factors and the learning from it.

Mr Husain highlighted that harms of all levels in the Trust remained below national levels, as did the number of deaths occurring in the organisation. Directors noted that there had also been no breaches of Duty of Candour.

Mr Husain confirmed that, as a leader in the adoption of the Patient Safety Incident Response Framework (PSIRF), the Trust continued to contribute to the learning and training of colleagues across the North West and beyond. He added that a Standard Operating Procedure (SOP) for joint investigations was in the process of being drafted.

Mr Husain reported that compliance levels had reached 92.1%, 82.4% and 86.3% for the Level 1a, Level 1b and Level 2 Patient Safety Training Modules respectively. He acknowledged that these levels were still falling short of the Trust's self-imposed threshold of 95% and confirmed that work was taking place through all available channels to improve them.

Mr Hodgson commented that it was reassuring that the Trust continued to remain a high reporting and low harm organisation despite the significant pressures and challenges that it was currently facing.

Mr Sarwar emphasised the importance of the Trust reaching the 95% target for the Level 1b Patient Safety Training Modules for Boards and senior leadership roles. He requested that all Directors ensure that they had completed this module before the next meeting.

RESOLVED: **Directors noted the report and received assurances about the reporting of incidents via the PSIRF.**

Board members to complete the Level 1b Patient Safety Training Modules before the next meeting.

TB/2024/069 ANNUAL PLAN AND ANNUAL BUDGET 2024-25

Mrs Brown referred Directors to the previously circulated report and explained that it was intended to provide a clear overview of the Trust's financial plans for 2024-25 for approval. She extended her thanks to her colleagues in the Trust's finance team for their significant efforts in developing the plan and emphasised that it showed a challenging savings target of £57,000,000 for the year. Directors noted that this would still leave the Trust with a

£30,000,000 deficit, reflecting the likely income that it would receive, and that further reductions in pay bills would be required to stay within budget.

Mrs Brown clarified that this could translate to a required reduction of around 600 whole time equivalents (WTEs) and that the bulk of this would be achieved through a combination of targeted actions to reduce temporary staffing and agency spend, increased rigour around newly vacant posts and new initiatives such as One LSC that would allow more efficient management of staffing gaps. She confirmed that a range of additional controls that had already been implemented across all spending categories would be further enhanced and advised that all non-pay expenditure and estates spend would need to be slowed down even further.

Mrs Brown emphasised that the Trust had a significant Waste Reduction Programme (WRP) of 7.7% to achieve by year end and explained that this was comprised of a number of Key Delivery Programmes (KDPs), each of which had an assigned Senior Responsible Officer (SRO). She added that individual service reviews would also be taking place to better understand any opportunities for further improvement and that work would be taking place with system colleagues to support positive impact on activity levels.

Mrs Brown stated that she had every confidence that teams would rise to the challenge but stressed that the Trust would maintain its position of not compromising on safety or quality to achieve its financial targets. She emphasised that this would make partnership working and the wider system collaboration even more fundamental to the Trust's plans.

Mrs Brown went on to reiterate that the plan being presented to the Board was very ambitious and that in her professional capacity she was unable to give assurance that the Trust would be able to achieve the targets outlined. She requested confirmation from Directors that they were content to confirm that the Trust would work to the best of its ability to get as close as it could, adding that colleagues were fully committed to reducing run rates and get the organisation to as a good a position as possible. Mrs Brown concluded by confirming that the plan had also been considered in detail by the Finance and Performance Committee and that members had been content to recommend it to the Board for approval.

Mr Rehman noted that the Trust's draft financial plan had been through a number of iterations and paid credit to the finance team for their work in developing it. He agreed that there was a significant risk in the plan and that Trust would only be able to confirm that it would work to the best of its endeavours to achieve all that it could. Mr Rehman urged the need to ensure

that clear monitoring was in place throughout quarter 1 and quarter 2 of 2024-25 so that trajectories could be developed and provide a clearer picture of how the Trust would achieve its financial requirements. He concluded by stating that he agreed that the plan was a realistic position for the Trust but reiterated that it came with significant risks.

Mrs Anderson commented that the strong stewardship from finance colleagues and the significant amount of work that had gone into developing the financial plan for 2024-25 was welcome. She agreed that a vigorous focus on reducing waste would be needed and that the Trust would need to give serious consideration to putting a stop to activities or services that it had previously done in the past. Mrs Anderson observed that the Board was being asked to sign up to a financial plan that it could not be certain was achievable but acknowledged that it would still have to ensure that every effort would be made to get as close as possible.

Mr Hodgson stressed that the Trust had a statutory obligation to live within its means financially, particularly given the extremely challenging financial times that it was currently operating in. He agreed that there would need to be a renewed focus on productivity going forward as well as a reduced pay bill and highlighted that good progress had already been made by the Trust regarding reductions in agency spend. Mr Hodgson added that the Trust was typically seen as a very productive organisation but acknowledged that using improvement methodology would be crucial to harnessing the goodwill across the organisation to reduce waste even further.

Mrs Atkinson stated that recognising the scale of the challenge involved with regard to the Trust's improvement approach would be key. She explained that there were a number of tools that could be used to engage with staff, one of which would be a 'Year of Improvement' initiative that would be taken forward to build improvement capacity in the Trust. Mrs Atkinson confirmed that waste reduction would be a strong focus for the year, with a number of opportunities for redesign to facilitate a more consistent approach to reviewing the Trust's services.

Mr Sarwar stressed that it was important to recognise that every partner organisation across LSC was in a similar position to that of the Trust. He added that the system as a whole had been operating outside of its means for some time and acknowledged that although some issues had not been within its gift to solve, others definitely had been. Mr Sarwar stated that

the Trust's performance in 2023-24 had put it in a strong position for 2024-25 but pointed out that a significant amount of change could occur over the coming 12 months. He went on to comment that the strong governance that was in place around the Trust's financial plan, such as the Quality Impact Risk Assessments (QIRAs) done around WRP schemes, provided additional assurance, as did the strength of the organisation's improvement methodology. Mr Sarwar acknowledged the risks associated with the financial plan but stated that it was right for the Trust to do everything that it can to meet the challenge. He reiterated that the financial plan had been reviewed and approved by the Finance and Performance Committee and requested confirmation from Board members that they were also content to approve it.

Directors confirmed that they were content to approve the annual financial plan and budget for 2024-25.

RESOLVED: **Directors received and approved the draft financial plan and budget for 2024-25.**

TB/2024/070 DRAFT PATIENT EXPERIENCE STRATEGY 2024-27

Mrs Pemberton referred Directors to the previously circulated Patient Experience Strategy and advised that it was being presented to the Board for approval. She explained that a substantial amount of engagement activity had taken place with various stakeholders to develop the strategy and that additional work had taken place to ensure that a range of measurable metrics were included.

Mrs Pemberton clarified that the main aims of the strategy were to encourage people to actively participate in how the Trust developed its services, reduce the impact of health inequalities, and widen engagement of patients and the public to promote a more diverse range of opinions. She highlighted that specific sections had been included relating to patients with learning disabilities and autism and to outline a series of key actions to ensure that their rights were protected, develop the workforce, and improve safety. Directors noted that dedicated sections had also been included on urgent and emergency care (UEC), maternity and neonatology areas.

Mrs Pemberton referred to the earlier discussions around Martha's Rule and confirmed that this was a key part of the strategy. She reiterated that a Call for Concern initiative had been implemented in the Trust, with funding received to facilitate two pilot programmes at RBTH and Burnley General Teaching Hospital (BGTH) and explained that all calls received would

be reviewed through the governance process in place both within divisions and through the wider organisation.

Mr Sarwar commented that the development of the strategy was timely and the right thing for the Trust to do. He emphasised the importance of the Trust remaining conscious of the role of patients in all of its activities.

In response to concerns raised by Mr Sarwar regarding the potential for carers to be lost due to the breadth of the strategy, Mrs Bosnjak-Szekeres work would be done through the Quality Committee to ensure that the voices of carers and their families are heard.

RESOLVED: **Directors received the report and approved the draft Patient Experience Strategy for 2024-27.**

TB/2024/071 **PEOPLE PROMISE EXEMPLAR PROGRAMME**

Mr Ireland referred Directors to the series of slides circulated prior to the meeting. He explained that the intention behind the People Promise Exemplar Programme was to help to create more sustainable cultures and systems and improve staff engagement and retention. Mr Ireland further explained that the programme was structured around the seven key areas outlined in the NHSE People Promise and confirmed that the Trust had completed three initial stages. Directors noted that the Trust's recently appointed People Promise Manager, Jane Wilkinson, would be focusing on engaging colleagues and socialising the Programme's associated plans during her first month in post. Mr Ireland confirmed that several pieces of work were underway around management pathways and recruitment and retention. He indicated that regular updates would be provided to the People and Culture Committee to enable closer monitoring of the progress being made but pointed out that robust engagement from colleagues across the Trust, including from the Board, would be key to its success.

In response to a query from Mr Hodgson as to whether any benchmarking had been done with other organisations, Mr Ireland confirmed that colleagues from another organisation in LSC that had run a successful programme had been in regular contact with Mrs Wilkinson and had helped to inform the Trust's 30-, 60- and 90-day submissions.

RESOLVED: **Directors received the report and noted its contents.**

TB/2024/072 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson referred to the previously circulated report and provided a summary overview of the Trust's progress against the ten maternity safety actions included in the Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Year Six.

Safety Action 1 - Perinatal Mortality Review Tool (PMRT): Miss Thompson confirmed that the Trust had successfully met all compliance requirements for this action and that the latest PMRT quarterly report, covering January to March 2024, had been included in the report (appendix two).

Safety Action 2 - Maternity Services Data Set (MSDS): Miss Thompson confirmed that the Trust had successfully met all compliance requirements for this action.

Safety Action 3 - Transitional Care (TC): Miss Thompson confirmed that the Trust had successfully met all compliance requirements for this action.

Safety Action 4 - Clinical Workforce: Miss Thompson explained that a risk had been identified in relation to the neonatal medical workforce and a requirement for the consultant rota to meet British Association of Perinatal Medicine (BAPM) standards. She confirmed that an action plan would be produced to address this risk and that this would be brought to future Board meetings throughout the year.

Safety Action 5 - Midwifery Workforce: Miss Thompson confirmed that an action plan was in place to address the shortfall in the staffing budget against the requirements outlined by Birthrate+. She also confirmed that the associated business case had been completed and was due for discussion and consideration.

Safety Action 6 - Saving Babies Lives v3 Care Bundle (SBLv3): Miss Thompson confirmed that the Trust had successfully met all compliance requirements for this action.

Safety Action 7 – Maternity Neonatal Voice Partnership (MNVP) User Feedback: Miss Thompson advised that a schedule and planner had been developed to address MNVP capacity issues.

Safety Action 8 – Training: Miss Thompson confirmed that a formal plan was being developed to demonstrate that a minimum of 90% of neonatal medical staff who attended neonatal resuscitations had a valid Resuscitation Council Newborn Life Support (NLS) certification by Year Seven of the MIS onwards.

Safety Action 9 - Board Assurance: Miss Thompson confirmed that the Trust was compliant against this action. She explained that the Perinatal Quality and Surveillance Model (PQSM) data for March 2024 had been submitted with additional rationale regarding third- and fourth-degree tear data.

Safety Action 10 - Maternity and Newborn Safety investigation Programme (MNSI) / NHS Resolution: Miss Thompson confirmed that the Trust was fully compliant against this action.

Miss Thompson went on to refer to the All-Party Parliamentary Group (APPG) Birth Trauma Report. She noted that this was the first time that a parliamentary report had been published on this area and was welcome, adding that it would help to promote more of a focus on a trauma informed approach. Miss Thompson stated that although this report had only been published two days prior, additional addendums would need to be made to the Trust's Patient Experience Strategy and all associated measurements would need to be aligned with the 12 asks outlined as part of the potential new National Maternity Improvement Strategy.

Mr Hodgson paid credit to the work done by Miss Thompson and the rest of the Trust's maternity and neonatal colleagues. He also agreed with Miss Thompson's suggestion for the Birth Trauma Report to be included as an addendum to the Patient Experience Strategy. Mr Hodgson noted that it remained to be seen whether the publication of the Birth Trauma Report would lead to additional commissioning elements being put into place.

Mr Rehman informed Directors that both he and Mr Murphy had had the opportunity to participate in a 'walk round' session in April 2024 and that it had been clear that maternity colleagues were aware of areas that required further strengthening.

Responding to a query from Mrs Bosnjak-Szekeres regarding the progress of the business case for funding to satisfy Birthrate+ staffing recommendations, Miss Thompson advised that she was still awaiting feedback on the first draft and that she would provide an update at the next Board meeting.

RESOLVED: **Directors received the report and were assured by the activity taking place to deliver safe, personal and effective care in the Trust's maternity and neonatal services.**

The Trust's Patient Experience Strategy will be revised and updated to reflect the findings and asks from the APPG Birth Trauma Report.

TB/2024/073 QUARTERLY COMMUNICATIONS ACTIVITY REPORT (Q1) 2024-25

Miss Wright indicated that she was content for the report to be taken as read, adding that it was intended to provide an overview of the work being done across the Trust's communications team.

Mr Sarwar extended his thanks to Miss Wright and to her colleagues for all of the work that they continued to do for the Trust.

RESOLVED: Directors received the report and noted its contents.

TB/2024/074 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Mr Hodgson referred to the previously circulated report and confirmed that it covered the period up to the end of March 2024. He highlighted that in the operating context that the Trust found itself working in, there were a number of positive performance items in the report, including performance against the four-hour A&E waiting time target, the faster diagnosis standard and good feedback through the Friends and Family Test (FFT).

b) Safe

Mr Husain referred Directors to the Safe section of the report. He explained that as the IPR covered the month at the end of the 2023-24 year, several Infection Prevention and Control (IPC) metrics had gone up. Mr Husain reported that there had been a total of 43 suspected cases of measles, 17 of which had ultimately turned out to be positive and 10 of which had been confirmed to have been caused by an index case that had initially occurred in the ED. He paid credit to the work done by colleagues in the IPC and occupational health (OH) teams in identifying the individuals affected.

Mr Husain went on to report that there had been a total of six cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) attributed to the Trust in 2023-24, against a trajectory of zero. He clarified that four of these had been determined to have been hospital-onset healthcare associated (HOHA) and two community-onset healthcare associated (COHA). Mr Husain advised that each of these cases had received an in-depth analysis and that only one had been determined to have been caused due to issues in case, with the other five deemed to have been unavoidable due to the complexities of the associated infections.

Mr Husain concluded his update by reporting that there had been another rise in Clostridium difficile (C. diff) in 2023-24, adding that the levels of overcrowding seen in UEC areas had likely been a significant contributing factor to this. He informed Directors that NHSE had recently changed the criteria around the reporting of C. diff infections which was likely to result in further increases in the number being reported.

RESOLVED: **Directors noted the information and assurance provided within the Safe section of the Integrated Performance Report.**

c) Caring

Mrs Pemberton referred Directors to the Caring section of the report. She highlighted that response rates to the FTT remained lower than expected in some areas and indicated that work was already underway to improve these. Mrs Pemberton reported that 19 new formal complaints had been opened in March 2024 and advised that a working group was in place to support divisions and ensure that response targets were achieved going forward.

RESOLVED: **Directors noted the information and assurance provided under the Caring section of the Integrated Performance Report.**

d) Effective

Mr Husain explained that the Trust's Summary Hospital-level Performance Indicator performance currently stood at 1.152 but explained that it would not be possible to provide any further assurance on this or on Hospital Standardised Mortality Ratio (HSMR) due to ongoing issues with accuracy of mortality data. He confirmed that it was expected that these issues would be addressed by July 2024, after which it would be possible to provide more accurate estimations of mortality rates. Mr Husain added that these issues were being compounded by the Trust's removal of SDEC from its datasets at the request of NHSE, which made it more difficult for the Trust to be compared to other organisations.

Mr Husain reported that the Trust's crude mortality rate stood at 2.8% and highlighted that this was lower than the average rate across the rest of the North West. He confirmed that the Mortality Steering Group (MSG) continued to closely monitor any outliers and carry out 'deep dive' investigations into any areas that required them.

Mr Hodgson noted that the implementation of the Trust's Electronic Patient Record (EPR) had undoubtedly had an impact on coding activity and advised that remedial action was being taken to address this as a priority.

Mr Sarwar emphasised that it was important to recognise that the Trust's implementation of its EPR had been as good as it could have been and that it had taken appropriate measures to mitigate any issues as much as possible.

RESOLVED: **Directors received assurance and noted the information provided under the Effective section of the Integrated Performance Report.**

e) Responsive

Mrs Montague reported that the Trust continued to see significant pressures across its UEC pathways, with a total of 22,952 patients attending in March. She advised that the Trust had remained ahead of trajectory with regard to the four-hour A&E waiting time target in April but acknowledged that there were still too many patients experiencing very long wait times in the Emergency Department (ED). Mrs Montague highlighted that the Trust's performance in relation to 65-week waiters, cancer and faster diagnosis standards had also been strong in March and that the data indicated that it had also hit its trajectories in April. She emphasised the importance of recognising the efforts from clinical and operational teams in ensuring that these performance targets continued to be met.

RESOLVED: **Directors noted the information provided under the Responsive section of the Integrated Performance Report and received assurance about the work being undertaken to improve patient care and experience.**

f) Well-led

Mr Ireland reported that sickness and absence rates in the Trust had continued to fall and stood at 5.6%. He acknowledged that this was still above the threshold of 4.5% and that additional work was needed to maintain this trend. Mr Ireland reported that turnover and vacancy rates remained low and well within threshold, with particularly significant reductions in the number of registered nurse vacancies. Directors noted that there would be a renewed focus on medical job planning through 2024-25 and that progress would be closely monitored through the People and Culture Committee.

Mr Ireland went on to report that appraisal rates continued to rise slowly but were still below the 90% target. He added that focused work was being done around this to improve compliance.

In response to a query from Mrs Bosnjak-Szekeres regarding the linking of appraisal compliance to pay progression which had been discussed at previous meetings, Mr Ireland confirmed that this had been re-implemented from the start of the 2024-25 financial year and that colleagues would no longer move up the pay scale if they had not completed an appraisal in the preceding 12-month period. He stressed that various mechanisms had been implemented to ensure that this could be avoided if possible.

Mrs Brown informed Directors that the Trust was currently at its draft accounts stage and confirmed that teams were working with external auditors to complete the accounts process for the year. She highlighted that the Trust had successfully achieved its agreed forecast outturn position, its capital and external finance limits and three out of four of the Better Payment Practice Tariff (BPPT) code targets. Mrs Brown reported that agency costs had come under the Trust's 3.7% pay bill target and the organisation had finished the year with a cash balance of £11.6m. She added that while this was a deficit position, as this was the first year of deficit for the Trust and it had a cumulative surplus, it had not breached break even duty Directors noted that the accounts were due to be fully finalised following the completion of the audit in June 2024.

RESOLVED: **Directors noted the information provided under the Well-Led section of the Integrated Performance Report and received assurance about the activity being taken to improve and maintain performance.**

TB/2024/075 REMUNERATION COMMITTEE TERMS OF REFERENCE REVIEW

At Mr Sarwar's request, Directors confirmed that they were content to approve the updated terms of reference for the Remuneration Committee.

RESOLVED: **Directors received the report and noted its content.**

TB/2024/076 TRIPLE A REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its content.**

TB/2024/077 **TRIPLE A REPORT FROM QUALITY COMMITTEE**

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its contents.**

TB/2024/078 **TRIPLE A REPORT FROM PEOPLE AND CULTURE COMMITTEE**

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its contents.**

TB/2024/079 **TRIPLE A REPORT FROM AUDIT COMMITTEE**

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its contents.**

TB/2024/080 **TRUST BOARD (CLOSED SESSION) INFORMATION REPORT**

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its contents.**

TB/2024/081 **REMUNERATION COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

RESOLVED: **Directors received the report and noted its contents.**

TB/2024/082 **ANY OTHER BUSINESS**

Mrs Bosnjak-Szekeres requested delegated authority from the Board for the ratification of a number of items via its sub-committees. These were:

The approval of the Trust's Annual Report and Annual Accounts for 2023-24 through the Audit Committee.

The approval of the Trust's Quality Account for 2023-24 through the Quality Committee and Audit Committee.

The sign-off of the Board's annual Digital Maturity Assessment through the Finance and Performance Committee.

RESOLVED: **Directors confirmed that they were content for delegated authority to be provided in relation to the items above.**

TB/2024/083 OPEN FORUM

Mr Sarwar reiterated that the meeting was the first time that the Board had held a meeting in a public venue and invited questions from the members of the public in attendance.

Responding to concerns raised around the Trust's appointment system and the lack of flexibility offered to patients in choosing a time and date of their preference, Mr Hodgson advised that similar feedback had been provided at other venues and that work was already underway to improve the organisation's booking processes. He added that Mrs Atkinson was also leading on other work to modernise the Trust's outpatient's department and ensure that it was better suited to meet the needs of patients and service users.

Mrs Atkinson confirmed the issues around the Trust's booking process were recognised and reiterated that a comprehensive outpatients transformation programme was due to be launched later in the year to address this and other areas of concern. She explained that a new patient charter had also been developed in conjunction with the Trust's Patient Participation Panel that would tie into this work. Mrs Atkinson emphasised that the Trust was keen to continue to hear from patients around how it could improve its processes and confirmed that she would be available for a further conversation after the meeting if it would be helpful.

Mr Hodgson added that additional funding had also been set aside for NHS organisations to improve their digital offering to patients and indicated that the Trust was looking at non-traditional ways of booking patients in for appointments or procedures.

TB/2024/084 BOARD PERFORMANCE AND REFLECTION

Mr Sarwar sought feedback from Directors as to whether they felt the Board had appropriately addressed and fulfilled its objectives in relation to its communities, staff, and stakeholders.
He stated that he felt that the Board had carefully considered the pressures on Trust staff and the needs and level of acuity in the local community and local population. Mr Sarwar acknowledged that the Trust's relationship with some of its stakeholders would benefit from being strengthened and noted that work was taking place to facilitate this.

RESOLVED: Directors noted the feedback provided.

TB/2024/085 DATE AND TIME OF NEXT MEETING

Mr Sarwar informed Directors that the next Trust Board meeting would be taking place on Wednesday, 10 July 2024 at 12:30. He added that a venue would be confirmed in due course.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **91**

10 July 2024 **Purpose** Information

Title	Action Matrix
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mr S Sarwar, Chairman
Date Paper Approved by Executive Sponsor	

Summary: The outstanding actions from previous meetings are presented for discussion. Directors are asked to note progress against outstanding items and agree further items as appropriate.

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

For Trust Board only: Have accessibility checks been completed? Yes

Previously considered by:

(91) Action Matrix

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2023/040: Maternity and Neonatal Service Update	A full business case regarding the additional funding required to satisfy the Birth Rate+ nursing and midwifery staffing recommendations will be developed and presented to the Board for approval at a later date.	Chief Nurse/ Head of Midwifery	Q1 2024-25	Update: The business case will be presented at a future meeting once it has progressed through the appropriate business case process.
TB/2024/064: Chief Executive's Report	Mr Hodgson will update Board members on the outcomes from the roundtable exercise with Helen Whately and local MPs at a later date.	Chief Executive	July 2024	A verbal update will be provided as part of the Chief Executive's Report at the next meeting.
TB/2024/068: Patient Safety Incident Response Assurance Report	Board members to complete the Level 1b Patient Safety Training Modules before the next meeting.	Board members	July 2024	Update: Following the Board meeting in May it was determined that Non-Executive Board members on this 'essential to role' training module. This matter was raised with colleagues from the Trust's Learning Hub for rectification and a direct link to the training module has been circulated to Non-Executive colleagues to enable them to complete it in the interim.

Item Number	Action	Assigned To	Deadline	Status
TB/2024/066: Corporate Risk Register and Risk Performance Report	Discussions to take place regarding the addition of RIDDOR incidents to the Trust's internal audit plan for 2024-25.	Audit Committee	October 2024	This proposal will be discussed in detail at the October meeting of the Audit Committee.
TB/2024/072: Maternity and Neonatal Services Update	The Trust's Patient Experience Strategy will be revised and updated to reflect the findings and asks from the APPG Birth Trauma Report.	Chief Nurse	July 2024	A verbal update will be provided at the next meeting.

Lancashire and South Cumbria Provider Collaborative

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT		**Item**	**93**
10 July 2024		**Purpose**	Information
Title	Chief Executive's Report		
Author	Mrs E Cooke, Joint Deputy Director of Communications		
Executive sponsor	Mr M Hodgson, Chief Executive		

Summary: A summary of relevant national, regional and local updates are provided to the board for context and information.

Recommendation: Members are requested to receive the report and note the information provided.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives. Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

1. Background

This report is divided into sections covering the following:

- National headlines relevant to the NHS and wider health and social care economy
- News and information from across the North West and Lancashire and South Cumbria system area, including details from the Integrated Care Board (ICB) and Provider Collaborative Board (PCB)
- Local and Trust specific updates

This report features reduced content due to the pre-election period (26 March – 4 May) in accordance with NHS local election guidance.

2. National Updates

Synnovis cyber attack

NHS England continues to work with Synnovis and the National Crime Agency to respond to the criminal ransomware attack of patient data managed by blood test management organisation Synnovis.

More than 3,000 hospital and GP appointments were disrupted by the attack when ransomware hackers infiltrated the computer systems of Synnovis, which is used by two NHS Trusts in London, and encrypted vital information making IT systems useless.

Synnovis confirmed through an initial analysis that the data published by a cyber-crime group had been stolen from some of their systems. Synnovis are working at pace to carry out the further analysis required to understand the full scale and nature of the data released and patients impacted**.**

It has been established that there is no evidence the cyber criminals have published a copy of the database (Laboratory Information Management System) where patient test requests and results are stored, although investigations are ongoing.

Recognising the critical importance of cyber security, the Trust Board recently attended a comprehensive development session focused on Information Governance. This session underscored the vital role cyber security plays in safeguarding sensitive information held by the Trust and in maintaining the integrity of the organisation’s operations.

UK Covid-19 Inquiry

The UK Covid-19 Inquiry will publish its first report and recommendations following its investigation into the UK's 'Resilience and preparedness (Module 1)' for the pandemic on Thursday 18 July 2024.

The Chair of the Inquiry, Baroness Heather Hallett, will present her recommendations in a live streamed statement on the Inquiry's YouTube channel soon after.

The first investigation's public hearings, which were held across six weeks in June and July 2023, heard oral evidence from witnesses including senior politicians as well as scientists, experts and civil servants.

The Inquiry's eighth investigation has opened examining the impact of the pandemic on children and young people and has set out plans to open two further investigations in 2024.

Module 8 will investigate the impact of the pandemic on children across society including those with special educational needs and/or disabilities. It will consider a diverse range of backgrounds, the impact of decision-making on children and young people and the long-term consequences of the pandemic. More details of the areas of investigation are included in the provisional scope for Module 8. The Core Participant application window will be open from 21 May to 17 June 2024.

Module 9 will focus on the economic response to the pandemic. This investigation will open in July 2024. A further investigation will be announced later in the Autumn which will explore the impact of the pandemic in various ways, including on the mental health and wellbeing of the population. Further details will be published at that time.

Publication of the infected blood inquiry final report

Sir Brian Langstaff has published the final report of the independent Infected Blood Inquiry. The Inquiry officially opened in 2018, with hearings lasting from April 2019 to January 2023.

This independent public statutory Inquiry was established to investigate the circumstances surrounding NHS patients being treated with infected blood and blood products from 1970s onwards.

It's estimated that over 30,000 people were infected by contaminated blood or blood products in the 1970s and 80s, with over 3,000 people dying as a result.

The Inquiry Report is documented over seven volumes:

Volume 1 – Overview and Recommendations

Volume 2 – People's Experiences and Trelor's

Volume 3 – What happened and why?

- Basic Concepts
- Knowledge
- Blood Services
- Blood Products and Addressing Risk

Volume 4 – What happened and why?

- Role of Government: Response to Risk
- Haemophilia Centres: Policies and Practice
- Pharmaceutical Companies
- Haemophilia Society

Volume 5 – What happened and why?

- Blood Transfusion: Clinical Practice
- Screening
- Lookbacks
- Public Health
- vCJD

Volume 6 – Response of Government Public Bodies

Volume 7 – Response of Government

Attention Deficit Hyperactivity Disorder Taskforce

NHS England's new cross-sector Attention Deficit Hyperactivity Disorder (ADHD) Taskforce will be co-chaired by Professor Anita Thapar and Joanna Killian.

The new taskforce brings together those with lived experience and experts from the NHS, local government as well as education, charity and justice sectors to gain a better understanding of the challenges affecting those with ADHD, including access to services and rising demand.

Since December, NHS England has been focusing on ADHD with senior clinicians and system leaders from across the country. Alongside the work of the taskforce, NHS England will continue to work with stakeholders to:

- develop a national ADHD data improvement plan
- carry out more detailed work to understand the provider and commissioning landscape

- capture examples from local health systems which are trialling innovative ways of delivering ADHD services and to ensure best practice is captured and shared across the system.

First medical director for mental health and neurodiversity appointed in NHS England
Dr Adrian James has been appointed by NHS England to support the transformation of services for mental health, autism, learning disabilities, and neurodiversity.

As President of the Royal College of Psychiatrists (2020-2023), he led the organisation through the Covid-19 pandemic, enhancing workforce wellbeing, and promoting equality, diversity, and inclusion. He also prioritised the Covid-19 vaccination for individuals with serious mental illness or learning disabilities.

Dr James is currently a board member of the NHS Race and Health Observatory, a member of the NHS Assembly, and was the first medical director of Devon Partnership NHS Trust. One of his key priorities has been achieving parity of esteem between mental and physical health.

Martha's Rule to be rolled out across 143 hospitals
Confirmation of the first sites to test implementation of Martha's Rule is the next step in a major patient safety initiative.

The scheme is named after Martha Mills, who died from sepsis aged 13 in 2021, having been treated at King's College Hospital, London, due to a failure to escalate her to intensive care and after her family's concerns about her deteriorating condition were not responded to.

The purpose of Martha's Rule is to provide a consistent and understandable way for patients and families to seek an urgent review if their or their loved one's condition deteriorates and they are concerned this is not being responded to.

The initial target was to enrol at least 100 sites. However, due to significant interest from frontline clinicians, this target has been expanded. So, the first phase of the programme will now be implemented at 143 locations across the country by March 2025.

As one of the organisations piloting this system, the Trust has received additional funding to implement Martha's Rule at both Royal Blackburn Teaching Hospital and Burnley General Teaching Hospital. At ELHT, the initiative has been named 'Call for Concern'.

Evaluation of how the system works in the pilot sites over the course of this year will inform proposals for Martha's Rule to be expanded further across all acute hospitals, subject to future government funding.

King's Birthday Honours 2024

NHS colleagues, including paramedics, nurses, and doctors, are among those recognised in the 2024 King's Birthday Honours list.

David Dean, Senior Paramedic Mentor at East of England Ambulance Service, and Ola Adel Zahran, Chief Technology Officer at Yorkshire Ambulance Service, received the King's Ambulance Service Medal for Distinguished Service.

Professor Janice Sigsworth CBE, Chief Nurse at Imperial College Healthcare NHS Trust, was awarded a damehood for her contributions to genomics in nursing and midwifery. Richard Douglas CB, Chair of the NHS South East London Integrated Care Board, received a knighthood for services to the NHS in the South East.

Professor Laura Serrant OBE, Chair of Sheffield Children's NHS Foundation Trust, was awarded a CBE for services to nursing in the North East and Yorkshire.

Joanne Fitzgerald, Senior Programme Manager at NHS England, received an MBE for her services to the NHS and advocacy for people with lived experience.

3. Regional Updates

The Lancashire and South Cumbria (LSC) Integrated Care Board (ICB)

Members of the Lancashire and South Cumbria Integrated Care Board (ICB) should have met on 19 June 2024.

Following the announcement of the general election on 4 July, NHS England advised that the NHS Joint Forward Plan for 2024/25 should be published after the election rather than by the original 30 June deadline. As this committee was intended to consider this document, the meeting was cancelled.

Provider Collaboration Board meeting – 13 June 2024

The Provider Collaboration Board (PCB) membership comprises the Chief Executives and Chairs of the five provider Trusts in Lancashire and South Cumbria and meets monthly. It is Chaired by Mike Thomas, Chair of University Hospitals of Morecambe Bay NHS Trust and

Aaron Cummins, CEO of University Hospitals of Morecambe Bay NHS Trust is lead Chief Executive.

At the June meeting, the Board discussed the progress to establish One LSC. The overview of this meeting is at the end of this report as Appendix 1.

4. Local and Trust specific updates

Use of the Trust Seal

The Trust seal has been applied to the following documents since the last report to the Board:

- On 4 June 2024 the seal was applied to a Consultancy Appointment between the Trust, Consort Healthcare (Blackburn) Limited and Ridge Partners LLP regarding monitoring surveyor services in relation to rectification works at Royal Blackburn Teaching Hospital, Blackburn. The agreement was signed by Mr Martin Hodgson, Chief Executive and Mrs Michelle Brown, Executive Director of Finance

Trust Board in the Community

In May, ELHT's Trust Board held its first public meeting since before the pandemic. Hosted at Turf Moor stadium in Burnley, the event successfully encouraged local community members to attend.

The Trust plans to hold the September Board meeting within the community as well. Details about the venue and timings will be shared closer to the date.

Stakeholder briefing event

On Tuesday, May 14, the Trust held its first virtual event of the year for its core stakeholders, including health and social care partners, third-sector providers, community organizations, local authorities, and educational institutions.

During the event, the Executive Board provided updates on the Trust's services, discussed the challenges faced, and highlighted recent improvements. They also answered questions submitted by attendees through the chatbox function of the virtual platform.

The next event is scheduled for Autumn, and we aim to make it even more engaging. The Executive Board welcomes and values feedback from our stakeholders to improve the event's format and content. Please let us know if there are any areas where you think we can improve this event.

Changes to the Trust's Executive Board

In July, the Trust initiated the recruitment process for three Non-Executive Directors and one Associate Non-Executive Director, aiming for appointments by mid-September.

The Trust seeks talented individuals with the senior skills and experience necessary for effective leadership in these roles. To enhance its decision-making capabilities, the Trust Board values diverse, inclusive, and compassionate leadership from individuals with a mix of skills and experiences from various backgrounds and lived experiences.

The Trust is particularly interested in candidates who understand the needs and priorities of local communities and can inspire the confidence of patients and the public. Applications are especially encouraged from women, individuals from local black and minority ethnic communities, and people with disabilities.

Further information and how to apply can be found on the Trust's and NHS England's websites.

Michelle Brown, the Trust's Executive Director of Finance, will be retiring in September 2024 after almost 30 years of dedicated service in the NHS, with 18 of those years spent at ELHT.

Michelle joined the Trust in December 2006 from Calderstones NHS Trust, where she served as Assistant Director of Finance. She was appointed Executive Director of Finance for our Trust in September 2019, following a decade as Deputy Director.

As a qualified accountant and member of the Chartered Institute of Public Finance and Accountancy (CIPFA), gained extensive experience across various NHS organisations in North Wales and Lancashire, including North Wales Health Authority, Glan Clwyd and Wrexham Maelor hospitals, and Burnley Healthcare NHS Trust.

Michelle's retirement marks the end of a notable career in healthcare, driven by her dedication to the organisations she has served and the NHS as a whole. Keeping a focus on those dependent upon NHS services has been central to her commitment to ensuring equitable healthcare access for all.

On behalf of all colleagues at the Trust, I extend heartfelt thanks to Michelle for her outstanding leadership and contributions and wish her the very best of happiness and health in retirement.

Industrial action

A further period of industrial action has taken place since the last Board meeting as part of a national dispute over pay. The decision to take action by the BMA followed the announcement of the General Election. Junior doctors conducted a full walkout which began at 7am 27 June 2024, ending 7am 2 July.

In close collaboration with colleagues and union representatives, the Trust maintained patient safety and adequate staffing levels by rescheduling certain routine and non-urgent appointments and procedures. This resulted in the majority of our services remaining operational.

Working with the broader healthcare system consistent messages to the public were issued, encouraging attendance at appointments unless advised otherwise and directing individuals to suitable pathways for health care and support.

EPR Update

It's been a year since the Trust implemented the Cerner Millennium electronic paper record (EPR) system. This initiative aims to enhance patient care by providing a seamless, accessible record that minimises the reliance on paper-based documentation.

ELHT now operates three EPR systems: Cerner Millennium, Badgernet (for Maternity and NICU), and EMIS (for Community Services). Additionally, there is access to Connected Care Records via LPRES, further integrating patient information across services.

The initial phase of implementing the new EPR was intense and presented its share of challenges, which are continually being addressed. Nonetheless, the transition has yielded significant successes.

Feedback from teams has been positive. Many team members have found the system very easy to understand and navigate. While there were a few initial teething problems, which are expected with any new system, the consensus is that the system now runs very well. Clinicians appreciate the easy access to clinical information that the system provides. Moreover, information is being shared more easily and effectively, both within the organisation and with other health services where appropriate.

Thanks have been extended to everyone for their dedication and hard work during the continued period of implementation. As we continue to optimise the use of our new EPR, we remain committed to ensuring safe, personal, and effective care is provided to all our patients.

Social care minister visits A&E

Helen Whately MP visited ELHT in May 2024, prior to the general election being called, in her role as Social Care Minister to see first-hand the challenges being faced by the Trust and the enormous amount of work being done by colleagues.

She was joined by local Kate Hollern (representing Blackburn with Darwen), Sara Britcliffe (representing Hyndburn) and Anthony Higginbottom (representing Burnley) as she walked around A&E and other departments and spoke to teams. Alongside being given an overview of the innovation, quality and safety taking place in the Trust, the Minister was also able to see the day-to-day pressures being faced, including how corridor care is becoming more regular.

As Minister of State for Social Care, Helen Whately was responsible for a range of areas, including urgent and emergency care, hospital discharge and community health services.

Thanks and appreciation were extended to all colleagues who assisted in the success of this visit.

NHS Confederation

Shazad Sarwar, Chair, Martin Hodgson, Chief Executive and Sharon Gilligan, Chief Operating Officer, attended the first day of the NHS ConfedExpo 2024. This annual event is one of the largest and most significant health and care conferences in the UK, attracting over 5,400 delegates across two days.

Amanda Pritchard, Chief Executive of the NHS, opened the conference by giving an open and honest speech which resonated with many of the issues the Trust is facing.

It emphasised collaboration and highlighted both achievements and challenges in healthcare. She praised the NHS's adaptability and recent milestones, including advancements in cancer vaccines, while also acknowledging persistent safety concerns and pledging improvements. Looking ahead, Amanda pointed out challenges such as an aging population with multiple health conditions and emphasised the need for innovation and transformation in primary and community care to meet these evolving healthcare needs effectively.

The speech concluded with a call to action for continued innovation, better management and leadership practices, and societal introspection on issues like obesity and gambling addiction that impact public health. Pritchard underscored the NHS's role in addressing these challenges collaboratively while striving for a healthcare system that is responsive, equitable, and sustainable for future generations.

Trust receives North West BAME Assembly Bronze Award

The Trust is proud to have achieved the North West BAME Assembly 'Bronze Award' in recognition of progress against the Anti-Racist Framework. As a strategic priority, the Aarushi Project has developed an anti-racism charter and pledge, driving our journey towards becoming a compassionate and inclusive organisation. The Trust applied for the award at the first opportunity and was one of only three organisations in the Lancashire and South Cumbria system to do so. The application included strong evidence of commitment to anti-racism and was praised for exemplary practices, such as strong senior leadership sponsorship, the Aarushi Project, and our anti-racism statement and charter.

Areas for development include measuring impact, establishing data baselines for stretch goals and health inequalities, and addressing race-based inequities. It is recommended that senior colleagues have specific anti-racism objectives, and educational opportunities be expanded beyond current leadership programmes.

The Trust is collaborating with race equality expert Candace Bedu-Mensah on developing our allyship framework and with Yvonne Coghill, former Director of workforce race equality, NHS London, and previous to that, Director for the Workforce Race Equality Implementation Team in NHS England/Improvement, on future board development. The Assembly suggests a maximum timeframe of 18 months between obtaining bronze and applying for silver.

Star Awards

The highlight of the Trust's colleague recognition calendar is the STAR Awards, which will take place on 11 July 2024. This year more than 600 nominations were received – the largest number in the history of the awards.

Judging panels, which included Executive Directors, Non-Executive Directors and senior managers had the arduous task of reducing the record number of nominations down to 33, selecting two finalists and a winner in each of the 12 categories, celebrating Trust values, innovation and team members who have gone the extra mile.

The ceremony will be live streamed from a professional broadcast studio, where Executive and Non-Executive Directors will announce the winners. The benefit of this virtual format is that as many colleagues as wish to attend will be able to join live and enjoy the event. And for those who can't join live, the event can be viewed later via catch-up.

The results of awards will be shared live on the night via the Trust's social media platforms, which can be found by searching @ELHT on X and Facebook. Information about the winners will also be published on the Trust's website following the event.

Heart Care Unit is open

The new Heart Care Unit at Royal Blackburn Teaching Hospitals opened its doors in May. The new unit brings together the Coronary Care Unit and the Cardiology Ward into a single location.

It is the result of many years of planning and development and includes a 10-bed unit for coronary care and 26 bed Cardiac Care Ward. Patient experience will be further enhanced with the inclusion of a cardiac assessment unit and cardiac ambulatory area.

There has been significant investment aligned to this development with new essential furniture and medical equipment to support the delivery of safe care and enhanced patient experience.

Ceremony officially opens Burnley's Spiritual Care Centre

Colleagues and guests joined together for the official opening of the new Spiritual Care Centre at Burnley General Teaching Hospital.

The Spiritual Care Centre at Blackburn Royal Teaching Hospital is well established and well used. In recent years, the Chaplaincy and Spiritual Care Team, along with the Trust, aimed to provide new and updated facilities at Burnley to meet the spiritual and religious needs of colleagues, patients, and their families. The new facilities fulfil this aim.
To mark this significant development, a special multi-faith ceremony was held, attended by colleagues and representatives from various faiths. The event featured an official ribbon cutting and a 'Dedication of the Chapel' service, with readings and prayers led by Canon Andrew Horsfall, Head of Chaplaincy and Spiritual Services at ELHT, Anglican Bishop of Lancaster Jill Duff, and Sister Catherine Ryan, a Chaplaincy volunteer.

Celebrating our nurses and midwives

Every year, the NHS across the country joins in celebrating both the International Day of the Midwife and International Nurses Day. These significant events recognise the invaluable contributions made by midwives and nurses to healthcare and the well-being of individuals and communities.

Peter Murphy, Chief Nurse, held webinars for nearly 400 midwives and 3,000 nurses to mark these occasions. The discussions centred around this year's themes: 'Midwives: a vital climate solution' and 'Our Nurses Our Future, The Economic Power of Care.'

Leading up to these special days, colleagues and patients were encouraged to nominate midwives and nurses who exemplified exceptional care and served as role models. Following a significant number of nominations, 10 nurses and five midwives were selected to receive bouquets of flowers presented by Peter Murphy, alongside his deputies Jane Pemberton and Jed Walton-Pollard.

Volunteers Week

Colleagues joined together in celebrations to mark Volunteers Week; a national awareness event set up to celebrate the amazing contributions volunteers make to communities across the UK.

The Trust is fortunate to have an incredible team of volunteers, including wayfinders, ELHT&Me Charity volunteers, chaplaincy volunteers, maternity team volunteers, ward volunteers and Macmillan volunteers. They all play a valuable role in helping us provide safe, personal and effective care.

As part of the celebrations Martin Hodgson, Chief Executive, personally wrote to each volunteer to extend a heartfelt thank you for their dedication and support. This gesture underscores our deep appreciation for the contributions our volunteers make. Thank you to all our volunteers for their invaluable service and commitment.

Estates and Facilities Day celebrations

This awareness day took place on 19 June and enabled the Trust to celebrate and promote the essential work our Estates and Facilities (E&F) colleagues carry out across all Trust sites.

This is the second annual awareness day dedicated to celebrating colleagues who preform essential duties to keep our hospitals operating efficiently and safely.

On their special awareness day, Martin Hodgson, Chief Executive, took the time to personally express gratitude to each member of our Estates and Facilities Team. Thank you for the hard work carried out to make sure our hospitals are a safe and supportive environment for all who use them.

Cause of Death – Coronial documentary

Filming for the latest series of the Cause of Death documentary, which focuses on the work of HM Coroner and partner agencies, has concluded.

Compelling stories and invaluable insights into the critical processes at both ELHT and Lancashire Teaching Hospitals have been captured. The production team, Candour, are in the post-production phase, with viewing for factual accuracies being carried out.

While a broadcast date is yet to be determined, anticipation is high for another impactful airing on Channel 5.

Emergency Theatres Documentary

Proper Content, an independent TV production company commissioned by Channel 4, has completed three months of filming in the Trust's emergency theatres, on wards, and in patients' residences.

The documentary '999 Critical List' focuses on the emergency theatre six list, capturing everything from minor surgeries to urgent category 1 cases. Viewers will follow patients and their families as they await an available slot on the list.

Highlighted cases illustrate the operational dynamics of the list, particularly when higher priority cases necessitate adjustments, showcasing the complex logistics involved in ensuring patients receive the best care.

The series aims to emotionally engage audiences by exploring broader themes of social care and the health challenges facing the UK today. Theatre six serves as a poignant reflection of the nation's health, showcasing a variety of illnesses and conditions that many individuals encounter in their lives. While patients remain central to the narrative, the series also emphasises the pivotal role of clinical colleagues in their care journey.

Currently in post-production, the series has been submitted to Channel 4 for critical review. Though a specific transmission date has not been confirmed, it is anticipated to premiere in Autumn 2024.

ENDS

Emma Cooke
Joint Deputy Director of Communications
26 July 2024

Provider Collaborative Board – 13 June 2024

Provider Collaboration Board – 13 June 2024
The Provider Collaboration Board (PCB) Joint Committee met on 13 June 2024. It received updates on the following standing items: system pressures and performance updates within Urgent/Emergency Care and Elective Care; Mental Health and Learning Disabilities, and Finances.

Performance management continues to be the responsibility of Trust Boards, with the PCB using performance data to inform wider strategic discussions on system transformation.

The Joint Committee has been established to give the PCB a mechanism via which to make decisions on a number of key programmes of work as agreed with Trust Boards. Updates on Central Services, the Clinical Programme Board, the Elective Recovery Programme and the Pathology Network were discussed under Joint Committee working items.

Current Performance Update – Urgent and Emergency Care and Elective Recovery

Work was ongoing to refine the information that would come to future PCB meetings in terms of system performance. This was likely to involve thematic reporting of risks and the use of statistical process control charts and would seek to facilitate shared learning across Trusts to help address variations in performance. A proposed approach would be discussed at the July meeting, taking into account the feedback from the recent session with Trust Boards which had been facilitated by Professor Chris Ham.

The system continued to take a mutual aid approach towards meeting targets particularly in relation to diagnostics and cancer.

While the Lancashire and South Cumbria (LSC) health system were meeting the interim ambulance turnaround target of under 30 minutes, traditionally there had been a much shorter turnaround at this time of year, so this needed to be kept under review. This would be escalated to the Urgent and Emergency Care Programme Improvement Board for discussion.

All providers are forecasting zero 78-week waits by the end of June 2024, meeting NHSE expectations and the total waiting list size remains stable.

Current Performance Update – Mental Health and Learning Disabilities

Helpful discussions had taken place with the Integrated Care Board on autism waiting times; however, it had been confirmed that no funding was available for 2024/25. Lancashire and South Cumbria Foundation Trust (LCSft) would provide a formal response and the issue would be picked up within the appropriate assurance meetings.

Board members congratulated the Chief Executive of LSCft for having been voted onto the Board of NHS Providers to represent Mental Health.

As part of a future meeting, LSCft would outline their offer to patients within Emergency Care and would also pick this up with the Chair of the North West Ambulance Service (NWAS) as

part of a wider review being carried out in terms of mental health provision within Emergency Departments across the North West.

LSCft – Whalley site update

On 1 April 2024, LSCft acquired the Whalley site from Mersey Care NHS FT. Formerly known as Calderstones, the vision and goal for the site is to create a community for restorative, regenerative health and wellbeing.

Following extensive stakeholder engagement, Phase One was completed, with a high-level site strategy, divided into four zones and three phases. The four zones are Service; Specialist Housing and Community; Community and Civic Wellbeing; and Nature, Leisure and Wellbeing.

Phase Two ran from January 2024 to May 2024 with momentum building to the transfer of the site. Key objectives of Phase Two were: finalising the high-level site development strategy; engagement with stakeholders in relation to planning; development of pre-acquisition; identification of meanwhile uses; support to understand baseline infrastructure; and identification of a range of potential alternative funding for opportunities across each of the four zone sites.

As part of the discussion about the Whalley site, it was noted that there were opportunities to develop a more comprehensive full-system provider estates strategy.

LSCft – Future vision

The Trust adopted the quadruple aim in July 2023, and subsequently began a programme of refreshing the Trust strategies through wide engagement across colleagues, community and service user groups, and partners across the health system.

Through this engagement, the decision was taken to move from multiple strategies to a single Trust strategy. The proposed LSCft Trust strategy 2024-2027 was aligned to the quadruple aim of: best possible care; joy and pride in work; improving health; and value for money, and incorporated the new Trust vision to provide the best mental health, learning disability, autism and community-based services for the population served.

Iterations of the strategy had been reviewed by both the Board of Directors and the Trust's Council of Governors. Outcomes had been defined for each element of the quadruple aim, with 28 metrics identified that will allow the Board of Directors and Trust Management Board to track progress towards the outcomes via a strategic dashboard. The Trust had also developed its transformation programmes for 2024/25 which will enable the delivery of the Trust strategy. This had also been supported by the development of a transformation dashboard.

Discussions would take place with the acute providers about the impact of this strategy on their individual Trust strategies.

Financial Update

The system had met the deadline for the submission of the financial plan with an agreed deficit of £175m. This was an increased saving of £17m on the original proposal and had been shared between the ICB and the four acute provider Trusts, with the ICB picking up 50% of this and the Trusts sharing the remainder. Should the system agree to the £175m deficit control total then NHS England would provide £175m of revenue deficit funding. NHSE will seek assurances that plans were on track before releasing this deficit funding.

As the system has an underlying deficit, NHS England has reduced the capital envelope for the system by £10m so that the associated cash can be freed up to assist with the revenue position. In addition, system resources will be top sliced by up to a further 1% in 2025/26 to help repay the underlying deficit.

LSCft had some Learning Disability Capital Funding that could provide some flexibility in-year providing this was then available to them in 2025/26.

One LSC Programme Update

Work continued towards formally establishing One LSC on 1 October 2024. Trust Boards would be considering the legal and governance framework (the strategic collaboration agreement, or SCA) in July. Briefing sessions for colleagues and Boards on the SCA were being organised.

Boards would need sufficient information to enable them to make the decisions necessary to agree to the principles set out in the SCA. If agreed this would enable progression to the next stage of the process of transitioning to One LSC, which would include the TUPE consultation.

While all five Trusts would be equal partners in the Provider Collaborative and One LSC, it was recognised that LSCft had some unique needs both as a provider of mental health services and in light of their newly developed strategy. This will be accounted for in the version of the SCA that they would sign. A letter confirming their position would be shared with all Provider Trust Boards.

The current priorities of One LSC's leadership team included increased communication and engagement to ensure colleagues have the information they need and that those in-scope feel part of the 'One LSC family'. To this end roadshows running from July to October were being organised in collaboration with staff side (trade union) colleagues. A methodology and a tracker would also be created to fully articulate of the benefits of establishing One LSC.

The Advisory, Conciliation and Arbitration Service (ACAS) were due to meet with staff side colleagues on 14 June to determine whether conciliation was appropriate and achievable in relation to the grievance they had raised.

Joint Committee members recognised the complexity of this change programme and extended their thanks to all those involved.

Clinical Programme Board Update

The PCB clinical vision is for a networked service delivery model which will enable providers to work more effectively together in the planning and delivery of clinical services. Operating at scale across Lancashire and South Cumbria, the network will be underpinned by consistent clinical policies and protocols, and harmonised support services.

By collaborating and working across single, larger, more resilient teams, providers will be able to standardise service quality and ensure they are able to more effectively leverage the various change programmes currently underway in the system. It will also give the opportunity to develop more specialist expertise associated with centres of excellence while allowing us to continue with the local delivery of services. There would be better and more equitable access for patients and a more satisfactory working environment for colleagues with the opportunity to develop expertise within specialties.

Resourcing of the reconfiguration programme is an ongoing issue with production of business cases for Urology, Head and Neck, and Cardiac having been delayed until December. Resourcing of the fragile services programme is also a risk. A resourcing plan has been presented to the Recovery and Transformation Board on a number of occasions and remains under review.

Trusts would be asked to set up their own clinical strategy or programme delivery boards which would be a conduit to the system Clinical Programme Board to ensure that everyone remained in the loop on this work. The SRO for this programme would attend individual Board meetings in the autumn to keep colleagues updated on progress and explore what the system strategy would mean for their services.

Discussions with NHS England were also underway around the pace of the Gateway Assurance process.

Elective Recovery Programme Board Update

Six 78-week waits were forecast for the end of May across the collaborative with plans in place to have zero 78-week waits at the end of June 2024. As of the 26 May, the unvalidated position was 828 65-week waits. The month end trajectory for May is 725.

Task and finish groups for orthopaedics, gynaecology, cardiology and ophthalmology were being formed and would meet throughout June to explore mutual aid opportunities and other collaborative approaches to mitigate 65-week risks in these four specialities.

The system-wide surgical hub business case to embed extended theatre sessions was to be presented to East Lancashire Hospital Trust's (ELHT) Finance and Performance Committee on the 3 June and University Hospitals of Morecambe Bay's (UHMBT) Trust Board on the 5 June. The Cost per Case pilot to mobilise weekend surgical hub capacity to return High Volume Low Complexity (HVLC) activity from the independent sector is now underway in Lancashire Teaching Hospitals (LTH), with UHMB and Blackpool Teaching Hospital (BTH) commencing lists in June. LTH held 13 CPC lists during April and May, allowing 53 primary hip and knee operations to take place. Approximately 20 CPC lists are planned for June across all three Trusts.

Subject to NHSE approval of the request to engage the support of Changeology, a new Outpatient Productivity project will commence in Quarter 2 in all acute Trusts.

Pathology Network Board Update

The business case for Pathology continues to progress well and will be brought to the July meeting for a decision.

PCB Chair

The PCB Board formally ratified Professor Mike Thomas' second term as Chair to commence when his first tenure in the role comes to an end on 17 August 2024.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **95**

10 July 2024 **Purpose** Approval
Assurance

Title	Nursing Professional Judgement Review
Report Author	Mr J Walton-Pollard (Deputy Chief Nurse) Mrs J Pemberton (Deputy Chief Nurse) Mrs M Dixon (Corporate Finance)
Executive sponsor	Mr P Murphy (Chief Nurse)

Summary: This paper will provide the bi-annual Professional Judgement Review which incorporates a formal evaluation of the Trust's ward/unit/department(s) staffing templates using a triangulated approach. This includes an analysis of 20 days census data utilising the Safer Nursing Care Tool (SNCT) (Shelford Model) during November 2023, a review of the December 2023 – February 2024 nurse sensitive indicators and the professional judgement of the senior nursing team.

Recommendation:

1. The Trust Board are asked to note the data in terms of fill rates, vacancy rates, sickness rates, staff turnover and recruitment plans.
2. The Trust Board are asked to consider and note the professional judgement and the assurance it provides.
3. The Trust Board are asked to note ongoing work to develop separate improvement cases in respect of supernumerary ward managers, BGTH in line with the wider elective care centre developments and the further development of PNA hours

Report linkages

Related Trust Goal	Deliver safe, high-quality care. Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 2 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 3 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	Risk ID: 3804,4043,9259,9468,9382,9568,5790,5791

Related to recommendations from audit reports	NA.
Related to Key Delivery Programmes	People Plan and Quality and Safety
Related to ICB Strategic Objective	High Quality and Efficient Services

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: Clinical Governance Committee

Introduction

1. In line with national guidance which recommends a professional nursing judgement is carried out every six months, an evaluation exercise was carried out in November 2023 against the recommendations of the August 2023 Professional Judgement review. This paper provides the six-monthly update as per national guidance.
2. The professional judgement was carried out in the month of November 23 using the nationally recognised acuity tool (Safer Nursing Care Tool (SNCT) Shelford model) as the Trust has a licence to use this tool. A correlation was also made with the relevant nurse sensitive indicators using data from December 2023 to February 2024 (see appendix one) along with the professional judgement of the Director of Nursing, Deputy Directors of Nursing, Divisional Directors of Nursing, Assistant Directors of Nursing, Matrons, and Ward Managers.
3. In line with national guidance, meetings with the above were held between January and February 2024, to review every inpatient template so that a correlation can be made with the SNCT data and nurse sensitive indicators. Assurance can be given that the divisional and corporate finance teams have been heavily involved, providing accurate and up to date information on establishments. It is worth noting that due to unprecedented demand on patient flow and challenges with Emergency Department capacity, there are extra escalation beds open (34) across the in-patient wards which were taken into consideration with the November 2023 census exercise.

Professional Judgement Winter Census 2023

General Points

4. The following general points should be noted:
    - As a result of this review, with a particular emphasis on the triangulated approach most of the current in-patient templates were professionally judged as safe.
    - The compliance against the templates (Actual v Planned) is monitored monthly in the newly formed Trust Wide Governance Committee and the established Quality Committee. Assurance can be provided the Trust does have a Standard Operational Policy (SOP) for the day-to-day management of nurse staffing which will be described in detail in the newly designed monthly safe staffing report, which is monitored at the Nursing and Midwifery Leaders Forum and the newly redesigned Trust Wide Governance Committee. There is an acknowledgment (see below) the Trust has and

continues to improve on the fill rates for Registered Nurse (RN) and Support Staff with an overall average fill rate for the period of Dec 23- Feb 24 >93% for Registered Nurses and > 95% for Support Staff. This is against a national trajectory of 85% (see appendix one) and is reviewed monthly by the Board of Directors as part of the integrated performance report.

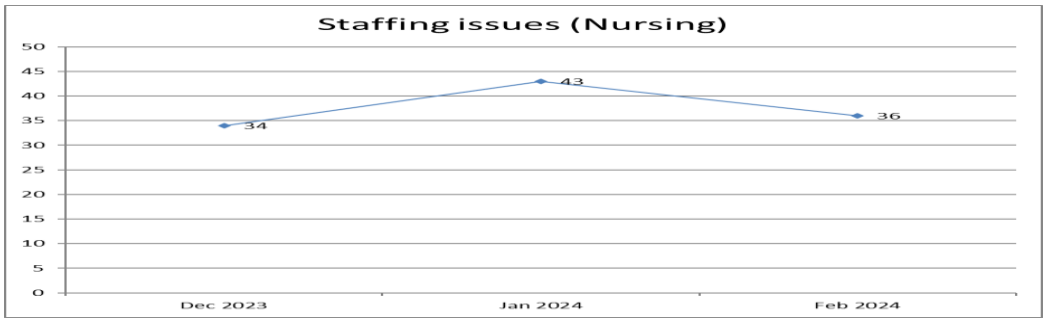
- There is a minimal nurse patient ratio of 1-8 with an additional shift co-ordinator during the early shift on all acute in-patient wards.
- It has been confirmed by the Safe Staffing Fellows at NHS England/Improvement (NHSE/I) that the SNCT census will potentially show some establishments as 'overstaffed' when comparing the census outcome to the establishment on smaller wards. This is exacerbated if acuity/activity is low. The Royal Blackburn Teaching Hospital (RBTH) site has several smaller (14 & 17-18 bedded) wards which need a minimum of 3 RNs per shift for clinical safety reasons. One exception to this is Ward C5 which has 2 RNs at night. This is supported using the triangulated approach as described above.
- The finance team have confirmed there is an uplift of 22% across all in-patient establishments. This is in line with national recommendations and consistent with the integrated care system. Ward budgets include a 22% uplift to both the budget and the establishment. This reflects the amount of time staff may be unavailable. The 22% is made up of 14% annual leave, 5% sickness and 3% study leave.
- All Ward Managers and community team leaders have supernumerary status one day per week which is not currently in line with the recommendations of the Francis report (2013) which states ward managers should have supernumerary status five days per week. It is proposed within this review that the ward managers and community team leaders have five days supernumerary. In comparison with the three other acute providers within the integrated care system, two have their ward managers supernumerary five days and one has them supernumerary three days per week. An improvement case to cover these costs is currently being undertaken.
- Where there is a recommendation for an increase in staff, assurance can be given that the Chief Nurse has visited the area to professionally judge the environment.

Professional Nurse Advocate Protected Time

5. Recognising the impact of the Covid-19 pandemic, the multifaceted and complex issues the aftermath has brought, with nurses feeling burnt out leading to concerns with nurses' mental health, an urgent call to introduce the availability of supportive measures towards the restoration and recovery for all nurses was required.
6. In response, the Professional Nurse Advocate (PNA) Training Programme was launched in March 21 to support the NHS recovery plan following the Covid-19 pandemic. The Programme is a virtual Level 7 accredited programme which is held virtually over 10 days and the academic assessment may include essays, poster presentations and competency portfolios, depending on which Higher Education Institute is used.
7. Monthly data recording is required from the PNA's to enable local, regional and national oversight. Protected time has not been agreed making it difficult for the PNA's to deliver their objectives and therefore, PNA activity monthly reporting to NHSE from the Trust is currently low.
8. The request is board support one hour per month per PNA to support the delivery of supervision for the current 22 PNAs which will increase to 35 PNA's. It is worth noting that NHS England guidance suggests that the Trust will need to increase further to 140 PNA's in the future. This is currently being absorbed within established ward budgets.

Nurse Staffing Related Incidents

9. Along with fill rates, incidents related to nurse staffing are monitored by the Deputy Director of Nursing. The tables below show the number of staffing related incidents per month and their subcategories for the period of December 2023 to February 2024. There have been no known staffing related incidents which have caused harm.



Subcategory	Total
Delay of more than 30 minutes in providing pain relief - (Due to Staffing)	1
Less than 2 registered Nurses / Midwives present on a ward during any shift	2
Staff indicated concerns	26
Staff shortage - Midwives	10
Staff shortage - nursing	71
Unable to reliably carry out intentional rounding	3
Total	**113**

Registered Nurse and Clinical Support Worker Sickness (Dec 23 to Feb 24)

10. The Sickness/Absence rates from December 23 – February 24 are displayed in the table below. Although there has been an improvement since the last review, sickness is still over the Trust trajectory of 4%. Whilst the Trust has an absence management policy, it is acknowledged that this could be more robustly applied if ward managers had supernumerary time to support staff who are absent from work.

Average	Number of staff	Occurrences	Covid Sickness %	Non Covid Sickness %	Total %
Support	1147	379	0.31%	9.24%	9.55%
N&M	2088	619	0.25%	5.87%	6.11%

Nursing Vacancies, Recruitment and Attrition

11. With the current recruitment of Internationally Educated Nurses, U.K. Educated nurses and the Trust's Nurse Degree Apprentice/Registered Nursing Associates due to qualify in September 2024. Taking attrition into account of 8-12 RNs per month, the Trust should be fully recruited by September 2024 for Registered Nurses/Registered Nursing Associates. This does not take into account any unfunded areas due to winter escalation or the extra staff temporarily agreed for the Emergency Department. The number of unfilled support worker vacancies is currently approximately 30 WTE.

Divisional Points to note

12. A summary of key points relating to each Division are outlined below.

Medicine and Emergency Care

13. Ward B4 have been working to 3 RNs on a night shift for the last 18 months but only have funding for 2 RNs. Utilising the triangulated approach, the professional judgement of the senior nursing team supports 3 RNs, and this is in line with other similar wards.
14. Ward C7 have been undertaking a test of change since the last professional judgement where they have put an extra clinical support worker on nights seven days per week. This is supported utilising the triangulated approach.
15. Wards D1, D3 and C11 have used funding for a 4th RN on the later part of the day shift to work a twilight shift. This is agreed using the professional judgement of the senior nursing team and is now embedded into practice.
16. The current staffing requirements for the Emergency Department is complex and fluid. In October 2023, the Executive Directors agreed a temporary uplift of 10 RN's and 7 support staff per shift to deal with the challenges the department is currently experiencing. In addition, the Trust has purchased the Safer Nursing Care Tool licence specifically for Emergency Care and staff have been fully trained to use this. However, on further discussion with the NHSE/I safer staffing fellows, it has become apparent that the tool does not consider patients who have been in the department greater than 12 hours. At present, most patients who require admission spend greater than 12 hours within the department due to pressures around flow. Therefore, it is not recommended any decision is made using the ED Safer Nursing Care Tool. The Head of Nursing for Emergency Care has written guidance for the number of staff required in relation to the number of patients at any one time. It is the professional judgment of the senior nursing team that this guidance meets the needs of the department which is broadly in line with RCN workforce standards (see table below).
17. In April 24, the Executive Team have agreed non-recurrent funding to uplift the RN's per shift from 22 to 28 and Health Care Support Workers from 12 to 18. The senior team within the Emergency Department have successfully recruited to their budgeted establishment for band five RN's. It is recommended the Board/Committee approve that further substantive funding is agreed to meet the needs of the current numbers to reduce reliance on agency and bank staff. This could potentially reduce the current run rate.

Reference guide for ED nurse staffing for escalated numbers in the department (this is a guide and professional judgement must be used from the ED matron- all essential areas of ED must be staffed as per professional judgment)

Number of patients in dept	Total RNs needed	Total HCSW's needed
55	22	12
60	23	13
65	24	14
70	25	15
75	26	16
80	27	17
85	28	18
90	29	19
95	30	20
100	31	21
Plus 1 RN and 1 HCSW for every increment of 5 patients in department.		

Plus 6 extra band 2 HCSW to support with 1:1 care.

Surgical and Anaesthetic Division

18. Wards B22 and B24 are both 23 bedded acute orthopaedic wards which take direct admissions from the emergency department. Using the triangulated approach, the professional judgement of the senior nursing team is asking to increase the RNs on a night shift by 1 however, the SNCT does not support this. The wards are an outlier when comparing them to similar acute wards in the Trust, therefore, it is recommended a further run of the SNCT is completed before any recommendation is made. The wards may wish to trial bringing in the 4 RN on the day shift a little later in the day to increase staffing at the beginning of the night shift.
19. Both theatre complexes on the RBH and BGH site have compared their budgeted establishment using the Association for Perioperative Practice (AfPP) guidance calculator which shows the establishments to be broadly in line with this guidance. However, both Matrons highlighted an issue with theatre 'overruns' which cause further pressure on staffing therefore, a separate business case is in development to address this.

20. Further work is needed to understand the budgeted establishment on the Chemo Unit at RBH and the staffing levels required however, there is no ask for investment at this time. The BGH budgeted establishment is professionally judged as adequate.
21. The elective centre at BGH is 0.54 WTE RN's and 4.45 WTE support staff underfunded to meet the requirements of their agreed staffing levels. This is currently being met with bank and agency. In addition, with the increase in activity over the last few years the unit is asking for an additional RN during the weekday day shift for escorts to and from theatre. There is no SNCT data for this unit as it is not designated 24 hours/7 days per week, so the tool is not applicable. However, there is a separate business case for the surgical hub model to be introduced at BGH therefore, a full staffing review will be undertaken for this unit in due course based on the anticipated activity.
22. The Critical Care Unit is staffed to Guidelines for the Provision of Intensive Care Standards (GPEC) standards. This is monitored through the ICS 'Peer Review' process bi-annually.

Paediatrics

23. As part of the review of activity for professional judgement, the children's observation, and assessment unit (COAU) is noted to have increased from 12,182 per annum 2021-22 to 14,030 2022-23 attends. Trends in attendance are noted with the greatest number of attendances between 11:00 - 23:00, peaking between 12:00 - 18:00 daily.
24. To maintain patient flow, ensure clinical risk is managed and patient experience is maintained the directorate are requesting a Band 6 co-ordinator 24/7. The co-ordinator is not currently supernumerary, and the department can take up to 22 patients currently at one time, which are cared for by the 2 RN's (3 on a twilight) on shift. In addition, the directorate are requesting an extension to the ward clerk hours who finish at 20:00 to 02:00. The ward clerk role is essential at reception for booking patients in, screening (if required), admitting to first net, signposting and supporting discharge. An additional HCA to cover the twilight (11:00 - 20:00) shift is requested to support the flow of patients with cubicle turnaround, nutrition and hydration and support where required. There is only 1 HCA on duty at any one time which is not sufficient to meet demand and is leading to staff fatigue. However, the Trust is working with NHSE to devise a SNCT which will be available for the next review.

Therefore, it is recommended the Trusts undertakes this review prior to asking for any further resource, it is also recommended that two six monthly reviews are completed prior to any ask for further resource.

25. The Children's Unit consists of High Dependency Unit/A side and B/C side across 2 cost centres.
26. The request through professional was for an additional 1WTE housekeeper, and, in fact professional judgement identified some RN and HCA hours that could be utilised elsewhere, namely, to support the COAU deficit.

Community and Integrated Care Division

Integrated Care Wards

27. Wards identified pressure relating to enhanced care requirements (1-1), particularly relating to falls prevention.
28. Utilising the triangulated approach, it has been identified that wards 22, Ribblesdale, Hartley and Reedyford require additional HCA hours for twilight and daybreak early shifts to support safe care. Use of these shifts has been proven to reduce the use of additional overnight HCA staff at Pendle and Clitheroe hospitals. This will be managed through bank shifts via the enhanced care criteria (1-1 SOP).
29. The Pendle wards (Hartley and Reedyford) have also requested an additional HCA on long days at weekends because they have significant work to do to support meal service including the dishwashing of crockery after every meal. This is captured on an estates held risk register relating to support staff provision to all 3 Pendle wards. Further work needs to be done with the estates division to develop a solution for the weekends.
30. In addition, utilising the triangulated approach Ward 19 have been identified as requiring a 4th night HCA which will give them equivalent to Ward 22 establishment which is an equivalent ward. The proposal is to none recurrently fund this as it is already in the run rate.
31. Ward 19 also houses escalation patients which has been constant for the last three months. Therefore, it has been identified an additional RN twilight shift is required as they have an additional 4 patients compared to the other CIC wards. This is again in the current run rate which needs to continue until the de-escalation of the beds.

Adult Community Nursing

32. The CIC division purchased the SNCT community licence and have now had the opportunity to run two sets of data at approximately six-month intervals. Whilst the tool shows the WTE head count to be broadly correct (see below), the professional judgment of the senior leadership has identified a cost neutral re alignment of services and skill mix.

	LOCAL STAFFING				RECOMMENDED STAFFING			CURRENT WTE		DIFFERENCE OF WTE		
TEAM	Team EST WTE	Team actual WTE (6mth average)	Bank staff FTE (6mth average)	ROSTER TOTAL	B4 to B7 (inc. headroom)	B3 (inc. headroom)	TOTAL	B4 to B7	B3	B4 to B7	B3	TOTAL
BC	18.74	15.28	1.51	16.79	18.37	1.31	19.68	17.74	1.00	-0.63	-0.31	-0.94
BE	20.00	16.78	0.57	17.35	18.76	2.23	20.99	18.33	1.67	-0.43	-0.56	-0.99
BW	18.20	18.53	0.53	19.06	23.55	1.10	24.65	17.20	1.00	-6.35	-0.10	-6.45
HC	20.77	15.85	1.29	17.14	17.91	3.20	21.11	18.37	2.40	0.46	-0.80	-0.34
HR	20.85	18.33	0.63	18.96	19.38	2.85	22.23	18.50	2.35	-0.88	-0.50	-1.38
OOH	11.70	10.90	1.35	12.25	9.64	2.91	12.55	10.24	1.46	0.60	-1.45	-0.85
PE	24.86	25.29	0.56	25.85	29.60	2.54	32.14	22.16	2.70	-7.44	0.16	-7.28
PW	25.52	20.67	1.11	21.78	24.96	2.12	27.08	23.92	1.60	-1.04	-0.52	-1.56
R	20.80	18.43	0.91	19.34	18.95	1.09	20.04	19.74	1.06	0.79	-0.03	0.76
RE	19.52	16.88	0.68	17.56	19.14	1.94	21.08	18.14	1.38	-1.00	-0.56	-1.56
RW	15.89	14.72	1.31	16.03	14.49	1.30	15.79	15.49	0.40	1.00	-0.90	0.10

Skill Mix – a cost neutral case for increasing the senior nursing leadership in District Nursing

33. The Queens Nursing Institute (2022) identified that the skill mix of teams should reflect the demand placed upon them by the population's needs. The research indicated that there are currently high rates of visit deferral and too much complex work was being delegated to nursing support workers. This is reflected in the local teams and is particularly noticeable when reviewing data concerning the timely assessment of new patients, and re-assessment of existing patients, by a Senior Nurse (Band 6 Sister/Band 7 Clinical Team Leader).
34. In ELHT the District Nursing Service provides nursing care for a third of all deaths that occur within the organisation. On average 85% of these deaths are verified by the District Nurses with bereavement visits offered in every case. Delivery of care during the last days of life requires a level of skill and experience which is developed in Senior Nurses. With patients' homes and care homes frequently being people's preferred place of death, and an ageing population, the demands on the District Nursing Service to deliver end-of-life care continues to be a high priority. Adequate Senior Nursing input in assessment and re-assessment of this cohort of patients is essential to ensure that people experience the best possible death, and families and carers are well supported.

35. Across the country, there are a high number of District Nursing Services where all Senior Nurses have completed the Specialist Practitioner Qualification in District Nursing. ELHT have increased the number of practitioners undertaking this course (currently 2 nurses on the traditional route, and 4 on the apprenticeship route) however, the divisional strategy is to ensure that the number of staff with this qualification continues to increase to redress previous years where recruitment onto this course was suspended or minimal.
36. The ELHT SOP - Assessment and Review of District Nursing Patients by Senior Nurses indicates when a Senior Nurse should assess or re-assess patients. Investigations into incidents (pressure ulcers in particular), complaints from families and patients, and inquest statement requests indicate that these targets are quite often not met. The most common reason for this is a lack of capacity in the team for Senior Nurses to undertake the visit in a timely way.

Extract from SOP for Assessment and Review of District Nursing Patients by Senior Nurses

Situation	**Timescales for assessment/re-assessment by district nursing sister**
High priority new patients: • End of life care • Pressure damage • Moderate to severe moisture lesions • New diabetic patients • Any type of drain in situ (e.g., wound/pleural) • Spinal cord injury patients with risk of autonomic dysreflexia • Complex Health Needs • Safeguarding concerns	First visit should be by a Senior Nurse Minimum of monthly re-assessment, or as condition changes.
Patients with new and ongoing safeguarding concerns	Re-assess at next available planned visit or urgent unplanned visit if risk is high
Pressure damage/moisture lesions	• New or deteriorating pressure damage should be re-assessed face to face within 24 hours. • Static pressure damage should be re-assessed weekly.

Situation	Timescales for assessment/re-assessment by district nursing sister
End of life patients	Re-assessment minimum of monthly, or as condition changes
Daily wound care	Review weekly in Team Safety Huddle and face to face re-assessment maximum 2 weekly
Long term insulin administration	Re-assess if blood glucose is unstable within 24 hours Routine reviews 12 weekly if stable
Fast track assessment	Within 24 hours
Continuing Health Care Checklist/Nursing Assessment	Within 7 days
Patients with catheters prone to: frequent blockages/bypassing/expelling – i.e., weekly, or more frequently Patients requiring catheter maintenance solutions for more than an initial 4 week or less course of treatment	Re-assess when a pattern of problems has been detected or catheter maintenance solutions have been used for more than an initial 4 week or less course of treatment
Patients with lower limb wounds: • In compression • Unable to tolerate compression	• Re-assess within 4 week of compression commencing • When treatment is discontinued
Patients who are non-concordant with recommended treatment plans	Re-assess at the next planned visit or sooner if required

37. The service has experienced a high rate of attrition at Band 5 and 6 RNs over the last 12 months:
    a. **21% turnover in B6** which equates to 7 colleagues of which 5 have moved out of the District Nursing service into Intensive Home Support Service and the Specialist Palliative Care Service, and 3 have moved into Primary Care.
    b. **27% turnover B5** which equates to 38 colleagues, as is evident from the data below – 18 staff have left ELHT and 20 moved out of the DN service.

Leavers August 2022- August 2023

Band	Head Count	Promotion to higher band in DN Service	Moved within ELHT	Left the Trust	% of Leavers
6	33	2	2	3	21%
5	169	8	20	18	27%
4	16	1	2	2	31%

38. Exit interviews with nurses leaving their Band 6 posts have cited a lack of job satisfaction due to the amount of shifts they are in the office co-ordinating the team. This will improve with the introduction of the District Nursing Clinical Triage Hub, however, daily co-ordination and leadership within the team is still required. Another key factor was the pressure felt by senior nurses who were aware that they were unable to meet the timescales of senior nurse reviews and their concerns about patient and staff safety when these visits were delayed. The nurses leaving these posts also cited a lack of progression options within District Nursing which would enable them to retain a clinical role.
39. Band 5 nurses also cited a lack of professional development opportunities into a more senior role as of the 169 Band 5 staff, there are just 33 Band 6 posts for them to aim to progress into. Moving to a Band 6 post in another service was one of the most common reasons for leaving District Nursing. Some more junior staff nurses also cited the pressure of working autonomously and assessing new patients in the community as a reason for seeking alternative jobs.

Pressure Ulcer Incidents

	PU's developed under our Care	Lapses in care	MASD developed under our Care
01.04.2021 to 31.03.2022	185	14	357
01.04.2022 to 31.03.2023	223	13	384
01.04.2023 to 31.08.2023	97	3	187

40. Between 2021 – 2023 the data demonstrates an increase in the number of pressure ulcers that have developed whilst patients have been under the care of the District Nursing service. A similar increase has also been evident with regards to MASD. Although there are a wide range of factors influencing the increase in these types of incidents, a timely assessment and re-assessment of patients by experienced senior nurses supports risk assessment, identifies deteriorating patients promptly, and ensures that patient safety is optimised.

Safeguarding Incidents

	Safeguarding Incidents
01.09.2021 to 31.08.2022	15
01.09.2022 to 31.08.2023	33

41. This data indicates that the number of safeguarding incidents reported by District Nursing in 2022 to 2023 has more than doubled since the previous year. This supports colleagues' observations that the complexity of patients on the caseloads is increasing significantly over time, and skilled and experiences senior nurses are required to support patients, families, and colleagues through cases where vulnerable adults present as being at high risk of harm.
42. The membership of the Multidisciplinary Senior Safety Huddle has also noted that there has been a significant increase in the number of patients who are homeless, and who are substance users which has added another level of complexity to the District Nursing caseloads.
43. By increasing the number of Band 6 posts in District Nursing the following will be achieved:
    - Improved patient safety and reduced risk
    - Greater concordance with frequency of initial and reassessment visits in line with national recommendations and local policy
    - Improved patient and family experience with the service
    - Improved end of life care
    - Reduction in pressure ulcers
    - Reduction in attrition rates
    - Improved job satisfaction and colleagues' wellbeing
    - Improved career progression options for community staff nurses

- Support the development of a highly skilled workforce with capacity to complete Specialist Practitioner Qualification

44. Through careful consideration of appropriate staffing levels in each team over a 24 hour period, and collaboration with finance, we are able to deliver a cost neutral increase in Band 6 nurses.Due to the large caseloads in the Pendle teams, there is a clear justification for creating a third Pendle Team. The QNI identify that caseloads over 150 can be difficult to manage effectively; the Pendle Teams have caseloads of over 400 patients. The intention is to create a third team however, to provide an equal skill mix as the other teams in the service, investment in staff in the Pendle area would be required. The establishment changes for community nursing have already been approved and actioned.

Maternity Staffing

45. In March 23, the Board of Directors approved £648K, recurrent annual revenue costs through the submission of a business case to fill some of the Birth-rate Plus (BR+) workforce assessment findings and part implement some of the recommendations of Midwifery Continuity of Carer (MCOC) as guided by Ockenden (2022). Maternity services have conducted several successful recruitment events including midwives qualified in September 23/ April 24 which will significantly reduce the funded vacancy rate to approximately 2 WTE, this is excluding maternity leave backfill. All posts have been recruited with a deficit of 7.50wte clinical midwives and 13.54 specialist midwives left to recruit following September 22 BR rate plus recommendations.
46. The independent Birth-rate Plus assessment is mandated and to complete every three years, next assessment due to commence in April 2025 to aid completion by September 25.
47. Birth Rate plus (BR+) is a framework for workforce planning, the principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG).
48. A second improvement case for the BR plus is required. Funding will be used to uplift the WTE staffing establishment and ensure the Trust Maternity services is BR+ compliant for the Midwifery workforce in 2024/2025 and achieve a full implementation.

Neonatal Nurse Staffing

49. ELHT neonatal unit nurse workforce requirements are not fully funded or aligned with the service specification for neonatal nursing. This is calculated using the relevant national workforce tool and recommendations by the British Association of Perinatal Medicine (BAPM) standards for nurse staffing. The National Nurse Workforce Tool (NNWT) for direct Patient/Cot side Care and the Northwest Neonatal Operational Delivery Network (NWODN) Quality Nursing Roles Calculator (QNRC) - For Quality Roles has been completed and submitted to the NWNODN in 2023.
50. Following the National Neonatal critical care review (NCCR). The Trust received some recurrent funding to increase cot side care WTE nurses, to reduce the deficit in compliance with British Association of Perinatal Medicine (BAPM) standards for nurse staffing. This was based on activity and acuity in the previous 3 years. All posts are recruited to and in post. It is recommended that the unit collates and monitors BAPM compliance monthly in the Divisional Governance Meeting so that assurance can be provided to the Trust Board at the six-monthly professional judgements.

Finance

51. The total spend on registered nurses and health care assistants across the Trust, including bank and agency for the past 3 years is shown in the table below. This includes pay awards.

Staff Group	2021/22 Annual Spend £	Sum of WTE worked at M12 2021/22	2022/23 Annual Spend £	Sum of WTE worked at M12 2022/23	2023/24 Annual Spend £	Sum of WTE worked at M12 2023/24
Registered Nurses / Midwives - Substantive	108,674,713	2,231	121,606,244	2,299	121,184,511	2,474
Registering Nurses - Bank	8,838,813	194	10,002,393	208	13,634,199	234
Midwives - Bank	964,763	18	1,255,428	14	1,439,093	21
Registered Nurses / Midwives - Agency	14,607,997	262	13,521,377	224	10,062,339	111
Total Registered Nurses / Midwives	**133,086,286**	**2,705**	**146,385,442**	**2,746**	**146,320,141**	**2,839**
Healthcare Assistant - Substantive	39,225,022	1,241	43,569,604	1,267	46,681,615	1,309
Healthcare Assistant - Bank	9,437,247	307	9,672,474	307	11,457,724	331
Total HCA	**48,662,269**	**1,548**	**53,242,078**	**1,574**	**58,139,340**	**1,640**
Grand Total	**181,748,555**	**4,253**	**199,627,520**	**4,320**	**204,459,481**	**4,479**

52. The cost of agency has reduced from £14.6m in 2021/22 to £10.1m in 2023/24 and continues to reduce. Agency spend has reduced from 11% of the total spend on registered nurses and midwives to 7%.

Staff Group	2021/22 % of staff group actuals £	2022/23 % of staff group actuals £	2023/24 % of staff group actuals £
Registered Nurses / Midwives - Substantive	82%	83%	83%
Registering Nurses - Bank	7%	7%	9%
Midwives - Bank	1%	1%	1%
Registered Nurses / Midwives - Agency	11%	9%	7%
Healthcare Assistant - Substantive	81%	82%	80%
Healthcare Assistant - Bank	19%	18%	20%

Finance appraisal of the professional judgment review of April 2024

53. The supernumerary status of the ward manager is being developed via a separate improvement case therefore no financial decision is required for this paper.
54. The Professional Nurse Advocate (PNAs) protected time is being absorbed within current working patterns for the 22 staff. A separate improvement case will be developed.
55. The table below shows the run rate effects of the changes that occurred in 2023/24 and will continue in the 2024/25. The Divisions were funded based on outturn for 2023/24 so have realigned the budget to reflect the establishment changes.

	Run rate effects 2023/24:-	
Area	**wte**	**£**
MEC Ward B4	1.02	44,857
MEC - Ward C7	2.82	101,523
MEC - Ward D1, D3 & C11	-	22,200
CIC - Ward 19	1.71	75,201
Total	5.55	243,781

56. Elective Centre at BGH - there is a separate improvement case for the surgical hub model to be introduced at BGH therefore, a full staffing review will be undertaken for this unit in due course based on the anticipated activity.
57. COAU – realignment of the budget has taken place within the Paediatric Ward areas.

Conclusion and Recommendations

58. The Trust Board are asked to note the data in terms of fill rates, vacancy rates, sickness rates, staff turnover and recruitment plans.

59. The Trust Board are asked to consider and note the professional judgement and the assurance it provides.
60. The Trust Board are asked to note ongoing work to develop separate improvement cases in respect of supernumerary ward managers, BGTH in line with the wider elective care centre developments and the further development of PNA hours.

Appendix one: Fill Rates February 2023 to February 2024

Monthly TREND							Number of wards below 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses/m	Average fill rate - care staff (%)	Average fill rate - registered nurses/m	Average fill rate - care staff (%)
Feb-23	90.1%	98.3%	97.6%	108.6%	27193	8.62	2	1	0	0
Mar-23	90.4%	98.2%	98.8%	107.0%	29788	8.67	0	1	0	1
Apr-23	91.4%	99.3%	101.2%	108.5%	27103	9.17	0	1	0	0
May-23	92.7%	100.3%	101.5%	110.2%	29172	8.95	1	1	0	0
Jun-23	93.2%	100.2%	101.1%	110.2%	28056	8.95	1	1	1	0
Jul-23	93.3%	97.7%	100.2%	109.6%	29766	8.61	0	2	0	0
Aug-23	92.6%	100.1%	100.5%	111.7%	30062	8.54	1	2	0	0
Sep-23	92.8%	97.6%	97.8%	107.2%	29886	8.26	0	2	2	1
Oct-23	94.6%	94.9%	104.5%	106.6%	31679	8.09	0	2	0	1
Nov-23	95.5%	97.4%	101.5%	109.3%	30083	8.35	0	3	0	0
Dec-23	93.4%	95.4%	100.0%	108.0%	30111	8.52	1	2	0	1
Jan-24	93.2%	95.9%	101.0%	108.3%	31392	8.19	0	4	0	1
Feb-24	93.5%	95.5%	100.5%	107.6%	29830	8.04	1	2	1	1

Appendix Two: Establishments and SNCT Data along with nurse sensitive indicators

Ward	Beds	Current Staffing Numbers per shift	WTE Current Uplift of 22%	SNCT Data Nov 23 WTE with uplift.	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	NAPF Status	Comments
						In the last 3 Months Dec 23 to Feb 24. **Assume falls no/low harm & pressure ulcer cat 2 unless stated**					
Ward 19 BGH	23	Early: 4 + 4 Late: 3 + 4 Night: 2 + 3	34.70	38.4	No Change	4	2	1	2	Green	Extra 4 escalation beds
Ward 22 BGH	27	Early: 4 + 4 Late: 3 + 4 Night: 3 + 4	41.54	38.5	No Change	10	1	1	4	Green	
CLI RB	32	Early: 5 + 4 Late: 5 + 4 Night: 3+ 4	43.92	44.6	No Change	23	3	2	7	Green	
RH	17	Early: 3 + 5 Late: 2 + 5 Night: 2 + 3	34.21	21.4	No Change	9	0	0	1	Green	Single side rooms as neuro rehab ward.
Hartley	24	Early: 4 + 3 Late: 4 + 3 Night: 2 + 3	31.48	34.7	No Change	7	2	0	9	Green	

Ward	Beds	Current Staffing Numbers per shift	WTE Current Uplift of 22%	SNCT Data Nov 23 WTE with uplift.	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	NAPF Status	Comments
						In the last 3 Months Dec 23 to Feb 24. **Assume falls no/low harm & pressure ulcer cat 2 unless stated**					
Pendle RF		Early: 4 + 3 Late: 4 + 3 Night: 2 + 3	31.48	33.6	No Change	10	0	2	3	Amber	
Marsden		Early: 4 + 6 Late: 4 + 5 Night: 2+Twi + 3	41.31	37.2	No Change	8	0	0	2	SPEC	
AMU	73	Early: 19 + 13 Late: 19 + 13 Night: 18 + 9	162.42	126.4	No Change	26	51	1	29	SPEC	High turn over of patients over large area.
B14	24	Early: 5 + 4 Late: 5 + 4 Night: 3 + 3	41.19	29.9	No Change	5	0	1	5	SPEC	Tracheostomy patients. Multiple specialities
B2	23	Early: 5+4 Late: 5 + 4 Night: 3+ 4	43.92	38.2	No Change	8	4	1	10	AMBER	Stroke Ward takes direct patients from ED

Ward	Beds	Current Staffing Numbers per shift	WTE Current Uplift of 22%	SNCT Data Nov 23 WTE with uplift.	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	NAPF Status	Comments
						In the last 3 Months Dec 23 to Feb 24. **Assume falls no/low harm & pressure ulcer cat 2 unless stated**					
B22	23	Early: 4 + 6 Late: 4 + 6 Night: 2 + 3	45.66	38.5	48.39	2	5 Cat 2 1 Cat 4 8 DTI	0	3	Green	Takes Direct patients from ED
B24	23	Early: 4 + 4 Late: 4 + 4 Night: 2 + 3	35.73	28.8	38.46	5 NH 2 Low	5	0	5	SPEC	Takes Direct patients from ED
B4	24	Early 4 + 6 Late: 3 + 6 Night: 2 + 4	43.93	37.1	44.95	9	12	1	5	AMBER	
B6	22	Early: 4+ 3 Late: 3 + 3 Night: 3 + 3	Winter Esc	Winter Esc		11	2	0	3	AW REVIEW	
B8	22	Early: 4+ 3 Late: 3 + 3 Night: 3 + 3	33.13	No data		2	2	4	1	GREEN	
C10	22	Early: 5+ 4 Late: 5 + 4 Night: 3 + 4	44.01	33.5	No Change	15	12	1	10	GOLD	Takes up to 10 NIV patients. Tracheostomy patients

Ward	Beds	Current Staffing Numbers per shift	WTE Current Uplift of 22%	SNCT Data Nov 23 WTE with uplift.	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	NAPF Status	Comments
						In the last 3 Months Dec 23 to Feb 24. **Assume falls no/low harm & pressure ulcer cat 2 unless stated**					
C11	22	Early: 4+ 3 Late: 3 + 3 Night: 2 + 3	35.73	35.2	No Change	16	6	2	8	AMBER	
C14a	17	Early: 4+ 2 Late: 3 + 2 Night: 2 + 2	26.5	21.3	No Change	5	1 DTI 1 Cat 2	1	3	SPEC	Complex HPB tertiary referral ward.
C14b	17	Early: 4+ 2 Late: 3 + 2 Night: 2 + 2	26.51	22.1	No Change	7	0	1	2	SPEC	Complex HPB tertiary referral ward.
C18a	18	Early: 4+ 2 Late: 3 + 2 Night: 2 + 2	26.51	23.9	No Change	1 LH 1 Mod	3 cat 1 1 DTI	0	1	SPEC	
C18b	18	Early: 4 + 3 Late: 3 + 3 Night: 2 + 2	29.24	24.2	No Change	9	2	0	3	GOLD	
DDU	48	Early: 8 + 6 Late: 8 + 6 Night: 6 + 8	73.96	71.8	No Change	22	5	14	10	AMBER	

Ward	Beds	Current Staffing Numbers per shift	WTE Current Uplift of 22%	SNCT Data Nov 23 WTE with uplift.	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	NAPF Status	Comments
						In the last 3 Months Dec 23 to Feb 24. **Assume falls no/low harm & pressure ulcer cat 2 unless stated**					
ESU	35	Early: 8 + 6 Late: 8 + 6 Night: 7 + 4	68.52	39.0	No Change	7	1	1	10	SPEC	High turnover of patients Takes direct from ED Multiple Specialties
C5	14	Early: 3+ 4 Late: 3 + 4 Night: 2 + 3	33.0	22.0	No Change	4	2	2	5	GOLD	Small Ward Dementia friendly
C7	22	Early: 4 + 3 Late: 4 + 3 Night: 2 + 2	30.18	33.1	32.99	9	2	2	1	GREEN	
C9	22	Early: 4 + 4 Late: 4+ 4 Night: 2 + 3	35.73	32.4	No Change	8	5	3	5	SPEC	
D1& D3	43	Early: 8 + 6 Late: 8 + 6 Night: 4 + 6	65.99	58.7	No Change	15	7	4	14	GREEN	Large Ward over big footprint.
OPU	46	Early: 10 + 7 Late: 10 + 7 Night: 5 + 7	79.65	71.1	No Change	31	18	3	24	AMBER	Large Ward Takes Direct from ED High Turn over

Ward	Beds	Current Staffing Numbers per shift	WTE Current Uplift of 22%	SNCT Data Nov 23 WTE with uplift.	Proposed Establishment	Falls	Pressure Ulcers	Complaints	Med Errors	NAPF Status	Comments
						In the last 3 Months Dec 23 to Feb 24. **Assume falls no/low harm & pressure ulcer cat 2 unless stated**					
WD 15	24	Early: 5 (4) + 4 Late: 5 (4) + 4 Night: 2 + 3 (2)	26.28	28.4	No Change	5	0	0	8	GOLD	
C6	25	Early: 4 + 4 Late: 4 + 4 Night: 3 + 3	38.48	31.6	No Change	5	7	1	5	SPEC	
C8	20	Early: 4 + 4 Late: 4 + 4 Night: 2 + 3	35.85	28.9	No Change	7	2	2	6	SPEC	

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Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD MEETING REPORT **Item** **96**

10 July 2024 **Purpose** Approval / Assurance / Information

Title	Corporate Risk Register Report
Report Author	Mr J Houlihan, Assistant Director of Health, Safety and Risk
Executive sponsor	Mrs A Brown, Associate Director of Quality and Safety Mr J Husain, Executive Medical Director
Date paper approved by Executive sponsor	

Summary: This report provides an overview of risk management performance activity and of risks presented onto the Corporate Risk Register

Recommendation: Members are required to note and approve the contents of this report

Report linkages

Related Trust Goal	Deliver safe, high quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.

	5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	See appendices
Related to recommendations from audit reports	Mersey Internal Audit Agency (MIAA) Risk Management Audit Report
Related to Key Delivery Programmes	Care closer to home Placed based partnerships Provider collaborative Quality and safety improvement priorities Elective and emergency pathway improvement People plan priorities Waste reduction programme
Related to ICB Strategic Objective	Improve population health and healthcare Tackle inequalities in outcomes, experience and access Enhance productivity and value for money Help the NHS support broader social and economic development

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Have accessibility checks been completed? Yes

Executive Summary

1. A summary of key points to note since the last meeting.
   a) The corporate risk register has nineteen risks. Five risks are newly approved. Fourteen risks have no movement or change in risk score. Three risks have been removed.
   b) Highest areas of risk relate to the current financial position, the management of medical devices, insufficient capacity to meet demand and sub optimisation of the electronic patient record system.
   c) Quality improvements continue to be made regarding the management of risks held on the risk register resulting in challenging key performance indicator targets introduced being met or exceeded.

Risk management and the impact of taking / not taking action

2. Risk management is the process of identifying, assessing, managing, controlling and reviewing risks in order to minimise harm, improve safety and performance. It is a health and safety legislative requirement and key line of enquiry of inspection used by regulatory bodies such as the Health and Safety Executive (HSE) and Care Quality Commission (CQC) when monitoring healthcare service provision.
3. The benefits of good risk management are that it minimises loss, enhances decision making, improves organisational resilience, supports statute legislation and regulatory compliance, supports license to operate requirements, facilitates strategic and operational planning, improves organisational efficiency and drives innovation. This in turn reduces financial, legal and insurance costs, enhances stakeholder confidence and improves credibility, reputation and commercial viability.

Corporate Risk Register (CRR) Performance Activity

4. A summary of key points to note since the last meeting.
   a) The CRR has nineteen risks. Five risks are newly approved. Fourteen risks have no movement or change in risk score. Three risks have been removed.
   b) Highest areas of risk relate to the current financial position, the management of medical devices, insufficient capacity to meet demand and sub optimisation of the electronic patient record system.
   c) A breakdown of risks by risk type shows twelve (63%) are clinical management risks, two (10.5%) are financial risks, two (10.5%) are health and safety risks, two

(10.5%) are data and digital risks and one (5.5%) relates to a risk of failing to comply with National Institute of Clinical Excellence (NICE) guidance.

d) A breakdown of risks by division shows 10 (52.63%) are Trust wide, four (21.05%) are corporate, two (10.53%) are within surgical and anaesthetic services, two (10.53%) are within diagnostic and clinical services and one (5.26%) is within medicines and emergency care services.

e) A summary and detail of risks held on the CRR is included within the appendices.

Risk Management Performance Activity

5. A summary of key points to note since the last meeting.

a) Numbers of open risks held on the risk register are down from 1,015 risks in Q4 2022-23 to 654 in Q1 2024-25, a decrease of 36%.

b) Risks identified as being significant or moderate are down from 862 risks in Q4 2022-23 to 562 in Q1 2024-25, a decrease of 35%.

c) Risks remaining open over 3 years old are down from 619 risks in Q4 2022-23 to 376 in Q1 2024-25, a decrease of 39%.

d) Overdue risks are down from 139 in Q4 2022-23 to 49 in Q1 2024-25, a decrease of 92%.

e) Less than 1% of all tolerated risks surpassed their review date.

f) Highest numbers of risks held are clinical related (68%) followed by health and safety (12%).

g) A breakdown of clinical risks shows the highest risk sub types relate to patient safety (28%) followed by workforce staffing (17%) and medical devices (16%).

h) A breakdown of health and safety risks shows the highest risk sub types relate to radiation (28%) followed by fire safety (12%), equipment management (9%) and environmental (9%).

i) Highest numbers of risks are held within DCS (30%) followed by SAS (23%).

j) Highest numbers of directorate risks are held within radiology (14%) followed by pathology (9%).

Mitigations for risks and timelines

6. A summary of recent mitigations for risks and timelines to note.

a) There have been a number of challenges presented which have significantly impacted on and detracted away from continued focus and commitment to

improving assurances of internal risk management systems, controls, culture and performance. These include:

i. External and internal drivers e.g. industrial action.
ii. Financial pressures.
iii. Changes in organisational strategic direction.
iv. Major organisational system and process change e.g. introduction of e-PR
v. Changes to strategic and operational frameworks (clinical and corporate)
vi. Changes to governance and assurance systems.
vii. Increasing service demands and competing priorities.
viii. Resources and staffing limitations.
ix. Workforce transformation.
x. Staffing levels and pressures.
xi. Past, historical risk management cultural norms and performance.

b) The decision not to implement a new total quality management system (Radar) has significantly impacted on advancing internal systems and controls for risk management through system design and of the need to respond, readapt and realign the approach to risk management.

c) Delays in upgrading Datix servers, competing organisational priorities and work projects, in particular, of Data and Digital and the Datix Manager in supporting system improvements due to implementation of the electronic patient record (e-PR) and of ensuring organisational compliance with national learning from patient safety event (LfPSE) requirements has further limited progression.

d) In addition, matters to advance internal systems and controls for risk management, through development and review of risk management strategy and framework, has been further compounded due to increasing work activity and organisational review of governance and assurance systems.

e) Despite these challenges, a significant amount of work has been undertaken prior to publication of the audit that focused on improvement work to avoid duplication, improve standardisation and the quality and quantity of risks held on the risk register. This is clearly demonstrable within reports and as part of introducing challenging set key performance indicator (KPI) targets which continue to be met or exceeded.

f) A comprehensive risk identification and classification exercise has been completed that strengthens strategic and operational risks and supports the movement towards a more integrated approach to risk management, with further work

required to reflect these changes within the risk management strategy and framework.

g) Work to avoid duplication, improve standardisation and the quality and quantity of risks held on the risk register remains ongoing.

h) The Risk Management Framework (RMF), process of escalation and use of the consequence scoring criteria to assess and score risks continues to be reaffirmed.

i) A comprehensive risk identification and classification exercise has been completed to help drive improvements regarding the management of risks. These include, but are not limited to:

   i. The identification of strategic and organisational risks measured against strategy, legislation, set standards and practice.

   ii. An extensive list of new risk type and risk sub type categories that provide a better risk management framework model i.e. clinical management, data and digital, emergency planning, finance, governance, health and safety, human resources, infection control, medical devices, medicines management and patient safety risks.

   iii. A nominated lead specialism or subject matter expert to manage risks within their areas of responsibility and control.

   iv. The mapping of risk types and sub types to nominated Committees or Groups to strengthen risk management governance whose duties are to oversee and seek assurances of risks being suitably managed.

j) A number of controls have been implemented to address concerns and drive improvements regards a steady rise in numbers of risks held on the risk register across divisions scoring fifteen or above not on the CRR. These include:

   i. The continued reaffirmation of the RMF and process of escalation.

   ii. Improved scrutiny and challenge of risk scores, controls and assurances and their validity against catastrophic, severe/major and moderate consequence scoring criteria.

   iii. More detailed assurance requirements within divisional reporting.

   iv. Specific inclusion and monitoring of risk management KPI metrics.

   v. More intensive focus and scrutiny by the Risk Assurance Meeting (RAM) and Executive Risk Assurance Group (ERAG).

   vi. Addressing the challenges of risk handlers or leads being unable to present risks due to conflicting priorities and urgent work activity.

k) The implementation of the above controls is having the desired outcome, resulting in a 32% reduction in risks scoring fifteen or above not held on the CRR.

l) In support, the effectiveness of Divisional Quality and Safety Board (DQSB) meetings in scrutinising risks before their presentation at the RAM is being undertaken. First meetings have been held within the Q1 2024-25 period with DCS, who hold the highest numbers of divisional risks, and Estates and Facilities, who hold the highest numbers of corporate risks. In addition, the use of deputy management meetings in reviewing risks and KPI metrics will further help mitigate controls.

m) An evaluation of risks held within PWE Healthcare and their integration onto the risk register has been completed.

n) A review of risk profiles to improve the quality of risks has been completed with manual handling, medical devices and security management lead specialisms.

o) A targeted review of all live and tolerated risks, whereby the current risk score has met its target score and continues to be well managed, and of their subsequent closure has been completed.

p) Work to support the data and digital service to improve the quality of risks held, in particular, regarding information governance and electronic patient record risks has been completed.

q) Assisting services in addressing the three hundred and ninety three risks requiring review in the next three months remains ongoing.

How the action / information relates to achievement of strategic aims and objectives or improvement objectives

7. Effective leaders and managers know the risks its organisation faces, prioritises them in order of importance and takes action to eliminate or reduce them to their lowest level practicable. A strong, effective governance and RMF that seeks to obtain quality assurance of the robustness of its internal management systems and controls, in particular, the identification and classification of strategic and operational risks, how they are managed, by whom, and where and their link to the BAF, remains crucial to the success of any safety management system and will help prevent the risk register from being inappropriately used.

Resource implications and how they will be met

8. The health, safety and risk management team continue to operate with extremely limited resources and capacity, with increasing service demands and many competing priorities delaying progress. This is further compounded by much challenging work still required to address past, historical risk management cultural norms and performance.

Benchmarking Intelligence

9. Work activities, whilst remaining diverse in nature, are measured more intensively in an effort to proactively influence, promote and drive a more positive risk management and safety culture, driven by changes or compliance with external drivers e.g. existing or proposed legislation, case law review, outcomes of key consultative documents, professional body guidance, influence of regulatory bodies etc, and internal drivers e.g. changes or developments in organisational strategy, objectives, workforce structures, service delivery models, job designs, competencies and behaviours, statistical analysis, audits and other key performance indicators.

Conclusion of Report

10. Risk management activity remains continuous with desired outcomes becoming more visible, however, much further significant and challenging work identified by the audit is still required to deeply embed the management and ownership of risks, improve governance and performance monitoring, increase levels of education, training and competency and remove past historical risk management cultural norms and performance.

Recommendations

11. The importance of risk profiling and mapping, improving the quantity and quality of risks held, better utilisation of lead specialisms and or subject matter experts, increasing awareness and understanding of the RMF and compliance with the process regarding escalation of risks remains a key area of focus. This is heavily impacting on the quality of risks held on the risk register.

Next Actions

12. A summary of key focused activity.
    a) System improvements to the Datix risk management module are to be made, with further enhancements planned that will include:

i. the review of RL Datix system upgrade and capabilities.
ii. profiling and mapping of new risk type and sub type categories.
iii. review of approval statuses.
iv. inclusion of nominated committees and or groups.
v. linking of risks, in particular, those scoring 15+ on the corporate risk register to the board assurance framework.
vi. creation of a mandatory actions required to be taken section.
vii. limiting access to the risk register to improve ownership, accountability and responsibility for the identification, assessment, management, control and review of risks and prevent the risk register for being inappropriately used.
viii. the removal of the 'other' risk type category as this does not add any value to the risk management process
ix. use of mandatory fields and minimum characters to avoid sections of risks being left blank.

b) Measures have been put in place to improve the risk management competencies of managers and key staff. Work to address risk management and risk assessment training, and its inclusion as part of the competency framework of managers, remains very challenging due to limited capacity and resource. The submission of a formal training evaluation report outlining health and safety competency and training needs, including risk management and risk assessment, training plans, resources and roll out required for delivery and of monitoring attendance and compliance, is now included as part of the workplan of the Health and Safety Committee. The coaching of managers and staff with responsibility for managing risks, along with the issue of new guidance, is helping provide a short term solution.

c) A detailed and extensive consultation process has been completed with lead specialisms and subject matter experts. It is expected open risks held on the risk register will significantly decrease as more focused attention is given to the utilisation of lead specialists and or subject matter experts in managing risks within their own areas of responsibility and control, leaving clinical services to focus more on their local operational risks. This will take place as part of system improvements made to the Datix risk management module.

d) A complete overhaul of the risk management strategy and framework, as detailed within the action plan, remains a key area of focus, with a more long term plan to integrate health and safety and risk management strategic frameworks to form a single, more integrated and unified approach.

e) The use of KPI and target criteria is to remain a key focus within the financial year.

How the decision will be communicated internally and externally

13. Decisions regarding the review and approval of risks and the validity of risk scores are made via DQSB meetings, at Committees and or Groups, and escalated through the approved governance framework.

How progress will be monitored

14. Progress in monitoring the quality and integrity of risks held on the risk register, in particular, those with a current risk score of fifteen or above, is undertaken at the RAM, Trust Wide Quality Governance (TWQG) and ERAG meetings.
15. A senior executive lead is nominated by the ERAG to monitor and review risks approved onto the CRR and ensure they are being managed and mitigated in accordance with the RMF.

Appendices

Summary of the CRR
Detailed CRR

Mr J Houlihan, Assistant Director of Health, Safety and Risk
25 June 2024

CORPORATE RISK REGISTER SUMMARY										
No	ID	Division	Title	Likelihood Score	Consequence Score	Risk Score	Exec Lead	Effectiveness of Controls	Risk Movement	Progress
1	10082	Trust wide	Failure to meet internal and external financial targets for 2024-25	5	5	25	M Brown	Limited	◁▷	No change
2	10086	Trust wide	Lack of adequate online storage for images may result in missed or delayed diagnosis	5	4	20	P Murphy	Inadequate	◁▷	No change
3	9545	SAS	Potential interruption to surgical procedures due to equipment failure	5	4	20	M Brown	Limited	◁▷	No change
4	9336	MEC	Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care	5	4	20	J Husain	Limited	◁▷	No change
5	8126	Corporate	Poor records management due to sub optimal implementation of new e-PR system	5	4	20	J Husain	Adequate	◁▷	No change
6	9746	Corporate	Inadequate funding model for research, development and innovation	4	4	16	K Quinn	Limited	◁▷	No change
7	8941	DCS	Increased reporting times in histology due to increased activity outstripping resource	4	4	16	K Quinn	Limited	◁▷	No change
8	8061	Trust wide	Patients experiencing delays past their intended clinical review date may experience deterioration	4	4	16	S Gilligan	Limited	◁▷	No change
9	8033	Trust wide	Increased requirement for nutrition and hydration intervention in patients resulting in delays	4	4	16	P Murphy	Limited	◁▷	No change
10	7165	Corporate	Failure to comply with RIDDOR	4	4	16	T McDonald	Limited	◁▷	No change
11	6190	Trust Wide	Insufficient capacity to accommodate patients in clinical within timescales	4	4	16	S Gilligan	Limited	◁▷	No change
12	10065	DCS	Pharmacy Technical Service refurbishment programme	3	5	15	J Husain	Inadequate	△	New
13	10062	Trust wide	Risk of harm and poor experience for patients with mental health concerns	3	5	15	P Murphy	Inadequate	△	New
14	9900	Trust wide	Poor identification, management and prevention of delirium	5	3	15	J Husain	Limited	△	New
15	9895	SAS	Patients not receiving timely emergency procedures in theatres	5	3	15	J Husain	Limited	△	New
16	9851	Trust Wide	Lack of standardisation of clinical documentation processes and recording in Cerner	5	3	15	P Murphy	Limited	◁▷	No change
17	9653	Trust Wide	Increased demand with a lack of capacity within ELHT can lead to extreme pressures and delays to patient care	5	3	15	P Murphy	Adequate	△	New
18	8808	Corporate	Breaches to fire stopping and compartmentalisation at BGH	3	5	15	T McDonald	Adequate	◁▷	No change
19	4932	Trust Wide	Patients who lack capacity to consent to hospital placements may be being unlawfully detained	5	3	15	P Murphy	Limited	◁▷	No change
	8839	SAS	Failure to achieve elective recovery targets	4	3	12	S Gilligan	Limited	▽	Removed
	8725	CIC	Lack of senior clinical decision making and inconsistent medical cover for CIC services	4	3	12	J Husain	Limited	▽	Removed
	7008	Trust Wide	Failure to comply with 62 day cancer waiting time target	4	3	12	S Gilligan	Limited	▽	Removed

Corporate Risk Register Detailed Information

No	ID	Title				
1	10082	**Failure to meet internal and external financial targets for 2024-25**				
Lead		Risk Lead: Charlotte Henson Exec Lead: Michelle Brown	**Current score**	**25**	**Score Movement**	⇔
Description		Failure to meet the Trusts financial plan and obligations together with the failure to meet the wider Lancashire and South Cumbria ICB system financial plan. Failure to meet the plan and obligations is likely to lead to the imposition of special measures and limit the ability of the Trust to invest in the services that it provides. The financial risk is made up of: 1. There are insufficient funds to provide the services to the population of East Lancashire. 2. Lack of control on how funds are allocated across partner organisations 3. A 7.7% efficiency target of £57.8 million for the Trust, a level that has never been achieved previously. 4. A Trust and system financial deficit that still needs closing.				
Controls and Assurances in place		**Controls** 1. Robust financial planning arrangements to ensure financial targets are achievable within the Trust. 2. Accurate financial forecasts. 3. Financial performance reports distributed across the Trust to allow service managers and senior managers to monitor financial performance. 4. Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made within delegated limits. **Assurances** 1. Frequent, accurate and robust financial reporting and challenge by the way of:- • Trust Board Report • Finance and Performance Committee Finance Report • Audit Committee Reports • Integrated Performance reporting • Divisional and Directorate Finance reports • Budget Statements • Staff in Posts Lists • Financial risks • External Reporting and Challenge		**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 A higher efficiency target than has ever been achieved in the past to ensure the Trust is fully engaged and playing their part in reducing efficiencies and the cost base. 2 The financial regime is managed at a system level rather than at a Trust level. 3 The financial gap is across the system not just the Trust. **Gaps / weaknesses in assurances** 1 Lack of understanding of full system risks. 2 Lack of airtime for discussion of the full system financial risks.	
Update since the last report		**Update 31/05/2024** **Risk score reviewed. No change in risk score** The Trust is reporting a deficit of £5.5m for the 2024-25 financial year to date, £3.0m behind plan. In with other providers across Lancashire and South Cumbria externally we reported break even at month 1. The reason for the movement from plan remains due to additional costs incurred from pressures in emergency medicine, underachievement of the waste reduction programme and system gap. Working to a £36.2m capital programme for the 2024-25 financial year, the Trust is £0.5m ahead of planned capital spend at end April-24. The cash balance at the end of March-24 was £11.1m, a reduction of £0.5m compared with the previous month. This position is supported by £6.2m of Provider Revenue Support Public Dividend Capital (PDC). The Trust is currently meeting the Better Payment Practice Code (BPPC) target to pay 95% of invoices on time by value and volume for both NHS and non-NHS invoices. Spend on agency staff was at 2.35% in month 1, considerably lower than the ceiling of 3.2% set by NHSE for 2024-25. The financial deficit and risk attached in meeting that deficit may mean a reduction in expenditure and headcount and remains a high risk whilst maintaining a high quality, safe and effective environment for staff and patents. **Next Review Date 28/06/2024**		**Date last reviewed**	**31/05/2024**	
			Risk by quarter 2024-25	**Q1**: 25	**Q2**:	**Q3**:	**Q4**:
			8-week score projection	**25**			
			Current issues	System wide external influences			

No	ID	Title				
2	10086	**Lack of adequate online storage for images may result in missed or delayed diagnosis**				
Lead		Risk Lead: Dan Hallen Exec Lead: Peter Murphy	**Current score**	**20**	**Score Movement**	⟺

Description	Capacity for storage and transfer of ECHO images from ultrasound machines used within Chronic Obstructive Pulmonary Disease (COPD) and Neonatal Intensive Care Units (NICU) services may result in missed or delayed diagnosis if no suitable clinical management or digital storage solution can be found. The ultrasound machines currently used have no option for storage and transfer of images currently being stored on scanning machines that have very limited memory availability. Once storage limits have reached, capacity and images cannot be offloaded and machines will stop functioning which may result in loss of images and the potential of patients having missed or delayed diagnosis of life saving cardiac abnormalities and pulmonary pathologies impacting on the management of care, patient safety and increased medicolegal implications if the risk is not suitably managed or controlled.	**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Additional cost implications for contract extension and a software storage solution. 2. Current ultrasound images stored on scanning machines have limited memory capacity. 3. Images transfers to desktop, through PACS and MS teams is ineffective. Attempted input of images onto PACS slows the entire system down, is too big to be sent via image exchange portal and has limited storage availability. Use of MS teams heavily reliant on availability of consultants to attend MS team meetings. 4. Patient transfers to other Hospitals may be unnecessary, unsafe and reliant on bed availability. 5. Limited assurance Royal College of Radiologists standards are being used to benchmark or measure performance or compliance. 6. Additional staff training in system use is required. 7. Development of a virtual private network (VPN) tunnel is under trial and not embedded as clinical management process. 8. Cranial ultrasound scans and echocardiogram images cannot be separated and stored with further exploration of how scans are stored required. 9. A planned strategy and system solution being brought in by the ICB to increase storage capacity is awaiting implementation. 10. Limited assurance policy and procedural controls regarding the lifecycle management of medical devices is robust, is being followed or suitably performance managed. **Gaps / weaknesses in assurances** 1. Common incident themes relate to equipment malfunction, delays in diagnosis, clinical symptoms warranting emergency transfer of patient to another Hospital and difficulties transferring images. 2. Cerner e-PR imaging module and set up requires further exploration to determine effectiveness. 3. Limited evidence of assurance current capacity levels are regularly checked and monitored. 4. Bridgehead solution remains fully dependent on the release of funding and approval by the ICB. 5. Solution offered by Siemens does not help image sharing with other Hospitals and effectiveness of direct image transfers still requires exploration. 6. Effectiveness of the Medical Devices Management Group in supporting the management of risk.
Controls and Assurances in place	**Controls** 1. The existing service contract has been extended. 2. Current ultrasound images stored on scanning machines and McKesson software installed on NICU computers. 3. Image transfer via desktop, through the PACS system, out of hours and via MS teams which have prevented transfer of a baby and safe overview of images. 4. Patient transfer to other Hospitals for echocardiology review. 5. Set standards on provision of an ultrasound service issued by the Royal College of Radiologists include key areas essential for delivery of high quality, effective ultrasound imaging services and examinations that services are expected to review and follow. 6. Organisational policy and procedural controls in place for the lifecycle management of medical devices. **Assurances** 1. Imaging incidents closely reviewed and monitored and linked to the management of risk. 2. Cerner e-PR has an imaging module, cloud storage and PAS patient list connection that capture, store, access and share imaging data and multimedia across the system providing a holistic patient view. 3. Current capacity levels regularly being monitored. Capacity within Childrens Observation and Admissions Unit is 117.2 GB (99.8% full) with 247.9 MB remaining. Capacity within COPD is approx. 250 GB and NICU is approx.. 800 GB with further capacity checks required. 4. The Technical Diagnostics Team within the Integrated Care Board (ICB) is exploring costs and solutions, with Bridgehead identified as a solution, along with cardio imagery. Planning parameters and vendor response in place for viability. 5. Work is underway with software providers for a temporary solution for the storage of images that does not add to current storage capacity. An approach has been considered for Siemens to partition VNA and assist with the holding of data and or for Sectra to provide a fully functional solution until a more permanent solution is found. 6. Regular meetings held between the Executive Medical Director, Chief Nurse, Director of Finance and Director of Operations for the Family Care Division to understand the risk and mitigations required. 7. Divisional Quality and Safety Meetings in place to review and support the management of this risk. 8. Medical Devices Management Group meetings in place to provide assurances of compliance regarding the lifecycle management of medical devices.		
Update since the last report	**Update 31/05/2024** **Risk score reviewed. No change in risk score** The ICB has ownership of the risk and is working on a digital solution that will better support the risk and reduction in risk scoring. **Next Review Date 01/07/2024**	**Date last reviewed**	**31/05/2024**
		Risk by quarter 2024-25	Q1: 20 / Q2: / Q3: / Q4:
		8-week score projection	12
		Current issues	System wide external influences

No	ID	Title				
3	9545	**Potential interruption to surgical procedures due to equipment failure**				
Lead		Risk Lead: Joanne Preston Exec Lead: Michelle Brown	**Current score**	**20**	**Score Movement**	⇔
Description		Theatre items that are out of service or obsolete pose a significant risk of complete failure which will impact on service delivery and patient safety. These items include theatre stack systems and Integrated theatre solutions which are now out of service contract. Additional critical medical devices and items are also due to be without support in the short and medium term	**Gaps and potential actions to further mitigate risk**			**Gaps / weaknesses in controls** 1 No spare parts availability internally or with supplier 2 Supplier has confirmed items now obsolete and replacement parts are no longer available 3 Possibility for loan kit to be unavailable 4 Potential for equipment to break and be no longer available 5 Field Safety Notices are not applicable as failure is due to age of equipment 6 Planned preventative maintenance of equipment for obsolete items is not included as part of contractual arrangements 7 A review of the responsibilities and arrangements within the medical devices policy is required **Gaps / weaknesses in assurances** 1 Increasing numbers of incidents identified 2 Meetings of the Medical Devices Management Group have not consistently taken place to allow monitoring and overview of equipment service contracts 3 Potential failure to report incidents of equipment issues or breakages 4 Delays in progress of the task and finish group may be experienced due to financial pressures
Controls and Assurances in place		**Controls** 1 Loan kit ordered when equipment broken if available (parts and items dependent) 2 Theatre staff fully trained and competent to work the equipment 3 Specialty scheduling and theatre oversight in place 4 Service contracts in place jointly managed between EBME and Theatres 5 Policy in place for the lifecycle management of medical devices monitored by the Medical Devices Management Group **Assurances** 1 Capital bids process in place 2 Business case to propose moving to a managed service and potential solution to the risk accepted by Board 3 Good relationship with and support from EBME, supplier and company representative 4 Breakages of choledoscopes fully investigated with theatres, EBME and supplier with the outcome of investigations finding no particular trend, with some breakages due to fragility of equipment and increased complexity of cases 5 Task and Finish Group established to progress replacement of equipment and managed service option 6 Monitoring at theatre and divisional meetings 7 Monitoring of incidents linked to risk and likelihood scoring criteria 8 Regular updates to exec team				
Update since the last report		**Update 17/06/2024** **Risk score reviewed. No change in risk score** Managed service has now been approved at Trust Board. Risk score to remain the same until service has been fully implemented and equipment replaced on site. The capital cost of the equipment is now over £1.4 million as further items are now obsolete. Finance are in process of finalising contract. **Next Review Date 17/07/2024**	**Date last reviewed**	**17/06/2024**		
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				20			
			8-week score projection	**20**			
			Current issues	Management of Medical Devices			

No	ID	Title				
4	9336	**Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care**				
Lead		Risk Lead: David Simpson Exec Lead: Jawad Husain	**Current score**	**20**	**Score Movement**	⟺
Description		A lack of capacity is leading to extreme pressure resulting in delayed delivery of optimal standard of care. At times of extreme pressure, increasing patient numbers across the emergency pathway makes the provision of care difficult, impacts on clinical flow, increases the risk of nosocomial infection spread as a result of overcrowding and poor patient experience leading to complaints. Staffing requirements are not calculated as standard to be able to care for increased patient numbers and complexity, with inadequate capacity within specialist areas such as cardiology, stroke etc. to ensure adequate clinical flow and optimum care.				
Controls and Assurances in place		**Controls** 1. Robust ambulance handover and triage escalation processes to reduce delays. 2. Operational Pressure Escalation Levels (OPEL) triggers and actions completed for ED and Acute Medical Units (AMU). 3. Established 111 / GP direct bookings to Urgent Care Centre (UCC). 4. 111 pathways from GP / North West Ambulance Service (NWAS) directly to Ambulatory Emergency Care Unit (AECU). 5. Pathways in place from NWAS to Surgical Ambulatory Emergency Care Unit (SAECU), Children's Observation and Assessment Unit (COAU), Mental Health, Gynaecology and Obstetrics and the Community. 6. ED streamer tool in place to redirect patients to an appointment or alternative service where required. 7. Daily staff capacity assessments completed and staff flexed as required. 8. Divisional Flow Facilitators established across all divisions to assist with clear escalation and 'pull through'. 9. Escalation pathway and use of trolleys in place for extreme pressures. 10. Zoning of departments to enable better and clearer oversight, staffing and ownership and isolation of infected patients, in particular, those with influenza and risks of cross contamination. 11. Corridor care standard operating procedure embedded. 12. Workforce redesign aligned to demands in ED. 13. Safe Care Tool designed for ED. 14. Full recruitment of established consultants. 15. Matrons undergone coaching and development on board rounds. 16. Reduced thresholds within critical care to support patient admissions. 17. Patient champions in post to support patients on corridors and volunteers utilised to support with non-clinical tasks. **Assurances** 1. Support provided by IHSS Ltd. in regularly reviewing admission avoidance. 2. Gold command in place to provide support. 3. Bed meetings held x4 daily with Divisional Flow Facilitators. 4. Hourly rounding by nursing staff embedded in ED. 5. Daily consultant ward rounds done at cubicles so review of care plans are undertaken. 6. Daily 'every day matters' meetings held with Head of Clinical Flow and Patient Flow Facilitators. 7. Daily visit by Infection Control Nurse to ED with patients identified as being not for corridor. 8. Increased bed capacity within cardiology. 9. High observation beds in place on AMU to support patients who require high levels of care. 10. Further in reach to departments in place to help decrease admissions. 11. Discussions ongoing with commissioners in providing health economy solutions via A&E delivery board. 12. Continuous review of processes across Acute and Emergency medicine in line with incidents and coronial process.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls and assurances** 1. Ambulance handover and triage escalation processes only effective if patients are transferred elsewhere and interventions are carried out. 2. OPEL triggers consistently remain at Level 4 with no escalation strategy should triggers be continuously met. 3. Clinical pathways are not being effectively utilised. 4. Patients not always keen to follow 111 / GP direct booking pathways to UCC. 5. Daily staff assessments are completed but there is still not enough staff to send support. 6. Limitations of 'pull through' and what can be achieved are due to challenges regarding patient discharge. 7. Extreme escalation highly dependent on flow. It does not always decrease pressures due to same sex / side room requirements. 8. Zoning of departments is only effective where severe overcrowding does not take place. 9. The corridor care standard operating procedure, hourly rounding by nursing staff and processes across acute and emergency medicine cannot be safely followed at times of severe overcrowding. 10. Workforce redesign undertaken twice yearly and despite a clear recruitment strategy and positive campaign, gaps in vacancies continue to remain high locally and nationally. 11. Safe Care Tool is completed twice yearly and has highlighted gaps between need and decision making. 12. Departmental board and walk rounds can take several hours due to severe overcrowding. 13. Reduced thresholds for support result in pushback from clinical areas vs a pull model. 14. Delays in the HR onboarding process is resulting in slow recruitment of volunteers and not enough to support demand. 15. Bed meeting actions can be person dependent e.g. consultants to discharge patients etc. 16. Further in reach to department support does not always occur due to staffing levels and space constraints, creating further delays. 17. Staff are not always available to redeploy to support at times of increased pressure. 18. Compliance with UK guidance for isolation of infectious patients creates further risks e.g. availability of side rooms etc. 19. Not all patients or staff follow infection prevention control policy requirements. 20. Not enough side rooms to support clinical requirements, in particular, patients identified as being not for corridor when severely overcrowded. 21. Reports not always accessed and meetings can be stood down due to operational pressures meaning data is not always enacted upon. 22. Added demand is coming from other NHS organisations due to better management of risk by ELHT. 23. No additional plan to support patients who require higher levels of care once high observation beds within AMUB are occupied. 24. A patient experience strategy is in place to support patients within ED but is heavily reliant on demand vs capacity so complaints continue to increase yearly despite interventions being put in place. 25. Friends and family results highlighting increasing concerns of waiting times. 26. System partners ability to flex and meet demands of local health population compounded with offer of mutual aid, with support with hospital diverts increasing risk

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<tr>
<td rowspan="5">Update since the last report</td>
<td rowspan="5">Update 21/06/2024.
Risk reviewed. No change in risk score
There remains significant pressures and overcrowding in relation to emergency and acute pathways, with highest attendances in Apr-24 which is leading to poorer patient experience and continuous trends regarding waiting times. Complaints are, however, lower than ever and managed quicker. The main issue is a lack of onward beds as up to one hundred patients can be waiting on corridors to come into the emergency department though this is showing signs of improvement since May-24. An improvement plan continues to show positive outcomes for initial and secondary quality indicators with the Trust continuing to informally support other emergency departments with regards their own improvements. Nursing vacancies are better than they have ever been with over recruitment to registered nurses. There has been three moderate incidents and one severe incident in the month of May-24, all of which are going through normal governance review systems.

Next Review Date 21/07/2024</td>
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<td colspan="4">21/06/2024</td>
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<td rowspan="2">Risk by quarter 2024-25</td>
<td>Q1</td>
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<td>20</td>
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<td>8 week score projection</td>
<td colspan="4">20</td>
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<tr>
<td>Current Issues</td>
<td colspan="4">Recovery and restoration pressures, recruitment and retention</td>
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No	ID	Title
5	8126	**Poor records management due to sub optimal implementation of new e-PR system**

Lead	Risk Lead: Daniel Hallen Exec Lead: Jawad Husain	Current score	20	Score Movement	⇔

Description

A lack of continuous optimisation and investment may lead to frustration and create disillusionment, leading to poor usage and productivity, unsafe workarounds, substandard data and ineffective clinical decision making.

Controls and Assurances in place

Controls

General

- significant resource in place to support improvement opportunities and deliverables
- dedicated senior consultant identified by Cerner to undertake work to review issues identified and support further development and actions required
- recruitment of e-PR champions, super users and floor walkers to support system implementation
- development of e-PR SharePoint one stop shop site of readily available resources e.g. workflow sheets, 'hot sheets' outlining brief instruction on how to complete tasks on Cerner and FAQ's covering general, clinical, administrative, IT, pharmacy and discharge processes

Clinical management

- improvement plan in place with identified learning outcomes spread across the Trust
- initial focus on outpatient areas i.e. head and neck, cardiology, urology, fracture clinical, gynaecology, respiratory and dermatology
- completion of project to identify all policies, procedures and guidance affected by system implementation
- prescribing is structured and follows a digital process with appropriate auditing capabilities
- replacement of ICE with Order Entry Catalogue and Order Entry Form to place requests and ordering of all surgical procedures and medications

Communication

- regular updates using a variety of trust wide communication systems, digital and social media platforms
- use of roadshows and walkabouts to raise awareness and demonstrate system use
- issue of role specific posters, flyers and key contacts
- use of displays across inpatient and staff areas

Education, training and competency

- registration process and extensive roll out of end user training and support
- development and issue of staff handbooks
- library of quick reference guides developed and available on SharePoint and e-Coach and organised by job role describing how to use particular tools or complete set workflows e.g. admission, transfer, discharge, prescribing etc.
- series of patient journey demonstration and training videos have been created and available to view on the learning hub and YouTube channel to help navigate the new system
- personalised demonstrations for doctors, nurses and allied health professionals
- clinician RTT training
- virtual discharge masterclasses held to demonstrate discharge processes for inpatients, outpatients, emergency department and same day emergency care to assist staff to successfully discharge a patient using the e-PR system and create full discharge summaries, with recordings routinely available from the e-PR hub on OLI
- power chart and revenue cycle (RPAS) e-learning videos covering a wide range of patient journey demonstrations such as;
- ED triage covering patient summary, staff check in to shift and work location, adult triage and assessment forms, Manchester triage, discriminators and dictionary, presenting complaints, nursing notes and observations
- ED doctors covering clerking, ordering tests and medication, patient status view, specialty referrals, documentation of decision to admit, bed requests, ED discharge workflow
- nursing inpatient admissions covering care compass, patient status overview and activity timeline, tasks to complete, admissions assessments including observations, pain assessments, EWS scoring, medicines administration and drug charts, discharge care plans, day of admission checklist, discharge planning risk assessment
- inpatient admission – doctor covering doctors worklist, admission documentation including auto text example, book patient for theatre, admission clerking notes including ability to forward to other recipients and available previous documentation within record
- inpatient preoperative checklist and discharge care plan (nursing) covering preoperative checklists, prior to discharge plan and discharge dashboard
- discharge (doctors) covering fit for discharge, discharge documentation and summary, discharge medication and discharge letter
- discharge (nursing) covering day of discharge checklist, key discharge information and PM conversation discharge of patient

Gaps and potential actions to further mitigate risk

Gaps / weaknesses in controls

General

- limited capital budget to invest in additional hardware or software as clinical requirements develop
- the lack of sufficient administrative resource
- lack of effective clinical management to support and maintain implementation may impact on service provision and delivery leading to a secondary impact on patient safety
- inability to rapidly flex current system to respond to emerging demands from 'external' NHS bodies for additional information

Clinical management

- key control issues identified regards elective outpatient and inpatients i.e. clinic set up and bookings; flow and discharge i.e. admission, discharge and transfer processes and discharge workflows; encounters; radiology integration; equipment and prescribing
- other issues identified relate to endoscopy booking issues; GP discharge summaries and reporting
- clinical management policies, procedures, systems and processes may not be in place or updated to reflect system changes following go live
- clinical management policies, procedures, systems and processes may not be followed by clinicians or are being effectively monitored by policy authors, committees and or groups
- there is more than one method of recording the same piece of information
- pharmacy medicines dispense system requires updating

Emergency preparedness, response and resilience

- limited assurance policy and or procedural requirements remain effective, are being monitored, reviewed or followed

Governance

- there is no robust document management solution currently in place e.g. imaging, documentation etc.

Digital

- local data and digital strategy in development to help drive successful implementation of e-PR system
- network instability which may lead to intermittent crashes
- extended contracts on existing digital systems that provide current cover causing unexpected, additional financial pressure
- no functioning information governance service at present
- impact on infrastructure if technology, clinical management and techniques are developed in isolation from main e-PR
- not all digital and clinical management systems are registered or known about
- current system contracts do not identify specific switch over dates and are being rolled over annually
- community services system is not connected to acute setting
- scanning solution not consistent across all specialties and case note groups
- rolling replacement of hardware and regular audits of IT service desk issues to identify challenges around themes such as reliable Wi-Fi etc.
- clinical incidents relating to system implementation and use to identify challenges
- integration architecture skills set is not native to the trust

Patient and staff safety

- limited assurance staff related health and wellbeing support systems are being used, monitored or reviewed for Cerner related issues

Gaps / weaknesses in assurances

Clinical management

- staff familiarisation and confidence with the new system to support safe clinical pathways e.g. admission, transfer, discharge and prescribing etc. which in turn may lead to backlogs and delays in patient flow
- limited assurance clinical pathways including assessments and workflows remain robust, are the most

	Emergency preparedness, response and resilience - policy and procedural controls in place relating to emergency preparedness, response and resilience, major incident and business continuity planning - paper based contingencies remain in place to allow and record data capture Governance - e-Lancs managed from one command centre Digital - national data and digital strategy in place to help drive successful implementation of e-PR system - stability of existing systems i.e. clinical and patient flow system (including capture of nursing documentation), digital dictation and scanning - improved digital infrastructure, network upgrades and digital solutions including storage to maintain and manage existing systems in place to help best utilise data sets and information from e-PR system - extended contracts on existing digital systems that provide current cover - register of non-core systems capturing patient information (feral systems) - decommissioning programme of digital systems underway - IT helpdesk and self-service portal in place to help resolve technical and general issues Patient and staff safety - staff access to a wide ranging staff health and wellbeing support mechanisms e.g. occupational health and wellbeing teams, employee assistance programmes, external organisations, staff side, freedom to speak up guardians etc. Task based - improved digital infrastructure and investment in new technology and equipment e.g. connectivity, large screen monitors for status and track boards, bed planning and control centres, use of barcode scanners for medication, patient wristband supply and scanning, workstations on wheels, laptop trolleys and bedside usage, medicine trolleys specifically built for ward medication dispensing, anaesthetic machines within theatres, badge readers for logging within inpatient and theatre areas, use of 24/7 device computers with access viewer software installed in clinical areas etc. - use of personalisation lab to allow customisation of system to suit individual needs e.g. doctor, allied health professional, nurse etc. **Assurances** General - digital solution meets regulatory and data set compliance requirements - system designed around national clinical requirements - back office and application support teams triage, troubleshoot and resolve issues - support with staff familiarisation and confidence on clinical management systems readily available from Cerner e-PR and e-Lancs expertise - business as usual support roles from executive team, directors, on call senior managers, matrons, enhanced service desk and self-service portal - early go live period identified has identified a number of issues relating to the technical design and adoption by staff which is expected due to the size and scale of implementation Clinical management - a stop, start and continue project, led by a clinical lead in improvement practice involving cross divisional engagement, has reviewed working practices across all clinical, operational, administration, human resources and governance processes - key control issues identified are being closely monitored with executive leads and through working groups - clinical document library outlining electronic and paper based systems covering policy and procedures, clinical risk assessments, bundles, care plans etc. - patient and statutory data sets captured in Bedrock Data Warehouse with reports in place - patient flow monitored through Alcidion MiyaFlow - patient care is visible and monitored through e-PR - patient activity is captured leading to accurate income reports - digital medical record capability shared within treatment and support teams Communication - regular webinars and team brief sessions held Education, training and competency - use of access fairs to ensure smooth staff logins - additional 940 hours available to support adoption and optimisation of system provided by Cerner for individual and team coaching Emergency preparedness, response and resilience - the EPRR committee benchmarks performance against national standards and provides assurances of organisational compliance Governance - weekly e-PR Programme Board meetings chaired by Medical Director - weekly incident management meetings chaired by Chief Operating Officer and Director of Service Improvement - weekly e-Lancs Improvement and Optimisation Group - use of specific working task groups as required - e-PR programme included as standing agenda item at Executive and Senior Leadership Group meetings		appropriate method of control, are being followed by staff or are being monitored and reviewed Communication - human factors and behaviours may be as a result of information fatigue and or culture/change acceptance Education, training and competency - accessing e-Coach may not be clearly understood or being utilised effectively by staff Emergency preparedness, response and resilience - limited assurance major incident and business continuity plans covering digital and clinical management systems may not be reviewed, tested, updated or followed to reflect e-PR implementation Governance - work underway to review longer term governance structure and arrangements to support the digital transformation journey - limited assurance monitoring and review of data within e-PR is being assessed to determine how well it is being used and of driving improvements - impact on mandatory national and local audit activity i.e. coding timelines, delays and observed changes in coded diagnosis reducing numbers of expected cases for submission - data behind GIRFT metrics and model hospital data is not being updated in a timely manner Staff safety - limited assurance HR/occupational health systems are being monitored against implementation to determine whether major system change is having a negative impact on staff health and wellbeing

	- progress on those key control issues identified undertaken at weekly Cerner incident management team meetings - monitoring and performance management of incidents reported through DATIX and IT helpdesk following system go live - learning from themes and trends converted into videos or quick reference guides and uploaded onto e-Coach - operational teams monitoring and reviewing clinical pathways - escalations, monitoring and performance discussed at ICB assurance meetings - governance arrangements to be reviewed in Jan-24 - ongoing assessment of staff feedback, incidents and problems raised through operational teams are assessed to look at change requests and training requirements <u>Digital</u> - completion of build work and excessive technical testing - all critical systems directly and indirectly managed by data and digital - 24/7 systems support in place - significant amount of business intelligence system data quality and usage reporting - consistent monitoring of clinical management systems and support via IT helpdesk - service desk e-PR tickets are continuously monitored - robust process in place for change requests <u>Patient and staff safety</u> - no patient or staff harm at present <u>Task based</u> - evaluation of issues undertaken by multi-disciplinary teams e.g. digital, clinical operational teams, learning and development, improvement hub, system support and leadership etc. through in person and observations utilising SPE+ improvement methodology		

Update since the last report	**Update 20/06/2024** **Risk reviewed. No change in risk score** The newly established data and digital senate group is overviewing the management of this risk and will focus on system based issues, clinical management issues, education and training issues, governance related issues and behavioural and competency based issues to take account of data submission and its impact on income, activity, mortality etc along with clinical informatics team supporting operational teams to daily monitor and action issues regarding discharge. **Next Review Date 19/07/2024**	**Date last reviewed**	**20/06/2024**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			20			
		8-week score projection	**20**			
		Current issues	System wide external influences			

No	ID	Title
6	9746	**Inadequate funding model for research, development and innovation**

Lead	Risk Lead: Julia Owen Exec Lead: Katie Quinn / Matt Ireland	Current score	16	Score Movement	⟺

Description	The Research, Development and Innovation Service within DERI is not centrally funded by the Trust. It is financed through complex funding streams such as the National Institute for Health Research (NIHR), Clinical Research Network (CRN) Greater Manchester and from income generated from commercial and non-commercial research activity. This model of funding is no longer sustainable	**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Commercial and non-commercial study income subject to change without warning leading to fluctuations in income or performance expected for funding provided and is non recurrent making forecasting extremely challenging. 2 Failure to look at funding model of Research, Development and Innovation could result in significant and rapid loss of highly skilled workforce and infrastructure severely damaging the Trust's ability to deliver vital ground breaking research for patients. These staff groups are specialised and once lost will take a considerable amount of time to re-establish. 3 Income generated from research and innovation rarely provides a within financial year return on investment in staffing resource and can take a few years for a new post to develop the surrounding portfolio within the service and is subject to exterior pressures within clinical and support services. 4 Research support function and SMT does not directly generate income, but is vital to support the research activity, be that developed research or hosted. The skilled expertise and advice given to prospective researchers helps increase potential for successful funding applications. Average success rate for grant applications is 17%, with unsuccessful grant applications still requiring support. 5 Not replacing staff has increased risk of not being able to deliver certain functions of the service, as well as increased pressure and stress on staff remaining, with current pressures unsustainable. **Gaps / weaknesses in assurances** 1 Rebalancing research portfolio to include more income generation from commercial research is happening but takes time to grow and establish. 2 Generated income limited without a dedicated research facility as clinical priority will take precedence for capacity (including support services). 3 Current recruitment freeze to non-clinical roles having an impact on staffing capacity to deliver current and expand research portfolio in line with DERI strategy and Research Plan. 5 Future benefits of investment realised over a longer trajectory such as research capability funding and income generation
Controls and Assurances in place	**Controls** 1. Finance within DERI moved from substantive education posts into research. 2. Investment in additional resources (B6 0.4 WTE and B4 0.2 WTE) for a six month period has allowed for better scrutiny and control of contractual and financial assessment of projects, timely raising of invoices and chasing aged debt. 3. Agreed proposals within business plan will see consistency in approach and alignment with other NHS organisations. 4. Procurement of Edge Research Management System allows for improved efficiency at capturing and costing for research activity and better financial oversight that was previously held. **Assurances** 1. Annual negotiations held with NIHR and CRN to proportionately increase investment to reflect balance and expansion of research portfolio across services allowing for movement of some posts to the CRN funding stream. 2. Fortnightly finance meetings between R&I Accountant, Deputy Divisional Manager for DERI and Head of R&I Department to review income and budgets. 3. Additional funding routes and benchmarking of financial models across other NHS organisations being explored. 4. Engagement with senior finance personnel and good lines of communication with executives to form a collaborative approach to the business plan.		

Update since the last report	**Update 20/06/2024** **Risk reviewed. No change in risk score.** Work has commenced to refine processes to recover trial income bringing in delivery and governance teams across research and development together to maximise income opportunities and of working with external partners to share good practice and use of EDGE in delivering income. **Next Review Date 19/07/2024**	**Date last reviewed**	**20/06/2024**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			16			
		8-week score projection	**16**			
		Current issues	System wide external influences			

No	ID	Title				
7	8941	**Increased reporting time in histology due to increased activity outstripping resource**				
Lead		Risk Lead: Dayle Squires / Victoria Bateman Exec Lead: Kate Quinn / Matt Ireland	**Current score**	**16**	**Score Movement**	⟺

Description	Increased reporting times in histology due to increased workload and reduced staffing numbers can lead to the mismanagement of patient care with long term effects, the non-compliance with national standards with significant risk to patients, poor patient experience if results are delayed, multiple complaints, low performance rating i.e. NHSE cancer performance, uncertain delivery of key objectives or service due to lack of staff and very low staff morale	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Dissection workload not adequately covered by clinical staff. 2. Activity increase higher than technical staff can complete, despite the issue of overtime and use of locum staff. 3. Failure of medical devices and equipment is adding to delays. 4. Volume of work marked urgent has increased by c.45%. 5. Gaps in recruitment of junior doctor posts remain. **Gaps / weaknesses in assurances** 1. Unexpected cancers found after waiting in backlog. 2. Surges in incidents regarding histology reporting times. 3. Poor monitoring and escalation of issues and meetings often stood down. 4. Some breaches fall outside the control of the Trust e.g. patients breaching targets due to complexity of pathways, comorbidities and patient choice.
Controls and Assurances in place	**Controls** 1. A 5 year workforce plan is in place to support recruitment and retention. 2. A locum consultant pathologist and biomedical scientist in post covering long term sickness and maternity. 3. Triaging of cases to prioritise cancer cases. 4. Breast workload referred to neighbouring NHS Trusts across Lancashire and South Cumbria. 5. Colposcopy screening cases referred to external provider. 6. Routine cases sent to external reporting services. 7. Additional dissection bench created to increase capacity. 8. Overtime being offered to existing staff to cover gaps and increase capacity. **Assurances** 1. Consultant staff supporting with dissection. 2. Work being triaged based on clinical urgency given the information provided upon the request form. 3. Weekly cancer performance meetings attended by the histology/performance manager. 4. Escalation process for priority cases is well established.		
Update since the last report	**Update 20/06/2024** **Risk reviewed. No change in risk score.** Risk has been reviewed and updated to reflect additional measures introduced e.g. recruitment and resource, review of systems and processes regarding managing capacity etc with a view of revisiting the likelihood and consequence criteria and lowering of risk score **Next Review Date 19/07/2024**	**Date last reviewed**	**20/06/2024**

Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	16			
8 week score projection	12			
Current issues	External influences regarding mitigation of risk beyond the control of the Trust. National shortage of histopathologists.			

No	ID	Title				
8	8061	**Patients experiencing delays past their intended clinical review date may experience deterioration**				
Lead		Risk Lead: Alison Marsh Exec Lead: Sharon Gilligan	**Current score**	16	**Score Movement**	⟺
Description		Patients are waiting past their intended date for review appointments and subsequently coming to harm due to a deteriorating condition or from suffering complications as a result of delayed decision making or clinical intervention.	**Gaps and Potential actions to further mitigate risk**			
Controls and Assurances in place		**Controls** 1 Red, Amber, Green (RAG) ratings included on all outcome sheets in outpatient clinic. 2 Restoration plan in place to restore activity to pre-covid levels. 3 RAG status for each patient to be added to the comments field on the patient record in Outpatient Welcome Liaison Service (OWLS) to capture current RAG status. This will allow future automated reports to be produced. 4 All patients where harm is indicated or flagged as a red rating to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers. 5 A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at the time of putting them on the holding list. 6 Process has been rolled out and is monitored daily. 7 Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reducing the reliance on holding lists in the future. 8 Administrator appointed to review all unknown and uncoded patients requesting clinical input and micromanagement of red patients in chronological order to find available slots. **Assurances** 1 Updates provided at weekly Patient Transfer List (PTL) meetings. 2 Daily holding list report circulated to all Divisions to show the current and future size of the holding list. 3 Meetings held between Divisional and Ophthalmology Triads to discuss current risk and agree next steps. 4 Requests made to all Directorates that all patients on holding list are initially assessed for potential harm due to delays being seen, with suitable RAG ratings applied to these patients. 5 Specialties continue to review patients waiting over 6 months and those rated as red to ensure they are prioritised. 6 Audit outcomes highlighted no patient harm due to delays. 7 Meetings held with Directorate Managers from all Divisions to understand position of all holding lists. 8 Individual specialities undertaking own review of the holding list to identify if patients can be managed in alternative ways. 9 Updates provided weekly to Executive Team.		**Gaps / weaknesses in controls** 1 Holding list remains high due to backlog from COVID-19. 2 General lack of capacity across specialties impacting on reducing holding list numbers. 3 Not all staff are following standard operating procedures for RAG rating of patients, leaving some patients without a rating. **Gaps / weaknesses in assurances** 1 Automated reporting system in development that will ensure oversight of risk stratified lists by specialty. 2 Current level of patients without a RAG rating classed as uncoded and unknown. 3 Patient appointments not RAG rated will drop onto the holding list if appointments are cancelled. 4 Patients added onto the holding list from other sources such as theatres, wards etc will not have a RAG identified.	
Update since the last report		**Update 04/06/2024** **Risk reviewed. No change in risk score** Continued increase in volume of patients and time constraints due to competing waiting list demands. A steering group has been put in place to explore a digital solution for validating waiting lists and a PEP+ operational group is being convened to review the PEP+ system and develop a process for managing the Trust waiting list validation programme. **Next Review Date 03/07/2024**	**Date last reviewed**	04/06/2024		
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				16			
			8 week score projection	16			
			Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
9	8033	**Increased requirement for nutrition and hydration intervention in patients resulting in delays**				
Lead		Risk Lead: Tracey Hugill / Mandy Davies Exec Lead: Peter Murphy	**Current score**	**16**	**Score Movement**	⟺
Description		Failure to meet nutrition and hydration needs of patients as set out within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which sets out the requirements for healthcare providers to ensure persons have enough to eat and drink to meet nutrition and hydration needs and receive support in doing so.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Non adherence to policy and procedural controls. 2 Inconsistent, inaccurate assessments and recording of malnutrition risk. 3 Lack of appropriate use of safeguarding processes. 4 Limited capacity of speech and language therapists, dietetics, endoscopy and nursing, including bank and agency, delaying assessments and impacting on feeding routes. 5 Limited capacity of nutrition support team undertaking ward rounds. 6 Lack of available housekeepers at weekends. 7 Training gap regarding nutrition and hydration training identified within doctors curriculum. 8 No process in place for the recording and review of non-mandatory training compliance. **Gaps / weaknesses in assurances** 1 Staff knowledge and confidence questionable in use of safeguarding processes in these cases. 2 No review of nutrition and hydration at ward rounds or timely best interest decisions. 3 Not all patients are weighed, with an over reliance on estimation of weight, not actual. 4 Recording of information in multiple places. 5 Current electronic 'MUST' toolkit insufficiently used to gather compliance reports and prevents healthcare assistants inputting weights. 6 Access to the nutrition support team is limited and instigated by dieticians and nutrition nurses rather than referral from ward. 7 Insufficient information provided in referrals to dieticians and speech and language therapists. 8 Timely review of blood results relating to parenteral feeding. 9 No medical representation at the Nutrition and Hydration Steering Group.
Controls and Assurances in place		**Controls** 1 Regulatory requirements and guidance written into nutrition and hydration provision to inpatients, parental nutrition, enteral feeding, refeeding, mental capacity and safeguarding adults policies and procedures. 2 Standard operating procedures and tools in place i.e. ward swallow screen, electronic malnutrition screening tool, food record charts and fluid balance, nasogastric tube care bundle, food for fingers and snack menus and nutrition and hydration prompts on ward round sheets. 3 Inclusion within Nursing Assessment and Performance Framework (NAPF) and ward managers audits 4 Training provided to staff that includes malnutrition screening, nasogastric tube replacement, nasogastric x-ray interpretation and nasogastric bridle, mouthcare, malnutrition identification and management, fluid balance, Percutaneous Endoscopic Gastronomy (PEG) management and food hygiene. **Assurances** 1 Nutrition and hydration prompt on ward round sheets 2 Inclusion within ward manager audits. 3 Monitoring of incidents and levels of harm, complaints, patient experience outcomes etc. as part of divisional reports. 4 Outcome results form part of the work plan of the Nutrition and Hydration Steering Group. 5 Inclusion via Nursing Assessment and Performance Framework (NAPF).			
Update since the last report		**Update 20/06/2024** **Risk reviewed. No change in risk score.** Nutritional consultant role now commenced in post. IHI nutrition project has been delayed. The complex nutrition team is to be launched in Mar-24. Ward rounds and outpatient clinics now in place. Risk score to be reviewed following complex nutrition team being embedded. **Next Review Date 19/07/2024**		**Date last reviewed**	**20/06/2024**	
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
					16			
				8 week score projection	**12**			
				Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
10	7165	**Failure to comply with RIDDOR**				
Lead		Risk Lead: John Houlihan Exec Lead: Tony McDonald	**Current score**	**16**	**Score Movement**	⟺
Description		Failure to provide quality assurance of legislative compliance regarding the reporting of certain types of injuries, diseases and dangerous occurrences to the Health and Safety Executive (HSE) within set regulatory timescales				
Controls and Assurances in place		**Controls** 1. RIDDOR reporting requirements contained within the scope of the incident management policy and procedure. 2. Responsibilities of staff to report any health concerns embedded within organisational health and safety at work policy. 3. Improved data capture and utilisation of incident management module of DATIX. 4. A centralised process is firmly established for the health and safety team to review and submit RIDDOR reportable incidents externally to the HSE. 5. Days lost off work as a result of a workplace accident or injury captured as part of the human resources sickness management and return to work processes. 6. Increased management and staff awareness and understanding of RIDDOR i.e. what is and what is not reportable, consequences and timescales involved, relevant work examples and the issue of guidance. 7. RIDDOR awareness training developed by health and safety team and rolled out to targeted staff groups i.e. members of the health and safety committee, lead specialisms and or subject matter experts, occupational health services, divisional quality and safety leads and teams and patient safety investigation leads. Further ad hoc training across divisional groups available, where necessary. 8. Increased senior management awareness of RIDDOR to help drive and reinforce the importance of ensuring legislative compliance. 9. New Occupational Health Management System OPAS-G2 now being used to capture and inform of the types of medically diagnosed occupational related disease, infections and ill health identified as being RIDDOR reportable. **Assurances** 1. Full review of legislative requirements completed and reviewed. 2. Specialist advice, support and guidance on RIDDOR reporting requirements readily available from the health, safety and risk team. 3. Continuous monitoring and review of all accidents and incidents to staff, patients, contractors and members of public reported in DATIX undertaken by the health, safety and risk team. 4. Thematic review of RIDDOR performance against legislative requirements included as an agenda item of the Health and Safety Committee, with escalation and or exception reporting to the Quality Committee, where necessary. 5. RIDDOR reportable occupational disease more explicitly included within occupational health performance reporting. 6. Collaborative working partnerships strengthened with clinical and non-clinical service specialisms and safety critical roles e.g. matrons, ward managers, patient safety lead investigators, incident and triage team, infection control, occupational health, estates and facilities, human resources, legal services, falls lead, manual handling lead, security management etc. should any significant trends be identified. 7. Attendance of health and safety team at weekly complex case review meetings to help identify and determine potential RIDDOR reportable incidents to patients. 8. RIDDOR performance included as part of Quality and Safety KPI performance metrics for senior management oversight and review. 9. Compliance with RIDDOR reporting timescales is improving but continues to remain challenging from 12% in 2021/22 to 47% in 2022/23 to 56% in 2023/24.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Delays determining RIDDOR reportable incidents due to increasing volume and complexity of accidents and incidents requiring review and investigation. 2. Limited assurance of policy or procedural compliance regarding timely reporting of accidents and incidents, of this being highlighted or captured within management systems or processes or it being performance managed. 3. No standardised investigation process or quality management system used to capture total days lost off work as a result of workplace accident leading to absence, avoidance or duplication. 4. New patient safety incident response framework may delay incident investigations and subsequent impact on external regulatory reporting requirements 5. Improvements in compliance heavily reliant on major changes to the incident management and triage processes and limited capacity and resource within the health and safety team. 6. Lead specialisms and or subject matter experts not being utilised effectively to review and investigate incidents within their own areas of responsibility and control and of determining RIDDOR as part of investigation 7. Gaps in quality management systems or processes, policy controls and risk assessment processes not being followed by managers and staff. **Gaps / weaknesses in assurance** 1. RIDDOR performance attracting the interest of the HSE and CQC. 2. Limited assurance of RIDDOR being used to benchmark performance as an important driver in reducing mitigating risks or improving safety management systems, processes or behaviours. 3. Increasing numbers of incidents being reviewed by the health and safety team account for 25-30% of all incidents reported in DATIX and continues to significantly impact on the work and resources of the team e.g. 6,539 were reviewed or investigated in 2021/22, 6,713 in 2022/23 and 6,677 for 2023/24. 4. Current trend analysis highlighting a 55% increase in RIDDOR reportable incidents compared to previous FTYD.	
Update since the last report		**Update 19/06/2024** **Risk reviewed. No change in risk score.** There has been a 1% increase in numbers of health and safety incidents compared to previous financial year and a 55% increase in total numbers reportable under RIDDOR. Action plan in place to review effectiveness of safety management systems monitored by the Health and Safety Committee. Compliance with RIDDOR reporting timescales is steadily improving and is currently at 56% but this still remains challenging. **Next Review Date 17/07/2024**		**Date last reviewed**	**19/06/2024**	
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
					16			
				8 week score projection	**16**			
				Current issues	Systems, capacity and workforce pressures			

No	ID	Title				
11	6190	**Insufficient capacity to accommodate patients in clinical within timescales**				
Lead		Risk Lead: Michelle Montague Exec Lead: Sharon Gilligan	**Current score**	**16**	**Score Movement**	⟺
Description		Insufficient clinic capacity for patients to be seen in outpatient clinics resulting in unbooked new patients and a very large holding list of overdue patients. In some cases, there is significant delay and therefore a risk to patients. Demand far outweighs capacity, and this has been exacerbated since the COVID-19 pandemic. All patients are risk stratified (red, amber, green) but still cannot be seen within timescales with additional risk that amber patients could be become red over time etc.		**Gaps and Potential actions to further mitigate risk**		
Controls and Assurances in place		**Controls** 1 An integrated eye care service is in place for specific pathways to help steer patients away from out of hospital eye care services. 2 New glaucoma virtual monitoring service in place to manage reviews and support the service. 3 Use of capacify sessions where doctors are willing and available. 4 Use of clinical virtual pathways where appropriate. 5 Action plan and ongoing service improvements identified to reduce demand. 6 A failsafe officer has been recruited to validate the holding list and focus on appointing red rated patients and those longest waiting. 7 Expanded non-medical roles e.g. orthoptists, optometrists, specialised nurses etc. 8 Additional ST's rotated for use one day per week from Aug-23 with 9 1 ST able to operate independent clinics. **Assurances** 1 Capacity sessions held where doctors are willing and available. 2 Increased flexibility of staff and constant review and micro-management of each sub specialty. 3 All holding list patients reviewed weekly by administrative staff with patients highlighted where required to clinical teams. 4 Weekly operational meetings challenge outpatient activity and recovery. 5 Arrangements made with college to support a further two ST's one day per week each.			**Gaps / weaknesses in controls** 1 Funding and insufficient staff numbers, competencies and skills mix to provide capacity. 2 Limited estates capacity and outpatient space to provide required clinics. 3 Limited opportunity to flex theatre to outpatient departments and vice versa. 4 Use of locums to support capacity sessions no longer in place due to lack of available space, gaps in competency, expertise and skills and challenges in practice regarding discharge, adding to holding list concerns. **Gaps / weakness in assurance** 1 Getting It Right First Time (GIRFT) report not yet created for patient waiting times above 25% within recommended timescales for review.
Update since the last report		**Update 20/06/2024** **Risk Reviewed. No change in risk score.** Whilst the new glaucoma virtual monitoring service is supporting the service, numbers of urgent glaucoma patients are still being received. An empty ST slot has been filled with a MCH awaiting a start date. The triage process is being reviewed and improved. The holding list remains a concern with numbers of patients awaiting review of appointments unable to be accommodated. **Next Review Date 19/07/2024**		**Date last reviewed**	**20/06/2024**	
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
					16			
				8 week score projection	**16**			
				Current Issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
12	10065	**Pharmacy Technical Service refurbishment programme**

Lead		Current score	15	Score Movement	
	Risk Lead: Michelle Randall Exec Lead: Jawad Husain				

Description

The aseptic units are not being maintained to external standards and there is a risk the air handling units, specialist equipment such as pharmaceutical isolators and HEPA filters in both units will fail due to planned and reactive failure in the maintenance and replacement schedule and a number of potential issues:

- Temperature fluctuations may lead to environmental breaches.
- Product degradation may lead to contaminated products being administered to patients.
- Delays in chemotherapy service provision when equipment fails may hinder cancer recovery plans and breaches in cancer targets.
- An increased higher risk of dispensing and reconstitution of high risk products in clinical areas if incorrect stock is used or staff exposure to products that may cause health issues.
- A reduced ability to support clinical trials of investigational medicinal products requiring aseptic preparation.
- Outsourcing is not possible for supporting research and development where aseptic preparation is required due to air handling unit or equipment failure.
- The clinical trials team are based in the aseptic unit and if the unit closes, clinical trials dispensing will cease and research will stop which may impacts on commercial viability, reputational damage.

Controls and Assurances in place

Controls

1. Auditing of aseptic units being undertaken by external service providers via the Interactive Quality Assurance of Aseptic Preparation Service Quality Management System.
2. Staff preparations using aseptic none touch technique to reduce contamination risk
3. Old outpatient dispensary identified to be able to store clinical trials
4. Risk assessment of monoclonal antibodies designed to look at new products being accepted on the formulary.

Assurances

1. The aseptic team is reviewing the system for any environmental breaches on a monthly basis via pharmacy quality meetings.
2. Quality exception report excursions are being investigation and error rate reviews undertaken
3. Monthly meetings taking place and urgent response service plans sent through from clean room specialist company.
4. Regular environmental testing undertaken of the unit and the workforce.
5. Transformation plans for aseptic unit in place, with an integrated care systems working group looking at long term service provision.
6. A north west pharmaceutical quality assurance regional audit is undertaken every 18 months.
7. Outsourcing of products is undertaken where possible to meet service demand.
8. Non aseptic medicine trials and other alternatives being explored to prepare aseptic products in clinical areas.

Gaps and Potential actions to further mitigate risk

Gaps / weaknesses in controls

1. Failure to comply with health technical memorandum guidance and quality assurance standards.
2. Dispersed oil testing and pressure differential failure in clean rooms visible on magnahelic gauges, interlocking doors not working.
3. A chemotherapy port has exceeded its life span with no plans in place regarding lifecycle management.
4. Contract with JLA (formerly Atlas) now expired, reports not being sent through, so having to review maintenance contract which is more expensive.
5. Difficult to manage all reports being recorded on the unit.
6. No environmental control in the old outpatient dispensary so not suitable for storing clinical trials unless upgrade works carried out.
7. Delays of up to forty four weeks ordering isolators adds to existing financial pressures and work programme constraints.
8. Growth restriction of aseptic unit with at least one pharmaceutical isolator not operational in last two years.
9. CIVA service has been stopped.
10. Outsourcing of parenteral nutrition service due to failing equipment.
11. Increased waste due to shelf life of outsourced products.

Gaps / weaknesses in assurances

1. Lack of national pharma support to provide aseptic service provision is putting a strain on services and workforce.
2. Multiple shut downs of the units have occurred in the last two years.
3. PFI agreed to upgrade aseptic unit but awaiting dates for lifecycle works to commence.
4. There has been a 15% increase in aseptic service provision in last two years with capacity and demand intensive.
5. Chemo and clinical trial demand growing and exceeding capacity of unit.
6. Review of capacity data highlighting workforce issues.
7. Environmental monitoring results have a two week response time causing delays in picking up any breaches.
8. Limitations in mutual aid due to age and condition of units across NHS organisations in the LSC area.
9. Workforce issues are leading to increased psychosocial risks.
10. Difficult to assess safety of MABs when in phase 2 of development, as COSHH data not available.

Update since the last report

New Risk
There is a risk of fluctuating isolator pressures due to cowling and internal pressures not normalising and faulty exhaust motor and anti-blow dampers not working requiring new filters

Next review date 24/07/2024

Date last reviewed	26/06/2024			
Risk by quarter 2024/25	Q1	Q2	Q3	Q4
	15			
8-week score projection	15			
Current issues	Systems, capacity and workforce pressures			

No	ID	Title
13	10062	**Risk of significant harm and poor experience for patients attending with mental health concerns**

Lead	Risk Lead: Lyndsay Parsons Exec Lead: Peter Murphy	**Current score**	**15**	**Score Movement**	

Description	The Trust is registered with the Care Quality Commission for the assessment and treatment of patients on the emergency care pathway who are subject to sections 136, 5,2 or 5.4 of the Mental Health Act. Patients are being admitted onto hospital wards who, whilst their acute physical health needs are being met, can present a risk in relation to their mental health needs when awaiting a more formal mental health assessment, a suitable mental health bed or transfer to other more suitable clinical pathways outside of the Trust and lead to patients not receiving coordinated care against standards, poor patient experience in the absence of specialist care and a deterioration in mental health condition.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Shared care protocols not formalised. 2. Informal arrangements not present when enhanced care lead is not on duty. 3. Risk assessments only provided for patients with medical recommendations in place and often provide limited information. 4. Infrequent availability of resource to address escalated patients via gold command due to bed availability. 5. Lack of clarity regarding the provision of support once ELCAS leaves the Trust. 6. Access to specialist advice for child mental health concerns only available from ELCAS until Jul-24. 7. Access to specialist advice for adult mental health concerns can only be accessed externally from LSCFT. 8. Lack of ability for specialised care plans to be written by mental health nurses to support patients within general adult acute ward environments 9. Limited control of other patients witnessing distress and deterioration in mental health conditions within ward environments. 10. Staffing levels not able to manage associated risk when gaps are not covered by specialist teams. 11. Acute staff often manage mental health risks without adequate training placing themselves and patients at risk 12. Incomplete or unsuitable environmental and clinical risk management processes 13. Lack of formal agreed shared care model results in inconsistent levels of support and gaps in provision. **Gaps / weaknesses in assurances** 1. Assurance processes not embedded or visible against jointly agreed standards. 2. No specialist input from mental health nurses to ensure appropriate actions are being taken. 3. The mental health liaison meeting is not linked to formal governance arrangements. 4. Compliance against s.136 pathway requirements not visibly reported across the Trust. 5. The LSCFT multi agency oversight group is not linked into formal governance arrangements 6. No access to specialist internal support for adult mental health concerns. 7. No access for staff to undertaken mental health training to support patients and families. 8. Requirements from treat as one documentation are outstanding 9. No formal oversight of ligature risk assessments
Controls and Assurances in place	**Controls** 1. Shared care protocol in place with Lancashire and South Cumbria NHS Foundation Trust (LSCFT). 2. Escalation of mental health patients via gold command. 3. Easy access to ELCAS / RAIS teams to provide flexible support for children. 4. Multi agency s.136 pathways in place. **Assurances** 1. Enhanced care lead nurse informally monitors and escalates gaps in completed risk assessments to the mental health liaison team based in the emergency department. 2. The mental health liaison meeting reports to the emergency department divisional management board meetings and facilitates joint working between the emergency department and mental health liaison team. 3. A new mental health interface meeting has been set up to provide assurances against established measures. 4. LSCFT multi agency oversight group monitors patient mental health activity and is chaired by the Integrated Care Board. 5. Incidents of harm involving patients with mental health or learning disabilities reported in Datix.		

Update since the last report	**New Risk** More formalised arrangements or service level agreements, with measurable standards or performance targets in relation to support from specialist teams or partners requires strengthening and assurance monitoring processes are to be linked to wider governance. **Next review date 19/07/2024**	**Date last reviewed**	**20/06/2024**			
		Risk by quarter 2024/25	**Q1**	**Q2**	**Q3**	**Q4**
			15			
		8-week score projection	**15**			
		Current issues	System wide influences			

No	ID	Title				
14	9900	**Poor identification, management and prevention of delirium**				
Lead		Risk Lead: Will Fielding Exec Lead: Jawad Husain	**Current score**	**15**	**Score Movement**	⇧
Description		National Institute of Clinical Excellence (NICE) guidance relating to the identification, assessment, management and prevention of delirium in acute hospital settings is partially and or not being met				
Controls and Assurances in place		**Controls** 1. A paper based delirium bundle and assessment is in place for clinical teams investigating and managing delirium. 2. A delirium awareness training module is available to staff with rapid tranquilisation training in support. 3. Available guidance on agitated delirium in elderly persons. 4. Patients with suspected delirium can be referred to relevant specialist nursing teams for support and review where required. **Assurances** 1. Delirium reports and updates produced and shared at dementia strategy meetings and the patient experience group. 2. Diagnostic data has identified a downward trend in delirium diagnosis since the introduction of the electronic patient record system. 3. A dementia champion documentation audit is being piloted monthly that includes seeking assurances of the effectiveness of delirium assessments. 4. A share point site has been created for signposting and resource identification. 5. A change request for the identification, management and prevention of delirium workflow has been approved with work underway to produce a single assessment question to identify delirium (SQID). 6. A training programme is in place to deliver delirium awareness key points training with training delivered to c.`40 staff members between Jan-24 to May-24. 7. A nationally accredited delirium awareness e-learning module has been added to the learning hub.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Existing digital clinical assessment does not fully identify delirium or populate a problem list. 2. Existing paper based delirium bundle does not utilise the 4AT delirium assessment and is not being routinely used in practice. 3. Compliance with dementia audits and outcomes requires stronger divisional support. 4. The training module for delirium is not a mandatory training requirement and does not fully mitigate the risks associated with delirium. 5. Published guidance and recommendations (agitated delirium in elderly) are not always followed. **Gaps / weaknesses in assurances** 1. Poor compliance with pilot assurance measures. 2. No reported compliance of delirium assessments for clinical areas captured. 3. No digital pathway for delirium management available. 4. A revised care plan for the prevention and management delirium is to be integrated into Cerner e-PR. 5. Work to create an investigation prompt for clinicians as part of the delirium diagnostic work flow and to assist clinical judgement underway.
Update since the last report		**New Risk 20/06/2024** The initial results from a national audit of dementia has identified limited assurances regarding the effectiveness of delirium assessments on patients that require them with the delirium pathway significantly reducing effectiveness. **Next review date 19/07/2024**		**Date last reviewed**	**20/06/2024**	
				Risk by quarter 2024/25	**Q1**: 15	**Q2**:	**Q3**:	**Q4**:
				8-week score projection	**15**	
				Current issues	System wide influences	

No	ID	Title				
15	9895	**Patients not receiving timely emergency procedures in theatres**				
Lead		Risk Lead: Nicola Tingle Exec Lead: Jawad Husain	**Current score**	**15**	**Score Movement**	⇧

Description	There is a risk that increasing demand on the emergency theatre due to increased hospital acuity may lead to delays in patients not receiving timely emergency procedures.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. No systematic approach in alerting and reviewing patients once listed. 2. No alert system when emergency patients have breached NCEPOD categorisation and not had timely emergency procedure. 3. Standing down of elective theatres or opening second theatres not always possible due to capacity and clinical priorities of elective patients. 4. Financial impact of cancellations on day of elective patients. 5. No bed capacity for surgical patients. 6. Not all cases are appropriately listed due to MDT requirements, times unknown, case complexity etc. which impacts on oversight at scheduling. 7. Known complex overruns are not always staffed requiring emergency staff to cover. 8. Regular overrun of elective theatres requires staff to relieve others who have to go home. Only six theatre staff available resulting in stopping of theatre six. 9. Limited assurance policy and procedural controls are effective or are being followed. 10. Reliance on voluntary staffing of capacity lists. **Gaps / weaknesses in assurances** 1. Potential for inappropriate categorisation when booking emergency patients. 2. Failure to discuss patient safety and risk at theatre triad and at divisional and directorate meetings. 3. Incident reports not always completed or capture severity of harm as unknown if there is a delay to surgery or disease progression. 4. Issues not highlighted if coordinator is not on duty. 5. Actions from meetings may not be enacted upon 6. Failure to manage capacity list due to lack of resource.
Controls and Assurances in place	**Controls** 1. All patients listed in accordance with NCEPOD guidance and time to theatre. 2. Patients reviewed by medical team to ensure they remain appropriately categorised and have not deteriorated. 3. Standing down of elective theatre based on clinical urgency and prioritisation. 4. Escalation standard operating procedure in place for patient flow. 5. Scheduling to ensure elective theatres are run in accordance with session time. 6. Senior theatre coordination and duty anaesthetist ensure efficient running of all operating theatres to prevent overrun. 7. Policy arrangements in place for ensuring elective procedures are booked in a timely manner to facilitate correct staffing for the elective capacity. 8. Additional second theatre at weekends to cover capacity. **Assurances** 1. Daily review of acuity of emergency list and capacity to assess availability of opening a second emergency theatre where required. 2. Theatre triad, directorate meetings held to discuss patient safety and risk at divisional and theatre directorate level. 3. Monitoring and review of incidents. 4. Emergency coordinator highlights capacity issues to duty anaesthetist and theatre operational manager. 5. Scheduling and oversight meetings in place for elective lists 6. Business case being made for additional theatre sessions.		
Update since the last report	**New Risk** Delays from emergency department can result in increased prioritisation of the patient due to rapid deterioration and requirement for a more rapid response to theatre, increasing category 1 (within 1-2 hours) and category 2a (within 2-6 hours) and category 2b (within 18 hours) acuity. **Next review date 10/07/2024**	**Date last reviewed**	**10/06/2024**

Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
	15			
8 week score projection	**15**			
Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
16	9851	**Lack of standardisation of clinical documentation process and recording in Cerner**				
Lead		Risk Lead: Clare Owen / Heather Coleman Exec Lead: Pete Murphy	**Current score**	**16**	**Score Movement**	⇧

Description	The introduction of Cerner e-PR system has created changes in documentation processes. There are numerous ways to navigate the system and document information in Cerner. As a result there is a lack of standardisation in documentation. This requires a coordinated way of standardisation and of providing policy and procedural guidance, education and support and effective ways to audit compliance of new systems and processes. A lack of standardisation when documenting in Cerner could result in the omission of documentation, evidence of care, duplication or contradictory information relating to the provision of care and potential that processes no longer align to clinical management policies, standard operating procedures and national guidance, with elements of documentation captured in existing audits no longer available to view.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Staff unaware of variation of processes in Cerner at go live so all processes need review and agreement to standardise. 2. Compliance audit reporting for some elements may not be possible or align to Cerner. 3. Unable to set up compliance reports until agreement of standardised process. 4. No electronic document management system or guidance on scanning in place. **Gaps / weakness in assurance** 1. Due to the volume of change requests and system analyst capacity, the alignment of system builds, audit and policy review is taking time to work through and prioritise. 2. Availability of lead experts to review system and advise and update policies is a timely process. 3. Limited assurance of monitoring scanning activity. 4. Limited capacity of reporting team to work on clinical reporting due to pressure for business as usual reports and resolving data quality issues for operational reporting.
Controls and Assurances in place	**Controls** 1. Appointment of a Chief Nursing Information Officer (CNIO) now in post. 2. New Integration Architect has been recruited to assist and upskill system analysts to execute change requests. 3. Head of Nursing leading review of the effectiveness of clinical management policy and procedural controls, risk assessment processes and care plans. 4. Library of quick reference guides on step by step instructions on common processes available via e-coach. 5. Training videos available on OLI, YouTube and the Learning Hub. 6. Review of clinical documentation included as part of Nursing Assessment and Performance Framework (NAPF). 7. Standardisation of clinical information and records management now obtained and can be audited. **Assurance** 1. Key processes lacking in standardisation are being identified. 2. Assurances provided by policy authors of the effectiveness of policy, procedural and risk assessment controls being aligned to Cerner. 3. Escalation process for Cerner related issues in place. 4. Engagement groups with staff and subject leads in progress to understand the issues. 5. A clinical records management group has been established to monitor and receive assurance of compliance. 6. Nursing risk assessments now available via systems reporting portal with other reports awaiting development. 7. Mini NAPF and audits of clinical areas undertaken by matrons with outcomes shared and enacted upon. 8. 93% of staff have received training on Cerner e-PR before 'go-live' date and all new staff complete training on commencement of employment. 9. Ongoing updates, including changes or handy tips, issued via trust wide approved communication systems. 10. Creation of One LSC model allows for pooling of resources across the region that will help address capacity.		
Update since the last report	**Update 29/05/2024** **Risk reviewed. No change in risk score** Review of systems and processes and standardisation will help the mitigation of this risk. Solution being explored regarding an electronic document management system and dedicated team to scan and upload documents with a governance wrap around however this may incur costs and take time to implement. As an interim guidance is being circulated around the legalities of scanning and uploading documents to raise awareness. There is still limited assurance regarding the monitoring of scanning activity across services. **Next Review Date 29/06/2024**	**Date last reviewed**	29/05/2024

Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	15			
8 week score projection	15			
Current Issues	System wide influences			

No	ID	Title
17	9653	**Increased demand with a lack of capacity within ELHT can lead to extreme pressure**

Lead	Risk Lead: Jane Dean Exec Lead: Pete Murphy	Current score	16	Score Movement	⇧

Description

Extra bed capacity is achieved by use of escalation beds in areas that have been risk assessed. Since January 2024 a standard operating procedure has been developed that introduced an extra trolley on each ward where there is inability to offload ambulances and patients are nursed on hospital corridors.

There is an increased risk extreme escalation to increase capacity within hospital environments will result in patient and staff physical and or mental harm as well as increasing privacy and dignity issues, hospital acquired infection, complaints, poor patient experience and reputational damage.

Controls and Assurances in place

Controls

1. Each ward has an individual risk assessment in place for the area in which the escalation bed space is to be opened and is reviewed as required.
2. Patients assessed by senior nurse on duty to ensure most appropriate patient is identified to be cared for in escalation bed.
3. Portable nurse call systems in place for additional bed to enable patients to alert staff when required.
4. Temporary storage made available as required.
5. Patient medications are stored within ward medication trolleys.
6. Patients placed onto the escalation bed are to be self-caring and able to stand to aid transfer to bathroom where possible.
7. Patients requiring electrical equipment or oxygen therapy are not to be allocated bed space.
8. Emergency equipment available if unexpected deterioration is experienced.
9. All staff to ensure adherence to infection prevention control policy and procedural controls.
10. A standard operating procedure in place to support and strengthen decision making of patient selection and placement when using escalation bed and trolleys.

Assurance

1. When escalation trolley is in use, the ward risk assessment is reviewed each day.
2. Assessment is signed by appropriate staff to confirm required needs are being met each time the area is opened.
3. A signature sheet is kept with the ward assessment and compliance of its use audited as required.
4. Extra equipment in use to support bed space e.g. patient call alarm, bedside table and crate for any belongings are being managed as per policy and procedural controls.
5. When equipment is not in use, it is the wards responsibility to ensure the electronic patient buzzer is kept on charge at the nurses station and checked twice daily as part of safety huddles.
6. Use of extreme escalation trolleys is monitored, incidents are reviewed, linked to the risk and investigated as appropriate, with lessons learned shared with staff.
7. The Electronic Patient Tracking System is updated to ensure the correct ward area is used at all times of extreme escalation.
8. Quarterly review of risk assessments are undertaken by the health and safety team via use of audits and incident review.
9. Monthly meeting are set up to review any incident reports received to identify any ongoing themes or increased risk.

Gaps and Potential actions to further mitigate risk

Gaps / weaknesses in controls

1. Lack of space around bed area affecting personal care and impacting on patent and staff safety.
2. Reduced access to electrical power sockets, oxygen and suction, overhead lighting and trailing wires and cables have increased slips, trips and fall hazards.
3. Reduced space where escalation bed is positioned has increased risk of patient falls due to compromised observation of patients and additional equipment in the area and is impacting on safer handling of patients and infection prevention and control adherence.
4. Privacy and dignity may be compromised due to privacy screens not allowing the same privacy as the curtains.
5. Poor patient experience leading to increased patient and relatives concerns being raised and potential risk of increased formal complaints and potential reputational damage.
6. Reduced space around bed/trolley for staff to safely deliver care. Lack of amenities for patients to enable them to be independent with some aspects of care e.g. no bedside table to provide access to personal belongings and diet and fluids within their reach.
7. Potential staff harm due to inability to safely handle patients and increased equipment in area
8. Increased nurse anxieties due to managing medical staff's expectations.
9. Staff morale and wellbeing may be reduced due to increased workload and managing patients and visitors expectations.
10. Due to the number of nursing vacancies and high agency or bank usage, there may be times, in particular, overnight, when the ward team are very junior and may be under already significant pressures leading to heightened stress and anxiety.

Gaps / weakness in assurance

1. Reduced space between bed spaces not adhering to national guidance and potential to increase risk of hospital associated infections.
2. Capacity and demand cannot be predicted.
3. Patients refusing to move to the trolleys if they are in bed.
4. Inability to find suitable patients to go onto the trolleys due to acuity or dependency.

Update since the last report

New Risk 20/06/2024
Risk score has been increased to 15 due to the introduction of trolleys on the wards and increased usage.

Next Review Date 19/07/2024

Date last reviewed	20/06/2024			
Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
	15			
8 week score projection	15			
Current Issues	System wide influences			

No	ID	Title
18	8808	**Breaches to fire stopping and compartmentalisation at BGH**

Lead	Risk Lead: John Houlihan Exec Lead: Tony McDonald	Current score	15	Score Movement	⟺

Description	Phase 5 breaches to fire stopping compartmentalisation in fire walls and fire door frame surrounds due to poor workmanship or incorrect product usage may result in faster spread of smoke or fire between compartments within a timescale <1 hr or 30 mins that compartments and doors are designed to provide.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Delays in implementing works 2. Lack of confirmation of integrity of fire door architrave surrounds and general gaps around and under fire doors. 3. The adequacy of fire stopping compartmentalisation between phase 5 and adjacent building (Wilson Hey) via survey remains outstanding, with no decision made on work to progress. 4. Not all locations within occupied areas have an updated fire safety risk assessment. 5. The review of the effectiveness of collaborative working arrangements regarding the completion, review and sharing of fire safety risk assessments for both occupied and non-occupied areas is required. **Gaps / weaknesses in assurances** 1. Lack of cooperation from partner organisations with information relating to construction drawings, test evidence and material in situ which is slowing down survey and project remedial / management works 2. Limited assurance of the robustness of fire safety management policy and or procedural controls regarding the risk assessment process and effectiveness of on-site fire wardens.
Controls and Assurances in place	**Controls** 1. Contractual arrangements in place between the Trust and its PFI partners in establishing duty holder responsibilities of building controls, testing and servicing of alarm systems and planned preventative maintenance programme. 2. Upgrade of suitable building fire detection systems in place to provide early warning of fire. 3. Fire risers and fire-fighting equipment in place, tested and maintained. 4. Fire safety management policy and procedural controls in place. 5. Fire safety risk assessments in place for occupied (Trust) and non-occupied (Consort) areas. 6. Fire safety awareness training forms part of core and statutory training requirements for all staff. 7. All relevant staff trained in awareness of alarm and evacuation methods. 8. Emergency evacuation procedures and business continuity plans in place across services. 9. Fire protection remedial works and find and fix process in place and project managed. 10. Random sampling and audit of project works being undertaken. **Assurances** 1. A fire safety committee has been established, chaired by an exec lead, to seek assurance and monitor progress and compliance. 2. Collaborative working arrangements in place between the Trust, its partners and third parties to identify and prioritise higher risk areas, address remedial works and defect corrections to fire doors and frame sealings 3. All before and after photographic evidence of remedial works recorded and appropriately shared 4. Fire wardens in place with additional fire wardens provided by partner organisations to maintain extra vigilance, patrol common areas across hospital sites and undertake fire safety checks 5. Provision of on-site fire safety team response in place. 6. External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place. 7. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England. 8. Independent consultant employed to review and oversee project.		

Update since the last report	**Update 01/06/2024** **Risk reviewed. No change to risk score.** Remedial work has not sufficiently progressed at this stage. A dedicated fire remediation project team is now overseeing the programme. Improvement works continue to be monitored and reviewed by the Fire Safety Committee **Next Review Date 01/07/2024**	**Date last reviewed**	01/06/2024			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			15			
		8 week score projection	15			
		Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
19	4932	**Patients who lack capacity to consent to hospital placements may be being unlawfully detained (Tolerated Risk)**

Lead	Risk Lead: Lyndsay Parsons Exec Lead: Peter Murphy	**Current score**	**15**	**Score Movement**	⟺

Description	Patients referred to Lancashire County Council and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DoLS) authorisation are not being assessed by these agencies within the statutory timescales, or at all, which means the DoLS is in effect unauthorised.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. The inability of the Supervisory Body to process assessments in line with set statutory provision. 2. As a result the Trust is unable to extend urgent authorisations beyond the maximum time permitted of 14 days. 3. In the absence of assessments patients will not have a DoLS authorised and will not have had relevant checks undertaken to ensure they are legally detained, leading to patients being detained without authorisation as not doing so would present an even greater risk. 4. Plans to change DoLS to Liberty Protection Safeguards (LPS) remains ongoing, with no date set for their implementation or subsequent publication of new National Approved Codes of Practice. **Gaps / weaknesses in assurances** No gaps or weaknesses in assurance identified
Controls and Assurances in place	**Controls** 1. Policy and procedures relating to the Mental Capacity Act (MCA) and DoLS updated to reflect the 2014 Supreme Court judgement ruling. 2. Mandatory training on the MCA and DoLS available to all clinical professionals. 3. Improvement plan introduced for the management of DoLS applications following internal audit to enable timely and accurate recording of applications made and to demonstrate application of MCA in absence of Local Authority (LA) review. 4. Applications being tracked by the Safeguarding Team. 5. Changes in patient status relayed back to the local authority acting as the Supervisory Body. 6. Ability to extend urgent authorisations for all patients up to 14 days in total. **Assurances** 1. The Supervisory Body is aware of the risk. 2. Policy and procedural arrangements being adhered to by wards along with applications continually made in a timely manner. 3. Quarterly review undertaken by Internal Safeguarding Board. 4. Legal advice and support readily available. 5. Additional support available for all ward based staff and provided by the MCA Lead and Safeguarding Team. 6. Patients not known to suffer any adverse consequence or delays in treatment.		
Update since the last report	**Update 20/06/2024** **Risk reviewed. No change in risk score.** Approval status changed to a tolerated risk. The mitigation of this risk is the responsibility of the Local Authority as the Trust cannot control the fact the Supervisory Body does not have the resource to meet the requirements for the assessment of patients. **Next review date 21/07/2024**	**Date last reviewed**	**20/06/2024**

	Q1	Q2	Q3	Q4
Risk by quarter 2024/25	**15**			
8-week score projection	**15**			
Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

10 July 2024

Item	**97**
Purpose	Information Action Monitoring

Title	Board Assurance Framework (BAF)
Executive sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance

Summary: The revised BAF and risk appetite statement are presented to the Board for review and ratification.

The cover report sets out the review journey and the methodology used for the annual review of the BAF. The new BAF is closely aligned to the key organisational and system strategies and to the Trust's goals outlined in the Strategic Framework.

Recommendation: The Board is asked to review and approve the new BAF risks for 2024-25, including the risk scores and the Risk Appetite Statement.

Report linkages

Related Trust Goal	Deliver safe, high-quality care
	Secure COVID recovery and resilience
	Compassionate and inclusive culture
	Improve health and tackle inequalities in our community
	Healthy, diverse and highly motivated people
	Drive sustainability

Impact

Legal	Yes/No	Financial	Yes/No
Equality	Yes/No	Confidentiality	Yes/No

Previously considered by:

Executive Directors and Director of Corporate Governance, May 2024

Executive Risk Assurance Group (ERAG), 30 May 2024

Committee Chairs, 31 May 2024

Board Workshop, 6 June 2024

Finance and Performance Committee, 24 June 2024

Quality Committee, 26 June 2024

Via email to Board/Committee members for comments and feedback, 28 June 2024

People and Culture Committee, 1 July 2024

Audit Committee, to be presented on 8 July 2024

Introduction

The Directors have undertaken the annual review of the Board Assurance Framework (BAF), which commenced in April 2024. As in the previous year, the review has been carried out utilising the principles of Improving Safe, Personal and Effective Care (SPE+) Improvement Methodology which emphasises the need to take a co-design and continuous improvement approach.

The Executive Team met as the ERAG on 30 May 2024. In addition, the Executive Directors with BAF risks assigned to them have met individually with the Director of Corporate Governance to develop the content of the individual risks.

The Trust's Committee Chairs have met with the Director of Corporate Governance on 31 May and the full Board also met collectively on 6 June 2024 to review, discuss and provide feedback on the newly developed draft risks.

Further discussion on the risks has been undertaken at the Committee meetings at the end of June 2024 and prior to the Board in early July 2024. An email with the latest version of the risks was sent to the Board and Committee members on 28 June for feedback and comments in advance of the paper being presented to the Board.

Development of BAF risks

Following discussions held with Executive Directors, the proposal was made to revise the wording of a number of the existing strategic risks. It was also agreed that there would be one additional risk developed to take into account the collaborative workstream on central services and One LSC, both from the perspective of the Trust as the host and also as a partner of One LSC. The revised and new risks for the next 12 months are set out below:

1. **Risk 1: (Risk Score 16 (C4 x L4)** The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
2. **Risk 2: (Risk Score 16 (C4 x L4)** The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
3. **Risk 3: (Risk Score 16 (C4 x L4)** A risk to our ability to deliver the National access standards as set out in the 2024-25 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.

4. **Risk 4: (Risk Score 16 (C4 x L4)** The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result its inability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
5. **Risk 5: (Risk Score 25 (C5 x L5)** The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
6. **BAF 6: (Risk Score 20 (C4 x L5)** (As Host)*:* Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services.
   (Risk Score 20 (C4 x L5) (As Partner)*:* One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.

As per previously agreed corporate governance processes, the full BAF is presented to the Committees for completeness and information, however, the Committees are asked to only discuss the risk scores and the mitigations and actions for the risks that are within their remit as follows:

a) Finance and Performance Committee: BAF 1, BAF 3, BAF 5 and BAF 6.
b) Quality Committee: BAF 2, BAF 3 and BAF 6.
c) People and Culture Committee: BAF 4 and BAF 6.

Proposed Risk Appetite Statement 2024-25

The Board also agreed to undertake a review of the Trust's Risk Appetite Statement for 2024-25. The statement below has been agreed by the Executive Directors and discussed at the Board session on 6 June 2024 and Committee's in June 2024. The three aforementioned Committees have met and agreed to recommend the revised risk appetite statement to the Board for ratification. The Board is therefore asked to review the document attached in appendix 1 and approve it.

In addition to the overarching Risk Appetite Statement, the Executive Directors have worked with the Director of Corporate Governance to review the risk appetite statement ratings for the individual risks, and these have been included below and will be reviewed bi-monthly:

BAF Risk	Risk Appetite Statement Rating
BAF 1: Integrated Care / Partnerships / System Working	Open/High
BAF 2: Quality and Safety	Minimal
BAF 3: Elective Recovery and Emergency Care Pathway	Moderate
BAF 4: Workforce	Open/High
BAF 5: Financial Sustainability	Cautious/Moderate
BAF 6: One LSC (Host and Partner)	Open/High

Connection with the CRR

BAF Risk	Linked CRR Risks	CRR Score
1: Integrated Care /Partnerships/ System Working	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 1.	N/A
2: Quality and Safety	ID 10086: Missed or delayed diagnosis if no solution for storage and transfer of echocardiogram (ECHO) images cannot be found. ID 9545: Failure to provide surgery due to breakdown of equipment. ID 9336: Lack of capacity can lead to extreme pressure resulting in a delayed care delivery. ID 8126: Potential to compromise patient care due to sub optimisation of the electronic patient record system. ID 9746: Inadequate funding model for research, development and innovation. ID 8941: Delays to cancer diagnosis (histology). ID 8061: Management of harm from the holding list. ID 8033: Complexity of patients impacting on ability to meet nutritional, and hydration needs. ID 7165: Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	20 20 20 20 16 16 16 16 16

BAF Risk	Linked CRR Risks	CRR Score
	ID 6190: Capacity and demand issue for outpatients. ID 9851: Lack of standardisation of clinical documentation processes and recording in Cerner. ID 8808: Breaches to fire stopping and compartmentalisation in walls and fire door surrounds – Burnley General Teaching Hospital. ID 4932: Patients who lack capacity to consent to placements in hospital may be unlawfully detained (tolerated risk).	16 15 15 15
3: Elective Recovery and Emergency Care Pathway	ID 9336: Lack of capacity can lead to extreme pressure resulting in a delayed care delivery. ID 8126: Potential to compromise patient care due to sub optimisation of the electronic patient record system ID 8941: Delays to cancer diagnosis (histology) ID 8061: Management of harm from the holding list ID 6190: Capacity and demand issue for outpatients ID 9895: Patients not receiving timely emergency procedures in theatre ID 9851: Lack of standardisation of clinical documentation processes and recording in Cerner ID 9653: Extreme escalation to increase capacity within the hospital may cause harm to patients and staff	20 20 16 16 16 15 15 15
4: Workforce	ID 9746: Inadequate funding model for research, development and innovation	16
5: Financial Sustainability	ID 10082: Failure to meet internal and external financial targets for 2024-25	25
6: One LSC (Host and Partner)	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 6. However they are in the process of being added to the CRR.	NA

The development of the BAF continues and the Directors are looking at reducing the volume of controls and sources of assurance in the risks to include only the ones that are mitigating

the current risks as opposed to the 'business as usual' measures in place for management of risks, which are currently included, this will help to further reduce the size of the BAF.

Work on aligning the BAF risks to the Corporate Risk Register continues and each BAF risk shows the corresponding risks from the CRR.

The heatmap is presented for the risks for 2023-24 and for the new risks for 2024-25 for comparison.

2023-24		LIKELIHOOD				
		Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
CONSEQUENCE	Catastrophic 5				BAF 2	BAF 5
	Major 4				BAF 1 BAF 4	BAF 3
	Moderate 3					
	Minor 2					
	Negligible 1					

2024-25		LIKELIHOOD				
		Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
CONSEQUENCE	Catastrophic 5					BAF 5
	Major 4				BAF 1 BAF 2 BAF 3 BAF 4	BAF 6
	Moderate 3					
	Minor 2					
	Negligible 1					

Recommendation

The Board is asked to discuss the BAF risks and the risk appetite statement and approve them.

BAF Risk 1 – Integrated Care / Partnerships / System Working

Risk Description: The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.

Executive Director Lead: Chief Executive / Executive Director of Service Development and Improvement

Strategy: ELHT Strategic framework (Partnership Working)

Links to Key Delivery Programmes: Care Closer to Home/Place-based Partnerships, Provider Collaborative

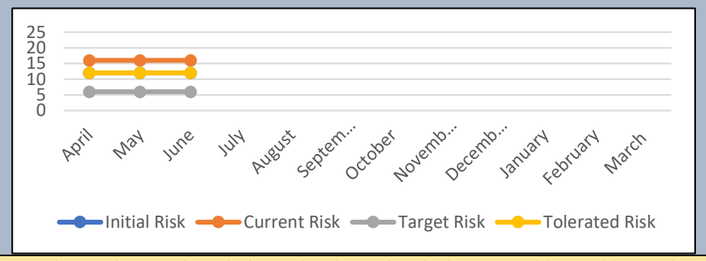
Date of last review: Board Strategy Session, 6 June 2024

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR): Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 1.

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating:	**C4 x L4 = 16**
Initial Risk Rating:	C4 x L3 = 12
Tolerated Risk	C4 x L3 = 12
Target Risk Rating:	C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Open/High

Controls: (What mechanisms, systems, rules and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact)

Lancashire and South Cumbria Integrated Care System/Board (ICS/ICB):

- The ICB has worked with partners to develop a Joint Forward Plan which continues to be reviewed and developed to reflect system strategy development and a refreshed system clinical strategy is in development
- The ICB continues to develop its commissioning approach and has formalised commissioning intentions for 2024/25 alongside a commissioning delivery plan
- The System Recovery and Transformation Programme and Board and System Leadership Oversight Group has refocussed for 2024/25 around delivery of key priority programmes and Financial Recovery
- The system Programme Management Office continues to develop to support delivery and monitoring of benefits realisation of system-wide programmes.
- ELHT has strong representation at all levels of system working and oversight groups. This is inclusive of Executive, senior clinical and operational representation at ICS working groups for key programmes, tactical co-ordination groups and planning groups to ensure alignment of plans.

Provider Collaborative Board (PCB):

- The PCB drives key programmes of work on both Clinical Services and Central Service redesign which feed into PCB Governance Structures and the system Recovery and Transformation Board.
- A Joint Committee has been formed to enable effective decision making for specified Programmes.
- ELHT plays a key role in the PCB including Chief Executive and Chair at PCB Provider Collaborative Board, lead Director Senior Responsible Officer (SRO) roles, representation at all other functional Director co-ordination groups and senior clinical and operational staff represented at clinical and non-clinical programme and working groups.
- The Clinical Services Programme Board, chaired by ELHT Chief Executive. oversees a programme of work focussed on clinical services configuration including fragile services.
- Central Services Programme Board oversees potential savings and other benefits of Central Services programmes opportunities with ELHT as the host of One LSC (refer to separate BAF risk 6).

Place-Based Partnership (PBP):

- Blackburn with Darwen Place and Lancashire Place including East Lancashire priorities are now agreed with place based delivery structures continuing to develop and be reflected in system commissioning intentions.
- Place + key forums in place to support delivery where needed across East Lancashire and Blackburn with Darwen e.g. Urgent and Emergency Care Delivery Board

ELHT:

- ELHT Strategic framework has been developed to ensure clear alignment of organisational aims to wider system aims.
- Key organisational strategies have been refreshed/developed to clearly outline ELHT priorities for development as a partner in the wider system.
- Strategy deployment framework/process will support development and delivery of organisational plans aligned to wider system, supported by Accountability Framework to monitor delivery.
- 11 Key Delivery and Improvement Programmes, with associated programme board and working groups, have been identified to ensure delivery against organisational aims and objectives and aligned to wider system programmes.
- In 2024/25 8 key improvement priorities have been agreed aligned to these programmes with clear fit to system priorities

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

Service delivery and day to day management of risk and control:

- ICS/PCB/PBP Updates are a standing agenda item at Executive meeting and Senior Leadership Group.
- PCB Programme Update reports to the PCB Joint Committee.
- Weekly monitoring of Key Delivery and Improvement Programmes via Executive Improvement Wall
- Trust Improvement Register monitored at Divisional Transformation Boards and Clinical Effectiveness Committees.
- Organisational plans for operational planning established and agreed via Trust and System planning processes.
- Accountability Framework implemented from January 2023 including weekly Improvement Wall updates as part of the weekly Executive Team meetings, Senior Leadership Group and quarterly Divisional Performance meetings.

Specialist support, policy and procedure setting, oversight responsibility:

- Standing agenda item at Trust Board where approvals will be established, and permissions are provided by the Board to let Executives progress the generation of ideas and options with external stakeholders.
- Board Chief Executive Officers (CEO) report including updates on system developments and engagement.
- System delivery plans are reflected in updates on Trust Key Delivery and Improvement Programmes. ELHT Key Delivery and Improvement Programmes established with relevant Programme Boards in place which feed into Trust sub-committees to report progress and give assurance.
- Strategic dashboards developed to enable monitoring of key Trust strategies at relevant Trust sub-committees with reporting to Trust Board twice a year.

Independent challenge on levels of assurance, risk and control:

- Provider Collaborative Board Business Plan signed off by all partners. Ongoing assurance on delivery provided via PCB Board and oversight groups.
- Trust, PBP, PCB plans feed into ICS-level plans as part of the national operational planning processes and are scrutinised by NHS Improvement/England.
- Regular communication with NHS England, NHS subsidiaries, Commissioners and Senior/Executive Management between teams.
- Mersey Internal Audit Agency (MIAA) audit of financial sustainability and improvement practice complete with action plan agreed and sign off at Audit Committee with substantial assurance
- MIAA audit of ELHT Business Planning processes complete with action plan agreed and sign off at Audit Committee with substantial assurance

BAF Risk 1 – Integrated Care / Partnerships / System Working

• ELHT Improvement Practice (Improving Safe, Personal and Effective Care (SPE+), developed to support delivery and build capacity for Improvement. Detailed Improvement Practice Development Plan (2022-25) in place with 1 year delivery plans generated each year to support embedding of improvement across the organisation.	

Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as Gap's in Controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.
Mitigating actions: actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.
Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	System strategies will continue to be developed and aligned as they are agreed.	Work with system partners to finalise system strategies and ensure full alignment with commissioning intentions and delivery plans.	Director of Service Development and Improvement with SRO leads	Sept 2024	Clinical strategy development work underway across the system. ICB Commissioning intentions developed and supporting delivery framework in development. Initial scoping of place priorities to Trust priorities complete and to remain under review Review of alignment of system, place and trust priorities undertaken as part of Trust planning process and being reviewed through Trust Sub-Committees.	G
2.	System (LSC, PCB, Place) delivery structures are still maturing to support effective implementation and realisation of benefits	Work with system partners to optimise delivery structures	Executive leads	Sept 2024	SROs supporting further development of delivery programmes through the Recovery and Transformation Programme, Provider Collaborative Board and Place e.g. community services/out of hospital programme. Continuing to align ELHT key delivery and improvement programmes and resources to support delivery and maximise benefits,	G
3.	Clear Clinical Transformation Programme development and delivery plans	Agreement of clear timescales for delivery of key priority programmes and benefits	Chief Executive and lead SROs	April 2025	Clinical strategy work to inform a roadmap to delivery of priority programmes over next 5 years and long-term plan linked to New Hospital Programme Work progressing on fragile service specialty priorities with clear programmes established	G
4.	Benefits for community services/out of hospital priorities not yet fully realised.	Complete the transfer of BwD Community Services to ELHT	Executive Director of Integrated Care, Partnerships and Resilience	July 2024	Community services transfer business case completed and agreed by all parties Mobilisation workstreams completed and facilitated a successful transfer on 1st July Continue to monitor transfer during early weeks to address any early implementation issues.	G
5.	Trust planning process will continue to mature to support floor to board connections of goals and priorities alongside wider system alignment	Ongoing review and improvement of planning processes at organisational and system level	Director of Service Development and Improvement	April 2025	All Trust strategy plans 2024/25 signed off via sub-committees with reporting mechanisms throughout 2024/25 agreed. Ongoing alignment of place with place and system partners. Ongoing work with Divisions to support connection of Trust goals to teams and individual objectives	G
6.	Ongoing development of SPE+ improvement Practice to support delivery of key improvement priorities and to build improvement capability across the organisation/system	Ongoing review and development of SPE+ Improvement Practice at organisational and system level to build capability and support delivery and refresh of SPE+ Practice Plan/Strategy in line with NHS Impact	Director of Service Development and Improvement	April 2025	'Year of Improvement' launched to develop SPE+ training offer to reach 3000 staff in 2024/25 Improvement hub team capacity identified to support key improvement priorities for 2024/25 Scoping of work to refresh Trust SPE+ Practice Plan/Strategy commenced to align to the new NHS Impact framework Continue to review the offer from NHS Impact to align organisational and national improvement priorities.	G
7.	Trust Accountability Framework can mature further to support and assure delivery of Trust priorities and realisation of benefits.	Review effectiveness of Trust Accountability Framework and further improve to support delivery	Director of Service Development and Improvement	Sept 2024	Review commenced of Accountability Framework including effectiveness of Divisional Quarterly Performance meetings, measurement and reporting framework Review of Integrated Performance Report underway and to be published in September. Review of Improvement Walls underway to refresh for 2024/25 priorities Improvement Walls being rolled out to operational areas e.g. ED, pathology	G

BAF Risk 2 – Quality and Safety

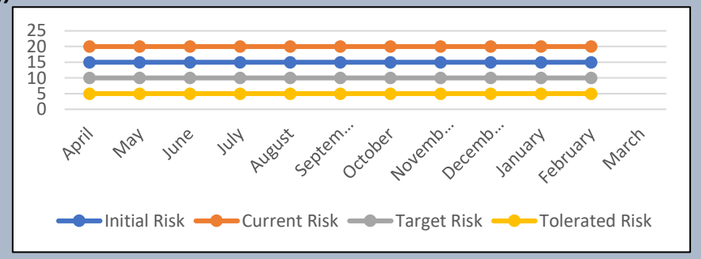
Risk Description: The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.		**Executive Director Lead:** Executive Medical Director and Chief Nurse	
Strategy: Quality Strategy	**Links to Key Delivery Programmes:** Quality and Safety Improvement Priorities	**Date of last review:** Board Strategy Session, 6 June 2024	**Lead Committee:** Quality Committee

Links to Corporate Risk Register:

Risk ID	Risk Descriptor	Risk Rating
10086	Missed or delayed diagnosis if no solution for storage and transfer of echocardiogram (ECHO) images cannot be found	**20**
9545	Failure to provide surgery due to breakdown of equipment	**20**
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**20**
8126	Potential to compromise patient care due to sub optimisation of the electronic patient record system	**20**
9746	Inadequate funding model for research, development and innovation	**16**
8941	Delays to cancer diagnosis (histology)	**16**
8061	Management of harm from the holding list	**16**
8033	Complexity of patients impacting on ability to meet nutritional, and hydration needs.	**16**
7165	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	**16**
6190	Capacity and demand issue for outpatients	**16**
9851	Lack of standardisation of clinical documentation processes and recording in Cerner	**15**
8808	Breaches to fire stopping and compartmentalisation in walls and fire door surrounds – Burnley General Teaching Hospital.	**15**
4932	Patients who lack capacity to consent to placements in hospital may be unlawfully detained (tolerated Risk)	**15**

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: **C4 x L4 = 16**
Initial Risk Rating: C5 x L3 = 15
Tolerated Risk C4 x L3 = 12
Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Minimal

Controls: (What mechanisms, systems, rules and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact).

Strategy and Planning:

- The Quality Strategy contains 14 core priorities which are routinely reported and monitored through the Quality Committee. These will be reviewed and updated annually through workshops with key partners.
- The Quality Strategy priorities for 2024/25 have been confirmed, with associated KPIs. Progress against the 2024/25 priorities is reviewed by the Executive team a minimum of quarterly via a presentation and update of the Executive Improvement Wall.
- The Patient Safety Incident Reporting Plan identified 5 priorities for investigation during 2022-24, the investigations now complete are moving to thematic review for organisational learning, led by the Improvement team. New priorities for 2024-25 have been agreed following engagement with key stakeholders, including the PPP and Healthwatch. following presentation at the Trusts Quality Committee and at the ICB Quality Committee. in November 2023
- Learning from the first year of implementing PSIRF has acknowledged priorities for 2022-23 were implemented over 18 months and therefore the 23-24 priorities are anticipated to cover until mid-2025.

Floor to Board Reporting and escalation (Risk and Quality):

- The Trust has an established quality assurance process supported through a formal Committee Structure. This provides the golden thread enabling reporting and escalation between the Divisions and the Board.
- The Trust Board, Quality Committee, Finance and Performance Committee, People and Culture Committee and Audit Committee all receive reports on risk/quality as part of their annual workplan, or as escalation where indicated.
- Escalation required outside of standard Committee processes is enabled through a weekly Senior Leadership Group, chaired by the Chief Executive or other Executive member to enable timely decision making and trust wide focus where required.

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

Service delivery and day to day management of risk and control:

- Monitoring against Model Hospital, Getting it Right First Time (GIRFT), National Institute for Health and Care Excellence (NICE) guidelines, Internal and Clinical Audits (local and national), specialist commissioning, CQC insight data (monthly)
- Quality Walkrounds including Executive and Non-Executives (not sure that these are if you look at the activity)
- Establishment of 3s visits to all areas of the Trust, to listen to both staff and patients/carers, receive feedback and take action.
- Nursing Assessment Performance Framework (NAPF) Process ongoing and reports to Quality Committee
- Safe, Personal, Effective Care (SPEC) process and the ratings of green/silver/gold wards/areas (mapped to the CQC Key Lines of Enquiry).
- Co-ordination of GIRFT through Audit and Effectiveness Team to identify Trust wide efficiency and effectiveness gains and reported to the Quality Committee regularly.
- Direct patient referrals into Same Day Emergency Care (SDEC) pathways to help bypass urgent care and ED.
- Admission avoidance through the use of Intensive Home Support Service (IHSS) in ED.
- Acute Care Team supporting resus in ED.
- Acute medical physician in reach into A&E from 8.30am to 8.30pm
- Patient champions in A&E
- Use of 24/7 ambulatory care on an intermittent basis to assist acute care (staffing dependent).
- Work is being undertaken with colleagues in primary care regarding patient pathways.
- Medical Examiners review the care provided to patients who have died in the Trust and can make recommendations or seek further action dependent upon their findings.

BAF Risk 2 – Quality and Safety

• All Divisions (including Estates and Facilities) have Quality and Safety meetings which coordinate Directorate assurance reports and escalation. Divisional reports are escalated to the Quality Committee through standard reporting and/or as patient/staff safety escalation points. • Statutory requirements are monitored specifically through Trust Wide assurance meetings including, but not limited to Mortality Steering Group, Patient Safety Group, Patient Experience Group, Clinical Effectiveness Committee, Infection Prevention and Control Steering Group, Safeguarding Board, Medicines Management Committee, Blood Transfusion Committee, Organ Donation Committee, Health and Safety Committee, all of which report to the Trust's Quality Committee, which is a sub-committee of the Board. • The Professional Standards Group and Employee Relations Case Review Group monitor professional/staff behaviours and all referrals to professional bodies. • The Risk Assurance Meeting coordinates and monitors all risks reported as potentially scoring 15 or above and escalates to the Executive Risk Assurance Group (ERAG) before inclusion onto the Corporate Risk Register. • The Patient Safety Incident Response Plan, Patient Experience Framework, Risk Management Framework and Clinical Effectiveness Framework co-ordinate the operational implementation of the priorities which are reported and monitored through respective assurance groups, and exceptions reported to Quality Committee. • Implementation of the Extreme Escalation Policy which replaces beds with trolleys in clinical spaces to assist the transfer of patients from ED into AMU/more appropriate environment. This in turn assists the capacity within the ED to see and treat other patients. Every morning at 8am, there is exec lead clinical safety meeting with A&E, divisions and flow team to manage and monitor patient admissions and flow. • Due to ongoing industrial action and sustained and increased unscheduled attendance and admission, twice a day IMT meetings have been stood up along with daily meeting with Place based partners and stakeholders. These meetings will be managed according to the OPEL level declared by the organisation • A&E Delivery Board lead by an Executive Director ensures processes are in place to help co-ordinate the care of patients between community, primary care, NWAS and ELHT. • A&E improvement board, developed with weekly executive review • Quarterly Divisional performance meetings where all elements of quality and performance are discussed. • The EPR Programme Board will run until the end of February 2024 and will be replaced by a new Digital and Data Board.	• Clinical Harms Review commenced from mid-December 2022 for patients waiting 52 weeks for treatment. It is being rolled over to specialties to assist in the management and prioritisation of waiting lists. • Complex Case meeting weekly to monitor and allocate for investigation any patient/staff safety incidents identified. • The Patient Safety Incident Response Framework implementation was reviewed through a workshop with Non-Executives present in November. This confirmed learning from the first 12 months and a core focus on continuing to improve systems and culture during 2023-24. • Monthly complaints and inquest drop-in sessions with each Division to monitor performance and highlight risk (are these happening? • Mobilisation of 24/7 IHSS service complementing the 24/7 Intermediate Care Allocation Team (ICAT) service Monday to Friday between 8am – 4pm for the ED front door team. • New PSIRP priorities have now been identified and included in the update Patient Safety Incident Response Plan due to be approved at Quality Committee on 1st November. • New model for patient safety culture reflecting the Insight/Involve/Improve model – integrating patient and staff safety data (in line with the National Patient Safety Strategy) has been agreed in principle with the Quality and Safety team. • Patient safety specialists are working with Deputy Director of HR to integrate staff safety metrics alongside patient safety. • Patient Safety Summit held in June 2023 following a number of Never Events and focused on receiving staff feedback on ELHT safety culture and psychological safety of staff. Learning from this is being rolled out in partnership with the Quality and Safety Team. • New Clinical Lead for Retention, Resilience and Experience commenced in post on 1 August 2023 with a focus on nursing and AHP workforce. • Work is being undertaken with ward managers and team leaders to review and learn from observations of patient care to improve patient care, outcomes and experience. • Quality Wall walkrounds have commenced (reviews of the quality KPI's in ED) • Triple S visits which are informal **<u>Specialist support, policy and procedure setting, oversight responsibility:</u>** • Integrated Care Board (ICB) have confirmed their contract requirements in relation to Quality reporting. Internal systems have been updated to ensure timely data and exception submission. First submission completed at the end of Q2. The Trust has continued to strengthen reporting against the updated Quality contract requirements and is proposing updates to the Quality metrics contained within the IPR to further strengthen internal assurance and visibility of these metrics • ICB Improvement and Assurance meetings (IAG), monthly executive to executive assurance meetings • ICB has split the assurance and safety functions with new leadership and focus. • Monthly Quality Review Meetings with ICB Quality Team continue. • Maternity and Newborn Safety Investigations (MNSI) (formerly Health Safety Incident Board) reports – review deaths and Health and Safety incidents. • Engagement meetings with Care Quality Commission (CQC) in place monitoring performance against the CQC standards. The Trust is preparing for its next Well-Led review, via Task and Finish Group working. • Patient Safety Incident Response Framework (PSIRF) supported through regular contact with NHS England Implementation Team. The Trust is supporting the adoption of PSIRF across the system as an active member of the implementation group. • Early adoption of Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards supported through regular contact with PHSO Local Safeguarding Children's Board (LSCB)/Safeguarding Adults Board (SAB) reporting on Care Act and Children Act Standards. • Arctic Willow winter specific EPRR exercise undertaken to ensure the NHS is adequately prepared for the winter period. • Regular Updates on ICB EPRR. • Regular meeting with Specialist Commissioner for tertiary services (Vascular, HPB, Neonates) <u>Independent challenge on levels of assurance, risk and control:</u> • Annual organisational appraisal report. • CQC inspections and preparation/evidence gathering ongoing. Internal assurance processes evidencing performance against CQC Quality Standards have been aligned to the updated regulatory framework. • The Internal Audit Plan for 2023-24 has being developed by the Mersey Internal Audit Agency (MIAA) in conjunction with Trust colleagues and improvement actions plan reporting to Audit Committee. • Regular Engagement meetings with General Medical Council (GMC). Coroner reviews of care provided through Inquest Processes. • Public Participation Panel (PPP) involvement in improvement activities and walk rounds. • PHSO complaints monitoring and external reports. Elective Care Recovery Board which includes regional and ICS level representation and scrutiny. • Quarterly Guardian of Safe Working report (GOSW) for junior doctors provided to the Quality Committee. • JAG accreditation in Endoscopy

BAF Risk 2 – Quality and Safety

	• Regular GIRFT assessment and bench marking • Annual organ transplant report to NHSE • Patient Safety Walkrounds • Board sign-off for SPEC recommendations • Review of MHUAC with Stakeholders

Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as gaps in controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.
Mitigating actions: Actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.
Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Fragility and availability of the medical workforce Health and Wellbeing of the Workforce	As part of WRP work has commenced to identify opportunities to reduce agency spend on medics. To strengthen the Patient Safety Culture in line with the Workforce Plan and a Just Culture Approach.	Executive Medical Director/ /Executive Director of People and Culture	Quarterly reviews with projected completion in Q4. March and June 2024	Long term This has been partially achieved and the Governance Assurance structure review completed. Despite systems working the fragility of the workforce planning through the introduction of professional judgement reviews of medical workforce through engagement with Divisions, DERI and HR. Job Planning Scrutiny Committee now embedded and focusing on productivity and VFM, recognising the need to increase effectiveness of Medical workforce in support of individual medics achieving their job plans. PCB and ICB are working closely in addressing the fragile services identified across LSC. Compassionate Conversations approach introduced as part of leadership training module to support psychological safety whilst learning from mistakes. Domestic Abuse and Sexual Violence workshop attended by Deputy Chief Nurse and Executive Director of People and Culture in October 2023, with a Trust meeting now in the calendar to commence the resultant work. Nursing professional judgment review process completed was presented to the Quality Committee in February and to the Trust Board in July 2024. Strengthening of job planning scrutiny panel with support provided to CDs by medical staffing team in job planning.	A
2.	Functionality of ePR causing issues with data quality, performance and effecting users capability to maximise the potential of the electronic system. Provision of histopathology within the Trust (medical and healthcare scientists) No longer just histopathology, its wider pathology department given the current IA/workforce discussions – see x-ref to BAF 4 and ABS to liaise with MI re inclusion in BAF 4.	Work is taking place across providers via mutual aid and exploration of outsourcing and open recruitment. Improvement work within Cell Pathology has initiated to identify internal efficiency opportunities. Continued effort to appoint into Biomedical Scientist (BMS) and Medical Laboratory Assistant (MLA) vacancies in the department. Action plan in place detailing short- and medium-term actions whilst improvement work is taking place. Datix system to ensure best use of resource within current contract. June 2024. (NRLS being phased out). Agree and implement a training plan for all users as a compulsory module.	Executive Medical Director	June 2024 to meet LFPSE	The Trust's cell pathology lab in May 2024 confirmed with NHSE that NRLS will be deactivated nationally significant backlog of samples at various stages of the process from 30 June 2024 and the reception to report. This has been escalated to the Executive Team and there is a risk on the risk register. From April 24 consultant vacancies in Histopathology have now all been filled. There are BMS and MLA vacancies which have impacted on the lab's productivity and throughput. From April 24 the improvement team are supporting within the lab to identify opportunities for efficiency. An action plan is in place to outline the work taking place in the lab to increase capacity and reduce the backlog which includes the use of temporary staffing and exploring alternative workforce options. Informatics has confirmed that a plan is in place to ensure that Datix is updated to meet the requirements of the new ongoing limited mutual aid from Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) and	R

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB). The Trust continues to use external providers to support with the backlog. The matter has been escalated to the national reporting system (LFPSE) to meet deadline. The Datix Manager has been requested to provide a roll out plan for the required training to implement LFPSE, inform an improvement case to clarify additional resource required to enable staff to continue report and manage incidents.	
		Cerner implementation has identified additional Make system updates and requirements improvements to Datix to ensure effectiveness. There is a need for relevant clinical document formats to be standardised and uploaded to Cerner eLancs team best use of resource needed to manage data cleansing and accuracy issues to enable timely reporting and performance monitoring and acting on change and service requests from staff/departments. Within current contract Update the Datix incident management module to ensure compliance with NHS England National Learning from Patient Safety Events (LfPSE) system requirements which is replacing the NHS England National Reporting and Learning System (NRLS) which is being phased out end Jun-24	Executive Medical Director	Q4Delay in implementation due to lack of resource /25	Executive team have agreed the formation of a Task and Finish group to address the operational matters identified as a part of business-as-usual activity whilst Data and Digital Board and Senate continue to have strategic oversight of the T and F group. Work being completed on policies and procedures in respect of scanning and recording documents within the ePR CRMOG is overseeing the review and the decision not to implement RADAR has delayed full implementation and has resulted in the continuation of Datix until such time as an ICS wide solution has been agreed, procured and implemented which has impacted on the inability of the Trust to meet the initial deadline of reporting using the national LfPSE system in Sept-23. Whilst access to the NRLS system can still be utilised that enables national reporting, this is scheduled to be decommissioned at the end of Jun-24. A temporary post in support of implementing RADAR ended in Dec-23 and a business case continues to be developed by the Datix Manager and Deputy Medical Director to support longer term improvements in system analysis and learning from quality metrics and in line with the national patient safety strategy. An upgrade to the Datix server to accommodate LfPSE requirements has been completed following financial approval, with support provided by the supplier (Datix). There is a risk if data migration cannot be achieved and supported by the Data and Digital team before the date of decommission that this will result in the failure to meet national target and resulting manual uploading of incidents and associated hidden costs. This work activity has been prioritised by the Datix Manager. A risk has been placed on the risk register (Datix ID 9786 lack of coordinated centralised end to end management of procedural documentation and clinical records) which is due for presentation at the Risk Assurance Meeting in Jun-24 and is linked to DATIX ID 9851 lack of standardisation of clinical documentation into processes and recording in Cerner and reporting to Data and Digital Committee monthly. Improvement team supporting outpatients/activity data capture e-PR currently held on the Corporate Risk Register A review of the board assurance framework and system improvements to the risk management module of Datix is currently taking place to capture data and digital / infrastructure risks	A
3.	Management of Deprivation of Liberty processes.	Introduction of Liberty Protection Safeguards. (LPS) Contact Lyndsay Parsons for update on this section	Executive Director of Nursing/ Executive Medical Director/ Executive Director of Integrated Care, Partnerships and Resilience	This date has been removed and there is no further date for implementation confirmed. June	Awareness raising ongoing. Potential significant workload associated to cover approx. 260 annual applications. The impact of LPS remains unknown. The ICB have appointed a system lead for LPS who has offered to support the Trust to assess the potential impact and potential resource	G

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
				2024 for non-emergency patients	requirements. This will be an issue across the PCB and the ICB have been asked to identify if a system approach could support a joint response. No change not off target New Head of Safeguarding now in place who will co-ordinate the Trust's response. An announcement was made on 05.04.2023 that the implementation of LPS would be delayed 'beyond the life of this Parliament'. As a result, all internal and external local and national working groups have been stood down for the immediate future. It is unlikely that the government will make a clear announcement/decision re the requirement to implement LPS. The Trust will await any update. Lancashire and South Cumbria NHS Foundation Trust (LSCFT) have agreed in principle to formalise support of Mental Health (MH) registration through the management of psychiatric medication, oversight of MH care plans, management of MH Act paperwork for any Section 5(2)s applied within ELHT and to provide training to staff on MH and Restraint. LSCFT have proposed a formal Service Level Agreement (SLA) at cost. SLA is in the process of being signed. Individual patient MH risk assessment and MH strategy shared by LTHT, currently being adapted for adoption at ELHT. Following multiple discussions with CQC registration team it has been agreed that registration for mental health patients will be assessed in relation to patient subject to section 136 initially. CQC registration assessment visit took place in October 2023 to consider the ED and Urgent Care mental health pathway. This is being co-ordinated in partnership with LSCFT. Only one registration updated following this visit will any further work towards the 5 (2)/wider sections being used across wards be considered. Registration visit completed by CQC in October 2023. Joint presentation by ED and LSCFT liaison team to CQC, who then walked the pathway through the emergency department. Significant pack of evidence re MH management within the emergency department provided to CQC. Verbal feedback from CQC Dec 2023 that application to register the emergency pathway for the assessment and treatment of patients subject to the MH Act has been successful. Specifically, that the evidence provided was of a standard that demonstrated we could provide safe care to this patient group of a standard that could be inspected against. CQC will write to formally notify the Trust of their decision in Jan 2024, after which we will have 28 days to accept the proposed extension to our regulated activities. This registration should have been in place to support the management of patients subject to Section 136 brought to our ED as a place of safety whilst awaiting assessment and will enable ELHT nurses to use Section 5 (2) and (4) to hold patients who may be a danger to themselves or others if they leave the department. A further extension of this regulated activity (to enable non-emergency treatment to MH patients on specific wards across the Trust) will be made once the additional support and resource is in place to enable the Trust to ensure this can be provided safely outside the emergency pathway. Mental Health Urgent Assessment Centre (MHUAC) service implemented Mental Health Liaison nurses supporting ED Urgent and Emergency Care (UEC) MH admission pathway	

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Ongoing review of systems in place to support this registration at LTHTR. Intention to replicate within ELHT and register once in place. Update provided to the CQC The Trust is moving to the development of the business case and eventual CQC registration of the Trust. Meeting arranged for 4th June between Associate Director of Quality and Safety, Deputy Divisional Director of Nursing MEC and Head of Safeguarding to review the CQC registration to see if there are any additional actions required beyond the assurances provided during the CQC visit across the Emergency Pathway. New risk created and presented to the Safeguarding Committee on 15th May (Risk ID: 10062) "Risk of significant harm and poor experience for patients attending with mental health concerns". Risk score agreed as 15. Head of Safeguarding to present to RAM in June for approval. Previous risk ID: 9557 Aggregated risk- Patient, staff and reputational harm as a result of the Trust not being registered for Mental Health provision to be closed as integrated into new risk. 8a Lead Nurse/Professional for Mental Health post has been added to TRAC, awaiting approval. Post is being funded via through a combination of vacancies within the Safeguarding Team. Job description has already been band matched to an 8a post	
4.	Financial Constraints	Constraints in finances will result in lack of investment into workforce, development of service, capital investment and revenue. This has the potential to negatively impact on quality and safety.	Executive Director of Finance / all Executive Directors	March 2025	Organisational focus on improvement methodology to improve productivity and efficiencies. Waste reduction programme with Execs leading as SRO for various workstream – chaired by the CEO. Consolidation of previously approved schemes and QIA for ongoing projects and the ones which have been deferred for a later date. Ongoing work through PCB on clinical strategy and services. Recruitment and retention campaign being undertaken as well as work to improve recruitment from overseas.	A
5.9	Lack of capacity to manage increased activity across the Trust EPR	Bed remodelling for managing increased activity Work with Place based partners in improving patient pathways Implement GIRFT and Model Hospital best practice approaches to care Complete ongoing work on clinical harms review management Data submission to national teams on activity, mortality, coding, audit to ensure that accurate and validated assumptions on income, HSMR/SHMI and activity. Quality of information added to the system remains an issue. Training is taking place with clinical/admin colleagues Coding and quality and affects mortality indicators too.	Executive Director of Finance / Executive Medical Director / Executive Chief Nurse / Chief Operating Officer	Quarterly review August 2024	Improvement Team working on bed remodelling. Established relationships through interface meetings with Place based leadership. Clinical Lead with responsibility for GIRFT and Model Hospital working with Q and S team. Ongoing work with our East Lancs team, coders and the Mortality Steering Group (with deep dives into outliers). Working with divisions on ensuring that that we capture activity levels. Working with national teams.	A

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

Risk Descriptor: A risk to our ability to deliver the National access standards as set out in the 2024-25 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.

Executive Director Lead: Chief Operating Officer / Executive Director of Integrated Care, Partnerships and Resilience

Strategy: Clinical Strategy & Operational Strategy

Links to Key Delivery Programmes: Elective and Emergency Pathway Improvement

Date of last review: Board Strategy Session, 6 June 2024

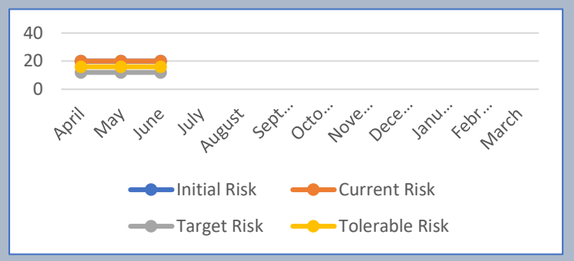
Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register

Risk ID	Risk Descriptor	Risk Rating
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**20**
8126	Potential to compromise patient care due to sub optimisation of the electronic patient record system	**20**
8941	Delays to cancer diagnosis (histology)	**16**
8061	Management of harm from the holding list	**16**
6190	Capacity and demand issue for outpatients	**16**
9895	Patients not receiving timely emergency procedures in theatre	**15**
9851	Lack of standardisation of clinical documentation processes and recording in Cerner	**15**
9653	Extreme escalation to increase capacity within the hospital may cause harm to patients and staff	**15**

Risk Rating (Consequence (C) x Likelihood (L)

Current Risk Rating: **C4 x L5 = 20**
Initial Risk Rating: C4 x L5 = 20
Tolerable Risk Rating: C4 x L4 = 16
Target Risk Rating: C4 x L3 = 12



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Moderate

Controls: (What mechanisms, systems, rules and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact).

Overall planning and delivery processes:

- Trust clinical strategy developed covering a 5-year period to support ongoing delivery and development of elective and emergency care services.
- Development of systems and processes to support reduction in risk to Health Equity supported by a plan to address health inequalities at place level.
- Development of system and processes to assess and reduce risk of clinical harm potential for patients on both the elective waiting lists and emergency care pathways ensuring safe, personal and effective care.
- Annual business planning and review of progress against delivery in place. This includes performance trajectories for all emergency and elective performance standards.
- A joint place delivery and improvement plan (via the Urgent and Emergency Care Delivery Board (UECDB)) for urgent and emergency care (UEC) in place. Further work around primary care access needs to be confirmed from place leads/ICB, work is being carried out around priority wards and integrated neighbourhood care. Updated the plan on a page for UECDB and this is based on three pillars; a) making it easier to access the right care b) increasing urgent and emergency care capacity c) improving discharge and expanding care outside of hospitals.
- Robust planning arrangements in place for planned strike, winter and bank holidays to ensure appropriate capacity planning in response to the demand forecast.

Operational Management processes:

- Active implementation and monitoring of elective improvement plans for 2024/25, diagnostic clearance plans and OP booking to ensure effective support for delivering the overall plan.
- Monthly Emergency Care Improvement Programme (ECIP) meetings are being refocused to support UEC improvements.
- Robust flow management system and processes in place with flow team and bed meetings for ongoing Situation Reports (SitRep) reporting and agreement of actions over 24/7 period and ongoing plans to strengthen discharge matron and patient flow facilitator role for supporting timely 7-day discharges

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

Service delivery and day to day management of risk and control:

- The Trust achieved agreed trajectories against all performance standards.
- A trajectory is in place to eliminate 65 weeks waits by September 2024 in line with planning guidance.
- Clear trajectories for other key targets for Referral to treatment times, 4-hour UEC target, Cancer, Diagnostics and activity levels in place and monitored via reporting to weekly operational team meeting, executive team meeting, senior leadership group.
- Site meetings 7 days a week ensuring timely escalation of delays (potential and actual) with corrective actions.
- Mobilisation of 24/7 IHSS service complementing the 24/7 ICAT service and Monday to Friday between 8am – 4pm for the ED front door team.
- Established a Trust Health and Equalities Committee chaired by the Chief Nurse feeding to the Quality Committee and People and Culture Committee

Specialist support, policy and procedure setting, oversight responsibility:

-
- Executive meet all with all divisions every morning (Monday – Friday) at 8.00am to support delivery manage risks and address any issues.
- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital.
- Cancer Alliance support on focussed areas requiring improvement.
- Lancashire and South Cumbria oversight and co-ordination via Elective Activity Co-ordination Team, Elective Care Recovery Group, Lancashire and South Cumbria Chief Operating Officers meetings.
- System level plan monitoring at Pennine Lancashire via UECDB and Integrated Care Board (ICB) level via relevant system forums
- Enhanced escalation policy which is activated when patients have been in the emergency department for an excessive amount of time (12 hours from arrival) in place 24/7supported by surge escalation capacity on the inpatient wards during times of pressure.

Independent challenge on levels of assurance, risk and control:

- Delivery of trajectories are monitored at ICB level through
- The monthly improvement and assurance meeting with the ICB

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

- Sustaining ambulance handover improvement and extending this to SDEC areas to spread ambulance handover performance. Monthly SDEC meetings now in place with involvement from NWAS colleagues.
- Data collection to identify target themes and services from the high intensity service users' group to inform the system demand management schemes for UEC. Specific focus around Mental Health pathways with Lancashire and South Cumbria Foundation Trust (LSCFT).
- Refreshed support to continue to strengthen internal ED processes to manage maximum time in department to 12-hours from arrival to discharge. This includes activation of enhanced escalation during surge and work in progress to finalise additional bed capacity on wards (Led by the Chief Nurse).
- Improve Multi-disciplinary Team (MDT) compliance against the agreed ward discharge process based on the best practice discharge bundle and board round effectiveness. A clinically led safe discharge MDT steering group in place.
- Clinical engagement with the required compliance to agreed standards and change plans ensuring ownership for discharge planning on admission.
- Sustaining community response services for both step-up (admission/attendance avoidance) and step down (timely discharge facilitation) care to maximise opportunities for admission avoidance and reduce demand for inpatient beds.
- Manage acute beds No Medical Criteria to Reside (NMC2R) to less than 10% of bed base with a stretch target of 5% of bed base in line with national requirements to maximise acute bed capacity for appropriate acute needs.
- Winter arrangements include the opening of a further escalation ward in December once the fire prevention works is completed and the Heart Centre is in place.

Oversight arrangements:

- Weekly operational meetings to monitor progress against KPIs, chaired by COO /Deputy COO.
- Monthly outpatient improvement group chaired by the Executive Director of Service Development and Improvement plan with Patient and Public Panel representatives.
- Theatre Utilisation Improvement Board in place and aligned with GIRFT requirements, targeting over 85% utilisation.
  Governance processes have been reviewed around theatre utilisation and introduced support and challenge sessions with the Chief Operating Officer and Deputy Medical Director for Performance for any specialties that do not achieve trajectory as intensive support.
  Embedding Elective Productivity and Improvement (EPIG) jointly chaired by Chief Operating Officer/Deputy Chief Operating Officer and Director of Service Development and Improvement to oversee the delivery of all elective care standards.

Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as gaps in controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.

Mitigating actions: actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.

Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Activity 109% of 2019-20 levels not achieved consistently.	The controls and weekly monitoring taking place to work towards the achievement of the 107% of 2019/20 activity.	Chief Operating Officer	March 2025	Work is going to determine achievement against this for 2023/24 but not 109 was not achieved due to industrial action, Cerner implementation and emergency pressures. Pans are in place to achieve in 2024/25.	A
2	Diagnostic clearance to 95% of patients receiving a diagnostic test within 6 weeks of referral by March 2025.	Implementation of Modality level delivery plans.	Chief Operating Officer	March 2025	ICS wide modelling completed, and discussion are ongoing around mutual aid to across the Lancashire and South Cumbria area ensuring patients have equity of access. The Trust continues to performance better than the national average and a trajectory is in place to meet the 95% standard by March 2025 in the in-line with the planning guidance. Endoscopy remains the biggest pressure area, but recovery plans are in place and monitored by the Chief Operating officer.	A

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					April and May – Echocardiogram, performance has deteriorated due to staffing levels due to sickness – recruitment being undertaken to address workforce challenges and improve performance	
3	Meeting Cancer Standards **National Ambition for the standards** 62 day – 70% by March 2025 31 day – 96% 28 day – 75% (77% by March 2025	Joint work with the Cancer Alliance on improvement Continued Tumour site level detail to prevent backlog Continued transparency of backlog delays at tumour site level for targeted preventative interventions Refresh of the cancer action plan to focus on delivery of faster diagnostic standard, 31 and 62-day standards.	Chief Operating Officer	March 2025	. Achieving trajectory for faster diagnosis standard, developing a trajectory for 31-day standard and working to get back on trajectory for 62-day standard and exploring external support. Cancer action plan refreshed and updated and monitored through the Cancer Steering Board The Trust achieved the agreed trajectory and this i now part of Business-as-Usual Management so can be removed. April Performance 73.90% 62-day standard 92.60% - 31-day standard 78.3% - FDS standard	A
4	Outpatient, Elective and Productivity	Outpatient Transformation Review to be undertaken. Review and improve booking processes as part of the Trust QI process ensuring standardisation across all outpatient areas. Elective Improvement Productivity Group to be established (EPIG)	Chief Operating Officer	March 2024	Review completed and high-level transformation plan has been shared and agreed at Finance and Performance committee. Next steps will be implementing EPIG to monitor improvements in productivity.	G
5	Maintain capped theatre utilisation at a minimum of 85%	Performance oversight and support Sustain improvements in achieving specialties and intensive support for other specialties	Chief Operating Officer	April 2024	As of week of 28th January the theatre utilisation report has now been built and we are able to obtain and monitor our performance for both capped and uncapped theatre utilisation. The BI and operational teams continue to monitor for data quality issue and areas requiring improvement The Division has actions they are undertaking to improve performance for both capped and uncapped theatre utilisation Performance for Capped Theatre Utilisation was at 84.6% for week ending 25th February. Due to information only recently been made available and the Divisional able to identify actions to improve and sustain performance the due date has been extended to April 2024 The Trust is now submitting theatre utilisation data to Model Hospital and performance is back to pre Cerner levels. This is closely monitored by the Chief Operating officer and oversight will be provided by the EPIG. June 2024 Theatre Performance (up to 16th June) Capped 86.96% Uncapped 93.75% Work continues to further improve capped performance	**G**

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
6	Continued risk of >78 week RTT breaches and risk of not delivering < 65 week maximum wait by March 2024.	Demand and capacity at specialty review completed with improvement actions Consultant and Junior Doctor strikes remain a risk to delivery. Mitigating plans in place focusing on clinical urgency, cancers and long waits as priority groups for any residual activity during this time. Rescheduling managed a working day before the strike to ensure managed displacement of slots.	Chief Operating Officer	September 2024	There are daily meetings with divisional reps on managing all patients at risk of breaching 78 and 65 weeks. The new planning guidance has altered the target for managing <65-week maximum wait from March 2024 to September 2024 The Trust has achieved the revised trajectories set for April - 207 against a trajectory of 307 May – 274 against a trajectory of 274 Daily monitoring continues as we work towards elimination of 65 weeks waits by September 2024.	**A**
7	Improved ED processes for managing to a maximum of 12-hours total time from arrival to discharge, transfer or admission to ward	Support consistent compliance to agreed internal ED processes to ensure timely senior reviews, decision making and use of alternative pathways including a stronger focus on reducing delays for patients on non-admitted pathways. Support timely access to ward admissions from ED through the improvement in flow principles and the Trust escalation capacity for managing a time limited surge/overcrowding in ED Ensure patients are streamed to alternative pathways and services.	Executive Director of Integrated Care Partnerships and Resilience / Chief Operating Officer	End of March 2024 Continued into 2025 as a result of the demand on ED and long waiting times due to beds.	Improvement Wall situated within ED and viewed by Execs weekly. There is a daily Executive led meeting to ensure exec oversight. Actions in place also include continued acute physician in-reach to the ED to support post take management plans for clinical decision making and treatment. Extending the footprint within ED by relocating Ambulatory Care and delivering the Urgent Treatment Centre in the Ambulatory Care department. Introduction of a new Acuity Triage model should improve the time to triage and support streaming patients into alternative pathways. Working with NWAS colleagues to book patients into UTC appointments slots where clinically appropriate.	A
8	Strengthen ward discharge bundle and clinical ownership for timely discharges	Embed the discharge bundle across all wards with clinical champions to promote best practice. Release the discharge matron colleagues from community bed management functions to enable a dedicated focus on pathway 0 discharges and ward support for preparing pathways 1, 2 and 3 patients for the community teams to case manage.	Executive Medical Director/ Executive Chief Nurse/Executive Director of Integrated Care Partnerships and Resilience	End of March 2024 New deadline set due to the ongoing implementation and learning from Cerner and refocusing on Everyday Matters to support safe and timely patient flow/discharge.	The Discharge care bundle is now commonly referred to as the discharge checklist following the implementation of Cerner millennium in June last year. The learning from a paper-based format moving to electronic was valuable and we now have a greater opportunity to monitor compliance towards the checklist being completed and ensuring the patient received a Safe, Personal and Effective discharge. We have noticed an improvement in compliance since the transition. A ward level discharge dashboard to support and embed improvements Following the implementation of the new EPR Cerner Millenium, a further test for change took place, with the creation of the live ward/organisational level discharge dashboard. A series of adjustments have been made to the electronic scrip, to include good practice around the SAFER principles in particular long length of stay reviews and NMC2R. This will be rolled out trust wide now the test and adapt phase had been successfully completed. A communication and engagement plan has now begun, kick starting at the April Nursing and Midwifery forum. The roll out will take approximately 8 weeks.	A
9	Bed model for medicine suggests a gap of around 100 beds (including the 53 de-escalated beds). This is further exacerbated with the immediate need to create decant wards at BGTH and RBTH sites resulting in a 53-bed reduction from 17th April 23.	Monitor impact of 53 bed reduction. Increased efforts around pathway 0 discharges with the discharge matron team. Continued admission avoidance via ED and SDEC pathways as well as IHSS team.	Executive Director of Integrated Care Partnerships and Resilience/ Chief Operating Officer	May 2024 due to impact of Heart Centre works being completed.	Bed model in place. Further work around non-elective LoS at specialty level in progress although overall LoS is within national average. CCU and B18 will relocate to new Heart Care Unit May 2024, This will create additional bed capacity but workforce resource will be required. Winter plan confirms the mobilisation of a winter escalation ward (B6) at the	**A**

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
		Home including rehab as a default for pathways 2. Increased use of pathway 1. Use of escalation beds and trolleys when required in extreme pressures			RBTH site from December 2023 – this has been extended into July Board approval a further 15 community beds will be mobilised with the transfer of the Albion Mill site from LSCFT to ELHT. This will be pilot scheme and aiming for go live date in April 2024 BGH Essential fire works continue with Ward 16 operating from Ward 22, loss of 27 beds. June – Bed modelling now complete and with Divisions to review the outputs Ward at RBH will become available in June following the completion of essential fire works	
10	Ambulance handover times	As part of an LSC collaboration the Trust is working with NWAS colleagues to improve ambulance handover times, admission avoidance and direct streaming to alternative pathways and service	Chief Operating Officer	End of March 2025	As part of the 2024-25 planning, the Trust is committed to improving ambulance handovers within 30 minutes. Working collaboratively with NWAS colleagues on handover times and processes including the improvement of the HAS compliance data There has been an improvement of patients' handovers within 30 minutes and HAS compliance in April and May . Our Service Development and Improvement are working alongside the ED & community team and NWAS representatives on improvement schemes to avoid conveyance, direct to Same Day Emergency Care services and direct into appropriate community services Early indications show that the UEC test of change pilots established and are showing encouraging results in diverting activity to alternative provision.	A
11	Temporary lack of data, including theatre utilisation data as a result of the implementation of Cerner (this was an expected outcome of the implementation of the system).	As a first step there is a need to rebuild all operational reports to the previous standard, with the second stage of the work to improve upon the quality of reports.	Chief Operating Officer/Chief Nurse	End of Jan 2025	The BI team continue to work internally and with Cerner on on-going data quality issues and monitoring through data quality reports. Issues are managed as identified. There is considerable work ongoing and mitigation in place around the UEC pathways, particularly regarding redefining datasets. An Executive Director led assurance meeting has been established and is chaired by the Chief Nurse to consider improvements within ED. In January a triple A system is being established which will also consider datasets and will be led by the Chief Nurse, Executive Medical Director and Chief Operating Officer. The Trust BI team are now able to pull reports there are still data issues and operational managers with BI senior analysts are working together to establish resource requirements to ensure data within Cerner is accurate and duplications are corrected.	A

BAF Risk 4 – Culture Workforce Planning & Redesign

Risk Description: The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of its inability to attract and retain staff through our compassionate wellbeing, equality, diversity and inclusion and improvement focused culture.

Executive Director Lead: Executive Director of People and Culture

Strategy: People Plan

Links to Key Delivery Programmes: People Plan Priorities

Date of last review: Board Strategy Session, 6 June 2024

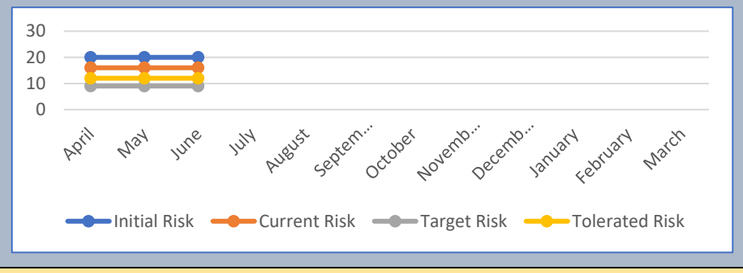
Lead Committee: People and Culture Committee

Links to Corporate Risk Register:

Risk Number	Risk Descriptor	Risk Rating
9746	Inadequate funding model for research, development and innovation	**16**

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: **C4 x L4 = 16**
Initial Risk Rating: C4 x L5 = 20
Tolerated Risk Rating: C4 x L3 = 12
Target Risk Rating: C3 x L3 = 9



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Open/High

Controls: (What mechanisms, systems, rules, and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact)

- Freedom to Speak Up (FTSU) Guardian and Ambassadors – in line with the national FTSU agenda. They report to the Staff Safety Group, People & Culture Committee and Trust Board.
- Agreed Integrated Care System (ICS), place-based workforce plans and Trust People Plan– The ICS plan stratifies actions to be delivered at organisation, place, and system level. The plan is monitored through the ICB People Board. Operational issues from these forums are picked up through the Executive team and reporting on progress is provided through the quarterly workforce report to the People and Culture Committee.
- The Trust People plan is operationally delivered through the Senior Leadership Group (SLG) and Divisional Management Boards (DMBs) and delivery is accountable through People and Culture Committee (PCC) as part of the Trust workforce report. This also forms part of the workforce section of the Integrated Performance Report (IPR).
- There is an agreed ICB Workforce Strategy that will be managed and delivered through the ICB People Board.
- Health and Wellbeing – a comprehensive health and wellbeing strategy and offering in place and leading the ICS Enhanced Health and Wellbeing and occupational health workstream. This is monitored through the One LSC governance structures. Regular updates are provided to the Board on wellbeing and a NED wellbeing guardian is in post.
- Department of Education, Research, and Innovation (DERI) Strategy clearly articulates the ambition of the Trust to support workforce, research and innovation to make the Trust a more attractive place to work. DERI reporting to the PCC.
- Recruitment – multi-disciplinary recruitment steering group in place, meeting monthly, to review vacancies and recruitment activity. Currently reviewing international nursing plan, with a view to reducing/ceasing as we are nearing zero registered nursing vacancies and have robust pipelines through domestic recruitment and newly qualified. Close work between Divisions, HR and DERI around education opportunities (nursing associates, apprenticeships), as well as centralised, value-based recruitment and development of new Healthcare Assistants. Medical recruitment group also in place and opportunities around medical apprenticeships ongoing – likely to commence September 2025.

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

<u>Service delivery and day to day management of risk and control:</u>

- International Recruitment Plan, along with more traditional recruitment pipelines will achieve the Trust goal of zero Registered Nurse vacancies by the end of Q2, 2024/25. Plans in place beyond this to maintain appropriate numbers/skills of registered professionals through universities, apprenticeships, and domestic recruitment.
- The Trust's Staff Safety Group oversees the day-to-day operational risks and interventions to ensure staff safety matters are addressed.
- Eight Staff Networks, each are supported by an Executive Lead and Non-Executive Champion and reporting through the Inclusion Group:
  - BAME,
  - Women's,
  - Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+),
  - Disability and Wellness,
  - Mental Health
  - Muslim
  - Overseas and International Staff Support
  - Armed Forces Veterans & Families
- The Chief Executive is the Executive Sponsor for the BAME Network and Anti-Racism Framework.
- Anti-Racist Framework and Allyship Framework launched as part of the Festival of Inclusion in 2023 and a working group established to embed during 2024.
- Freedom to Speak-Up (FTSU) – the Trust has FTSU Ambassadors embedded across the organisation to support the FTSU Guardian in enabling staff to raise concerns. The Trust continues to recruit new Ambassadors to increase access and fill gaps caused by turnover, including discussions with our local BMA representative about increasing the number of FTSU Ambassadors within the medical workforce.
- MIAA (internal) audit of the FTSU service in December 2022 gave substantial assurance.
- FTSU included within the Trust's mandatory training programme.

BAF Risk 4 – Culture Workforce Planning & Redesign

• Anti-racism - Project team (Aarushi) established as part of the CQA with support from the improvement team taking forward four themes. BAME network engagement underway on antiracist statement, framework and draft strategy led by Aarushi leads, Campaign support being provided by communications team. Health equity training piloted with ops teams to be rolled out by HE Lead and Inclusion Team with support/ eLearning to be developed by Marmot foundation. Developing an EDI dashboard which will support Trust and Divisional EDI goals. Regular updates to be provided in the overall EDI update paper that will come to the PCC and to Board. Establishment of work programmes is underway including inclusive recruitment, talent management, anti-racism campaign	• Continued expansion of the Team Engagement and Development (TED) Tool across the organisation enabling teams to manage team culture. • The Trust's Behaviour Framework continues to be embedded across the organisation and is now integrated into the recruitment and appraisal processes. • Flexible working manifesto in place to assist staff and managers in exploring opportunities to work flexibly. • The Trust's Leadership Forum has been established since September 2022 and seeks to engage stakeholders across the Trust and system. • The Trusts new SPE+ leadership programme has been launched with the first cohort nearing conclusion. Roll out of the additional leadership modules has been launched, including a focus on wellbeing for leaders and managers. The Core Management Pathway will launch in Q1 2024/25. • Reviewing Divisional workforce metrics and support through Divisional Performance Meetings. • Further alignment of leadership and Organisational Development (OD) activities to the Safe, Personal, Effective Plus (SPE+) Improvement Practice as part of Trust Improvement Continuum has been scoped and built into Improvement Practice Development Plan. • Recruitment and Retention Group have oversight of the vacancies and risks associated with non-medical staffing – overseen by Senior Leadership of the Trust. Significant progress on data quality, looking at vacancy rates, alongside colleague absence and bank/agency usage. • Job planning panels – have established a job planning scrutiny panel who review medical job plans to ensure that they are all compliant with regulatory guidance. • Medical Recruitment and Retention Steering Group • Project M: support for managers launched in January 2024, through the sharing of practical tools and peer support models • Extension of inclusion elements of workforce dashboard being developed, which can be used in divisional performance review meetings and for presentation at People and Culture Committee. • The Trust is part of Cohort 2 of the People Promise Exemplar Project with NHS England, linking with the regional NHSE Team and Systems Retention Lead and taking forward a 30, 60, 90-day programme of improvement linked to the People Promise to improve retention and morale. The People Promise Manager is now in post. • A review of mental health support for colleagues across the Trust has been commissioned through LSCFT. • Leadership programme in place, including specific work to support members of the workforce who have been internationally recruited. • Close working with DERI around career pathways which is linked to values-based recruitment. <u>Specialist support, policy and procedure setting, oversight responsibility:</u> • Executive Director of People and Culture is involved in a national staff experience forum. • Integrated Care System (ICS) Equality, Diversity, and Inclusion (EDI) collaborative is in place to support the development and sharing of best practice. • Two cohorts of our bespoke, local Mary Seacole Programme (commencing November 2023 and March 2024) are underway, with a total of 28 internationally educated nurses being supported to develop their knowledge and skills in leadership and management. • ICS Culture and Belonging Strategic Group established • ICS OD Collaborative established • Trust Chair and NED EDI lead are members of the regional BAME Assembly. • The Trust is participating in developing the ICS Belonging Strategy. • Recruitment, retention, and staff in post data is monitored through IPR and Quarterly Workforce Report to People and Culture Committee. • Human Resources (HR) Directors Group across the ICS inform and monitor delivery of the system level workforce agenda but also direct Trust activity where collaboration has been agreed or where opportunities have been identified. • Executive Director of People and Culture is the health member on the Lancashire LEP Skills Advisory Panel. • Aarushi Project at ELHT becoming intentionally anti-racist is part of the Clinical Quality Academy programmes of improvement and has agreed scope with executive sponsorship from CEO and a Board development session in June 2024. Communication campaign to be launched after the May local elections and Project Team presenting at a range of Trust forums to raise awareness. <u>Independent challenge on levels of assurance, risk, and control:</u> • WRES and Workforce Disability Equality Standard (WDES) standards are monitored nationally and reported to the People and Culture Committee then to the Trust Board on an annual basis. • Workforce Race Equality Standard (WRES) and Workforce Diversity Equality Standard (WDES) action plans with timelines in place. Regular reporting to the People and Culture Committee and the Trust Board on progress. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust staff networks.

BAF Risk 4 – Culture Workforce Planning & Redesign

	• National Staff Survey reports and benchmarks the Trust's performance against other organisations at a national and regional level. • to the Trust works within the national FTSU framework and is accountable to the National Guardian for delivery. • Reporting to the People and Culture Committee, Trust Board and the ICB People Board on a regular basis to provide assurance and address areas of challenge. • Workforce Plan submission – there is an annual workforce plan submission to the national regulator which is triangulated internally with finance and activity data and aligned to our clinical strategy. This is monitored through the Integrated Care Board (ICB). 2024/25 plan submitted 25 April 2024. • Monitored by NHS England and the ICB on our bank and agency spend, with a requirement to report any breaches of NHSE cap – ELHT has remained within the NHSE cap since October 2023 and zero off-framework since August 2023. • Significant reductions in agency usage of registered nurses have seen over 50 agency nurses join our internal staff bank in the last 3 months. • Workforce elements of Annual Internal Audit Plan agreed. • There is a Bank and Agency Oversight Group in place across the PCB to ensure delivery against the Value Stream Analysis (VSA) outputs. • Internal and ICB vacancy control panels provide oversight on recruitment. • Monthly IAG meetings with the ICB which scrutinise the workforce KLOE.

Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as gaps in controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.

Mitigating actions: actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.

Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Reducing the Trust vacancy gap	To achieve zero registered nurse vacancies and improve turnover through recruitment and workforce transformation activity.	Executive Director of People and Culture	End of September 2024	A recruitment and retention group continues to work towards a trajectory to deliver zero vacancies by September 2024. This group is also developing initiatives to assist in retention of staff through greater flexible careers, flexible working, benefits etc. The Trust is working with colleagues across the ICS to deliver a workforce capacity programme aimed at reducing vacancies and securing future workforce pipelines. Specific work is underway to address shortages in specific roles, leading to fragile services such as diagnostics. International recruitment has been a success, delivering on plans and a decision has been taken to reduce the next intake and review future plans, so as not to impact on opportunities for newly qualified nurses, where we have a very strong pipeline.	G
2	Improve Trust retention levels / Develop Retention Strategy	Implementation of targeted plan to deliver the national People Promise of Flexible Working and development of a Trust Retention Strategy.	Executive Director of People and Culture	September 2024	Work on developing the Trust's retention strategy is ongoing, the strategy to go through Executive Team (July/August 2024) and then be presented to People and Culture Committee (September 2024). A number of pilots have been undertaken regarding team-based rostering which have gone well. This work is ongoing, particularly around the exploration of further flexible working opportunities and the Trust wishes to build on the learning from the National People Promise exemplars. The Trust is included in the second cohort of exemplar Trusts, and this will inform this work. The Trust's People Promise Manager commenced in post in May 2024. This will provide an additional focus and access to a network of national, regional and system level colleagues to enable spread of learning. PID submitted to NHS England and regular reports of progress will be brought to PCC, Staff Sponsor Group to ensure we are monitoring impact. A People Promise update will be provided to each of the People & Culture Committee meetings for the duration of the programme.	G

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
4	Risk of staff leaving the NHS due to burnout.	On-going delivery of the ELHT People strategy underpinned by a compassionate and inclusive culture	Executive Director of People and Culture	A milestone report wo be provided to the People and Culture Committee in September/ November 2024	The People & Culture Directorate continue to explore how staff can be further supported during this ongoing period of unprecedented demand. Given the on-going need identified regarding supporting staff with their mental health an external review has been commissioned to review the existing staff mental health pathways and interventions. This work is due for completion by 12 July 2024 Project M – a peer support group for line manager wellbeing was launched in January 2024 by the CEO with 300+ managers engaged with the sessions. The LSC occupational health and wellbeing collaborative programme has been identified as one of the functions to move across to OneLSCc. PCB OH and Wellbeing services are currently scoping a future service specification in readiness for the future model. People Promise Exemplar programme – project initiation includes a pilot project linked to burnout, full project plans to be completed by August 2024. Line manager development in pipeline with people promise induction for new managers due to commence on 25 July 2024, with monthly sessions thereafter. Wellbeing for leaders programme is now available in the Trust (NHS England).	A
5	Risk of loss of service due to national industrial action.	Ongoing management of action through Industrial Action Cell.	Executive Director of Integrated Care, Partnerships and Resilience	Ongoing with next update to the Board in July 2024.	The potential impact of any industrial action is monitored through the Industrial Action cell which now meets as/when action is called. The remaining issues relate to Junior Doctors, who retain a live mandate (supported by BMA, HCSA and Unite). The Trust awaits details of the 2024/25 pay award and once published, the response of trade unions. Further local issues have been experienced in Path Lab, with recently called (early April) industrial action stood down. The strike mandate has now expired and improvement work is showing positive outcomes. Industrial action is a standing item at the People and Culture Committee.	G
6	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients due to the specific impact of racism.	Trust becoming anti-racist. Progress being made through using improvement science, adoption of NW BAME Assembly framework. Programme of transformational culture change to be developed through allyship as a journey of development.	Executive Director of People and Culture	End of March 2025	**Anti-Racism** Project team established with support from the improvement team taking forward four themes and targeting work to within Family Care Division in first instance. CEO as Executive Sponsor. Diagnostic work underway to support the design of a board development session in July. Campaign support being provided by communications team for launch in July (after the elections). Too Hot to Handle report – review ongoing by HR, EDI, FTSU and Staff Side in respect of cases at ELHT to ensure we reflect on practices and ensure we learn from these findings, through our existing monthly case review meetings and Professional Standards Group Trust is developing an EDI dashboard which will support EDI goals by end of August 2024 Aarushi Project team presenting at different forums within the Trust to raise awareness before the full campaign is launched in July 2024.	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Regular updates to be provided in the overall EDI update paper that will come to the PCC (July) and to Board.	
7.	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients due to protected characteristics.	Development of a culture of inclusion and belonging. Ensuring that inclusion is embedded as everyone's business. Person-centred approaches to people practices, through informed and engaged line managers. Processes for reasonable adjustments are improved and embedded. Vibrant staff networks.	Executive Director of People and Culture	End of March 2025	**General** Review of terms of reference for the Inclusion Group ongoing, with a draft produced in June 2024, alongside a 12-month draft workplan, both of which will be tabled in July 2024. The Inclusion Group is now chaired by the Trust Chairman and future agendas are to be co-produced. **Inclusive recruitment** - A working group has been formed, initial meetings in June 2024, to review attraction, recruitment, selection and progression, through an inclusion lens. The outcome will be a manager toolkit and updated manager training, focussing on quality and inclusion, with changes made to policy based on improvement work. Initial pilot of toolkit to take place in July 2024, finalised toolkit and training by end of November 2024. **DAWN** Following valuable feedback through the People & Culture Committee staff story and a recent presentation to Executives, a working group has been formed to improve how we support colleagues with a disability, including making reasonable adjustments in a timely manner. An initial meeting was held on 25 June 2024to commence a QI. **Mental Health** Review into the provision of MH support for colleagues is underway following the MH staff survey carried out by the network. **Neurodiversity** TAFG in place for 12 months and has recently become a network. Aim is for group to lead the development of a positive culture regarding neurodiversity including a toolkit, training, and support. A hidden disabilities project has launched with greater awareness in key teams like people and culture, awareness for line managers. **LGBTQ+** The Network is aware of the impact of national messages related to gender identity having a negative impact on wellbeing of the community. It will join with system partners to advance LGBTQ+ inclusion and help to develop the allyship framework for the Trust whilst the future of the Rainbow Badge accreditation becomes clearer. **Women's Network** Is supporting the advancement of the Sexual Safety charter in the Trust which is being led by the Head of Safeguarding with support from HR and other teams.	A

BAF Risk 5 – Financial Sustainability

Objective: The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Providing VFM needs to be explicit in the descriptor

Executive Director Lead: Executive Director of Finance

Strategy: Finance Strategy

Links to Key Delivery Programmes: Waste Reduction Programme

Date of last review: Board Strategy Session, 6 June 2024

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR):

Risk ID	Risk Descriptor	Risk Score
10082	Failure to meet internal and external financial targets for the 2024-25 financial year	25

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: **C5 x L5 = 25**

Initial Risk Rating: C5 x L4 = 25

Tolerated Risk Rating: C5 x L3 = 15

Target Risk Rating: C5 x L2 = 10

Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/Moderate

Controls: (What mechanisms, systems, rules and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact)

Organisation

- Financial Recovery plan in place including additional Trust level controls, weekly Executive led meetings with each Division, Executive led workforce control, vacancy freeze and current stop on all non-essential spend
- Medium term financial strategy to Finance and Performance Committee in October 2023 and Trust Board in November 2023
- Financial plans for 2023-24 developed via annual planning process, signed off at the Trust Board in July 2023.
- Revised forecast for 2023-24 submitted to ICB and national team (early December 2023)
- Divisional financial recovery plans in place and overseen by the Executive Director of Finance as well as lead Directors, reviewed at Financial Assurance Board
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations. The last review was completed in April 2023.
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Waste Reduction Programme (WRP) are reported and scrutinised through the monthly Finance Assurance Board with Executive and cross-Divisional team representation, Capital Planning Board chaired by the Director of Finance, and Finance and Performance Committee, sub-committee of the Board.
- Planning guidance awaited for 2024-25. Draft plans submitted to Finance and Performance Committee.

System

- System finances monitored through System Finance Group (includes representation of all providers and Integrated Care Board (ICB)) to facilitate understanding and actions associated with the overall system financial position.
- System improvement Value Stream Analysis (VSA) on bank and agency undertaken in September 2022, identifying further potential savings. Governance structure in place to review progress.
- Central services collaborative programme underway with ELHT confirmed as hosts
- System financial controls implemented from August 2023 (central services recruitment, general recruitment and non-pay controls/thresholds).

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

Service delivery and day to day management of risk and control:

- 2023-24 revised forecast outturn submitted to ICB and national team.
- 2022-23 financial targets achieved in accordance with agreed stretch plan to break even.
- Trust breakeven duty not breached
- Financial plan and delivery of ongoing performance scrutinised via Finance and Performance Committee with key risks identified
- Corporate Risk Register updated for latest financial risks facing the organisation with action plans in place to mitigate risks which are regularly reviewed and updated
- Divisional, Trust wide and system Waste reduction programmes continuing to be developed, savings not fully identified, QIRAs will be completed for all schemes.
- Additional financial controls are in place to reduce spend.
- Financial recovery actions underway.
- In-depth review of the additional financial pressures identified in year have been determined. Mitigations etc will be reported through Finance and Performance Committee.
- Financial controls document has been developed and circulated through the Trust. Trust and ICB additional controls currently applied
- ICB level financial governance through System Finance Group and ICB proposals being reviewed by provider governance.

Specialist support, policy and procedure setting, oversight responsibility:

- Benefits realisation team is now recruited to and is supporting development of a robust benefits realisation framework for the organisation and to support delivery of key projects associated with waste reduction programme and the action plans resulting from the divisional financial recovery meetings
- Corporate collaboration – full participation in all areas and opportunities identified.

BAF Risk 5 – Financial Sustainability

	Independent challenge on levels of assurance, risk and control: • Internal and external audit – agreed internal audit plan for 2023-24, clean Head of Internal audit opinion received, clean external audit of annual accounts for 2022-23. Counter fraud workplan for 2023-24 agreed. • Mersey Internal Audit Agency (MIAA) audit of Care Quality Commission (CQC) Well-led evidence completed • One NHS Finance Towards Excellence Accreditation shows that the finance team's processes and procedures are working. It proves that we have developed a culture where staff feel appreciated, and successes are celebrated. ELHT Finance Team are accredited at the highest level (Level 3). High level of qualified staff in department (53%) with a further 35% in training.

Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as gaps in controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.

Mitigating actions: actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.

Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance.

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	No signed contract nor agreed financial plan for 2023-24	Continue to develop plans for system, region and national sign off, and documenting all risks of reducing expenditure in line with expectations.	Executive Director of Finance	Financial plan will not be formally agreed. Contract – end March 2024	System plan agreed internally but with significant financial risk. Plans received but not accepted/approved. Financial plan signed off by Trust Board July 2023, with full documentation of risks associated with achievement of said plan. Contract work continuing for the year – not currently signed due to continued work on income plans Work has begun on the LSC system financial plan for the next 3 financial years. There are a number of outstanding queries between the Trust and ICB, the Trusts' contracting team are working to address these No further changes will be applied in the current financial year, the focus is to ensure any queries are resolved for 2024-25 Following the implementation of the ePR the activity data issues are being worked through. The Trust has been informed it is not likely to be monitored against the ERF target in year due to the data issues and will be reviewed in May 2024, giving the Trust more time to work through the issues	A
2	Fully identified Waste Reduction Programme (WRP) 2023-24/Financial recovery plan. Risk to elective recovery, quality and safety of stretch target financial plans	Continue work with Divisions and central to develop plan for 2023-24. Ensure all schemes have Quality Impact Risk Assessments (QIRA) assessment, and document risks of non-delivery, cost reduction. Ensure Board oversight of all risks. Ensure safety not compromised.	Executive Director of Finance / Executive Directors	End March 2024	£40m is identified and is being worked up. (74% of the cumulative of the WRP and system gap at £54m) Finance Assurance Board is now chaired by the Chief Executive with full Executive Team presence. Divisional Improvement boards are in place. Revised timeline due to the challenging financial situation.	A
3	Lack of full knowledge of system financial flows recognised in the NHSE review	Work with system CFOs to determine full flows and impact on ELHT	Executive Director of Finance	Q4 2023-24	Remains outstanding – Block contract review underway, part of financial strategy and recovery Work to continue through Provider Finance Groups. Work is ongoing to achieve full transparency There is no further update at this time, a further update will be provided at the March Board meeting. A full contract review will take place as part of the 2024-25 review process.	B

BAF Risk 5 – Financial Sustainability

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
4	ICB/PCB workplan identification and capacity	Work with system to ensure plan developed and capacity gaps rectified and mitigated	Executive Director of Finance	In progress Updates due in March 2024	2 system meetings to identify specifics. Joint meeting CFOs/Operational colleagues to take place. Work on the system roadmap to be continued with new PCB finance lead. An update will be provided to the Finance and Performance Committee in January and to the Board in March 2024.	R

One LSC BAF Risk- ELHT as Host

Risk Descriptor

As Host: Staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services.

As Partner: One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations

Executive Leads: Executive Director of Finance
Executive Director of Service Development and Improvement
Director of Corporate Governance

Strategy: Indirectly links to all and overall Trust strategy.

Links to Key Delivery Programmes: Provider Collaborative

Date of last review: Board Strategy Session, 6 June 2024

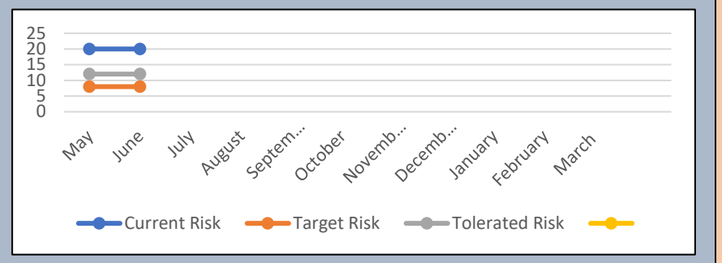
Lead Committee:
Finance and Performance Committee
People and Culture Committee

Links to Corporate Risk Register (CRR):

Risk Rating (Consequence (C) x Likelihood (L)):

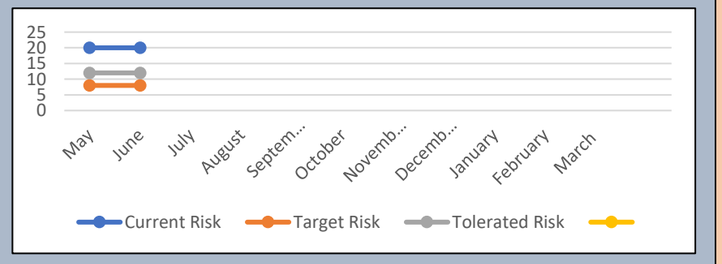
As Host

Current Risk Rating:	**C4 x L5 = 20**
Initial Risk Rating:	C4 x L5 = 20
Tolerated Risk	C4 x L4 = 12
Target Risk Rating:	C4 x L2 = 8



As Partner

Current Risk Rating:	**C4 x L5 = 20**
Initial Risk Rating:	C4 x L5 = 20
Tolerated Risk	C4 x L3 = 12
Target Risk Rating:	C4 x L2 = 8



Effectiveness of controls and assurances:

As Host

	Effective
x	Partially Effective
	Insufficient

As Partner

	Effective
x	Partially Effective
	Insufficient

Risk Appetite: Open/High

Controls: (What mechanisms, systems, rules and procedures do we already have in place that help us to either mitigate the risk from occurring or reduce the potential impact)

The LSC Provider partners and ICB have been working together to identify ways of collaborating (refer to BAF risk 1 for details of collaborative working) on the delivery of central services across the area. This had resulted in delegated powers bestowed by the individual Trust Boards to the PCBJC to deliver on the agreed objectives.

The process included identifying a host Trust (ELHT) with a comprehensive programme for the planned transfer on 1 October 2024.

One LSC Managing Director and senior leadership team in place to work together with the Programme Director and report regularly on progress thorough system and provider governance channels.

Lancashire and South Cumbria Integrated Care System/Board (ICS/ICB):

1. Progress being reported into the Recovery and Transformation Board

Provider Collaborative Board (PCB):

1. Provider Collaborative Board Joint Committee (PCBJC) meeting monthly and regular reporting on progress and decisions sought on delegated items as required.
2. Central Services Executive Sub-Committee (CSESC) as a sub-committee of the PCBJC with a remit for the delivery of the collaborative element for central services under the delegated authority for operational matters. Membership made up of 5 provider CEOs or their deputies who are voting Executive Board members of the provider Trusts.
3. Strategic Collaborative Agreement sets out the high level legal, commercial and governance principles of collaboration amongst the partners. Plans in place for approval by the partners Board and ratification by PCBJC in

Assurances: (This is the confidence we have in the effectiveness of the controls and action plans in place (e.g. regular risk reports, audits, regular monitoring at the Directorate Quality meetings or Risk Meetings etc.)

Service delivery and day to day management of risk and control:
Internal group with a defined terms of reference links into the operational governance via ERAG and Executive Team
Formation of the hosting Board will add an additional layer of governance to ensure seamless service delivery and management and mitigation of risks at host and partnership level

Specialist support, policy and procedure setting, oversight responsibility:
Existing PCBJC and CSESC terms of reference form the foundation of policy and procedure for central services collaboration including system oversight
The emerging governance and performance infrastructure for One LSC (to be in place by September 2024) will add an additional layer to the collaboration infrastructure together with the Strategic Collaboration Agreement, business transfer agreement and supply agreement which need to be agreed by the partner Boards before the transfer date can commence.

Independent challenge on levels of assurance, risk and control:
MIAA as internal auditors will audit the governance and management processes of One LSC
ICB as the regulatory body will also provide a scrutiny of the collaborative arrangements for central services.

advance of the transfer date on 1 October 2024. The governance infrastructure sitting below the SCA is being organically developed with the input of the professional groups.

ELHT

ELHT (as partner and host) has put in place and continues to develop the governance infrastructure to ensure that it delivers on its partner and host obligations. The monitoring of the One LSC and other services hosted by ELHT will be through the hosted services Board, the plans for which are to be in place before the transfer date. Regular monitoring of host and partnership activities and assurance about governance and risk management will occur through the ELHT Board and sub-committee structure and operational groups, such as the Executive Team, ERAG and One LSC Planning Group.

1. Trust Board
2. Audit Committee
3. Finance and Performance Committee
4. People and Culture Committee
5. Quality Committee
6. Executive Team
7. Executive Risk Assurance Group
8. Finance Assurance Board
9. One LSC Planning Group
10. Hosting Board (to be formed)

Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as Gap's in Controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.
Mitigating actions: actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.
Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Strategic collaboration agreement, business transfer agreement and supply agreement has not yet been signed off.	Sign off by all partner Boards before the transfer date of 1 October 2024	Executive Director of Finance Director of Corporate Governance (partners for own Trusts)	End September 2024	Various work through the professional groups with external lawyers continue July Board round will receive the latest draft for socialisation for review with sign off planned for August/September for all partners.	A
2.	Agreement not yet reached with NHSE on the sign off process to establish One LSC from a partner or host perspective.	Continued liaison with NHSE to build on the positive work in relation to the sign off procedure with the regulator.	Executive Director of Service Development and Improvement Managing Director of One LSC	End September 2024	Positive developments following liaison with NHSE on the process for regulatory sign off.	A
3.	The governance infrastructure sitting below the SCA needs to be organically developed with the input of the professional groups. No formal governance structure in place for a number of workstreams at this time and the overall One LSC governance and performance framework which will seamlessly dovetail into the governance processes of the partners organisations	Working through the professional groups and one LSC leadership on a multi-disciplinary approach in finalising the governance infrastructure sitting underneath the SCA. Move from the informal working groups into a more formalised model.	Director of Corporate Governance Managing Director of One LSC Executive Directors for professional groups	End September 2024	A number of regular professional group meetings in place with workgroups planned for August for a multi-disciplinary approach to establish the building components of the governance and operational infrastructure before the transfer date.	A
4.	Establishing the monitoring of the One LSC and other services hosted by ELHT through the Hosted Services Board.	Developing the terms of reference and agreeing them at ELHT level, linking into existing Trust governance processes and socialising with system partners.	Executive Director of Finance Executive Director of Service Development and Improvement Director of Corporate Governance	End September 2024	Work commenced on the Terms of Reference (TORs) and will be taken through the One LSC Planning Group in August and socialising with partners throughout September 2024	A
5.	TUPE transfer and consultation processes and resources are to be determined.	This is dependent on numerous factors, including the resolution of the union grievance.	Executive Director of People and Culture	End September 2024	Progress being made in this area with the professional group leading on advising on the governance for TUPE and constructive engagement with staff. Positive progress with union colleagues with regard to resolving the grievance.	A
6.	Due diligence not yet assessed and will potentially impact the cash position of ELHT as the host.	Commencement of the due diligence with each of the services leads, including asset transfers	Executive Director of Finance Executive Director of People and Culture	End July/ early August 2024	Plans in place for the due diligence process to commence and be monitored through the One LSC Planning Group and Finance Assurance Board, ERAG and Executive Team.	A

One LSC BAF Risk- ELHT as Host

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Board level monitoring through Audit Committee and Finance and Performance Committee.	
7.	Corporate capacity to support the set-up of One LSC is still to be fully scoped and transferred in advance.	Close liaison with Managing Director for One LSC and Directors for confirmation and linking into the One LAS performance and governance framework which is being established.	Executive Directors of all corporate functions	End August 2024/early September	Mapping of processes is being undertaken and progress to be monitored through the One LSC Planning Group	A
8.	Further work to ensure that the communication plan and co-ordination of it delivers its desired objectives and results in positive and constructive engagement with all stakeholders.	Collaborative working with the One LSC MD, SRO for LSCPCB to ensure that the communication plan is enhanced.	Executive Director of Communications and Engagement Executive Director of People and Culture	End July 2024	Discussions at Executive level and system level on the best approach to communication and staff engagement. Monitoring to take place through the One LSC Planning Group.	A

Appendix 1: Risk Appetite Statement 2024-25

2024-25 Risk Appetite Opening Statement (as discussed at Board Workshop on 6 June 2024)

Key context for Risk Appetite Statement 2024-25:

- Impact of demand and pressure on services alongside the financial context has the potential to impact on quality
- Impact of general election is unknown
- Impact of NHS structural reorganisation is maturing but still being felt – the focus now needs to move to delivery
- Some opportunities of the Health and Social Care Act changes have started to support delivery e.g. community services transfer in July, now need to identify and maximise other opportunities
- Top-down performance management system approach
- Health inequality and equity challenges
- National/International financial challenges and impact on public finances and resulting pressure on NHS finances and threat of financial intervention
- Public and patient expectations and our ability to truly engage them
- Workforce – health and wellbeing, workforce planning and transformation
- System strategy – still in development, lack of alignment and too many priorities
- Provider Collaborative – maturity of partnership, delivery of programmes, governance
- Capacity and skills for delivery and pace required
- Quality must not be compromised and needs to further improve

2024-24 Risk Statement

The response to the risk should be in proportion to the level of risk identified and in accordance with the risk appetite and tolerance levels set by the Board of Directors.

As a provider of healthcare services, the Trust generally has a **'minimal'** appetite for risks to the quality and safety of patient care. This also applies to any risks to the health and safety and wellbeing of patients, staff, contractors and visitors.

When any risks to the quality and safety of patient care and health and safety and wellbeing are identified the objective should always be to reduce the risk to as low a level (tolerance) as is practicable before it is accepted, or to avoid it altogether where that is an option.

The appetite of the Trust where risks to its finances, resources or the continuity of its services are concerned is described as **'cautious'**, which means that safe options are preferred. The aim should still be to reduce the risk as far as is practicable, but it is possible that a '**moderate'** level of risk may be tolerated when all circumstances are considered. This would be particularly relevant when balancing these types of risks with safety risks as part of the same decision.

The appetite category of **'open' / 'high'** is applicable where the Trust is prepared to accept a higher level of residual risk than usual in pursuit of potential benefits when considering risks and decisions relating to collaboration, innovation and transformation objectives.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

10 July 2024

Item	**98**
Purpose	Information Decision

Title	Patient Safety Incident Response Assurance Report
Authors	Mr L Wilkinson, Incident and Policy Manager Mrs J Hardacre, Assistant Director of Patient Safety and Effectiveness
Executive sponsor	Mr J Husain, Executive Medical Director

Summary: The Trust Board is asked to receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP) and the outcome of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel decision-making process on high level investigation reports.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do. Invest in and develop our workforce. Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

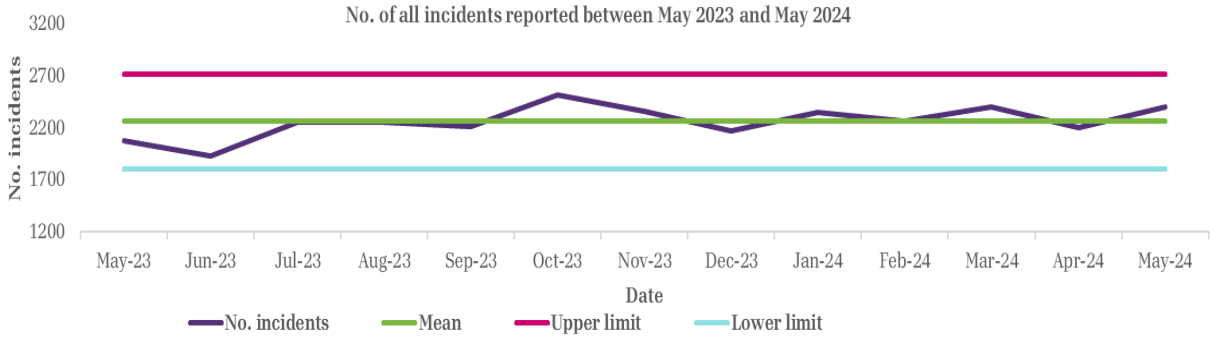
Previously considered by: No formal Committee

Patient Safety Incident Response Framework Report

Reporting Period:		April and May 2024
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group. The last meeting held was 28th May 2024 with 22 members in attendance and the meeting was quorate.
1a.	**Alert**	A Never Event regarding a retained vaginal swab from suturing was reported in April 2024 by Family Care Division. The Division completed a round table investigation where it was agreed that the incident met the Nation Priority of a Never Event. The round table identified immediate safety actions which have been implemented whilst a full PSII in currently taking place. PSII Lead has met with the patient and agree the investigation and report will be completed by mid-August. Any new learning or further safety improvements will be shared with the division.
1b.	**Advise**	The Trust went live with the new national Learning from Patient Safety Events (LfPSE) on 24th June 2024 which replaces the National Reporting Learning System (NRLS). The change to LfPSE incorporates several new questions when reporting an incident and these have been built into the Trust DATIX system and includes not only physical harm but psychological harm to a patient. Due to the changes in harm requirements this may have an impact on how the Trust extracts information for the Patient Safety dashboard. This is currently being reviewed and will be monitored over the next 3 months. Since 1st May 2024, a change has been made to the Datix system to capture contributory factors based on the SEIPS model for all incidents that have been investigated. This data has been used to enhance the review of themes and trends. As more date is gathered over the next few months, it will enable us to begin identifying trends and areas for further exploration and escalation.
1c.	**Assure**	There has been an increase in in the completion of IR2s across nearly all divisions, with all clinical divisions now achieving over 80% compliance. As incidents are completed within a timelier manner allows for quicker identification of any required improvements. The target of 90% has not been set by NHS England but set by ELHT as good practice and a measure of our safety culture. Continued monitoring via the Patient Safety KPI Dashboard.

1. Incident Reporting

1.1 The Trust reports and manages incidents in line with the New National Patient Safety Incident Response Framework. Over the last year, there continues to be expected variation in the number of incidents reported per month. However, reporting levels remain with control limits, this is common cause variation which we would expect with the nature of incident occurrence and reporting.



Graph 1: Incidents reported over last 12 months.

1.2 All harm levels remain below national levels.

1.3 Incidents resulting in death have remained at a consistent level for 3 months, and below the average from the previous year.

2. Duty of Candour

2.1 There have been **0** breaches, of Duty of Candour, as set out in CQC Regulation 20.

3. Safety Incident Responses (IR2s)

3.1 In line with the New Patient Safety Incident Response Framework all incidents not being investigated as a Patient Safety Response, or a Patient Safety Incident Investigation the Trust has set a target that these should be reviewed and actioned within 30 days of reporting. A KPI of 90% has been set and appendix B provides an overview by division.

3.2 There continues to be an improvement in the number of IR2s completed within 30 days, with nearly all Divisions now achieving over 80% compliance.

4. Patient Safety Responses (PSR)

4.1 All incidents that are of moderate or above harm and/or have key safety issues identified, and do not meet the national or local reporting priorities for a PSII are required to have a Patient Safety Response (PSR) completed and are managed within Division. Appendix C provides a breakdown of the number of open PSRs by division and number of any open more than 3 months.

4.2 There has been a reduction in the number of open PSR investigations in most Divisions, however, there has been an increase in the proportion of those that have been open for more than 90 calendar days.

5. Patient Safety Incident Investigations (PSII) National and Local Priorities

5.1 In April 2024 and May 2024, the Complex Case meeting reviewed 26 incidents of which 7 met the PSIRF Priorities for reporting and require a PSII, these have been allocated to lead investigators within the Patient Safety Team. All PSII reports and safety improvement plans are presented at the Patient Safety Incidents Requiring Investigation (PSIRI) Panel for Trust approval and signoff.

5.1.1 A Never Event regarding a retained vaginal swab from suturing was reported in April 2024. The Family Care Division completed a round table investigation where it was agreed that the incident met the Nation Priority of a Never Event. The round table identified immediate safety actions which have been implemented whilst a full PSII in currently taking place. This investigation and report will be completed by mid-August.

5.2 A KPI dashboard of PSIIs is provided is appendix D. At the end of May 2024, the Trust had 24 open PSII incidents of which 4 were being investigated by MNSI.

5.3 At the end of May 2024 there was 1 PSII which had been open longer than 6 months and 2 MNSI reports.

5.3.1 2 x MNSI reports are overdue which are outside of the control of trust. One was received from MNSI in May 2024 and is awaiting the Divisional improvement plan prior to presenting at PSIRI.

5.3.2 At the time of writing the 1 PSII was overdue by a week and has been approved by the Division and now approved by PSIRI on 12th June 2024.

5.4 In April 2024 and May 2024, 10 PSII reports have been approved by PSIRI and closed.

6 PSIRI Panel Approval and Learning from Reports

6.2 During April 2024 and May 2024, of the 10 approved by PSIRI Panel there were 7 new PSII reports, 7 identified learning.

6.2.1 Each baby counts (eIR1258249) – The investigation was completed by MNSI, the report was approved with some amendments required to the improvement plan. The areas identified for improvement identified by MNSI were:

- The Trust to ensure that the categorisation of CTGs occurs at all clinical reviews as part of the full assessment of the condition of the woman and baby.

6.2.2 Neonatal death (eIR1264716) – The report was not approved with some improvements required to sections of the report, further explanations to be included and a review of the recommendations to make them specific. The areas identified for improvements were:

- Parents to be offered the opportunity and be encouraged to accompany baby to NICU as soon as the baby is admitted to NICU.
- Babies in NICU to have vital signs monitored at all times in line with guidance.
- Inotropic support should be commenced promptly and accurately once required.
- Ensure that a nominated Lead professional has a helicopter view of acuity and activity within NICU.

6.2.3 Incident resulting in death (eIR1264250) – The report was approved with no amendments required. The areas identified for improvements were:

- Patients who are referred for endoscopy procedures are prioritised as in line with the national framework.
- Explore how the service can align the endoscopy patient tracking list with the national D-codes outlined in the national framework.
- Explore options as to how the service can amend the endoscopy referral request system to align with the D-codes of the national framework.
- Implement a patient re-review process for delayed endoscopy procedures, this should consider but not limited to the processes outlined in the operational guidance.

- Implement a process to communicate with referrers and patients that provide clarity on likely timescales for an endoscopy procedure and safety netting advice, this should consider but not limited to the processes outlined in the operational guidance.

6.2.4 Incident resulting in death (eIR1263724) – The report was approved with some minor typographical errors and removal of PID required. The areas identified for improvement identified were:

- Introduction of a process of enhanced monitoring via the Divisional Falls steering group wards that have had falls resulting in moderate or above harm.
- The ward involved to provide assurance that it was implemented the Falls Prevention Action Plan.
- Ensure the ward involved submits adequate data to the monthly falls audit, with assurance via the monthly matron's report.
- Ensure that any falls incidents resulting in harm where there have been issues with the completion of falls documentation are linked to the appropriate risk.
- Ensure there is consistent language used in Policy and Guidance related to the levels of enhanced care observation.
- Review the enhanced care audit in conjunction with the falls audit to enable wards to identify where improvements are required.

6.2.5 Neonatal death (eIR1259422) – The report was approved with the dates of completion of action to be reviewed and the addition of one action. The areas identified for improvements were:

- Persistent tachycardia to be included in guidance as an early sign of sepsis to prompt early screening and commencement of antibiotics.
- Sepsis guidance to be updated to include the introduction of sepsis screening for neonates.

6.2.6 Incident resulting death (eIR1260575) – The report was approved, however the improvement plan was not submitted and required review via Chairs action. The areas identified for improvement were:

- Trust to consider making staff training on NEWS and recognition of the deteriorating patient mandatory within basic, intermediate and full life support training.

- Division to support nursing staff to embed the escalation flowchart that has recently been developed to ensure there is freedom to escalate unwell patients to the on-call Consultant.
- Division to support junior doctors with the recognition and escalation of a deteriorating patient without relying on early warning scores.

6.2.7 Incident resulting death (eIR1266439) – The report was approved. The areas identified for improvement were:

- Explore whether the Cerner 'ward/unit' overview of patients situated on a unit/ward can automate the inclusion of the most recently determined enhanced observation risk assessment level.
- Implement a process to enable co-ordinators to maintain oversight of patients who require enhanced observations and ensure these are undertaken.
- AMU to consider reviewing the timing of safety huddles between all roles to support with effective handover of critical information.
- Trust to explicitly define within the relevant systems and policies, which patient dependency information is required to be inputted into the Safer Nursing Staffing Tool.

7 Patient Safety Incident Updates

7.2 The Trust went live with the new national Learning from Patient Safety Events (LFPSE) on 24th June 2024 which replaces the National Reporting Learning System (NRLS). The change to LFPSE incorporates several new questions when reporting an incident and these have been built into the Trust DATIX system and includes not only physical harm but psychological harm to a patient.

7.2.1 As well as going live with LfPSE, since 1st May 2024, another change has been made to the Datix system to capture contributory factors based on the SEIPS model for all incidents that have been investigated. This data has been used to enhance the review of themes and trends.

7.3 The Patient Safety Team have reviewed and updated the Trust Introduction to Human Factors Training which is now available to book on the Learning Hub. To support easier access and attendance the training has been split to two half day sessions and will be delivered over the next 12 months at RBH, BGH and via Teams. The first sessions were delivered on Friday 21st June and will run monthly.

7.4 AQuA are delivering the above training to support staff completing Patient Safety Response investigations on 28th June and 5th July. On completion of delivery the Trust will review feedback on the training provided and developed their own in-house training for PSRs which will be available to book on the Trusts learning hub.

7.5 A review has taken place on the PSII process to look at ways of improving the timescales to complete the investigations which include:

- Complex Case Group TOR (responsible for agreeing which incidents meet the criteria for a PSII)
- The role of the Family Liaison Officer
- Rapid Reviews to be completed on all PSIIs within 5 days to inform any immediate safety improvements required and inform the TOR for the PSII so they are more focused on the key issues.
- Arrangements to make discussion with staff involved in incidents easier and quicker.
- Development of Safety Improvement Plans

8 Mandatory National Patient Safety Syllabus Training Modules

8.2 On 27th February 2023, the National patient safety syllabus training modules 1a, 1b and 2 which the Trust has made mandatory for staff across ELHT. The Trust has seen a positive uptake of the training, figures shown in chart below.

Table 3: Patient Safety Syllabus Training (as of 24th April 2023)

Patient Safety Training Modules	KPI Target	% of staff completed training
Patient Safety Level 1a – all staff	95%	93.60%
Patient Safety Level 1b – Boards and senior leadership	95%	84.40%
Patient Safety Level 2 – Essential to role	95%	88.80%

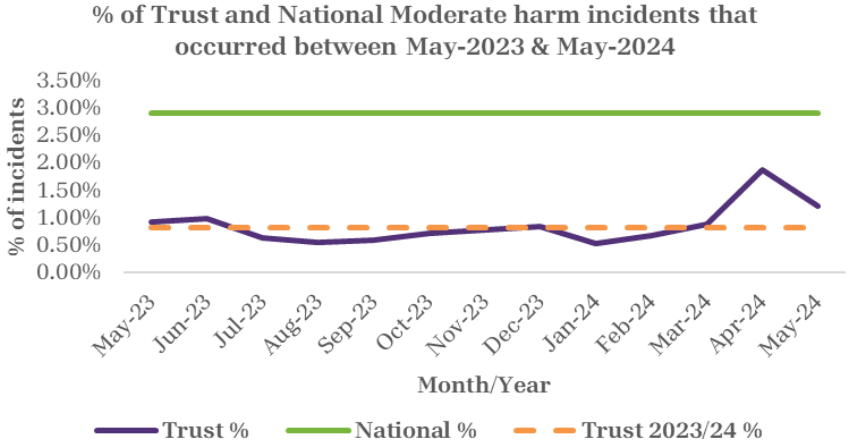
9 Maternity specific serious incident reporting in line with Ockenden recommendations

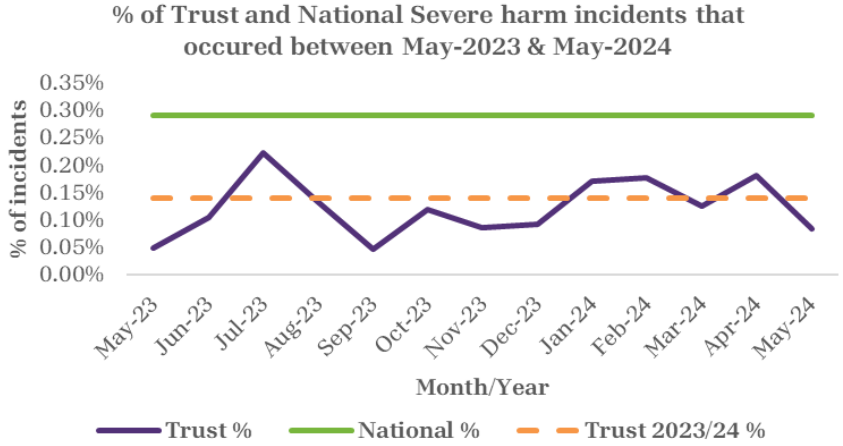
9.2 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 58 maternity related incidents have been reported on StEIS of which:

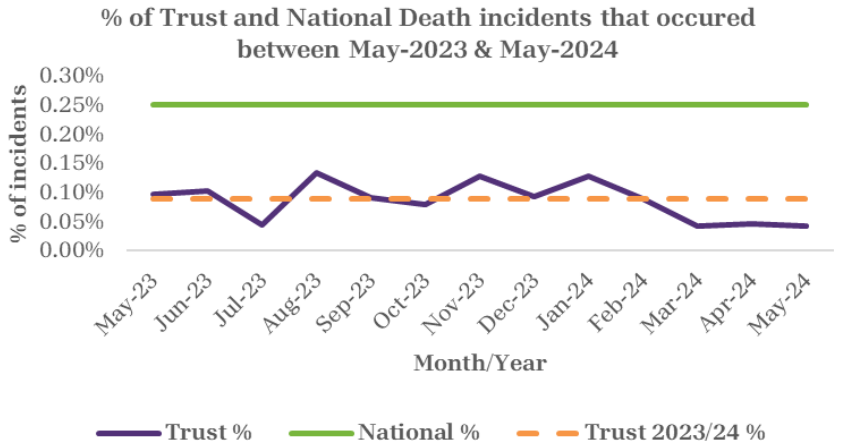
- 37 have been closed by the ICB with learning.

- 14 have been agreed for de-escalation from StEIS.
- 4 are currently being investigated by HSIB.
- 3 are currently under investigation by the Trust.

Appendix A: ELHT Incidents by Moderate harm or above Vs National Average







Appendix B: KPI Dashboards for Safety Incident Responses (IR2)

Division	Number of SIRs (IR2s) by Month Target 90%	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	Trend
CIC	Total IR2 reported	336	368	391	331	306	362	314	410	378	341	315	
	(total number investigated) % complete within 30 calendar days	(284) 84.52%	(303) 82.34%	(348) 89.00%	(300) 90.63%	(283) 92.48%	(313) 86.46%	(247) 78.66%	(354) 86.34%	(333) 88.10%	(300) 87.98%	(281) 89.21%	↑
DCS	Total IR2 reported	122	141	128	139	174	143	148	138	129	110	112	
	(total number investigated) % complete within 30 calendar days	(77) 63.11%	(91) 64.54%	(76) 59.38%	(75) 53.96%	(99) 56.90%	(90) 62.94%	(104) 70.27%	(101) 73.19%	(90) 69.77%	(85) 77.27%	(93) 83.04%	↑
FC	Total IR2 reported	238	330	253	252	348	307	245	237	221	284	283	
	(total number investigated) % complete within 30 calendar days	(154) 64.71%	(225) 68.18%	(201) 79.45%	(171) 67.86%	(259) 74.43%	(173) 56.35%	(193) 78.78%	(177) 74.68%	(185) 83.71%	(222) 78.17%	(228) 80.57%	↑
MEC	Total IR2 reported	796	883	885	877	926	880	947	947	915	992	903	
	(total number investigated) % complete within 30 calendar days	(578) 72.61%	(629) 71.23%	(624) 70.51%	(601) 68.53%	(732) 79.05%	(772) 87.73%	(793) 83.74%	(823) 86.91%	(762) 83.28%	(863) 87.00%	(762) 84.39%	↓
SAS	Total IR2 reported	386	457	385	391	542	425	346	415	397	434	344	
	(total number investigated) % complete within 30 calendar days	(252) 65.28%	(332) 72.65%	(248) 64.42%	(264) 67.52%	(366) 67.53%	(332) 78.12%	(270) 78.03%	(304) 73.25%	(335) 84.38%	(291) 67.05%	(276) 80.23%	↑
Corp	Total IR2 reported	40	70	53	78	79	78	69	82	89	83	87	
	(total number investigated) % complete within 30 calendar days	(16) 40.00%	(34) 48.57%	(20) 37.74%	(55) 44.87%	(44) 55.70%	(39) 50.00%	(14) 20.29%	(40) 48.78%	(44) 49.44%	(37) 44.58%	(47) 54.02%	↑
Trust Total	Total IR2 reported	1918	2249	2095	2068	2375	2195	2069	2229	2129	2244	2044	
	(total number investigated) % complete within 30 calendar days	(1361) 70.9%	(1614) 71.7%	(1517) 72.4%	(1466) 70.8%	(1783) 75.0%	(1719) 78.3%	(1621) 78.3%	(1799) 80.71%	(1749) 82.15%	(1798) 80.12%	(1687) 82.53%	↑

Total number of IR2s open on DATIX over 30 calendar days old						
Division	CIC	DCS	FC	MEC	SAS	Corp
No. open	20	33	56	127	107(30*)	267

* Number of 104-day cancer breaches which require a clinical harm review and can take longer than 30 working days to complete.

Appendix B: KPI Dashboards for PSRs

Division	Number of PSRs open	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Trend >90
CIC	No. open	41	41	43	26	47	51	73	47	29	39	55	40	→
	No. open more than 90 calendar days	15	5	7	6	7	2	2	7	5	7	5	5	
DCS	No. open	6	8	11	11	17	19	19	19	21	7	9	8	↓
	No. open more than 90 calendar days	1	1	4	6	9	4	2	3	5	2	1	0	
FC	No. open	28	35	33	27	36	43	43	40	47	40	53	54	↑
	No. open more than 90 calendar days	13	13	14	15	11	13	12	12	16	9	11	17	
MEC	No. open	83	118	135	157	168	141	105	107	125	94	124	115	↑
	No. open more than 90 calendar days	25	25	36	39	45	28	12	19	15	16	18	24	
SAS	No. open	44	49	41	49	55	57	71	76	60	56	51	50	↑
	No. open more than 90 calendar days	1	9	12	11	13	11	21	19	15	16	13	17	
Trust	No. open											292	277	↑
	No. open more than 90 calendar days											48	66	

Appendix B: KPI Dashboards for PSIIs

PSII reports (including HSIB/PMRT)	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Total / Trend
No. incidents at Complex case	22	20	21	22	31	25	20	31	32	41	23	3	291
No. incidents agreed as PSII including (MNSI was HSIB)	5 (2)	2 (0)	1 (0)	6 (0)	3(2)	0	1(0)	4(1)	3	5	5	2	39 (5)
No. over 6 months	3	6 (2)	10 (2)	10 (2)	8(2)	6(2)	7(4)	5(4)	6(5)	6(4)	5(3)	3(2)	↓
Total No. of PSIIs Open including (MNSI was HSIB)	30 (6)	29 (4)	29 (4)	32 (5)	28(6)	26(6)	24(6)	19(5)	23(6)	23(4)	25(4)	24(4)	↓
No. approved/closed by PSIRI including (MNSI was HSIB)	3 (1)	3 (1)	0	3 (0)	5(0)	2	4	9 (2)	4	5	5	5	48 (4)

TRUST BOARD REPORT **Item** **99**

10 July 2024 **Purpose** Approval / Assurance / Information

Title	Maternity and Neonatal Services Update
Report Author	Miss T Thompson, Divisional Director of Midwifery and Nursing (Maternity Safety Champion)
Executive sponsor	Mr P Murphy, Executive Director of Nursing. (Board Level Maternity/Neonatal Safety Champion)

Summary: The purpose of this report is to provide:
1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Maternity Safety Ambition, specifically relating to the ten CNST (Clinical Negligence Scheme for Trusts) maternity safety actions included in year six of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. (Appendix 1 - CNST year 6 criteria)

2. Updates regarding ELHT (East Lancashire Hospitals Trust) maternity services response to the NHS England/Improvement (NHS E/I) – Ockenden review of maternity services/Three-year plan
3. Safety intelligence within maternity or neonatology care pathways and programmes that pose any potential risk in the delivery of safe care to be escalated to the trust board.

4. Continuous Quality and Service improvements, progress with celebrations noted.

Recommendation: The Board of Directors are asked to.

- Receive and discuss the CNST-MIS update, all compliance reports, and recommendations for year 6 quarter one
- Provide bimonthly reporting to ELHT trust board with any barriers that may impact on the implementation and longer-term sustainability plans and deliverables aligned with the maternity and neonatology safety
- Discuss any safety concerns with Trust board members aided by floor to board agendas further guided by the Executive and non- executive board safety champions.

Report linkages

Related Trust Goal	Deliver safe, high-quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse, and highly motivated people Drive sustainability	
Related to key risks identified on Board Assurance Framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.

	2 The Trust is unable to fully deliver on safe, personal, and effective care in line with the requirements of the NHS Constitution, relevant legislation, and Patient Charter.
	3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
	4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) because of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
	5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor (None)
Related to recommendations from audit reports	Audit Report Title and Recommendation/s (None)
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to Maternity incentive Scheme (MIS) Year 5.
Related to ICB (Integrated Care Board) Strategic Objective	State which ICB Strategic Objective the paper relates to continue to deliver on the National Maternity and Neonatology Safety Ambition.

Impact

Legal	Yes/No	Financial	Yes/No
Equality	Yes/No	Confidentiality	Yes/No

Previously considered by:

1. INTRODUCTION

The purpose of this report is to provide:

1. An overview of ELHT maternity and neonatal quality and safety programmes resulting from national policy and Maternity and Neonatology safety ambitions. The Secretary of State's ambition to halve the number of stillbirths, neonatal deaths, maternal deaths, and brain injuries by 2025 is a key focus. This will also include a reduction of the pre-term birth rate from 8%-6% by 2025.

2. A monthly progress summary with any exceptions will be evidenced at ELHT trust boards with clear plans specifically relating to the ten CNST maternity safety actions included in year six of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. **(Appendix 1)**

3. Regular updates regarding ELHT maternity and neonatology services in response to the NHS England/Improvement (NHS E/I) – Full Ockenden review, Three Year Delivery Plan and neonatal critical care review are submitted to sub-group Quality Committee to inform Trust Board.

   This bi-monthly assurance report will be submitted to the ELHT Board of Directors for appropriate assurance, oversight, monitoring and escalation within the maternity and neonatology services.

2. CNST - MATERNITY INCENTIVE SCHEME

2.1 Summary overview

Green indicates progressing without concern

Orange indicates barriers/ risk to compliance identified

Red indicates non-compliance identified

Safety Action	Progress	Progress update to present & Comments
1. Perinatal Mortality Review Tool (PMRT)		● All deaths from the 8th of December 2024 (start of the Y6 reporting period) required deadlines have been met above the required % compliance thresholds. See dashboard in report below. ● Q1 PMRT will cover Apr-Jun cases and will be reported to September Trust Board.
2. Maternity Services Data Set (MSDS)		● July 2024 will be the month reviewed for compliance of this safety action. ● Continued review of the published scorecard monthly. See most recently published monthly dashboard below.
3. Transitional Care (TC)		● Q1 audit Apr-Jun will be complete and submit to September Trust Board. ● Main cause of term admissions to NICU identified via audit is respiratory disease – in-depth audit of this topic due to be presented to the perinatal audit meeting in July which will form the basis of the improvement project required. Confirmation will be included in the September Trust Board report.
4. Clinical Workforce		● Locum SOPs (Standard Operating Procedure) in place aligned with CNST Y5 requirements. ● Q1 Apr-Jun consultant attendance audit assurance/ escalation to be reported to Trust Board in September ● Anaesthetic team have been briefed with requirement to produce 1 month rota evidencing compliance to ACSA standards. ● Neonatal Nursing workforce action plan to be continued as submitted to Trust Board during CNST Year 5 reporting period. ● **Identified risk** – Neonatal Medical workforce. CNST Year 6 includes requirement for the consultant rota to meet BAPM standards. It has been identified that an action plan will need to be complete for this ask.
5. Midwifery Workforce		● Birthrate+ exercise was completed using August-October 2021 data and the final report was published September 2022. This therefore meets compliance of being within previous 3 years. ● **Identified risk** - Current staffing budget does not reflect established identified via Birthrate+ as required. Action plan is in place as per CNST Year 5 and Business Case remains in progress. ● Birthrate+ acuity app continues to monitor compliance with supernumerary labour ward co-ordinator and 1:1 care in labour. Substitute coordinator added for CNST year 6 with a defined escalation plan.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 81% overall implementation as per previous LMNS assurance visit. Progress has been made locally which will be formally assessed at the 11th September 2024 LMNS visit. ● Further progress and sustainability of current implementation continues with close oversight from Obstetrics Clinical Director.

7.User Feedback		● MNVP workplan 2024-25 is currently under review by MNVP lead – to be presented to the LMNS Board July 2024. ● Engagement schedule in place for MNVP lead to attend sessions and gather feedback. ● **Identified Risk -** Review of MNVP capacity and a deputy MNVP lead role to engage with community and gain feedback underway with Healthwatch to ensure ELHT have equitable resource. ● Patient experience group for Maternity and Neonatology implemented to review and action CQC (Care Quality Commission) maternity survey results and FFT (Friends and Family Test) (Friends and Family Test) results. ● Themes identified via the above group are shared with MNVP lead for co-production of improvements.
8. Training		● Fetal Monitoring training, multi-disciplinary emergency training (PROMPT) and Newborn Life Support training all monitored for required attendance via this safety action. ● **Identified Risk:** a formal plan will need to be in place demonstrating how a minimum of 90% of neonatal medical staff who attend neonatal resuscitations have a valid resuscitation council NLS certification by year 7 of MIS and ongoing. Currently our FY2 junior doctors, of which there are 8 each rotation, do not hold this certification.
9. Board Assurance		● Floor to Board bi-monthly meetings with Board-level, maternity, and neonatal safety champions in place. ● Perinatal Quality & Surveillance Model (PQSM) March 2024 data set submitted with additional rationale regarding 3rd&4th degree tear data. ● Triangulation of claims, incidents, complaints bespoke exercise diarised for July 2024.
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Assurance from governance leads that all requirements for MNSI reporting are met.

2.2 Key updates and exceptions per Safety Action

2.2.1 Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Table 1 Perinatal Mortality Review Tool – Dashboard of PMRT Cases

* Indicates that the cases in this month have not yet met deadline dates for this step of the process. The dashboard will automatically populate compliance figures once the deadline month has been reached.

**Please note the 'reports not due' section beneath each compliance figure to ascertain if the compliance % is yet to increase due to further cases in that month yet to reach deadline.

CNST - PMRT

(All measures reported against month of death)

* = Data not relevant for month
n/a = Data not available at time of report

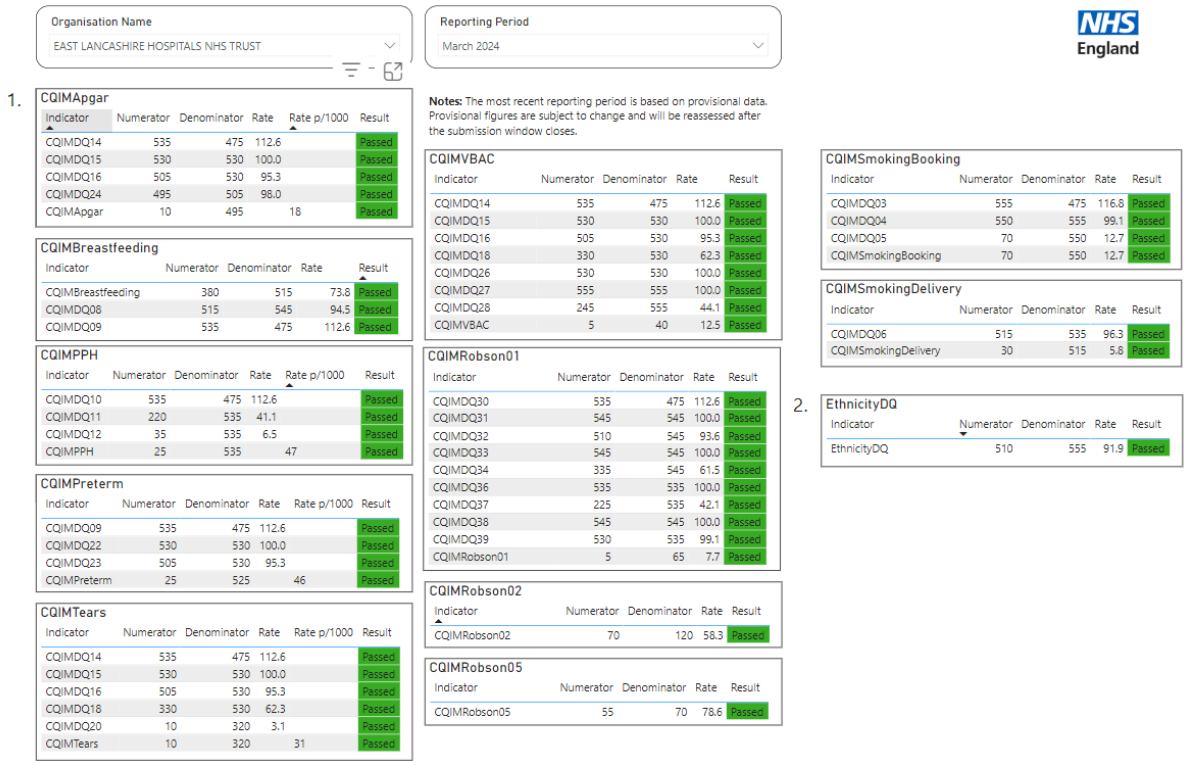
		Reporting Measure	Threshold	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Monthly Trend
SAFETY ACTION 1	PMRT01a	Total Number of Stillbirths (= 24 weeks)		1	2	1	1	1	1	2	4	0	
	PMRT01b	Number of Neonatal Deaths		0	3	1	0	1	1	3	3	3	
	PMRT01c	Number of late fetal loss between 22+0 and 23+6 weeks		0	0	0	0	1	0	0	0	0	
		Total Eligible Cases		1	5	2	1	3	2	5	7	3	
	PMRT02a	a) i Number of cases reported to MBRRACE within 7 days		1	5	2	1	3	2	5	7	3	
			100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	PMRT 06a	c) i Number PMRT tool started 2 months		1	5	2	1	3	2	4	4	1	
			95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	*	*	*	
	PMRT05a	c) ii Number PMRT published reports by 6 months		1	4	2	0	0	0	0	0	0	
			60%	100.0%	80.0%	100.0%	*	*	*	*	*	*	
	PMRT05c	Number PMRT published reports not due		0	0	0	1	3	2	5	7	3	

The reporting period for CNST Year 6 was to include all eligible cases from 8 December 2023 to 30 November 2024 however on the 24th of June 2024 an update to the guidance was published as below:

'The year 6 scheme in relation to SA1 is for deaths from the 8th of December 2023 but this wasn't announced until the 2nd of April 2024 and the supporting downloadable reports were not fully available until mid-May.
In view of this, the verification of Safety Action 1 will exclude notifications, SA1a), and the review started standard under SA1 c) for deaths between the 8th of December 2023 and the 1st of April 2024.
Note that at the conclusion of the year 6 scheme all activities to meet the year 6 SA1 standards should continue, prior to the announcement of the start of year 7.'

As demonstrated via the above PMRT dashboard, all required time limits have been met to the required compliance thresholds within this period.
CNST Year 6 continues the requirement for quarterly reports to be submitted to Trust Board, Quarter 4 covering January-March 2024 data was submitted to May 2024 Trust Board. The Quarter 1 report covering April-June 2024 data is due to be submitted to September Trust Board.

2.2.2 Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?



Organisation Name: EAST LANCASHIRE HOSPITALS NHS TRUST
Reporting Period: March 2024
NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	535	475	112.6		Passed
CQIMDQ15	530	530	100.0		Passed
CQIMDQ16	505	530	95.3		Passed
CQIMDQ24	495	505	98.0		Passed
CQIMApgar	10	495		18	Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	380	515	73.8	Passed
CQIMDQ08	515	545	94.5	Passed
CQIMDQ09	535	475	112.6	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	535	475	112.6		Passed
CQIMDQ11	220	535	41.1		Passed
CQIMDQ12	35	535	6.5		Passed
CQIMPPH	25	535		47	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	535	475	112.6		Passed
CQIMDQ22	530	530	100.0		Passed
CQIMDQ23	505	530	95.3		Passed
CQIMPreterm	25	525		46	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	535	475	112.6		Passed
CQIMDQ15	530	530	100.0		Passed
CQIMDQ16	505	530	95.3		Passed
CQIMDQ18	330	530	62.3		Passed
CQIMDQ20	10	320	3.1		Passed
CQIMTears	10	320		31	Passed

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes.

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	535	475	112.6	Passed
CQIMDQ15	530	530	100.0	Passed
CQIMDQ16	505	530	95.3	Passed
CQIMDQ18	330	530	62.3	Passed
CQIMDQ26	530	530	100.0	Passed
CQIMDQ27	555	555	100.0	Passed
CQIMDQ28	245	555	44.1	Passed
CQIMVBAC	5	40	12.5	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	535	475	112.6	Passed
CQIMDQ31	545	545	100.0	Passed
CQIMDQ32	510	545	93.6	Passed
CQIMDQ33	545	545	100.0	Passed
CQIMDQ34	335	545	61.5	Passed
CQIMDQ36	535	535	100.0	Passed
CQIMDQ37	225	535	42.1	Passed
CQIMDQ38	545	545	100.0	Passed
CQIMDQ39	530	535	99.1	Passed
CQIMRobson01	5	65	7.7	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	70	120	58.3	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	55	70	78.6	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	555	475	116.8	Passed
CQIMDQ04	550	555	99.1	Passed
CQIMDQ05	70	550	12.7	Passed
CQIMSmokingBooking	70	550	12.7	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	515	535	96.3	Passed
CQIMSmokingDelivery	30	515	5.8	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	510	555	91.9	Passed

The “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series, as above, publishes each month and this is used to evidence sustained compliance to the 11 data quality measures and further ethnicity data quality measure as required.

July 2024 will be the month submitted into CNST Year 6 evidence to evidence compliance for this reporting year. This will be available to view on the above scorecard in October 2024.

2.2.3 Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

‘Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.’

Q4 (January-March 2024) data review and audit presentation was submitted to May Trust Board and found significant assurance against compliance. Q1 (April – June 2024) is due to be submitted to the September Trust Board.

'***Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.'***

As indicated in the findings of the Transitional Care audit, the most prevalent cause of term admission to NICU is respiratory disease:

- January 2024 - 24 term admissions to NICU - 12 main cause of respiratory disease - 12/24 (50%)
- February 2024 - 17/32 (53%)
- March 2024 - 7/20 (35%)

To further review this key cause and inform improvement ideas a focussed audit has been commenced to review term admissions due to respiratory disease alongside reviewing data such as caesarean section rates, indications, and outcomes. The findings will be presented at the joint maternity and neonatal audit meeting in July 2024 and following this an improvement project will be registered as per the CNST requirement.

2.2.4 Safety action 4 – Can you demonstrate an effective system of clinical workforce planning to the required standard?

A detailed review and analysis of the current Obstetric and Gynaecology medical workforce, aligned to current clinical activity and associated risks within the Directorate has been prepared and will be presented to The Trust Professional Judgement review panel for Medical Staffing on the 12th July 2024.

The paper outlines speciality level information around the current workforce gaps, how those gaps are being covered, challenges in recruitment and the actions being taken to address the vacancies substantively.

The report details additional funding requirements to deliver the workforce requirements which will enable service developments in line with national directives. This includes developments aligned to the Clinical Negligence Schemes for Trusts (CNST) for compensatory rest,

Ockenden report recommendations, which emphasises the need for dedicated consultant cover for gynaecology emergencies, the 3 year delivery plan for maternity & neonatal services and gynaecology elective recovery.

2.2.5 Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The biannual midwifery staffing report (detailing August-December 2023 data) was submitted to January 2024 Trust Board. The next report (detailing January-July 2024) will be submitted to September 2024 Trust Board.

This report stated the ask for Birth rate plus requirements for staffing establishment as reflected in the September 2022 recommendations. The business case for the deficit in funding is completed with an outcome awaiting panel discussions.

2.2.6 Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?
'Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.'

An overview of the current progress with the 6 elements of SBL (Saving Babies Lives) is as follows, this reflects 57/70 interventions implemented overall – 81% which was agreed with the LMNS at the assurance visit in January 2024:

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	6/10 interventions implemented and evidenced **(60%)**
Element 2 - Fetal Growth Restriction	17/20 interventions implemented and evidenced **(85%)**
Element 3 - Reduced Fetal Movement	2/2 interventions implemented and evidenced **(100%)** [1 intervention contains 4 asks)
Element 4 - Effective fetal monitoring during labour	4/5 interventions implemented and evidenced **(80%)**

Element 5 - Reducing preterm births and optimising perinatal care	24/27 interventions implemented and evidenced **(89%)**
Element 6 - Management of Diabetes in Pregnancy	4/6 interventions implemented and evidenced **(67%)**

Meetings with the LMNS have been diarised throughout the CNST Y6 reporting period as below, this provides the forum to meet the ask '*continued quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle.'*

- 11th September 2024
- 6th November 2024
- 8th January 2024

On the 19th June 2024, the transformation team and directorate manager met with the LMNS lead for saving babies lives v3 to discuss progress. Although official evidence and sign-off of compliance progress will be available following the visit scheduled on the 11th September as above, it was noted that all elements of the care bundle remain on track for full implementation with particular progress made in relation to Fetal Monitoring and Management of Diabetes in Pregnancy.

2.2.7 Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

'Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member'

The invitation to the bi-monthly Floor to Board meeting of the safety champions has been extended to the MNVP lead as a member since April 2024. The MNVP lead attended on the 12th of June 2024 as evidenced within the minutes of the meeting (appendix 2).

Through attendance at this forum MNVP Lead Anne Goodwin was able to report an update discussed at the ICE (LMNS Insite Coproduction and Engagement) meeting, the Service User lead for the ODN (Operational Delivery Network) has requested MNVP leads and representatives do not attend neonatal service user engagement sessions to collate feedback unless they have lived experience or the service lead for ODN is present before the relevant training has been given to avoid retraumatising families inadvertently.

This is reflected in the technical guidance of CNST Safety Action 7 'It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided.'

ELHT MNVP lead will liaise with the service user lead for ODN to attend the NICU coffee mornings to engage with neonatal families in collaboration going forward, until training for MNVP leads is established. This ensure this important cohort of women and families continue to have their voices heard and inform any improvement required to our services.

'Evidence of a joint review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as a coproduced action plan.'
A full update on the progress of responding to the CQC maternity survey has been submitted within the Quality Committee Floor to Board report (item 2.1) in June 2024 as a sub-committee of Trust Board (appendix 3). Identified survey themes for co-production with the MNVP include: 'feeling left alone during early labour,' 'gaining the help you need during labour,' and 'postnatal care.'
This is progressing well via facilitated focus groups in the community, the first taking place on the 25th May 2024 in Briarfield, Burnley. MNVP Lead will provide a full report of feedback following further focus groups however reported that overall feedback was positive around these topics.

2.2.8 Safety action 8: Can you evidence the 3 elements of local training plans and 'in-house', one day multi professional training?

The three elements of training monitored via the Maternity Incentive Scheme remain as per previous years:

- **Fetal monitoring and surveillance (in the antenatal and intrapartum period) training** – 90% attendance for midwives, obstetric consultants and all other obstetric doctors who contribute to the obstetric rota. May 2024 dashboard shows 99% compliance for all relevant groups.

- **Maternity emergencies and multi-professional training (PROMPT)** – 90% attendance for obstetric consultants and doctors, midwives, maternity support workers, anaesthetic consultants and doctors who contribute to the on-call rota in any capacity. May 2024 dashboard shows an average of 91% attendance across all required groups. Anaesthetic compliance has dropped below the required 90% in May 2024 due to rotation of the trainee anaesthetist. This is being monitored by the Maternity Training Team who are actively contacting these colleagues to arrange their training dates.

  A new ask for 70% attendance for non-obstetric anaesthetics doctors who contribute to the on-call rota in any capacity – this has been to the dashboard for monitoring and May 2024 dashboard for this cohort shows 100% compliance.

- **Neonatal basic life support** –

  The update published by MIS on the 24th June 2024 also states changes to the guidance for SA 8:

  'All neonatal staff undertaking responsibilities as an unsupervised first attender / primary resuscitator attending any birth must have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework.

  Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance. Please note that Trusts should be working towards this position for this year (year 6) of the Maternity Incentive Scheme in line with the published MIS year 6 document: A minimum of 90% of paediatric/neonatal medical staff who attend neonatal resuscitations unsupervised should have been trained and assessed in line with the guidance above.'

  90% attendance for neonatal consultants, junior doctors (who attends any births unsupervised), neonatal nursers (who attend any births unsupervised), advanced neonatal nurse practitioners, and midwives. Midwives and Maternity Support Workers complete this module within

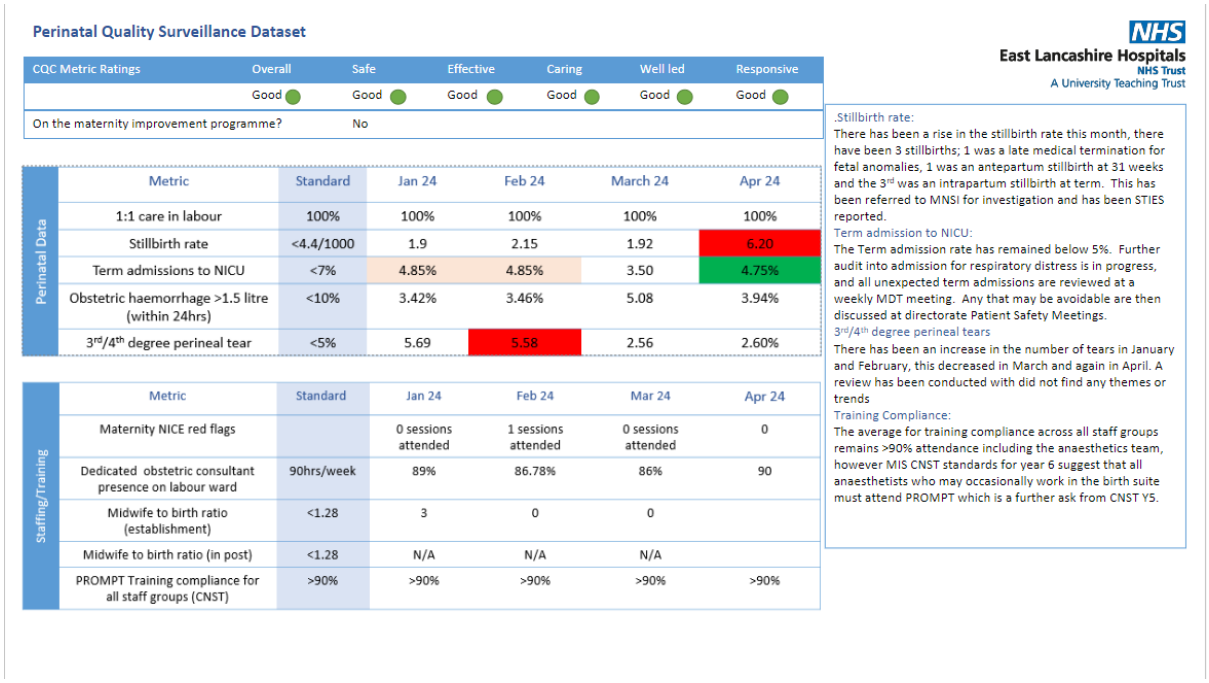
the PROMPT training day, and the May 2024 dashboard confirms compliance in attendance above the 90% threshold required.

Neonatal nurses and ANNP's are meeting the 90% compliance threshold.

2.2.9 Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

'Evidence that a review of maternity and neonatal quality is undertaken at every Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs).'

Perinatal Quality Surveillance Model (PQSM) Minimum Data Set May 2024:



Perinatal Quality Surveillance Dataset

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

CQC Metric Ratings	Overall	Safe	Effective	Caring	Well led	Responsive
	Good	Good	Good	Good	Good	Good
On the maternity improvement programme?		No				

Perinatal Data

Metric	Standard	Jan 24	Feb 24	March 24	Apr 24
1:1 care in labour	100%	100%	100%	100%	100%
Stillbirth rate	<4.4/1000	1.9	2.15	1.92	6.20
Term admissions to NICU	<7%	4.85%	4.85%	3.50	4.75%
Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	3.42%	3.46%	5.08	3.94%
3rd/4th degree perineal tear	<5%	5.69	5.58	2.56	2.60%

Staffing/Training

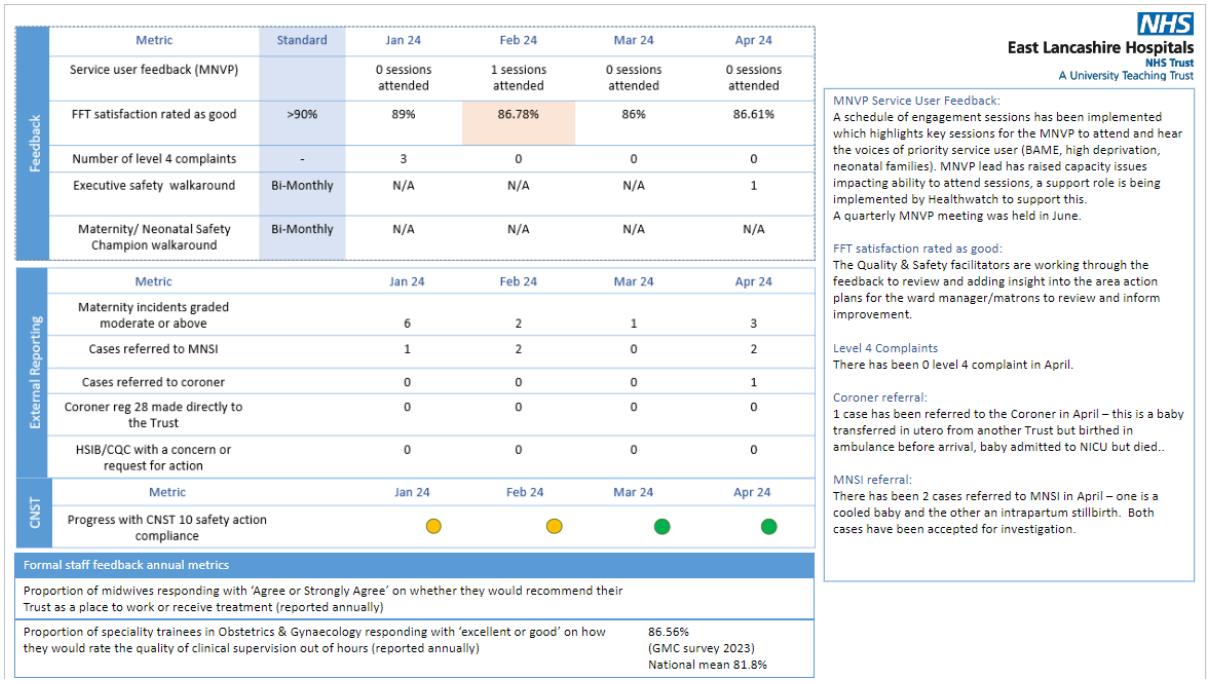
Metric	Standard	Jan 24	Feb 24	Mar 24	Apr 24
Maternity NICE red flags		0 sessions attended	1 sessions attended	0 sessions attended	0
Dedicated obstetric consultant presence on labour ward	90hrs/week	89%	86.78%	86%	90
Midwife to birth ratio (establishment)	<1.28	3	0	0	
Midwife to birth ratio (in post)	<1.28	N/A	N/A	N/A	
PROMPT Training compliance for all staff groups (CNST)	>90%	>90%	>90%	>90%	>90%

.Stillbirth rate:
There has been a rise in the stillbirth rate this month, there have been 3 stillbirths; 1 was a late medical termination for fetal anomalies, 1 was an antepartum stillbirth at 31 weeks and the 3rd was an intrapartum stillbirth at term. This has been referred to MNSI for investigation and has been STIES reported.

Term admission to NICU:
The Term admission rate has remained below 5%. Further audit into admission for respiratory distress is in progress, and all unexpected term admissions are reviewed at a weekly MDT meeting. Any that may be avoidable are then discussed at directorate Patient Safety Meetings.

3rd/4th degree perineal tears
There has been an increase in the number of tears in January and February, this decreased in March and again in April. A review has been conducted with did not find any themes or trends

Training Compliance:
The average for training compliance across all staff groups remains >90% attendance including the anaesthetics team, however MIS CNST standards for year 6 suggest that all anaesthetists who may occasionally work in the birth suite must attend PROMPT which is a further ask from CNST Y5.



Feedback

Metric	Standard	Jan 24	Feb 24	Mar 24	Apr 24
Service user feedback (MNVP)		0 sessions attended	1 sessions attended	0 sessions attended	0 sessions attended
FFT satisfaction rated as good	>90%	89%	86.78%	86%	86.61%
Number of level 4 complaints	-	3	0	0	0
Executive safety walkaround	Bi-Monthly	N/A	N/A	N/A	1
Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	N/A	N/A	N/A	N/A

External Reporting

Metric	Jan 24	Feb 24	Mar 24	Apr 24
Maternity incidents graded moderate or above	6	2	1	3
Cases referred to MNSI	1	2	0	2
Cases referred to coroner	0	0	0	1
Coroner reg 28 made directly to the Trust	0	0	0	0
HSIB/CQC with a concern or request for action	0	0	0	0

CNST

Metric	Jan 24	Feb 24	Mar 24	Apr 24
Progress with CNST 10 safety action compliance				

Formal staff feedback annual metrics	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	86.56% (GMC survey 2023) National mean 81.8%

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

MNVP Service User Feedback:
A schedule of engagement sessions has been implemented which highlights key sessions for the MNVP to attend and hear the voices of priority service user (BAME, high deprivation, neonatal families). MNVP lead has raised capacity issues impacting ability to attend sessions, a support role is being implemented by Healthwatch to support this.
A quarterly MNVP meeting was held in June.

FFT satisfaction rated as good:
The Quality & Safety facilitators are working through the feedback to review and adding insight into the area action plans for the ward manager/matrons to review and inform improvement.

Level 4 Complaints
There has been 0 level 4 complaint in April.

Coroner referral:
1 case has been referred to the Coroner in April – this is a baby transferred in utero from another Trust but birthed in ambulance before arrival, baby admitted to NICU but died..

MNSI referral:
There has been 2 cases referred to MNSI in April – one is a cooled baby and the other an intrapartum stillbirth. Both cases have been accepted for investigation.

This dataset has been reviewed and discussed with safety champions as per the Floor to Board minutes (**appendix 2**).

'Is the Trust's claims scorecard is reviewed alongside incident and complaint data.'

The Trust has identified a need to review the categories available within the incident and complaints reporting system (DATIX); the Divisional Director of Midwifery attended the

Trust-wide workshop regarding a review of complaints categories on the 18th of April. A bespoke multidisciplinary (MDT) workshop to review the obstetric and maternity incidents categories has also taken place on Wednesday 8th May resulting in the overhaul of the categories as facilitated by the Datix manager for the Trust. The changes to the categories have been presented to the wider maternity team at the Perinatal Governance Board and colleagues have provided their input and comments.
These activities will improve the recording of incident and complaints, and therefore improve the ability to identify themes from the reports available from the system.

A bespoke meeting has been diarised on the 31st July 2024 with all safety champions and governance team colleagues to review the claims scorecard alongside the incidents and complaint data currently available, and update of the outcome of this activity will be presented to September Trust Board.

'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.'

The culture improvement plan as informed by the results of the SCORE culture survey is monitored and lead by the Maternity and Neonatal Quadrumvirate, who meet monthly with a direct focus on safety and culture listed within the agenda.

As per previous updates, further communication channels are being explored for use to ensure the results and themes of the survey have been disseminated widely and understood by all staff such as a podcast led by the Quadrumvirate and area leads. An infographic has been produced to communicate to staff the key initial findings of the culture survey and the ongoing improvements led by the quadrumvirate [**Appendix 4**]

To continue this ELHT maternity & neonatal services have engaged with an opportunity to train Culture Coaches who will be supported to hold cultural conversations on an ongoing basis, and work directly with individual teams on local culture improvements. Four Culture Coaches have been identified from our Midwifery, Obstetric, Neonatal and Quality governance teams who will receive training from the NHS England Perinatal Culture & Leadership Team.

2.2.10 Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

The Perinatal Quality Surveillance Model – Minimum Data Set as above contains monthly data of the number of HSIB/ MNSI cases reported and accepted or rejected. Rationale and further detail are also included within the data set for assurance and/ or discussion where needed.

A detailed overview of cases within the reporting period to present are provided in the in the document submitted in (**appendix 5**).

3. CONCLUSION

On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board will continue to inform progress with assurances of the ten CNST maternity safety actions throughout the reporting period.

Any other matters of safety or concerns if apparent will continue to be reported through the bimonthly maternity and neonatology safety champions floor to board agendas and reflected within trust board papers for further discussions as and when required.

Perinatal Quadrumvirate:

Tracy Thompson, Divisional Director of Midwifery and Nursing
Martin Maher, Clinical Director of Obstetrics
Savi Sivashankar, Clinical Director of Neonatology
Charlotte Aspden, Directorate Manager of Maternity and Neonatology
July 2024

Appendix 1 – CNST-MIS Y6 Guidance

MIS-Year-6-guidance .pdf

Appendix 2 – Floor to Board meeting minutes June 2024

[3] 12.06.2024 - Floor to Board.docx

Appendix 3 – Floor to Board Quality Committee Report June 2024

Floor to Board Report Quality Committee Ju

Appendix 4 – SCORE Survey Infographic

SCORE Culture Survey Infographic (1

Appendix 5 – MNSI Reporting Overview

CNST SA 10 Year 6 June 24 update.doc

Maternity Incentive Scheme (MIS)

Year 6

What to expect – An overview of changes

MIS Year 6 document – due for publication 2 April 2024

We have made some amendments to how the MIS document is presented this year to try and simplify the requirements and improve clarity. We hope this will help support Trusts and make it easier to focus on the safety standards in the scheme.
The primary requirements for each safety action are now at the front of the document, and the technical guidance can be accessed at the back. There is a clear index and links throughout the document enabling you to jump to other sections.

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	7	0	0	0	7
2	3	0	0	0	3
3	4	0	0	0	4
4	23	0	0	0	23
5	5	0	0	0	5
6	6	0	0	0	6
7	7	0	0	0	7
8	16	0	0	0	16
9	10	0	0	0	10
10	8	0	0	0	8
Total	89	0	0	0	89

Key:

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

The MIS document will be published with an accompanying audit/compliance tool this year. The tool has been designed to support you as you work towards compliance with the MIS safety actions.
It is not mandatory to use this tool, but we hope you will find it helpful.
The tool has been developed for your internal use only and is not intended for submission to NHS Resolution. It will allow you to track your progress with the actions and record when supporting evidence has been approved and where it is saved.

We anticipate that the Year 6 document will be published 2 April 2024. The compliance period will end 30 November 2024. The submission deadline will be 12:00 midday on 3 March 2025.

NHS Resolution will also be launching a Maternity Incentive Scheme workspace on the FutureNHS platform. We hope this will provide improved access to consistent information and guidance about the scheme in response to any queries. We will provide a series of webinars and resources that will be available on the platform. It will also offer the opportunity to share learning and tools that work well across the system, using examples of best practice / what good looks like. For those that do not wish to join the platform, information will continue to be provided by existing methods.

The MIS Team will be attending a number of local, regional and national meetings over the coming year to provide updates on the Maternity Incentive Scheme. Please contact them on nhsr.mis@nhs.net if this is something you feel would be helpful for your team.

The ten safety actions

We have worked with the Safety Action Leads to streamline some of the requirements of the safety actions where possible this year, while ensuring that this does not compromise the safety improvements that contribute to improved outcomes for women and families accessing maternity services.

To aid your forward planning, we have provided a very brief overview of any significant changes in this letter. Any aspects of safety actions not directly referenced below may be assumed to be essentially unchanged from Year 5 of the MIS. Further information will be available within the full published document in April 2024.

Please note: Where any elements have been removed from safety actions, this may not mean there is no requirement for this activity to continue in order to ensure best practice. However, it may be that it is no longer reportable as a requirement to meet full MIS compliance.

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 8 December 2023 30 November 2024 to the required standard?

- Compliance period commences immediately following MIS year 5 (in line with Safety Action 10).
- Removed requirement within MIS to demonstrate surveillance information completed within 30 days.
- Removed requirement within MIS to complete the review to the draft report stage by four months after the death.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

- Removed requirement within MIS to report on Midwifery Continuity of Carer pathway indicators.
- Removed requirement within MIS to demonstrate two people registered to submit MSDS data.

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

- Removed requirement within MIS to audit all 37+ week admissions to the neonatal unit (NNU).
- Focus on transitional care pathways for babies between 34+0 and 36+6.
- Introduce (any) quality improvement initiative to decrease admissions and/or length of stay to NNU.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Obstetric Workforce

- Removed requirement within MIS to demonstrate compliance with the Royal College of Obstetricians and Gynaecologists' (RCOG) guidance on compensatory rest.
- Removed option to demonstrate compliance with RCOG guidelines on engagement of locums with an action plan.

Neonatal Workforce

- Updated to reflect November 2022 BAPM Service Quality Standards.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

- An allocated midwifery coordinator in charge of the labour ward must have supernumerary status *at the start of every shift*. An escalation plan must include the process for providing a substitute coordinator in situations where there is no coordinator available.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives (SBL) Care Bundle Version Three?

- Removed requirement within MIS for providers to demonstrate implementation of a specific percentage of interventions.
- Agreement of a local improvement trajectory with the Local Maternity and Neonatal System (LMNS), and subsequently quarterly reviews to confirm progress against that trajectory, with optional use of the SBL implementation tool.
- Evidence of work towards full implementation / sustained improvement.
- Evidence of regionally shared learning.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and co-produce services with users.

- Trusts should work with their LMNS/Integrated Care Board (ICB) to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place, with appropriate escalation if not.
- Provide evidence of MNVP infrastructure being in place.
- Provide evidence of MNVP Lead as a member of key Trust Safety and Governance meetings (working towards being a quorate member).

Safety action 8: Can you evidence the following three elements of local training plans and 'in-house', one day multi professional training?

- It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will no longer be measured in Safety Action 8.
- All anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric anaesthetic on-call rota *in any capacity* must attend maternity emergencies and multi-professional training.

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

- Discussions regarding safety intelligence must take place at the Trust Board *(or at an appropriate sub-committee with delegated responsibility),* as they are responsible and accountable for effective patient safety incident management in their organisation.
- Discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan using the Patient Safety Incident Response Framework (PSIRF).
- Removed requirement within MIS for Non-Executive Directors and Board Safety Champions to be registered with the dedicated FutureNHS workspace.

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?

- Updated to reflect changes to MNSI reporting criteria.

East Lancashire Hospitals NHS Trust

Floor to Board
Maternity & Neonatal

June 12, 2024

15:30

Microsoft Teams

Group Members: Peter Murphy | ~~Khalil Rehman~~ | ~~Dr Savi Sivashankar~~ | Mr. Martin Maher ┼ Tracy Thompson | Ruth Dawson | Charlotte Aspden | Sophie Counsell | Katie Rodwell | Anne Goodwin | Rajasri Seethamraju

Line through indicates apologies for this meeting.

DISCUSSIONS

Item: **Ongoing Actions**

Action	Comments	Outcome
Confirm when the central review of medical job planning will be undertaken in Neonatology. PM	**12/06/2024** C Aspden advised the post has been readvertised due to ongoing challenges recruiting a NICU consultant. The advert was modified to advertise for a resident locum consultant, and the interviews will take place at the end of July. C Aspden thanked the neonatal medical team for their efforts to cover the on-call rota due to the current pressures and recent changes with consultants' personal circumstances. SS update April 2024 'Job plan meeting for sign off will be in April. Discussions re: dedicated time for PSR reviews/PSR meetings/CNST targets will be discussed. 2 gaps in consultant rota-ongoing with no success in recruitment- interview held on 21/3/24. Jobs will go out for advert again with modification.' R Dawson added the governance meetings have been more structured and IR1s are being delt with. Alex Brooks-Moizer is attending the ATAIN meetings. Action to remain as per above vacancies.	Ongoing
TT to summarise the requirements for neonatal housekeeping staff in an email to P Murphy to raise with the chief nurse of the ISC. TT/PM	**12/06/2024** T Thompson advised the risk is now complete but requested guidance from P Murphy and will present as part of the meeting agenda. 04/05/24 Benchmark the risk against other trusts and raise at next weeks 2:1 meeting with P Murphy and J Pemberton. TT TT update April 2024 - Risk assessment to present [Risk ID]: TT completed with R Dawson & K Sansby	Ongoing
Bring the agenda item – 'Safety issue: medical workforce staffing for maternity and difficulties with securing locums/ICB rate card' to the next meeting or email Jawad Husain cc P Murphy to escalate the issue. MM	**12/06/2024** M Maher advised the paper has been sent to P Murphy today. M Maher summarised the 2 issues faced: Gap in junior staffing levels due to juniors wanting to work less than full time hours, plus our IBC rate card being lower than surrounding areas limiting what we can offer. Doctors are waiting until 48 hours before a shift to confirm so they will be paid break out rates / consultants are having to act down to fill	Complete

	the gaps. A new rate card is due to be published by the IBC. Currently understaffed by 2/3 consultants per week resulting in emergency c sections being carried out in emergency settings. The paper will be presented at the professional judgement meeting by M Willett.	
Email P Murphy with the BR+ business case details to ensure this is added to the agenda for review next meeting. CA/PM	**12/06/2024** T Thompson advised she has met with J Pemberton to risk assess the business case in view of the NHS financial position. We have not received an outcome of the business case yet and T Thompson will update at Trust Board on the 10th July.	Complete
Contact BR+ to arrange the review as per CNST year 6 and provide an update at the next floor to board. CA	**12/06/2024** C Aspden has contacted BR+ who have advised they will start our review 3 years from the date we received the report therefore we are on their forward planner for summer 2025.	Complete
Reinstate 1:1 meetings between A Goodwin and T Thompson. TT/AG	**12/06/2024** A Goodwin advised meeting with T Thompson/L Bardon 1:1 would be beneficial and requested a catch up meeting to be scheduled. A Goodwin to forward availability to Elaine Garnett.	Ongoing
Email Dan Hallen cc P Murphy to invite him to the next floor to board meeting to discuss the maternity IT risks. CA	**12/06/2024** P Murphy has escalated this with the relevant line manager regarding attendance at the meeting.	Complete
New Actions from this meeting		
S Counsell to review the technical guidance for CNST SA 7 to confirm we are covering the CNST brief regarding gaining MNVP feedback from neonatal families. SC		New
To arrange meetings with service users on a monthly basis to gain feedback from all areas within our service and produce a 'you said, we did' report.		New
Add information on what the SCORE survey is and the aim of the improvement plan to the staff infographic and add the SCORE survey action plan to the next meeting agenda. KRo		New
Invite Ian Wilkinson to the next meeting / once the SPC charts are complete to give an overview of the portal and review our data relating to the PQSM overtime. KRo		New
Email Sharon Gilligan, Jawad Hussain and Pete Murphy with the details of the obstetric theatres issue for review. MM		New

P Murphy requested the actions are updated with progress prior to the meeting and only exceptions raised at this meeting.

Item: **Mat Neo National Programmes (3 Yr plan/ CNST/ Ockenden)**

Conclusions:

- C Aspden advised we have received confirmation from finance on our CNST rebate, work is ongoing to break this down and pull out the funding opportunities for maternity.

- S Counsell shared the CNST overview tracker noting all items in the challenges column have already been escalated to trust board through the trust board report and discussed as per process.

- A Goodwin gave an update from the ICE (LMNS Insite coproduction and engagement) meeting that Victoria Walsh (Service User lead for the ODN) has requested MNVPs do not attend neonatal service user engagement sessions unless they have lived experience or Victoria is present before the relevant training has been given to avoid retraumatising families. This ask can be considered when recruiting to the engagement officer post. Action: S Counsell to review the technical guidance for CNST SA 7 to confirm we are covering the CNST brief regarding gaining MNVP feedback from neonatal families. R Dawson advised Victoria Walsh has been invited to our NICU coffee mornings in the past and we are happy for her to attend along with Anne.

- Maternity CQC survey - S Counsell confirmed the full CQC survey action plan has been included in Junes Quality Committee report, highlighting Anne Goodwin has been supporting us to gain more feedback for clarity on some of the key themes from the survey that needed a more in-depth view. A Goodwin will be attending two more focus groups to gain a wide range of feedback to support the CQC survey results and triangulate this with other feedback we collect as a trust. P Murphy stated the CQC survey questions are subjective and encouraged us to meet with service users to gain rich, direct feedback on our organisation. Action: To arrange meetings with service users on a monthly basis to gain feedback from all areas within our service and produce a 'you said, we did' report.

- CNST SA 9 triangulation – S Counsell advised the meeting has been diarised on the 31st July to triangulate the claims score card with incidents and complaint themes, however a second meeting will need to be scheduled in October to meet the CNST requirements. The triangulation exercise is being informed by the workshop to overhaul the Datix categories with Tom Undy, we have redesigned our categories agreed at Perinatal governance board and returned to Tom. T Thompson thanked everyone for their contributions to the workshop and suggested Tom Undy should be invited to the triangulation meeting to offer technical support. S Counsell advised she has met with Kath Sansby to discuss NHSR attending the meeting to present the claims score card. P Murphy also suggested Barry William should be invited from a complaints perspective.

Item: Perinatal Culture SCORE Surve

- S Counsell shared the SCORE survey infographic designed to be shared with staff to update them on the key themes, actions and outcomes of the SCORE survey. T Thompson attended a very productive band 7 learning even as part of some of the actions. T Thompson suggested adding information on what the SCORE survey is to remind staff or inform new staff. Action: Add information on what the SCORE survey is and the aim of the improvement plan to the staff infographic and add the SCORE survey action plan to the next meeting agenda. K Rodwell

Item: Safety Intelligence, Examples of Best Practice, Identify Challenges

- **PQSM Minimum Data Set** – S Counsell shared the PQSM dataset prepared by Katherine Sansby. M Maher advised an audit has been carried out following the previous concerns around 3rd/4th degree tears providing assurance there were no specific issues and the rate has now fallen back under the less than 5% threshold. The stillbirth rate has been high in April with 4 stillbirths reported, prompting a deep dive and mortality review into each still birth case and some incidental learning has come out of two of the cases. One expected stillbirth, and one baby had known abnormalities, but the family wanted to continue with the pregnancy. The two other cases did have some incidental learning that we don't believe has affected the outcome, these will follow the PMRT process. The term admission to NICU rate is at 4.75 therefore below the 7% threshold however triangulation around term admission rates, IOL, c section, respiratory distress is ongoing, and the output will inform our quality improvement project for CNST SA3.
  R Dawson added term admissions seem to have settled down and a lot of work is going on around this, all unexpected admissions are constantly reviewed.
  P Murphy suggested building SPC charts around the risk areas into the report to allow us to compare the data overtime. S Counsell advised Ian Wilkinson and Andrew Lumsden are currently working on building these SPC charts on power BI along with other metrics we are required to report on. M Maher explained the SPC charts will be monitored at Perinatal governance board and any exceptions brought to this meeting. Action: Invite Ian Wilkinson to the next meeting / once the SPC charts are complete to give an overview of the portal and review our data relating to the PQSM overtime. K Rodwell.

  Maternity

T Thompson gave an example of best practice as we have had two external inspections from the peadiatric audiology inspection with the national screening team that went really well and links with our pathway on the newborn hearing agenda. An area highlighted for improvement was to collaborate with other directorates across our division for assurance around incidents and managing these.
T Thompson advised we have completed our BFI 7 year gold revalidation submission today with a fantastic presentation from all involved. We were given one recommendation however we have passed and are the only hospital in the country to have achieved this.

M Maher raised an issue regarding maternity obstetric theatres as we have two dedicated theaters plus gynae 4 theatre as overspill but has never been funded from aesthetics, however its is not uncommon that due to complexity we will have two emergency theatres running together. This is an issue on days we have elective section lists running as one of the theatres is in use leaving us with only one obstetric theatre and gynae 4 for overspill. Elective pressures have resulted in funding becoming available to staff gynae 4 meaning we have had step down an elective gynea theatre. P Murphy advised this needs to be added to the risk register to take this to RAM. Action: P Murphy asked M Maher to put this in an email to Sharon Gilligan and Jawad Hussain to understand this in the meantime to help provide mitigations. M Maher

C Aspden added the obstetric theatres issue is included in the elective sections business case as this business case will solve the issue of increasing our elective capacity however it will increase the pressure on our theatres. C Aspden advised there is already a risk held by SAS regarding theatre availability and staffing that would need to be amalgamated with our elective section risk to present the issues as a whole at RAM on Tuesday.

T Thompson highlighted that although this risk is being managed this is putting a lot of extra pressure on staff to provide the best level of care for our patients. A concentrated focus is also being put on PNW and the readmissions for jaundice with could be linked to the flow and surgical capacity resulting in ladies going home earlier however this is yet to be reviewed. M Maher added this is affecting staff wellbeing as they are becoming exasperated with this situation becoming the norm.

Neonatology
R Seethamraju highlighted recent challenges in NICU regarding infections as over the last few months our septicemia and line infection rate has increased. This was picked up by an audit carried out on the unit after noticing an increase in infection and highlighted a couple of babies have been born in compromised conditions and difficult deliveries. An action plan has been devised and the way we remove our lines has been changed as well as putting a hold on an ask of the optimisation passport to give the hydrocortisone to preterm babies to confirm if this is linked to the infections or not. R Dawson added there is a focus on the nursing team and fluid line changes and hand washing. The IPC team were attending the ward to carry out spot checks which have been good, and nothing was picked up that will pinpoint the infections. T Thompson thanked the NICU team for their work and collaboration with the IPC team; this work must be reflected in the IPC committee report.

Item: **Maternity & Neonatology Risks (scoring 15 and above)**

Conclusions:

- **Neonatal Housekeeper/BC and risk assessment**

- **Diabetes Risk (marked down to 12)**
  T Thompson updated this risk is in a better position now due to the hard work from the Maple Team. The improvements were made cost neutral, although we still have a gap in the DCM role. The next piece of work will be looking at consultation times, to fit in another 150 consultations in community settings and ensure the consultations can be for 30 minutes.

- **C-section Risk Update**
  Updated above.

- **Mat Neo IT Issues**
  9954 – (12) Community Connectivity for Community midwives
  9867 - (9) Unable to share effectively safeguarding information about newborn babies attending ED and Paediatrics
  New Risk – Access to historical CTG's and clinical information through the K2 legacy system
  10000 - (12) Server Migration & Decommissioning Programme - Risk of Failure or Data Breach

10045 - (15) Inability to provide complete patient records from Badgernet of an adequate standard to meet Legal and Coronial requirements

C Aspden advised the IT issues have already been escalated through a request to V Hampson, highlighting the priority risk 10045 around our coronial processes. P Murphy has been made aware of the IT issues and is working to get these reviewed through our corporate IT team processes.

T Thompson has scheduled a meeting to review the digital roles within our division due to maternity using three EPR systems including Cerner. Currently we have one specialist band 7 midwife, support from band 6 hours in neonatology 3 days a week and some nonrecurrent band 6 hours in maternity that is currently a gap due to posts being band 7 in other maternity units. The meeting is to consider additional roles and how we can collaborate with our trust informatics team and align this with our governance requirements as we must be able to deliver on CNST requirements. The uplift required has been included within the business case, however working with our clinical informatics team is important when writing the job description.

Item: **Maternity & Neonatal Voice Partnership – Exceptions**

A Goodwin updated the MNVP work plan is ready to be shared with ELTH and the wider MNVP group. Work is required around the CNST actions and the feedback from the recent service user engagement session was mostly positive with a few comments to be looked at in more detail. Two more sessions are in the planning stage and once these are confirmed the dates can be shared to include a midwife if possible. The LMNS have reviewed the meetings and reorganised these to free up some time and alongside our engagement lead post that is out for advert this will put us in a good position. T Thompson explained the engagement officer lead post has been put in place due to the amount of work required and hours Anne can commit to as our MNVP, plus offer support, cover for annual leave and succession planning. A Goodwin also recruited a volunteer through health watch who had their DBS checks and training to support the MNVP. T Thompson asked for the MNVP workplan to come to the next quad meeting for review/ sign off.

Item: **NAPF Exceptions & CQC Surveillance Exceptions**

Conclusions:

- S Counsell advised the CQC ‘should do’ action plans have been reviewed and updated with the governance leads and Lizzie Saunders, these are currently being quality assured with L Saunders and will be brought to the next floor to board meeting.
- R Dawson shared NICU have been awarded their third green NAFP last week, a lot of brilliant work has gone into this and although the issues with infection control are apparent shows the team are doing something right. NICU will now go to silver spec in September.
- T Thompson added both the Birth Centre's have had their first NAPF’s and both received amber results. At the beginning of May, the Postnatal ward received their second amber NAPF resulting in them losing their spec status due to the gaps noted in the assessment. A series of meetings with the MDT team on postnatal NAPF will be held and the review of PNW consultant cover will be triangulated with the NAPF requirements and leadership on the ward.
  T Thompson highlighted the concern around the postnatal ward and the feedback from our FFT results. This has been discussed at PEG with the deputy chief nurse and a bespoke update will be given in the next PEG report. P Murphy noted awareness of the activity and issues on postnatal ward and agrees the action plans will support us to improve this result.

Item: AOB

Conclusions:

- S Counsell gave assurance she has been through her maternity leave handover with C Aspden who praised Sophie on the detail of the handover document. The meeting group thanked S Counsell for all the work she has done for the division.

Other Information

Observers:

None

Resources:

Floor to Board Meeting SharePoint
CNST SharePoint

Special notes:

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

QUALITY COMMITTEE REPORT **Item**

26th June 2024 **Purpose** Approval
Assurance
Information

Title	**Floor to Board report for Maternity &Neonatology services**
Report Author	Tracy Thompson (Divisional Director of Nursing & Midwifery)
Executive sponsor	Peter Murphy, Executive Director of Nursing. (Board Level Maternity/Neonatal Safety Champion)

Summary: To provide regular updates on behalf of ELHT (East Lancashire Hospitals Trust) maternity and Neonatal safety champions following scheduled 'floor-to-board' meetings, executive and non-executive walk arounds with other relevant trust wide patient, quality, and governance forums.
Collaboration with the quality committee board is primarily a direct focus for updates on improving maternity and neonatal safety aligning compliance, assurance and evidence of any escalation or improvements related to the National directives including the maternity incentive schemes, LMNS (Local Maternity and Neonatal System) deliverables aligned with funding streams, Ockenden immediate and essential actions and the three-year delivery plan for maternity and neonatology.

Recommendation: Quality committee members are asked to receive the report, note the contents acknowledge Maternity/Neonatology services progress and exceptions aligned with the deliverables within the time limits adding any recommendations. Any areas requiring improvement plans welcome further discussions.

Report linkages

Related Trust Goal	Deliver safe, high-quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse, and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal, and effective care in line with the requirements of the NHS Constitution, relevant legislation, and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) because of ineffective workforce planning and redesign activities and its ability to attract and

		retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Related to key risks identified on Corporate Risk Register	
Related to recommendations from audit reports	
Related to Key Delivery Programmes	Clinical Negligence Scheme for Trust – Maternity Incentive Scheme (CNST-MIS) Maternity & Neonatal 3-year delivery plan
Related to ICB (Integrated Care Board) Strategic Objective	

Impact

Legal	Yes/No	Financial	Yes/No
Equality	Yes/No	Confidentiality	Yes/No

Previously considered by:

1. Maternity and Neonatology 3-year delivery plan – An introduction

The three-year delivery plan published by NHS England in March 2023 (appendix 1) aims to make care safer, more personalised, and more equitable. The plan continues and aligns to the recommendations set out in the independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford (Ockenden Report, 2022), by Dr Bill Kirkup on maternity and neonatal services in East Kent (Reading the Signals Report, 2022), and previously Morecambe Bay (Kirkup Report, 2015)

The plan sets out the responsibilities specific to the Trusts, to the ICB's (integrated care boards) as a partner within an ICS (integrated care system) - the Local Maternity and Neonatal System (LMNS) is the maternity and neonatal arm of the ICS who provides assurance to the regional teams who further are responsible for the relationship between ICB's and NHS England.

The plan asks services to concentrate on four high level themes:

- Listening to and working with women and families with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care

Maternity and Neonatal services aim is to reflect the four themes within the three-year plan as the structure for Floor to Board reports presented at ELHT Quality Committee, further informing staff teams and service users with a mirrored approach. One example being the Maternity and Neonatal Newsletter to staff and service user friendly infographics as updates to be shared through the MNVP (Maternity and Neonatal Voice Partnerships) agendas alongside updates via the trust website. Standardised communication with all colleagues and service users working towards the shared goals and ambitions of the 3-year delivery plan is an essential part of the perinatal culture.

2. Theme 1 - Listening to and working with women and families with compassion

This theme is further defined by 3 objectives;

1. Care that is personalised
2. To Improve equity for mothers and babies
3. To Work with service users to improve care.

2.1 CQC (Care Quality Commission) - Women's Experience of Maternity Care Survey 2023

This update follows the previous context and detail given within the February and June 2024 Quality Committee reports. The full results as analysed by IQVIA can be viewed in appendix 2.

The current update of the actions and improvements informed by the Maternity CQC survey was reviewed at the Maternity Patient Experience and Lessons Learned group on the 16th May 2024, however this is a live document with continuous review between group meetings where required.

Three themes from the survey were identified for Maternity & Neonatal Voice Partnership (MNVP) co-production, as it was felt that these responses required further depth and understanding to truly inform improvements. This aligns to and helps to evidence compliance with the CNST Safety Action 7 requirement of co-production of improvements with the MNVP.

- 'Were you left alone at a time that worried you' analysis of the results found that 76% of respondents did not feel left alone, however of the group who answered 'yes' 12% were referring to early labour.
- 'During labour & birth were you able to get help when you needed it' the results show that 5% of respondents answered 'no.'
- 'Thinking about care in the hospital after birth, were you treated with kindness and compassions' the results show that 6% of respondents answered 'no'.

ELHT MNVP lead has agreed to conduct 3 focus groups to further investigate these themes, ensuring to capture a wide range of service users across our areas and demographics. The first focus group has taken place on Friday 24th May in Briarfield, Burnley supported by a senior midwife and we are awaiting the feedback summary of this event.

The findings of the CQC survey are triangulated with feedback from other routes such as the Friends and Family Tests (FFT) to identify common themes and trends and ensure responses are streamlined and improvements fully informed. A reduction in the amount of FFT responses being submitted to Maternity Care has been identified, and area leads have been tasked with ensuring this is communicated to all women and families to encourage response.

Furthermore, a theme related to negative experience on the Postnatal Ward, which aligns to the CQC survey finding, has been identified from the FFT responses. The Matron for this area is leading on a rapid improvement response which will be reported in detail to the Patient Experience Group in August 2024 and the Consultant Midwife is leading on a review of the Debrief pathway for women to access postnatally who need further support following birth – a detailed update for this project will also be presented in August.

CQC Maternity Survey Action/ Improvement Plan

Survey - Area of concern	Survey - Related survey question/s	IQVIA Recommendation	Local Action	Triangulation	Action owner / lead	Date for review at Maternity PEG	Status	Update
1. Care while pregnant	B08 'During your antenatal check-ups, were you given enough time to ask questions during your pregnancy	1a. Review the scheduling of antenatal appointment to ensure that adequate time is given	Undertake a piece of work to understand the implications of extending the appts to 30 mins. **Considerations needs to be discussed at senior level:** Staffing models, location & estate needs = cost implications **Discussions with TT suggests pilot to extend appts is underway - KS to gain confirmation.**	**FFT** - results are also raising issue with time in appointments/ women feel rushed. **IR1s** - theme of time constraints causing issues. **MNVP** - Feedback theme of appointment timings - specific to diabetic clinic. **MNSI** - Staff raising time implications through MNSI interviews **Parliamentary Birth Trauma Report -** Notes appt. lengths as contributory	Director of Midwifery/ Deputy Director of Midwifery/ Directorate Manager	20/06/2024	Ongoing - no issues	• 28 week & sweep appointments double appt times in place. • Midwives have autonomy to double individual appointments where required however this impacts wider appointments and this would require standardising. • Willow & Blossom COC teams have a 30 minute appt slot template - these teams have seen benefits of this. • Diabetic clinics - themes of feedback around waiting and running over prevelant for this clinic
			IR1s to be raised for each clinic running late. **Type:** Patient/ Staff **Category:** Problem with appointments/ admissions **Sub-category:** Error in management of appointment/ delay in clinic **EJ re-iterate the ask for clinic IR1s to reported in this agreed way to allowing for report to be pulled.** AR to pull report of a month for next PEG meeting	N/A as above	Birth Centre Leads/ Matron Q&S Facilitator	20/06/2024	Ongoing - no issues	Team agreed at April 2024 to re-circulate communications regarding IR1s for clinics running late. • Email has been sent to ask for IR1s to be sent as agreed. Issues with clinics seem to be with children centres and IT issues.
	B17 'Thinking about your antenatal care, were you treated with dignity and respect?'	1b. Review privacy and confidentiality advice with staff as a possible way to address concerns	Liaise with IQVIA to further understand the recommendation made in order to agree beneficial improvement	To be reviewed - is this theme coming through any other feedback routes?	Q&S Team	20/06/2024	Ongoing - needs support	• IQVIA did not offer further clarification.
2. Labour and Birth	C12 'Were you left alone by a midwife or doctor at a time that worried you?'	2a. Review the question breakdowns to see which stage of labour women felt they were left alone.	Identify from results breakdown at what time women feel they are being left alone and to what extent		Transformation Team	15/04/2024	Complete	During early labour - 12% During later labour - 7% During birth - 2% Shortly after birth - 9% Didn't feel left alone - 76%
			Results indicate main feedback on this to be around 'early labour.' IOL - Link into IOL workstream and ongoing patient experience survey specific to this pathway. Bring survey results to this group once complete.		Consultant Midwife/ Matron/ Transformation Lead	20/06/2024	Ongoing - no issues	
			Results indicate main feedback on this to be around 'early labour.' Latent Labour (spontaneous): Review current information for patients around latent labour to review if this is being given right place/ right time		Transformation Team	20/06/2024	Ongoing - no issues	K Rodwell reviewed the website for latent labour information: on EMPOWER page, terminology page, stage of labour has section and link to tommys. Check Real Birth App for latent labour information - review monthly reports of uptake of this app.
			Review of complaints to assess any feedback around 'feeling left alone' Review 3 months data Jan-Mar 2022		Q&S Facilitator	16/05/2024	Complete	Only 1 complaint mentioned feeling left alone during review period re a women left outside theatre : no complaints theme
			Liaise with MNVP to assess if 'feeling left alone' is being reported throug this route		Q&S Lead	20/06/2024	Ongoing - no issues	A Goodwin as MNVP lead is facilitating focus groups to gain more in-depth feedback on this. First diarised for 24th May 2024 with Anjuli Lord to attend and support

			Action TBD dependant on above deeper dives: PEG group discussed ideas: Challenge, coaching conversations, reminding staff, team meetings, walk rounds, documentation if leaving room, communication to women, add to weekly wisdom > 1-1 care in labour.			TBC	Not started	
	C14 'During labour and birth, were you able to get a member of staff to help you when you needed it?'	2b. Consider why some women say they were unable to get help from staff during labour if they needed attention.	Liaise with MNVP to collate some local more detailed feedback on the kind of help women feel they need, how they are asking for help, from whom etc? to identify co-production.		Q&S Lead/ Transformation Team	20/06/2024	Ongoing - no issues	A Goodwin as MNVP lead is facilitating focus groups to gain more in-depth feedback on this. First diarised for 24th May 2024 with Anjuli Lord to attend and support
			Recruitment & Retention Lead to discuss FFT/ Survey theme with staff for understanding of context - what is causing pressure/ tension for the staff? - Conduct engagement meetings with staff - kindness, compasssion, professional, caring. Use of SCORE culture survey results to cross-reference to.		Recruitment & Retention Lead	20/06/2024	Ongoing - no issues	Working group set up to discuss and undertake piece of work exploring why staff might not be kind or compassionate, identify any issues or barriers and staff wellbeing.
			Liaise with MNVP to identify Birth Stories specific to care postnatally		Q&S Lead/ Transformation Team	TBC	Ongoing - no issues	A Goodwin as MNVP lead is facilitating focus groups to gain more in-depth feedback on this. First diarised for 24th May 2024 with Anjuli Lord to attend and support
3. Care in hospital after birth	D05 'Thinking about care you received in hospital after the birth of your baby, were you treated with kindness and understanding?'	3a. Remind staff that kindness and compassion is a key part of delivering high quality postnatal care	Review any current issues with visiting previously identified e.g. partners respect for the ward (use of equipment/ not dressed appropriately) and if this is an ongoing issue / how this affects staff. **Review IR1, complaint, FFTs for themes - 3 month Jan-Mar 2022 X 3 month Jan-Mar 2024** *^ Review if this is specific to PNW or apparent in any other areas?*	IR1 Review - Aggression towards staff due to visiting Complaints Review - Visiting themes FFT Review - Visiting & staff attitude Themes	Q&S Facilitator	20/06/2024	Ongoing - no issues	Carry forward from May
			Liaise with Well Team for specific support on PNW i.e. coaching conversations, Well Away Day, Leaders Well Being Afternoons etc.		PNW ward manager and matron	20/06/2024	Not started	Carry forward from May
	D08 'Thinking about your stay in hospital, how clean was the hospital or ward you was in?'	3b. Review the compliance of cleaners and provide clear expectations of cleaning requirements	Review Mini-NAPF results & monthly domestic audit relating to cleaning to identify any specific areas of concern and back to this group escalate to group. **Feedback with assurance if no issues seen.** **Noted issues with receiving domestic audit reports - Matrons to support ward manager to raise any issues with this.**		All ward managers	20/06/2024	Ongoing - no issues	Work ongoing with mini-napfs and spot checks by matrons. CBS domestic walkrounds and reports are regular and fed back to domestics teams.
4. Feeding your baby	E02 'Were your decisions around feeding respected?'	4a. Ensure that all women are given full support and consistent advice about feeding their baby	Upon review of the details of the report, response shows women felt that decisions were respected 'Yes, always' - 84% and 'Yes - sometimes' 12%. Overall Yes = 96%	BFI team complete Mother audits on regular schedule and will escalate if any themes on this become apparent through this forum	BFI	Complete	Complete	Maternity and NICU both meet UNICEF Baby Friendly Initiative requirements with maternity maintaining gold standard
5. Care at home	F05 'Would you have liked to have seen or spoken to a midwife more often?' *Breakdown of results shows 34% of mothers wanted to see/ speak to a midwife more often after birth at home. 6% said less often and 60% felt it was the right amount*	5a. Look at frequency of visits and ensure mothers are directed to mental health support should they need it	Finalise Digital Video re. mental health and wellbeing to be given to women at discharge and available once at home to signpost to mental health when needed	Birth Trauma Report (parliamentary)	Transformation Team	20/06/2024	Ongoing - no issues	Video has been filmed in February 2024. Currently being edited by professional company.

3. Theme 2 - Growing, retaining, and supporting our workforce

The three-year plan states that 'The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability.' This theme is further defined by:

Objective 4. Growing the workforce,

Objective 5. Value and retain the workforce, and

Objective 6. Invest in skills.

3.1 Maternity Workforce Programme

This programme has been in place since July 2022, introduced as a Direct Support Offer from NHS England with the overall aim 'to grow midwifery establishment, support providers to reduce band five and six midwifery vacancies (where regional support allows), and to ensure the development of a sustainable midwifery recruitment pipeline with all providers.
Locally the programme has been led by the Recruitment and Retention Lead Midwife post which was implemented also in July 2022. National non recurrent funding has been allocated to all trusts for this post.

A review of the programme and it's key objectives has been completed as led by the Recruitment & Retention Lead Midwife and Maternity & Neonatal Project Manager. To support this the requirements as mandated by national programmes including those from the NHS England High Impact Areas for Workforce, Ockenden Full Report and Maternity & Neonatal 3 Year Delivery Plan have been aligned to this local programme. This allowed us to revise the objectives and ensure they reflect the status and challenges of the service for 2024-2025.

One key objective is to 'Continue with a rolling recruitment programme for midwives interested in working at ELHT, inclusive of Recruitment Events where the vacancy rate is above 10 WTE and Open Days where the vacancy rate is below 10 WTE to ensure the programme meets the current need of the service.' A maternity recruitment event was held on the 18th May 2024, advertised via Eventbrite and had over 100 responses to attend. Existing band 5&6 rotation midwife vacancies (17 WTE) were advertised using TRAC and interviews were held on the day of the event. The event was supported by a representative from each clinical area and specialist midwives.

89 applicants applied for these posts, 59 were shortlisted and 35 taken to interview which took place at the event. Following the interviews, we successfully offered 25 full and part time posts, predominantly newly qualified, which has succeeded in midwifery staffing reaching full establishment from September 2024.

3.2 Obstetric Workforce

An obstetric workforce paper has been completed by the clinical director of obstetrics and directorate manager to meet the requirements of the additional demand and capacity needed to cover standard operations. This is in draft format currently being reviewed at divisional level.

4. Theme 3 - Developing and sustaining a culture of safety, learning, and support

The three-year plan states that 'An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive.' This theme is further defined by:

Objective 7. Develop a positive safety culture,

Objective 8. Learning and improving, with

Objective 9. Support and Oversight.

4.1 Shared learning and improving

The maternity and neonatal transformation team in conjunction with the perinatal quadrumvirate host a quarterly newsletter which is circulated to staff in both digital and print formats. This shares key updates, learning and improvements from across the directorates and is formatted to follow the four themes for the 3-year delivery plan. This helps with staff understanding of the overall programme and our local ongoing pieces of work.

4.2. Perinatal Culture – Building a perinatal team

Neonatal consultant lead Dr Amitava Sur presented to the North West Safety Summit a comprehensive update regarding the perinatal team at East Lancashire Hospitals Trust and the improvement journey including a timeline of improvements from 2017 – 2023 [appendix 3].

5. Theme 4 - Standards and structures that underpin safer, more personalised, and more equitable care

The three-year plan states that 'To deliver the ambition set out in this plan, maternity and neonatal teams need to be supported by clear standards and structures. This includes being enabled to implement best clinical practice for all families, having high quality data to inform the decisions of clinicians and leaders, and having digital tools that enable information to flow.' This theme is further defined by:

Objective 10. Standards to ensure best practice

Objective 11. Data to inform learning

Objective 12. Making better use of digital technology.

5.1 Ambitions to enable better use of digital technology for Maternity and Neonatology

The 3 year plan records the following ambitions with regards to digital technology:

- Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them.

- All clinicians are supported to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, secure networks, and training.
- Organisations enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices.

Digital requirements are also mandated by other Maternity and Neonatal Programmes such as the CNST - Maternity Incentive Scheme which monitors compliance with data quality via the Maternity Services Data Set (MSDS). This data is pulled directly from the electronic patient record so training of staff to record efficiently is vital to this.

The maternity and neonatal quadrumvirate are currently reviewing the structure of the digital team roles and responsibilities aligned with clinical informatics support available to the directorates against these programme requirements and ambitions. The current digital structure within Maternity and Neonatology includes a digital midwife (Band 7 – full time), digital neonatal nurse (Band 6 – 3 days) and a digital lead obstetrician (x1 PA).

6. National Programmes & Investigation Report Responses – Key updates April 2024 FTB/QC

6.1 Clinical Negligence Scheme for Trust – Maternity Incentive Scheme (CNST-MIS)

The national CNST-MIS results have now been published as of the 10th of April 2024 and confirm that ELHT Maternity Services achieved compliance against all 10 safety actions for CNST Year 5.

7. Recommendations

7.1 The committee is asked to acknowledge this summary paper under the four themes of the three-year plan with any exceptions and updates as an assurance that the National maternity and Neonatology agenda is being implemented as a step wise approach with both divisional and trust board assurances. This is in collaboration with the Local maternity & Neonatal system (LMNS), NW (Northwest) regional teams and integrated care system (ICS).

8. Conclusion

8.1 Quality, Safety, and performance are closely monitored within Maternity services here at ELHT, any immediate actions to maintain a high standard of quality and safety for mothers and families in collaboration with the maternity and neonatal safety champions is demonstrated with evidence to support any actions through scheduled bi – monthly floor to board meetings. A copy of the most recent floor to board minutes are reflected in (appendix 4)

8.2 The committee is asked to receive and acknowledge this floor to board report and to request any further information if required on behalf of ELHT maternity & Neonatology services to the maternitytransformationteam@elht.nhs.uk or contact any of the ELHT maternity and Neonatology safety champions.

Executive Maternity Safety Champion – Peter Murphy
Non- Executive safety champion – Khalil Rehman
Midwifery Safety Champion – Tracy Thompson
Obstetric Safety Champion – Mr Martin Maher
Neonatology Safety Champions – Dr Savi Sivashankar and Ruth Dawson

Appendices

Appendix 1- Maternity and Neonatology 3-year delivery plan

2023 - 3 year mat neo plan (2).pdf

Appendix 2 – 2023 CQC Maternity Survey Results

East Lancashire 2023 Maternity presentatio

Appendix 3 – Perinatal Culture Presentation

Maternity safety summit (2).pptx

Appendix 4 – Floor to Board Minutes

[3] 12.06.2024 - Floor to Board.docx

Healthier Pennine Lancashire

NHS
East Lancashire Hospitals
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SCORE Culture Survey

The SCORE culture survey is provided to all NHS trusts as part of their participation in the Perinatal Culture and Leadership 'Quad' Programme. Following the debrief sessions held last year the quad have amalgamated the feedback and suggestions to develop themes and priorities to be worked on over the coming months.

Theme		Action	Status
Leadership		Develop / enhance the ward co-ordinator role resources and support	In progress
Leadership		Offer sessions to all ward managers / co-ordinators on adaptive leadership styles to support leadership in a fast-paced and often changing environment	In progress
Leadership		Review MDT handover and effective communication processes as a collaboration between service/ ward areas: - Reinstate the 057 bleep and joint 10am walk round between maternity and neonatology	**Complete**
Leadership		Instate a postnatal senior ward round to support leadership on the ward and review consultant leadership in other areas	In progress
Psychological Safety		Reduce pressure for staff around discharge by implementing the digital videos (via grant from Electricity North West)	In progress
Psychological Safety		Learning from the positive - Obstetrician deep dive session to understand the positive feedback from the survey to share learning	**Complete**
Culture – MDT workforce		Reinstate face to face meetings - PMRT meeting now takes place face to face to allow for maternity and neonatal colleagues to engage	**Complete**
Comminucation		Carry out a review of all communication routes to maternity and neonatology colleagues	**Complete**
Communication		Identify all current use of social media channels to support the communications stratagy	In progress
Communication		Review the current use of Share to Care as a communication route against original aims & purposes	In progress

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CNST SA 10 update /June 24

Name	Incident	MNSI consent	MNSI DOC letter sent	NHSR leaflet given	Referred to MNSI	Case accepted	Reported to NHSR	Claims Reporting Wizard
Emma Daffern	Cooled baby/ Neonatal death	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Abdullah	Cooled baby	Yes	Yes	Yes	Yes	Accepted	Yes	Yes
Bell	Cooled baby	Yes	Yes	Yes	Yes	No	N/A	N/A
Rafiq	? HIE	Yes	Yes	Yes	Yes	No	N/A	N/A
Gunton	NND	Yes	Yes	N/A	Yes	No	N/A	N/A
Mani	Maternal Death	Yes	Yes	N/A	Yes	Yes	N/A	N/A
Nutter	Cooled	Yes	Yes	Yes	Yes	No	N/A	N/A
Khan	Cooled	Yes	Yes	Yes	Yes	No	N/A	N/A
Sheen	Maternal death	Yes	No	N/A	Yes	Yes	N/A	N/A
Hussain	Cooled Baby	Yes	Yes	Yes	Yes	No	N/A	N/A
Carr	Cooled Baby	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Arthern	Intrapartum stillbirth	Yes	Yes	N/A	Yes	Yes	N/A	N/A
Imran	Maternal Death	Yes	Yes	N/A	Yes	Yes	N/A	N/A
Naz	Cooled baby	Yes	Yes	Yes	Yes	Yes	Yes	Awaited
Mahmood	Cooled baby	Yes	Yes	Yes	Yes	Yes	Yes	Awaited

Evidence of letters and referrals and acceptance are on Sharepoint;

MNSI rejection and acceptance information CNST year 5

Evidience of MNSI NHSR DOC letters given to families

Improving Safe Personal and Effective Care

SPE+

East Lancashire Hospitals NHS Trust
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Priorities for 2024-25
Trust Board 10th July 2024

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Process for developing our priorities for 2024/2025

East Lancashire Hospitals NHS Trust
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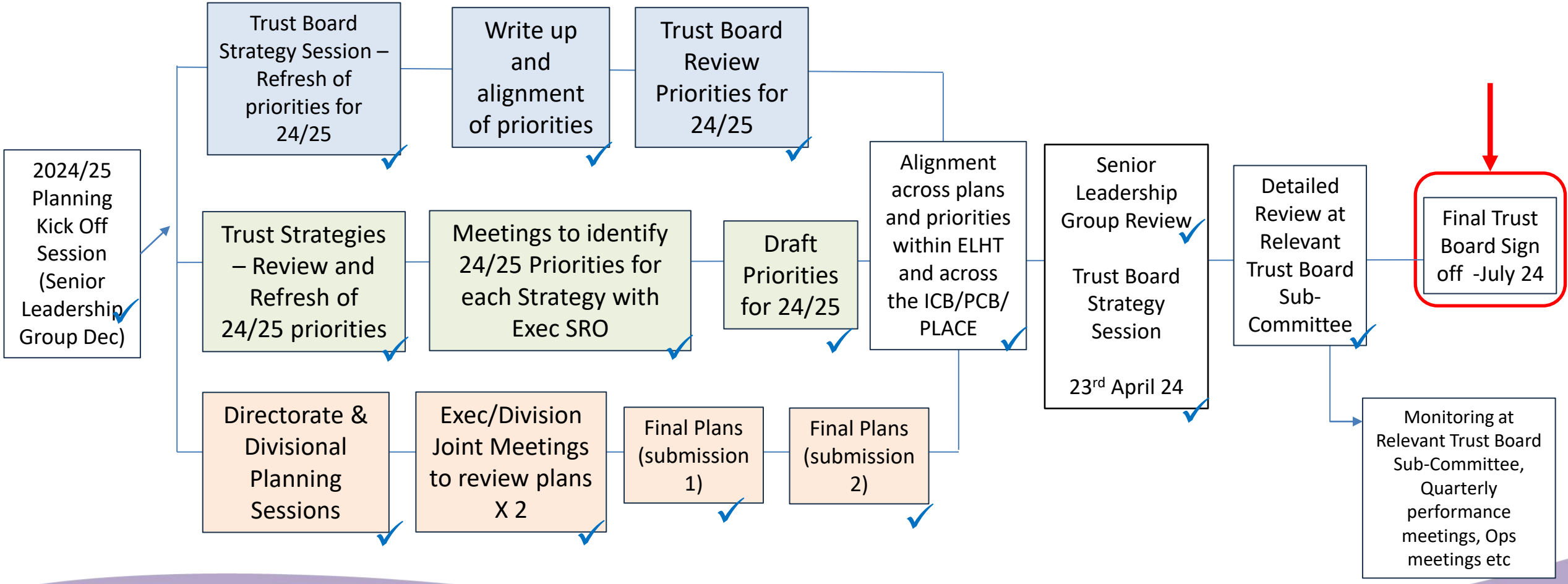

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❖ Ongoing ✓ Complete

Strategic Framework 2024-25

East Lancashire Hospitals NHS Trust
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We have updated our Strategic Framework as follows

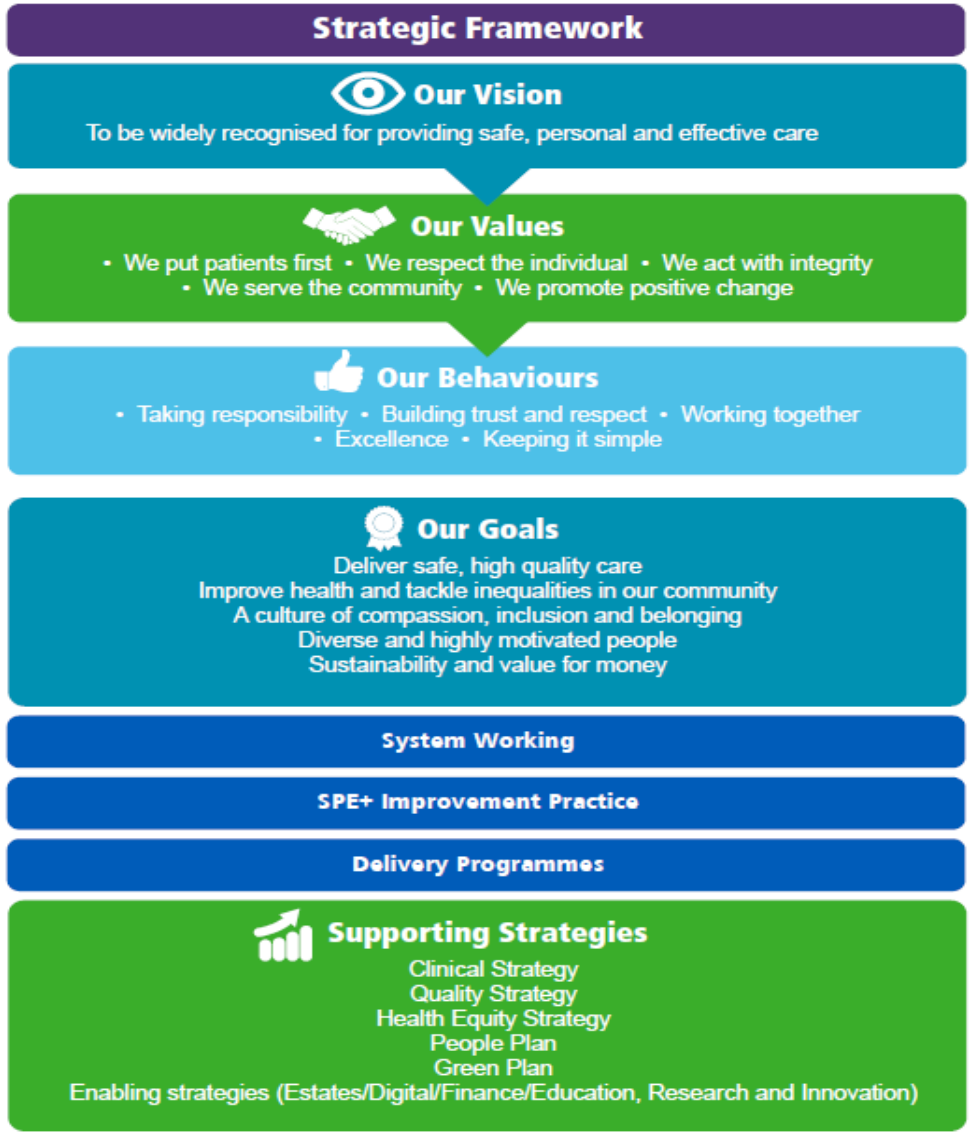
Our Goals:

Remove:

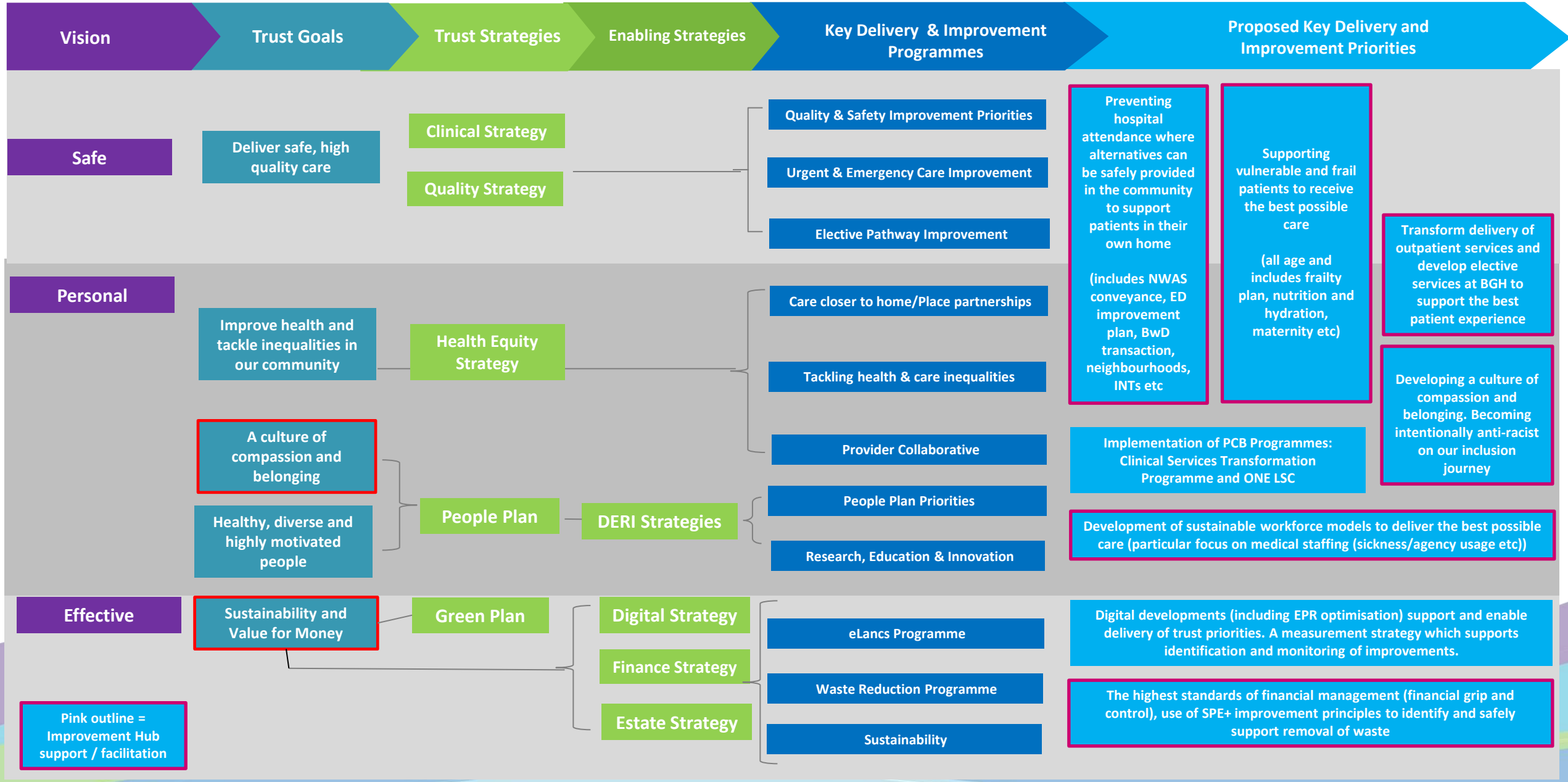
- Secure covid recovery

Update:

- A culture of compassion, inclusion and belonging.
- Sustainability and Value for Money



Key Delivery and Improvement Priorities 2024-25



Trust Strategies - Priorities 24/25

East Lancashire Hospitals NHS Trust
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Clinical Strategy Priorities 24/25

Elective Surgical :

- Continue with elective recovery with further improvements in 52 week waiting position by increasing capacity in key clinical pressure specialities
- Trauma & Orthopaedics (T&O) - work with the CLEAR team and develop a clear clinical strategy for T&O
- Review of Haematology workforce using a blended workforce approach to manage capacity gaps
- Working with Lancashire and South Cumbria Clinical Programme (Head and Neck, Urology, Vascular, Stroke, Pathology, Fragile Services)
- Regional Head and Neck Cancer Centre (planning work only)
- General surgery development (including review of urgent cover, colorectal expansion and HPB system redesign)
- Increase robotic/hybrid capacity utilisation at Burnley General Hospital (BGH) and the use of the BGH elective centre

Elective Medical :

- Haematology/Chemotherapy Unit development (planning work)
- Cardiology Burnley Teaching General Hospitals outpatient review

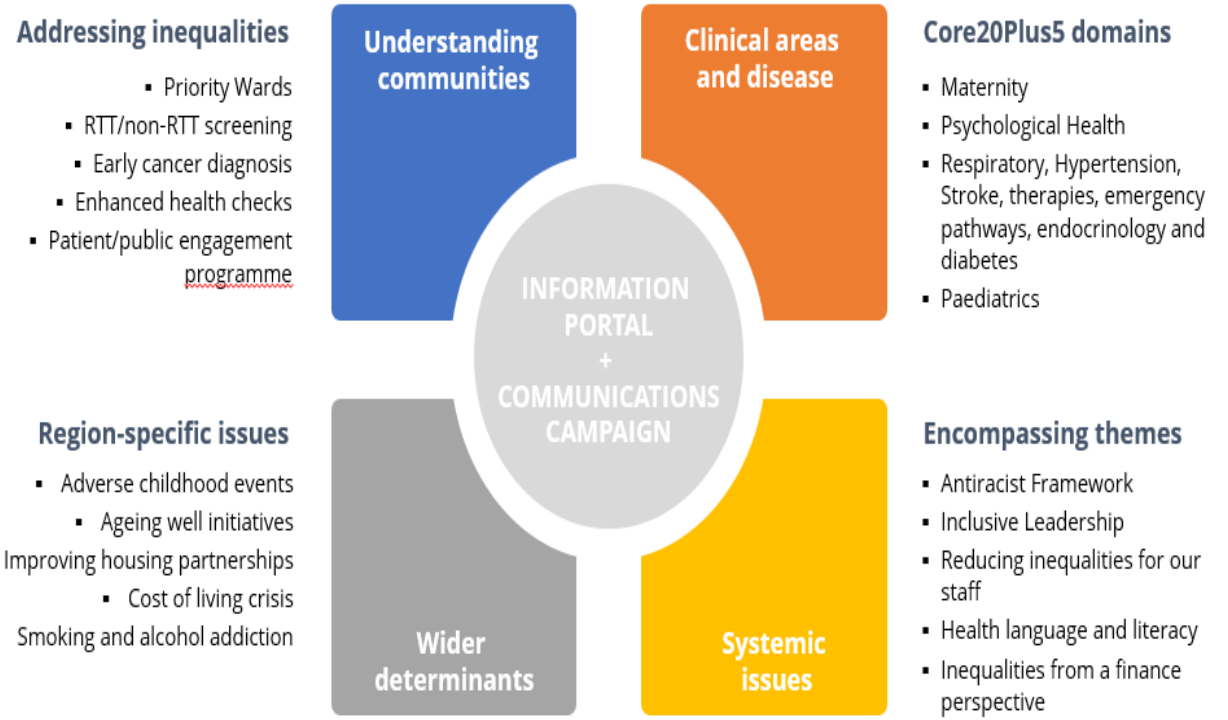
Diagnostics :

- Optimise the role of healthcare scientists and therapies, maximising skills as part of blended workforce, maximising capacity and efficiency
- Phase 9 Radiology Burnley Teaching General Hospitals (planning and case build up)
- Outpatient Improvement and Transformation

Urgent & Emergency Care / Community :

- Right size the medical bed base
- Frailty Improvement Work
- Same day emergency care services expansion
- Maternity Services Developments
- Paediatric Level 2 Critical Care – continue working with network partners
- **Population Health :**
- Driving health equity and access
- Personalised Care
- Further integration of acute and community healthcare through the community services transfer project

Health Equity Strategy: Priorities and themes 2024-25



Trust Strategies - Priorities 24/25

East Lancashire Hospitals NHS Trust
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Quality Strategy Priorities

- Improve the time completion of reports linked to patients' deaths where it is going for inquest
- Further develop Patient Safety skills and knowledge to support staff to complete high standard Patient Safety Response at a divisional level
- Improve corporate and divisional data tracking for assurance on the management of incidents meeting investigations under PSIRF (Patient Safety Incident Response)
- Further develop the Patient Safety SharePoint site as a one stop shop for learning from incidents
- Improve the monitoring and assurance of divisional safety improvement actions for incidents
- Compliance with Level 1 and 2 mandatory patient safety training
- Improve data analysis, triangulation, visibility and reporting (DATIX)
- Improve the quality of incident reporting through implementing LFPSE (Learn from patient safety events) requirements
- Improve risk management through risk profiling and mapping
- Strengthening the Patient Safety Culture through links to a Just Culture Approach
- Named Patient Safety Specialist to complete National Training level 3 and 4 as required by NHS England
- Ensure staff have support to enable them to feel psychologically safe when involved in incidents
- Review the Patient Safety Specialist role and resource in line with national requirements
- Building audit capability across the organisation through skills development by providing audit training for focused groups leading/ undertaking CAE activity and Identifying opportunities for automation of data collection for continuous audit & registry activity
- To increase engagement with audit and effectiveness work by Implement central audit registration process via DATIX and provide focused training for SCELs on roles and use of CAE SharePoint Page
- Explore alternate formats for delivery of audit training i.e. videos and guides on clinical audit process at ELHT with support from the department of Research, Education & Innovation (DERI)
- Work with Clinical Teams to align with GIRFT (Getting it Right First Time) Network Strategy Priorities
- ELHT Nutrition & Hydration IHI Breakthrough Series Collaborative
- PSIRP (Paritnet Safety Incident Response Framework) priorities – Medication errors, discharge planning and safeguarding patients with learning disabilities.

Estates Strategy Priorities

- Heartcare Unit
- Emergency Care Village
- Calico Site Phase 1 & 2
- Chemotherapy Unit
- Phase 9 Radiology Unit
- Pharmacy outpatient scheme (Lloyds Pharmacy)
- Outpatient review and repurposing clinical space
- Repurposing of community sites
- EPR (Electronic Patient Record) estate opportunities to be realised.
- Digitation of medical records
- Trust HQ Decant ward
- Theatre upgrades
- Fire prevention work
- Ward lifecycle work
- Sustainability agenda
- LED lighting
- Sustainability adaption plans
- Improving staff facilities
- Keyworker accommodation
- Multistorey car park with EV charging

Trust Strategies - Priorities 24/25

Digital Strategy Priorities

- Optimisation of Oracle Millennium ePR (electronic patient record)
- Progress harmonisation of current systems in partnership with Integrated Care System (ICS) providers
- Develop One LSC approach in ICS collaboration
- Commence legacy systems decommission/ housekeeping protocol
- Continue increased ICB/S corporate collaboration
- Further develop the Bedrock data warehouse to support service development
- Develop community systems in line with primary and community clinical strategies
- Set out Data & Digital strategy and governance approach

Green Plan Priorities

The Trust has a detailed set of objectives against our key 3-year improvement priorities and will continue to work in 24/25 on this plan. It focuses on the key priorities:

- Workforce & Systems Leadership
- Sustainable Models of Care
- Digital Transformation
- Travel and Transport
- Estates and Facilities
- Medicines
- Supply Chain and Procurement
- Food and Nutrition
- Climate Adaptation

People Plan Priorities

We are Compassionate & Inclusive

- Build a compassionate and inclusive workplace where everyone feels valued and a sense of belonging
- Become an intentionally anti-racist organisation.
- Embed inclusive & value-based recruitment for all roles, at all levels to ensure a truly representative workforce.

We are Recognised and Rewarded

- Relaunch appraisal process to enhance employee engagement, experience, wellbeing and belonging.
- Pilot inclusive talent management and succession planning, reducing disparities in progression and career development.
- Through People Promise Manager work to embed all aspects of the NHS People Promise to improve retention and improve employee experience.

We have a voice that counts

- Increase engagement and listening to bring people together to make a difference.
- Improve engagement with and results of staff survey through high impact actions that are felt and seen by staff.

We are safe and healthy

- Create an environment where colleagues can have a good day at work, even in challenging circumstances
- Work to understand and prevent burnout through compassion and healthy working practices

We are always learning

- Strengthen, promote & support career development pathways
- Explore digital, technological and AI solutions to create efficiencies and improve our services.
- Drive workforce transformation to support future workforce and financial challenges and meet the needs of our local population.

We work flexibly

- Continue to embed flexibility by default to support inclusion, belonging, health & wellbeing and retention
- Strengthen recording and reporting processes to allow us to fully understand flexibility of workforce

We are a team

- Improve alignment, governance and accountability of People & Culture agenda and teams, breaking down barriers and bringing together people with the right skills to progress our priorities demonstrating impact.
- Collaborate as part of the wider system to transform corporate / support services and ensure the spread and scale of good practice for benefit of local populations.
- Focus leadership & management development on leading teams with compassion, cultural competence and inclusion to develop psychological safety, resilience and belonging.

Governance & Accountability

- Ensure sufficient grip and control is in place to deliver priorities, improvements and WRPs ensuring the identification of benefits and risks
- Contribute to and enable efficiencies, improvements and productivity gains at an organisation and system level, ensuring equality and quality impacts and understood and mitigated

Trust Strategies - Priorities 24/25

East Lancashire Hospitals NHS Trust
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Financial Strategy Priorities

Current Baseline- NHS Trusts have a statutory duty to achieve breakeven duty. ELHT has never, at any point since its formation in 2003 breached this duty. Our draft accounts for 23-24 continue to demonstrate this (albeit with a reduced cumulative surplus), however we are now showing a significant underlying deficit as we exit 2023-24. As a result, our financial challenge for 2024-25 is to reduce our cost base by 7.7% (£58.9m)

Drivers of Deficit – We will continue to review our drivers of our deficit and our resultant income and expenditure position. It is important to understand this in detail to consider any mitigating strategies.

Grip and Control – The Trust takes its stewardship of tax payers money very seriously. We will focus on ensuring expenditure is through appropriate delegated authority and in line with the Standing Financial Instructions of the Trust.

Waste Reduction Programme – The Trust's waste reduction programme is aligned to the key deliverables of its strategic objectives. It is important that the programme is not seen as purely finance focussed and separate to the day to day operations of the Trust.

Collaboration and Transformation – As we work towards increased system working, there are opportunities for collaboration which must be realised. The Trust will actively participate and influence decision making in respect of our services, ensuring all decisions aim to improve quality, delivery, impact on staff and patients and our financial recovery. It is recognised that there may be individual service changes that result in a higher cost to ourselves but a reduction to the system overall. In these circumstance we would still expect improvements to the other indicators.

Department of Education, Research & Innovation (DERI) Strategy Priorities

To provide excellent education, training and learning opportunities to support the current and future workforce in delivering the best care for our patients

- Develop a competent, capable, caring and sustainable workforce with equal opportunity for all
- Provide excellent education and training opportunities for the future workforce
- Provide high quality learning environments with a culture for lifelong learning
- Develop excellent in patient safety training through simulation
- Ensure effective governance for all education and maximise the use of resources and funding to support delivery of the Education Plan
- Work in partnership to lead the education agenda forwards utilising a system wide approach

To work with system partners to integrate research activity into all areas of ELHT for the benefit of our patients and colleagues in the NHS

- Patient and Public Involvement (PPI)
- Workforce, culture and leadership
- Strengthen and develop our partnerships
- Developing our organisation and systems

To be recognised across the region as an exemplar site for the development and adoption of innovative practice within healthcare through greater collaboration with local and regional partners

Recommendation

The Trust Board are asked to note the conclusion of the planning process for 2024/25

The Trust board are asked to approve:

- The update to the Trust's Strategic Framework
- The key Delivery and Improvement Priorities for 2024/25
- The Key Strategy plans on pages for each key Trust Strategy following review and approval at relevant Trust sub-committees

The Trust Board are asked to note that updates will be provided every 6 months to the Trust Board and key improvement measures will be incorporated into the Integrated Performance Report from September 2024.

TRUST BOARD REPORT **Item** **101**

10 July 2024 **Purpose** Information
Action
Monitoring

Title	Independent Review of Greater Manchester Mental Health NHS Trust Recommendations / ELHT Response
Report Authors	Corporate Head of Nursing, Heather Coleman Associate Director of Quality & Safety, Alison Brown Deputy Chief Nurse, Jane Pemberton
Executive sponsor	Pete Murphy, Chief Nurse
Date Paper Approved by Executive Sponsor	8 July 2024

Summary: In September 2022 the BBC's Panorama aired a programme showing patients being abused whilst in the care of a Greater Manchester NHS Trust. Subsequently an independent review of the Greater Manchester Mental Health NHS Trust was commissioned. This was conducted by Professor Oliver Shanley and published in January 2024 with shared learning for all NHS Trusts. The paper makes 11 recommendations, this paper demonstrates ELHTs responsiveness and assurances to the learning detailed in the independent review.

Recommendation: Monitoring of compliance of the recommendations via Trust Wide Quality Group (Part A) with exceptions to the Trust Quality Committee via the AAA report.

Report linkages

Related Trust Goal	Deliver safe, high-quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to

	attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	Quality and Safety Improvement Priorities
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

1. Introduction

The BBC Panorama programme which showed patients being abused whilst in the care of an NHS Trust was acknowledged by the National Director for Mental Health as 'heartbreaking and shameful to watch'. It was also acknowledged that collectively the NHS needs to leave 'no stone unturned' to identify, eradicate and prevent this kind of abuse from happening. This was issued with a formal request for NHS Organisations to urgently review their services to consider 'could this happen here'?

The recently published independent review (January 2024), whilst specific to a local Greater Manchester Mental Health Trust (GMMH), has significant learning and recommendations that should be considered by all Trusts.

This paper provides a baseline assessment on these 10 recommendations at East Lancashire NHS Trusts. Compliance of the recommendations will be monitored throughout the Trust Wide Quality Group (TWQG) on a monthly basis.

Recommendations and assurances

<u>Voice of patients, families, and carers</u>

Recommendation 1

'The Trust must ensure that patient, family and carer voices are heard at every level of the organisation. The Trust must respond quickly when people experience difficulties with the service they receive and make lived experience voices central to the design, delivery and governance of its services'

The Trust continues to be committed to hearing the voice of the population it serves. This is evidenced in the 2024 updated Patient Experience and Engagement Strategy which was contributed to and influenced by key partners including patient representative groups. Our

ambitious strategy encompasses people with learning disabilities, dementia, carers, maternity care, children and young people, Martha's Rule, and those patients that have English as a second language.

- There are clear key performance indicators in place to enable monitoring which will be via the Trust's Patient Experience Group, reporting into the Trust Wide Quality Governance (TWQG) meeting. Exceptions and progress will be shared with the Trusts Quality Committee.

The Trust Board routinely receives a patient story to understand patient experience and shared learning identified. To involve and hear the population we serve the Trust has a well embedded Patient Participation Panel (PPP) that has been in place for almost five years. The PPP members comprise of carers, ELHT patients (current and former), and representatives from Lancashire and Blackburn with Darwen Healthwatch and work with staff to ensure the patient voice is embedded with improvement projects. There is a recently established Children and Young Person's Forum, working in collaboration with schools within ELHT's footprint ensuring the younger persons voice is heard. The Trust has also recruited and started to introduce Patient Safety Partners (PSP) who will represent the patients voice within corporate meetings and in short and long-term service development initiatives.

- The introduction of PSPs within the NHS is a relatively new project, and its initial impact and potential will be reviewed in an annual report.

To support Martha's Rule (April 2024) ELHT have developed the 'Call 4 Concern' process. The first wave of implementation is aimed at all inpatient activity, allowing the patient, carer, relatives, and staff to request a second clinical opinion on a patient's condition, posters are displayed throughout all clinical areas.

- KPIs are being monitored and reported to Nursing and Midwifery Forum monthly.

A recent MIAA review of the Trusts complaints procedures gave an outcome of 'moderate assurance' with some recommendations, in particular, around the timeliness of responses based upon the newly revised KPIs.

- A quality improvement approach to improve all complaints related procedures is underway and being monitored via the Trust's Patient Experience Group (PEG), reporting into the Trust Wide Quality Governance (TWQG) meeting. Exceptions and progress will be shared with the Trusts Quality Committee (QC) .

The Trust routinely monitors feedback from patients and families via Friends and Family Tests (FFT) and participation patient surveys. All of which are report through PEG, TWQG and QC.

Leadership

Recommendation 2

'A strong clinical voice must be developed and the heard and championed Board to floor, and in wider system meetings'

At every Executive and Board meeting there are standing agenda items around Quality and Safety. Focused descriptions alongside actions are agreed and monitored at these meetings.

There are robust benchmarked clinical managerial structures for clinical divisions. Most recently, investment has been made with the allocation of resources to the appointment of a second Deputy Director of Nursing.

The Trusts Accountability Framework articulates developing a culture of responsibility, accountability, empowerment, and continuous improvement. It details the roles and responsibilities of staff to achieve this, the triumvirate and corporate responsibilities, and the floor to board assurance framework. This committee meeting structure is well embedded however, a review of internal Clinical Governance has been undertaken and as a result an updated Trust Wide Governance Committee has been introduced (May 24). This will further strengthen the assurance around key corporate and divisional risks.

Coaching and mentoring

The Trust has established systems and processed for colleagues to access coaching, mentoring and supervision including a new offer for Executive Coaching. All coaches are quality assured and offer coaching in line with our values and cultural aspirations. We have;

- Delivered updated Inclusive Coaching Conversations during January 2024 with positive feedback and developed and tested a new Mentee Awareness session aimed at Internationally Educated staff.
- Increased accessibility of CPD sessions for internal coaches and mentors, shortening the sessions and increasing frequency, through collaboration NWLA to provide Lunch and Learn sessions. ELHT delivered the session in March with 30 staff attending.
- Increased available coaches and mentors on the network through:
  - Providing three formal programmes to increase the number of qualified coaches, Leadership Mentors and HLM (Healthcare Leadership Model) 360 Facilitators.
  - Engaging all staff networks to promote coaching offer and request staff to train as leadership mentors.
  - Contacting staff trained with NWLA as leadership mentors and offering additional CPD to enable them to become Career Mentors allowing us to meet an increase in demand for career mentoring.
  - Contacting senior ELHT staff with previous experience of coaching and asking them to become Senior Leadership Mentors.
  - Quarterly system introduced for contacting network coaches and mentors to ensure up to date information regarding their availability.
  - Embedded Professional Midwifery Advocate (PMA) process and introduced the Professional Nurse Advocacy (PNA) role.

The Trust has implemented quarterly evaluations of coaching and mentoring activity enabling us to assess the impact of the service and also use the feedback to further promote through the Leadership Newsletters. The evaluation showed intervention either fully achieved goals (66%) or had some impact on goals (64%)

Culture

Recommendation 3

'The board must develop and lead a culture that places quality of care as its utmost priority, which is underpinned by compassionate leadership Board to floor. This culture must ensure that no staff experience discrimination'

The Trust has a well-established Values and Behaviour Framework which is embedded into the performance appraisal system and supports the Trust vision to deliver safe, personal and effective care. Teams are encouraged to develop a team behaviour framework which describes how the Trust values and behaviours are lived at team level and what patients, families, customers and colleagues should expect. This is also embedded in the Team Engagement Journey which is the Trust's approach to team development. Values based recruitment is being embedded.

The Trust and specifically the People and Culture Directorate are committed to reviewing and improving governance and accountability processes so that assurance and risks related to workforce and culture are reported to the Board in a timely and effective way. The People and Culture Committee was established in 2023 to ensure adequate time was afforded to the workforce agenda which includes staff stories and strategic oversight of the People and Culture agenda. This will be further enhanced with the development of a culture and belonging dashboard, divisional equality, diversity and inclusion (EDI) dashboards and a specific annual report for inclusion and belonging.

The Trust has included the development of a culture of inclusion and compassion as a strategic priority for 2024/25 and a commitment to become an intentionally anti-racist organisation. Both are Board objectives alongside the commitment to the development of our diverse staff networks that provide an opportunity for Board members to triangulate data, performance reporting with lived experience and to drive transformation. The Trust has committed to achieving the bronze award of the NW BAME Assembly Anti-Racist Framework in 2024, through the actions of the Aarushi Project, and oversight of the BAME staff network.

The Leadership and Management Strategy has 5 priorities and describes the Trust's Leadership Framework which sets expectations on how leaders and managers behave and enact our values and behaviours. This specifically references the culture we want to create to

ensure that we deliver quality outcomes and experience and foster a deep sense of belonging; one of compassion, inclusion and continuous improvement. This Framework is the basis for all the leadership and management development that is developed and delivered internally including programmes and modules for e.g. SPE+ Leadership Core Pathway, Compassionate Conversations (national pilot site), Introduction to Health Equity and Inclusive Leadership, New Managers Induction. In addition, the Trust offers localised national programmes, such as Mary Seacole Local, NHS England's Wellbeing Programme for Leaders and NHS Resolution's Compassionate Conversations. Compliance is detailed in **appendix 1.**

ELHT is part of Cohort 2 for the People Promise Exemplar and has modelled the Core Management Induction Pathway on the People Promise themes. The Inclusion Team and staff networks are collaborating with the Well Team to promote a culture of speaking up, belonging and cultural transformation by encouraging colleagues to join a staff network and become an ally.

The Trust Freedom to Speak Up (FTSU) policy now aligns with NHS England's guidance. In October 2023 we implemented FTSU Training, compliance is detailed in **appendix 2** and a requirement to increase to the 95% target for all levels, in particular band 9 and above roles. The FTSU Ambassador colleagues currently reflect the diversity of the workforce, however this is a continuous recruitment process.

Board Development is planned for June and October on inclusion and belonging. The Trust has a Health Inequalities Committee chaired by an Executive Director and an Inclusion Group chaired by the Trust Chair. Whilst in its infancy this committee has already identified workstreams with SMART measures to see an immediate impact to its work.

Workforce

Recommendation 4

'The Trust must work with its current and future workforce levels to recognise, adapt to and manage the safety challenges that a staffing shortfall may pose, including ensuring the stability of nursing staff. The Trust must develop a representative, competent and culturally sensitive workforce which is supported to provide service that meet the needs of its communities'

The Trust is participating in Cohort 2 of the national People Promise Exemplar to embed the People Promise and improve employee experience and to drive retention. The Trust is preparing to submit its 90-day submission following a review of our staff experience and retention data and surveys.

The Trust is one of the biggest providers of clinical placements within Lancashire and South Cumbria. We work in partnership across the system to ensure workforce supply, education and training are meeting the needs of our communities. The majority of nursing students trained within the Trust commence employment with us on qualification and we have a high-quality preceptorship programme and legacy mentor support to aid retention.

The Directorate of Education, Research and Innovation (DERI) has a Strategy and related Education Plan to support continuous development of staff with the intention that that feel invested in and stay within the Trust.

Over the last 12 months we have addressed the nursing and AHP workforce shortages with recruitment campaigns including internationally educated staff and Health Care Assistants and have an education programme in place to ensure they have the right skills and competencies to meet the needs of our patients and pathways to develop and progress.

We have an annual Training Needs Analysis for all staff which is reviewed on an ongoing basis to ensure that the education and development needs of our workforce are met. We also provide a range of internal training programmes including simulation-based education with a human factors and patient safety methodology.

We ensure that we have an adequate supply of skilled mentors, supervisors and educators to deliver education and supervision to all of our learners. All supervisors of students have attended appropriate training.

Estates and Environment

Recommendation 5

'The Trust needs to have a better understanding of the quality of its estate and the impact of this on the delivery of high-quality care, including providing a safe

environment. It must ensure that essential maintenance is identified and carried out in a timely manner and that the cleanliness of units is maintained.'

ELHT National PLACE Assessments 2023

The PLACE assessment programmes offer a non-technical view of the building and non – clinical services provided across all hospital providing NHS funded care and aims to promote the principles established by the NHS Constitution that focus on areas that matter to patients, families, and carers:

- Putting patients first
- Active feedback from public, patients and staff
- Adhering to the basis of quality care
- Ensuring services are provided in a clean and safe environment that is fit for purpose.

PLACE assesses several non-clinical aspects of the healthcare premises identified as important to by the patients and public, known as domains:

- Cleanliness
- Food and Hydration
- Privacy, dignity, and wellbeing
- Condition, appearance, and maintenance
- Dementia: how well the needs of patients with Dementia are met
- Disability: how well the needs of patients with a disability are met

The learning outcomes for National PLACE Assessment are presented at all the relevant groups and committees for consideration and identified objectives for improvement for the group and the organisation, **Appendix 3** details 2023 PLACE results.

The annual National PLACE Assessment criteria is embedded in the Trust Nursing Assessment and Performance Framework which ensures continued self-assessment by the Trust throughout the year and supports continued improvement agenda.

National Standards of Cleanliness

The Trust is committed to the highest standards of hygiene and cleanliness and recognises the importance of this to aiding infection prevention and control and quality of care.

A Task and Finish group has been established and chaired by the lead Infection Control Nurse to roll out the new National standards of cleanliness requirements for the Trust. This includes:

- Updated cleaning frequency schedules are currently being rolled out across all sites to be displayed at the entrance of every ward and department.
- Reviewing audit processes and triangulation of soft and hard intelligence to support clear learning, action, and sustainable improvement including (technical & managerial, cleaning audits, NAPF, IPC and annual National PLACE Assessment) in line with the new cleaning standards audit accountable requirements and CQC requirements.
- Ensuring patient services rotas across sites to capture demand and resource alignment to allow the correct level of service to meet the Trust clinical needs and national standards of cleanliness.
- All staff are planned to carry out a back to basic training programme to support the sustainable standards required.
- All nursing teams to undertake training in line with roles reasonability for cleaning in line with the new National Standards of Cleanliness.
- Capital funding (3-year strategy) requirement has been identified for cleaning machinery to improve processes and standards of cleanliness.

  - The Task and Finish group, once dissolved Divisions will provide assurances on delivery through Trust PLACE meetings.
  - In 2023 the Nursing Assessment Performance Framework (NAPF) commenced the inclusion of a Patient Services Supervisor on every NAPF to lead on and expedite any environmental / PLACE elements of the NAPF.

<u>Governance</u>

Recommendation 6

'The Trust must ensure that its governance structure (and the culture that is applied within) supports timely escalation and that the right information can be used at the right level, by the right staff. There must be much greater focus on the validation and triangulation of information to ensure that quality issues can be resolved quickly and learning can take place'

The Trust has an established Quality Governance Team, which provides strong, embedded support within clinical divisions. The workload of this Team is monitored to ensure that resource needs can be identified and rectified if necessary.

The current extensive committee structure is under review to further strengthen, ensuring that information flows from floor to board and providing adequate assurance that risk is being managed.

There is a strong incident reporting culture, all staff have access to DATIX incident reporting system and are encouraged to report incidents in line with the Trusts Incident/Accident Reporting Policy C003. Over the last 5 years the Trust has seen a 28% increase in the number of incidents that are reported and reviewed to improve safety through learning.

Information is proactively gathered and reviewed to ensure that safety concerns can be identified. This includes monitoring incidents, complaints and litigation for themes and learning, as well as patient feedback. Additionally, there are regular reports on staffing and staff satisfaction.

The Trust provides a wide range of training to enable staff to supervise, support and coach learners and colleagues.

National Patient Safety Training Levels 1 and 2 mandatory for all staff including bank staff to support further developing patient safety Culture within the Trust. The current position for ELHT National Patient Safety training is;
Level 1a , all staff = 93.3%
Level 1b, 8a and above including Board members = 83.5%
Level 2, essential to role for clinical staff = 83.3%

The Trust introduced the new National Patient Safety Incident Response Framework (PSIRF) in Dec 2021 which supports the Trusts to be more proactive rather than reactive to incidents. The Trust has developed a Patient Safety Incident Response Plan which identifies local priorities for investigation and quality improvement. The local priorities have been identified using the triangulation of date from key areas including incidents, complaints, risks, inquests, staff, patients and the families.

The Trust holds a weekly Complex Care meeting with representation from the Quality Governance department (risk, incident and complaints leads), safeguarding, and members from the respective Divisional triads. Also in attendance is a member from the Medical Examiners Office. The meeting reviews all new potential moderate and severe harm and/or concerns for agreement as to threshold for what type of investigation. Considers any matters raised that may impact on patient safety and decides how that might be escalated for further examination/action (potential through an existing governance meeting).

Human Factors training is provided for all staff, available to book on the Learning Hub. The training is designed to help staff gain an understanding of human factors approaches and look how to apply these to help improve safety within their work and working environment and how it relates to improved patient care and culture.

Clinical audit is embedded within the Trust, with forward planning and contribution to national audits. The trust also participates in the GIRFT programme. The Trust is updating the integrated performance reporting including a review and improvement to the process of governance around information sharing and escalation.

Workforce and development

Recommendation 7

'The Trust must ensure that Edenfield provides compassionate high-quality care and that all staff, permanent or temporary have the skills, knowledge and support to achieve this'.

The Trust currently assesses its culture through usage of the annual and quarterly staff surveys using the people promise themes and additional engagement and morale scores to track progress and highlight areas of focus for action. The Staff Sponsorship Group oversees the development of divisional actions plans and is chaired by the Chief Executive. Divisional performance meetings also track progress and any risks or issues around people and culture. Teams with a deteriorating position or below average performance are highlighted for follow up support from corporate functions. Trust priorities are agreed, and Big Conversations take place on key themes including raising concerns, engagement in change, supporting for mental wellbeing, developing line managers.

Teams are supported through the development of team leaders as team coaches through TED (Team Engagement and Development). As well as running an open programme and targeting this to teams who report below average staff survey results, the Trust is carrying out a test of change with a group approach to support broader OD changes by running co-located or clinical pathway teams together as a cohort to support sustainable change e.g., Autism Pathway, Estates and Facilities, Coronary Care.

Implementing the quarterly evaluations of Team Leader as Team Coach (TED) has enabled us to assess the impact of the service and use the feedback to further promote through the Leadership Newsletter. The evaluation showed intervention either fully achieved goals (50%) or had some impact on goals (50%), see some quotes below:

- *'Have Team Champions who plan wellbeing events- social activities. Introduced 1:1 Sister assurance Visits- a Sister works alongside a junior member of staff to mentor, offer feedback and support in skill and knowledge development. Introduced Team debriefs where staff have protected time to discuss any concerns, ways of working and offer any new ideas'.*
- *'Developed team purpose with vision, values and mission statement. Team has set up liaison meetings with other services to improve collaborative working on shared objectives'.*

Improvement Plan

Recommendation 8

'The Trust should review the improvement plan again following receipt of this report's findings to develop further clarity about the problems they are trying to solve and the actions that need to be taken to achieve better outcomes. It needs to be clear on how all actions will be evaluated so that it can be assured about whether changes being made are having the desired impact. The plan should be prioritized to ensure that actions are sequenced, build on each other, and prioritise the quality of care people receive from ELHT. This includes ensuring a balanced approach between the scale of the improvements required and setting out a realistic time scale for implementing identified actions with the support of their system partners'

Following the completion of this baseline assessment, compliance will be monitored via the TWQG on a monthly basis and assurances to Quality Committee in the format of a 6 monthly.

Elsewhere in the organisation

Recommendation 9

'We identified common concerns across services we visited at the Trust, which were also prevalent within Edenfield. The Trust and the wider system must consider how that understand issues identified in these services (and others) in more detail'

Our senior managers show a genuine desire to continuously improve our safety culture and performance and recognise that safety, and the consistency and reliability in which our services operate, remains crucial if we are to deliver safe, personal and effective care that enhances our credibility, reputation and future. Executives receive assurance from across the organisation though a number of well embedded processes. Examples of these include;

- Divisional quarterly performance meetings.
- Senior Support and Share (SSS) weekly walk rounds.
- Executive Quality Walkrounds.

System oversight

Recommendation 10

'The organisations with responsibility for regulation, oversight and support to GMMH must review their current systems of quality assurance. They must also review how they work together collectively to identify concerns in a provider at an early stage to prevent tragedies like those seen at Edenfield from reoccurring. Where learning is identified that applies nationally, this must be cascaded by the relevant organisation'.

The Trust actively engages with all required regulatory visits. The CQC hold quarterly engagement meetings and the Trust has cultivated an open and honest reporting culture which supports regular contact with the CQC in response to open enquiries. In addition to this the Trust provides monthly assurance data to the ICB in line with the quality metrics contained within the current contract, escalations from which are reported to NHSE via the ICB Quality Committee/QSB.

All open enquiries from the CQC/MHRA/HSE and other regulators/ICB are monitored and themes/trends escalated through the TWQG which is chaired by a member of the clinical executive team.

The Trust works closely with Place-Based Partnerships within Lancashire and Blackburn with Darwen to support effective partnerships and collaboration including vulnerable services or those potentially in distress. This has been built on from the learning through the Covid-19 pandemic during which the Trust supported partners in relation to the provision of PPE and in-reaching to support and sustain a local care homes in which residents were at risk to requiring transfer due to the sustainability of the home. Further examples include:

- Supporting the transfer, a number of vulnerable primary care practices (PWE) which have since been integrated and sustained as part of the Trust's Community and Integrated Care Division
- The transfer of adult physical health community services in Blackburn with Darwen from Lancashire and South Cumbria NHS Foundation Trust to East Lancashire Hospitals NHS Trust as part of a system-led strategy to ensure resilience, sustainability, critical mass and equity of service across the Trust's geography.

The Trust contributes to both Place and System partnerships through undertaking and modelling a range of leadership roles at Place, Provider Collaborative and ICS including chairing system board and SRO roles (Nursing, Diagnostics, Community and Operations). As part of this there is a mature and well-embedded improvement methodology which supports the delivery and development of services internally and externally with partners. This is linked to the Trust's strategic framework which outlines the Trust's vision, values, goals and priorities which in turn informs the annual business planning process.

> *'NHS England must review and clarify the role of the Greater Manchester Adult Secure (Northwest) provider collaborative and the governance structures needed to oversee this role. The responsibilities of the collaborative need to be discharged by staff with the right experience and expertise. In light of the concerns identified in this report in relation to Adult Forensic Services (and wider issues in the Trust's Specialist Services), the role of GMMH as lead provider needs to be reviewed by NHS England. If this arrangement is to continue, support should be provided to GMMH to stabilise the current situation and to develop it to deliver the role effectively in the future'*

The Lancashire and South Cumbria Provider Collaborative (PCB) brings together the five NHS provider trusts in Lancashire and South Cumbria to improve health and healthcare. The Trusts work together as equal partners to make sure patients, their families and communities' benefit across the whole of the area and aim to the reduce health inequalities and improve services, outcomes and people's experiences of accessing healthcare. The partnership also aims to ensure that Lancashire and South Cumbria is a great place to work.

The principles guiding the work of the Provider Collaboration Board have been agreed by the chairs and chief executives of the five trusts as follows:

- Work together as **one structured system** to achieve excellence.
- Have a **trusting, transparent and open** approach.
- **Share data and best practice, learning together when things go wrong.**
- Build a positive, aspirational culture based on **continuous improvement.**
- Encourage our staff to be **creative, innovative and aspirational** in what we want to achieve for our population and for each other.

- Be **inclusive**, ensuring joint working between the NHS, local authorities, the voluntary, community, faith and social enterprise (VCFSE) sector, and private providers.
- Work as **part of the Lancashire and South Cumbria system.**

The vision of the Provider Collaborative is as follows:

1) The best health and wellbeing for our population

This is important because across Lancashire and South Cumbria, deprivation and poor health affects many of our communities and differences in life expectancy and quality of life vary significantly. These health inequalities are neither acceptable nor fair.

2) High-quality services

This is important because our services are under unprecedented pressure which risks quality and safety. Moreover, not everyone has the same access to services, and service quality can vary depending on where you live.

3) A happy and resilient workforce

This is important because staff are our biggest asset. It is through our colleagues' great work that we deliver a great service. Our staff are, however, under tremendous pressure. Ensuring their wellbeing is paramount, as is attracting the best talent to come and work with us.

4) Financial sustainability

This is important because like health systems nationwide, we are facing significant financial challenges. We need to make every penny count and ensure the best value possible for the taxpayer. Ensuring we are financially sustainable means we can continue providing high-quality services to our communities.

The PCB is governed by a Board comprising the Chairs and Chief Executives of the 5 NHS Provider Organisations in Lancashire and South Cumbria. The Board meetings on a monthly basis and oversees a range of programmes of work including acute clinical reconfiguration and consolidation of central services. The PCB works closely with the Lancashire and South

Cumbria Integrated Care Board and Integrated Care Partnership to ensure system alignment, governance and collaboration for improvement, transformation and change.

Appendix 1

Recommendation 3

Recent activity in this area:

Core leadership pathway	21 participants in 2024 on pilot programme , mid-way evaluation demonstrates positive impact on participants.
Leadership forum	Attended by over 100 colleagues, open access.
Project M (peer wellbeing support for managers)	Monthly sessions attended by over 70 colleagues, innovative approach to wellbeing and developing peer support.
Coaching and mentoring	69% increase in coaching and mentoring requests in 2023/24 (111 requests) with 38 internal coaches and mentors.
Team development	22 team leaders trained in TED, 20 TED coaches trained
Leaders wellbeing support	236 preceptors completed resilience training, 19 staff completed mindfulness and compassion training.
Compassionate conversations	6 trainers active, 40 staff trained.
Mary Seacole local	30 internationally educated staff on programme.
Leadership and management modules	Action centered leadership fully booked, leading with emotional intelligence piloted, leading clinically under development, Handling difficult conversations on offer. Introduction to compassionate and inclusive leadership under development Handling conflict, under development.
EDI training	Full TNA under review to ensure it reflects the breadth of development needed to support EDI improvement plan including anti-racism, reasonable adjustments, cultural competence, neurodiversity, inclusive recruitment and talent management

Appendix 2

FTSU Training

Level 1 and 2 are required learning for all staff with a 2 yearly refresher

Level 3 is for senior staff in Band 9 roles and above with a 3 yearly refresher

The compliance target is set at 95%. Currently compliance within the Trust is:

Subject	No. Staff Assigned	Percentage of Staff Compliant
Freedom to Speak up: Level 1	10375	81.5%
Freedom to Speak up: Level 2	10375	77.1%
Freedom to Speak up: level 3	38	34.2%

Appendix 3

ELHT PLACE results 2023

Score per Domain	National 2023	ELHT 2023	ELHT 2022
Domain score for cleanliness	98.10%	95.14%	94.60%
Domain score for Food	90.86%	81.20%	80.84%
Domain score for Org Food	91.17%	88.07%	90.39%
Domain score for Ward Food	90.98%	79.13%	78.48%
Domain score for Privacy and Dignity	87.49%	87.22%	84.09%
Domain score for Condition and Appearance	95.91%	89.16%	91.71%
Domain score for Dementia Friendly	82.54%	87.59%	83.45%
Domain score for Disability	84.25%	87.86%	83.72%

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **102**

10 July 2024 **Purpose** Assurance

Title	Integrated Performance Report
Report Author	Mr D Hallen, Director - Data and Digital
Executive sponsor	Mrs S Gilligan, Chief Operating Officer

Summary: This paper presents the corporate performance data at May 2024

Recommendation: Members are requested to note the attached report for assurance

Report linkages

Related Trust Goal	Deliver safe, high quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to here.
Related to ICB Strategic Objective	State which ICB Strategic Objective the paper relates to here.

Impact

Legal	Yes/No	Financial	Yes/No
Equality	Yes/No	Confidentiality	Yes/No

Previously considered by:

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- Average fill rates for registered nurses/midwives and care staff remain above threshold.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) was above the 77% target in May at 80.93%.
- Performance against the ELHT four hour standard was 80.00% in May.
- No patients waited over 78 weeks.
- The number of RTT pathways over 65 weeks is below trajectory at 274.
- The Cancer 28 day faster diagnosis standard was above target in April at 78.3%.
- Friends & family scores remain above threshold for inpatients, outpatients, and community in May.
- The overall Trust performance from the range of patient experience surveys was above the threshold of 90% for 4 of the 4 competencies.
- The Trust turnover rate continues to show a significant reduction on pre-covid levels at 5.9%.
- The Trust vacancy rate is below threshold at 4.4%.

Areas of Challenge

- There were 4 Steis reportable incidents in May. None of these were never events.
- There were 8 healthcare associated clostridium difficile infections identified in May.
- There were 11 post 2 day E.coli bacteraemia identified in May.
- There were 5 Klebsiellas detected in May.
- There are some issues impacting the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). This includes: coding backlog, removal of SDEC data and data quality in the submission. As a result, neither metric is currently considered a robust measure of mortality.
- There were 5 stillbirths in May and 1 maternal death.
- There were 1200 breaches of the 12 hour trolley wait standard (60 mental health and 1140 physical health).
- There were a total of 3146 ambulance attends with 1118 ambulance handovers > 30 minutes and 388 > 60 minutes.
- Friends & family scores in A&E and maternity are below threshold.
- Performance against the cancer 62 day standard was above the 70% threshold in April at 73.9%.
- Performance against the cancer 31 day standard remains below the 96% threshold in April at 92.6%.

- The 6wk diagnostic target was not met at 11.7% in May.
- In May, the Referral to Treatment (RTT) number of total ongoing pathways has reduced on last month to 72,283.
- In May, there were 3,832 breaches of the RTT >52 weeks standard, which is below the trajectory.
- In May, there were 6 breaches of on the day operations cancelled and not rebooked within 28 days.
- Sickness rates are above threshold at 5.7%
- Compliance against the Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 13%.
- The Trust is reporting breakeven against a deficit plan of £5.0m at Month 2, however our current run rate is showing a deficit of £6.4m against this plan.

No Change

- The complaints rate remains below threshold and is showing no significant variation.
- There were 0 P.aeruginosa bacteraemia identified in May.

Data Completeness

The table below shows the status of the metrics included in this report

Latest month available	
Latest update not available, reported up to last month	
Update not available	

Metric	Data Source	Lead	May-24	Date available
C diff, e coli, p.aeruginosa, klebsiella		Infection Control - Laura Moores		
Mixed sex breaches		Corporate information		
Average fill rates		Corporate information		
Staffing narrative		Heather Coleman		
Nurse Staffing - Fill rate table		Heather Coleman		
Steis		Incidents team		
VTE		Corporate information		Metric in development
Pressure ulcers		Jane Pemberton		Graph not available
Friends & Family		Corporate information		
Number of complaints	Datix	Corporate information		
Complaints per 1000 contacts		Corporate information		
Patient experience		Quality - Sarah Ridehalgh/ Melissa Almond		
SHMI trend	National published SHMI	Performance team		Awaiting update following resubmission
HSMR	Dr Foster	Performance team		Awaiting update following resubmission
LeDeR		Julie Clift/ Alison Brown		
Structured judgement reviews (SJR)	Datix	Performance team		
Stillbirths	Maternity dashboard	Kathryn Sansby/ Carol Bell		
Maternal deaths	Maternity dashboard	Kathryn Sansby/ Carol Bell		
CQUIN	CQUIN Update	Andrew Costello		
A&E ELHT performance	Submitted performance	Corporate information		
A&E national performance	NHS Statistics	Performance team		
12 hr trolley waits		Performance team		
Ambulance handovers	NWAS	Performance team		
Ambulance handovers ELHT breaches	NWAS	A&E - Adele Dibden/ Claire Ashcroft		
RTT ongoing, over 40, over 52 wks	Submitted performance	Corporate information		
RTT ongoing graphs	Submitted performance	Corporate information		
RTT admitted/non-admitted	Submitted performance	Corporate information		
RTT average wait and ongoing %	Submitted performance	Corporate information		
RTT national	NHS Statistics	Performance team		
ELHT cancer - ELHT	Submitted performance	Cancer services - Victoria Cole		
ELHT cancer - national position	NHS Statistics	Cancer services - Victoria Cole		
Delayed Discharges Chart		Andrea Isherwood/ Kathryn Heyworth		
Emergency readmissions		Corporate information		Awaiting update following resubmission
Diagnostics % waiting over 6 weeks		Corporate information		
Diagnostic national performance	NHS Statistics	Performance team		
Average LOS benchmarking	Dr Foster/ Model Health	Corporate information		
Average lengths of stay		Corporate information		
Operations cancelled on the day		Corporate information		
Sickness, vacancy, turnover		HR - Mudassir Gire		
Overtime & Temporary costs		Finance - Ammaarah Yakub		
Appraisals		Learning hub team		
Appraisals AFC		Learning hub team		
Job plans		Salauddin Shikora		
Information governance		Learning hub team		
Core skills training		Learning hub team		
Finance/use of resource		Finance - Allen Graves		

Safe

	Indicator	Target	Actual	Variation	Assurance
M65	MRSA	0	1		
M64	Clostriduim difficile (C.diff) - 'Hospital onset healthcare associated (HOHA)'	n/a	7		
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	1		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	53	16		
M124	E-Coli (HOHA)	n/a	6		
M124.ii	E-Coli (COHA)	n/a	5		
M124.iv	E-Coli cumulative from April (HOHA & COHA)	129	25		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	0		
M155.ii	P. aeruginosa bacteraemia (COHA)	n/a	0		
M155.3	P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)	7	0		
M157	Klebsiella species bacteraemia (HOHA)	n/a	3		
M157.ii	Klebsiella species bacteraemia (COHA)	n/a	2		
M157.3	Klebsiella species bacteraemia cumulative from April (HOHA& COHA)	41	12		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	1		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	22.0		
M69	Serious Incidents (Steis)	No Threshold Set	4		
M70	Central Alerting System (CAS) Alerts - non compliance	0	1		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%			

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	96%		
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	26%		
C40	Maternity Friends and Family - % who would recommend	90%	79%		
C42	A&E Friends and Family - % who would recommend	90%	76%		
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	14%		
C44	Community Friends and Family - % who would recommend	90%	95%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	97%		
C15	Complaints – rate per 1000 contacts	0.40	0.20		
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	N/A	N/A		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at May-23)	N/A	N/A		
M74	Hospital Standardised Mortality Ratio - Weekday (as at May-23)	N/A	N/A		
M75	Hospital Standardised Mortality Ratio - Weekend (as at May-23)	N/A	N/A		
M159	Stillbirths	<5	5		
M160	Stillbirths - Improvements in care that impacted on the outcome	No Threshold Set	n/a		
M89	CQUIN schemes at risk	CQUIN schemes have been reintroduced for 2022/23			

Responsive

	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	77.0%	80.0%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	77.0%	80.9%		
M62	12 hour trolley waits in A&E	0	1200		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	1118		
M84	Handovers > 60 mins (Arrival to handover)	0	388		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	43.7%		
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set	58.2%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	72,983	72283		
C37.4	Referral to Treatment (RTT) 65 Weeks (Ongoing)	300	274		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	3877	3832		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	5.0%	11.7%		
C50.1	62d General Standard	70.0%	73.9%		
C50.2	31d General treatment standard	96.0%	92.6%		
C50.3	28d General FDS	75.0%	78.3%		
M9	Urgent operations cancelled for 2nd time	0	0		
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	6		
M138	No.Cancelled operations on day	No Threshold Set	98		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re-admissions within 30 days				
M91.1	Emergency average length of stay (excluding 0 and 1 days)	No Threshold Set	10.6		
M91.2	Emergency average length of stay (including 0 and 1 days)	No Threshold Set	7.7		

Well Led

	Indicator	Target	Actual	Variation	Assurance
M77	Trust turnover rate	12.0%	5.9%		
M78	Trust level total sickness rate	4.5%	5.7%		
M79	Total Trust vacancy rate	5.0%	4.4%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	81.0%		
M80.35	Appraisal (Consultant)	90.0%	100.0%		
M80.4	Appraisal (Other Medical)	90.0%	100.0%		
M80.2	Safeguarding Children	90.0%	94.0%		
M80.21	Information Governance Toolkit Compliance	95.0%	92.0%		
F8	Temporary costs as % of total paybill	4%	13.2%		
F9	Overtime as % of total paybill	0%	0%		
F1	Cumulative variance to planned financial performance (deficit) (£m)	£0.0	-£6.4		
F2.1	WRP achieved YTD - variance to plan (£m)	£0.0	-£7.2		
F3	Liquidity days	-21.1	-18.9		
F4	Capital spend v plan	85.0%	103%		
F18a	Capital service capacity	0.3	-0.1		
F19a	Income & Expenditure margin	-4.4%	-9.8%		
F21d	Agency spend as a proportion of total pay bill (£m)	3.2%	2.4%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	95.9%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	98.4%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	97.8%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	99.2%		

NB: Finance Metrics are reported year to date.

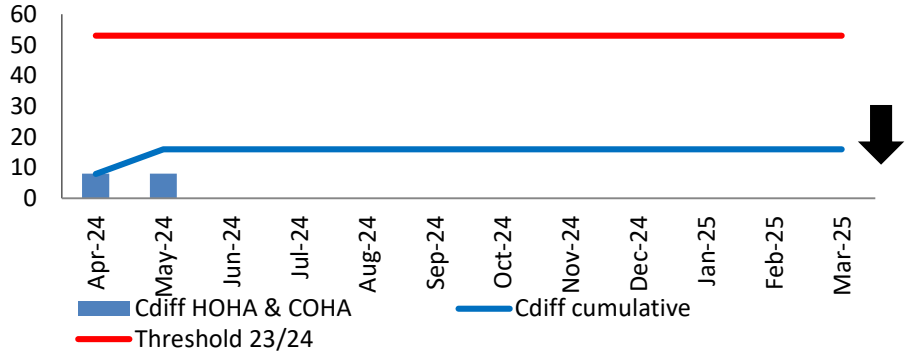
KEY

SPC Control Limits

The data period used to calculate the SPC control limits is Apr 18 - Mar 20.

SAFE

C Difficile (HOHA &



From April 2024 there will be a change in reporting of hospital acquired HCAI data as per updated guidance from UKHSA (UK Health Security Agency). Where a patient has been admitted directly after attendance to A&E it is requested the decision to admit date is entered as the A&E decision to admit date rather than the inpatient admission date.

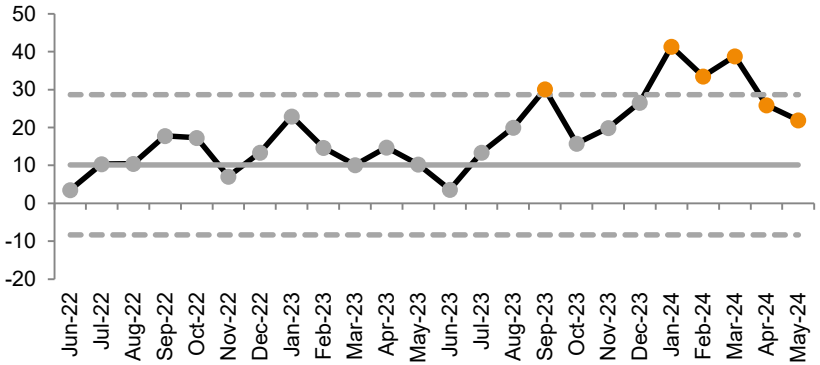
There was 1 post 2 day MRSA infection reported in May. So far this year there have been 1 case attributed to the Trust.

The Clostridium difficile objective for 2024/25 has not yet been set by NHS England. 2023/24 was to have no more than 53 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)'. The figure for cases reported in 2023/24 was 101.

There were 8 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in May; 7 HOHA and 1 COHA.

The detailed infection control report will be reviewed through the Quality Committee.

C Diff per 100,000 Occupied Bed Days (HOHA)



The rate of HOHA infection per 100,000 bed days is significantly higher than normal variation in May.

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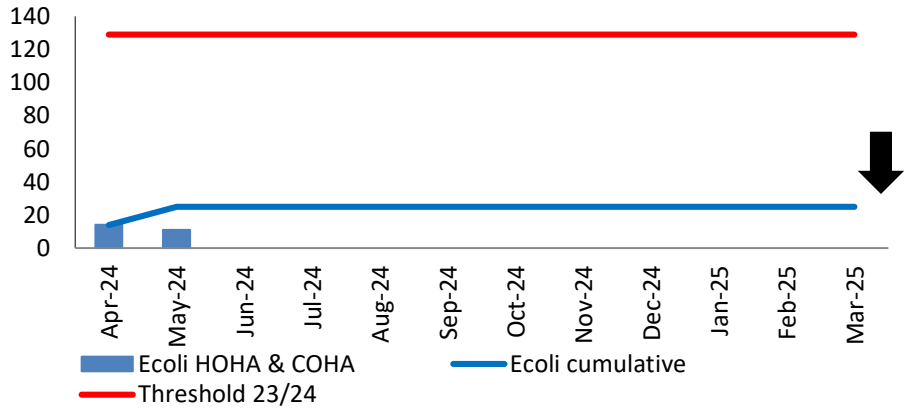
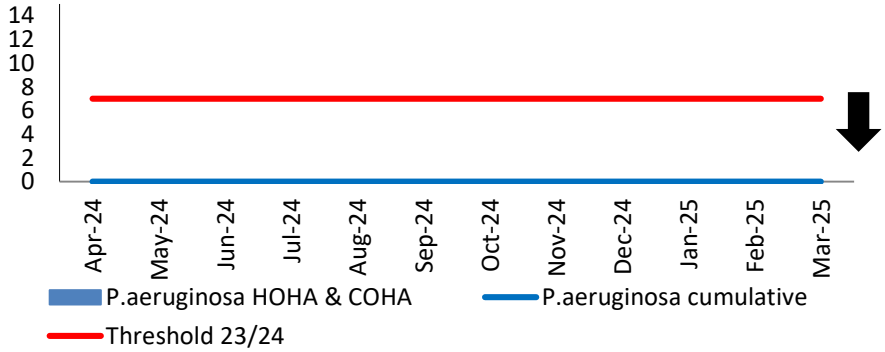
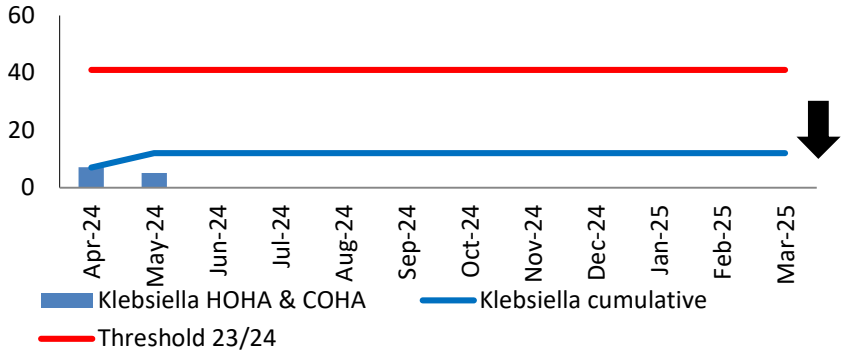
E. Coli (HOHA & COHA)



P.aeruginosa



Klebsiella



The UK Government has developed a new AMR 5 year national action plan, 'Confronting antimicrobial resistance 2024 to 2029', which builds on the achievements and lessons from the first national action plan. Its overall aims are to:

* optimise the use of antimicrobials.
* reduce the need for, and unintentional exposure to, antibiotics.
* support the development of new antimicrobials.

The National action plan contains a number of ambitions, including:

* By 2029, we aim to prevent any increase in a specified set of drug resistant infections in humans from the 2019 to 2020 financial year baseline.
* By 2029, we aim to prevent any increase in gram-negative bloodstream infections (which are described as difficult to treat infections) in humans from the FY 2019 to 2020 baseline.
* By 2029, we aim to increase UK public and healthcare professionals' knowledge on AMR by 10%, using 2018 and 2019 baselines, respectively.
* By 2029, we aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline.
* By 2029, we aim to achieve 70% of total use of antibiotics from the access category (new UK category) across the human healthcare system.

No trajectories have been set for 2024-25 by NHS England.

The 23-24 trajectory for reduction of E.coli was 129 HOHA & COHA. The total for 2023-24 was 134.

There were 11 reportable cases of E.coli bacteraemia identified in May; 6 HOHA and 5 COHA.

There were no reportable case of Pseudomonas identified in May.

There were 5 reportable cases of Klebsiella identified in May; 3 HOHA and 2 COHA.

Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

The work on catheter care, prevention of line infections, sepsis and improving hydration will help prevent healthcare associated bloodstream infections.

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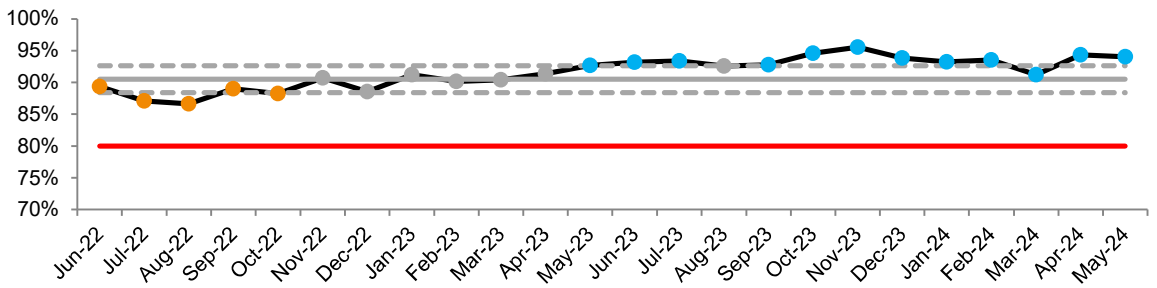
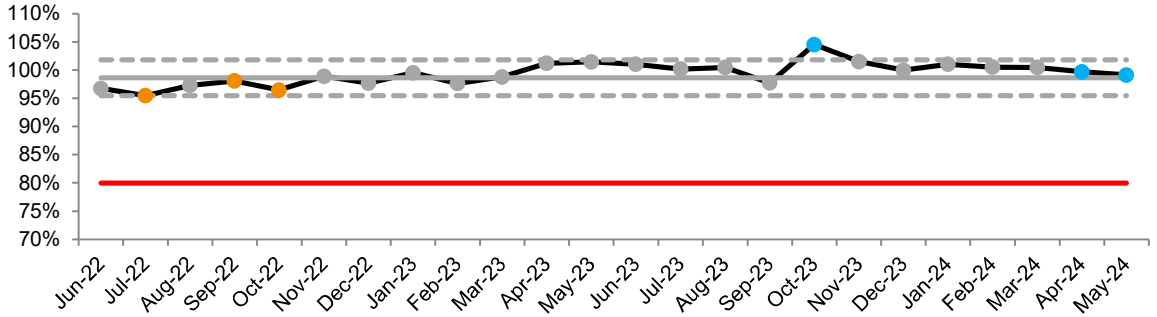
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



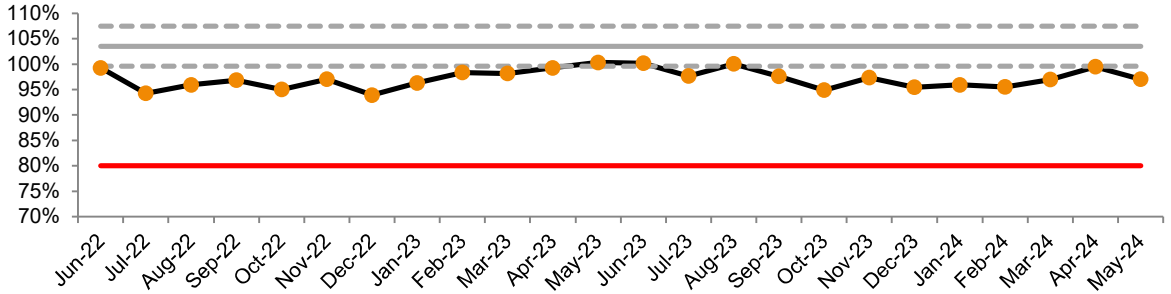
The average fill rate for registered nurses/ midwives during the day is showing improving variation when compared to the pre covid levels. Based on current variation it will consistently be above threshold.

Registered Nurses/ Midwives - Night



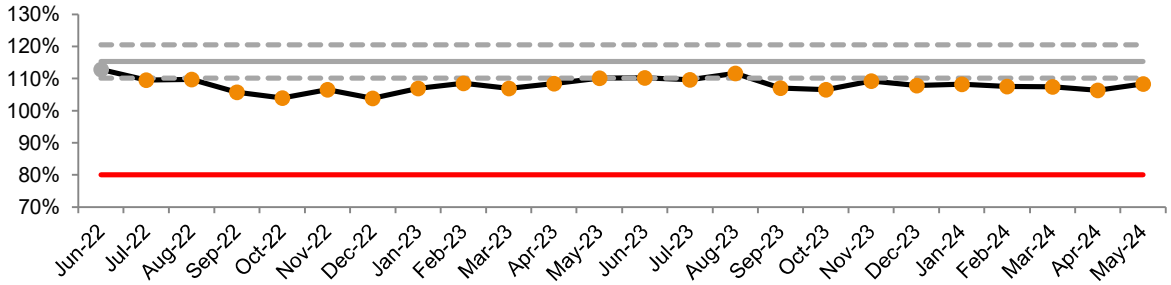
The average fill rate for registered nurses/ midwives at night is showing improving variation when compared to pre-covid levels. Based on current variation it will consistently be above threshold.

Care Staff - Day



The average fill rate for care staff during the day continues to be below the pre covid levels, however based on current variation will consistently be above the threshold.

Care Staff - Night



The average fill rate for care staff at night continues to be below the pre covid levels, however based on current variation will consistently be above the threshold.

SAFE

Throughout the month, the planned nursing and midwifery staffing levels for the 42 inpatient wards at East Lancashire Teaching Hospitals were compared with the actual staffing levels daily. This allows the calculation of a percentage fill rate for each ward, day, and night.

The table below demonstrates average fill rates per hospital site at ELHT in May.

	Day Average Fill Rate %		Night Average Fill Rate %	
Hospital site	**Registered nurses / midwives (%)**	**Care staff (%)**	**Registered nurses / midwives (%)**	**Care staff (%)**
Royal Blackburn	93.8	94.0	99.2	109.2
Burnley General	95.2	100.6	98.9	108.5
Clitheroe Community	86.1	110.9	101.1	100.8
Pendle Community	97.6	114.8	100.0	102.6
Total	**94.1**	**97.1**	**99.2**	**108.3**

*Clitheroe Community (Ribblesdale Ward) have high long and short sickness, this was 13.7% in April and now reduced to 12% in May, no particular themes. 1.88 WTE band 5 vacancies, NQN allocated to commence in September due to the geographical location unable to place internationally recruited nurses here.

Latest Month - Average Fill Rate

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
May-24	94.1%	97.1%	99.2%	108.3%	31,886	8.02	0	1	0	0

SAFE

Monthly Trend

The table below demonstrates the month-on-month overall average fill rate, CHPPD and wards < 80%.

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)
May-23	92.7%	100.3%	101.5%	110.2%	29,172	8.95	1	1	0	0
Jun-23	93.2%	100.2%	101.1%	110.2%	28,056	8.95	1	1	1	0
Jul-23	93.3%	97.7%	100.2%	109.6%	29,766	8.61	0	2	0	0
Aug-23	92.6%	100.1%	100.5%	111.7%	30,062	8.54	1	2	0	0
Sep-23	92.8%	97.6%	97.8%	107.2%	29,886	8.26	0	2	2	1
Oct-23	94.6%	94.9%	104.5%	106.6%	31,679	8.09	0	2	0	1
Nov-23	95.5%	97.4%	101.5%	109.3%	30,083	8.35	0	3	0	0
Dec-23	93.4%	95.4%	100.0%	108.0%	30,111	8.52	1	2	0	1
Jan-24	93.2%	95.9%	101.0%	108.3%	31,392	8.19	0	4	0	1
Feb-24	93.5%	95.5%	100.5%	107.6%	29,830	8.04	1	2	1	1
Mar-24	91.2%	97.0%	100.5%	107.5%	30,877	8.23	0	2	0	1
Apr-24	94.3%	99.5%	99.7%	106.4%	30,852	8.05	0	1	1	1
May-24	94.1%	97.1%	99.2%	108.3%	31,886	8.02	0	1	0	0

There were 42 wards included in the review.

SAFE

During May <80% fill rate:

< 80% Care staff		
Day	NICU	27.40
Night	-	-

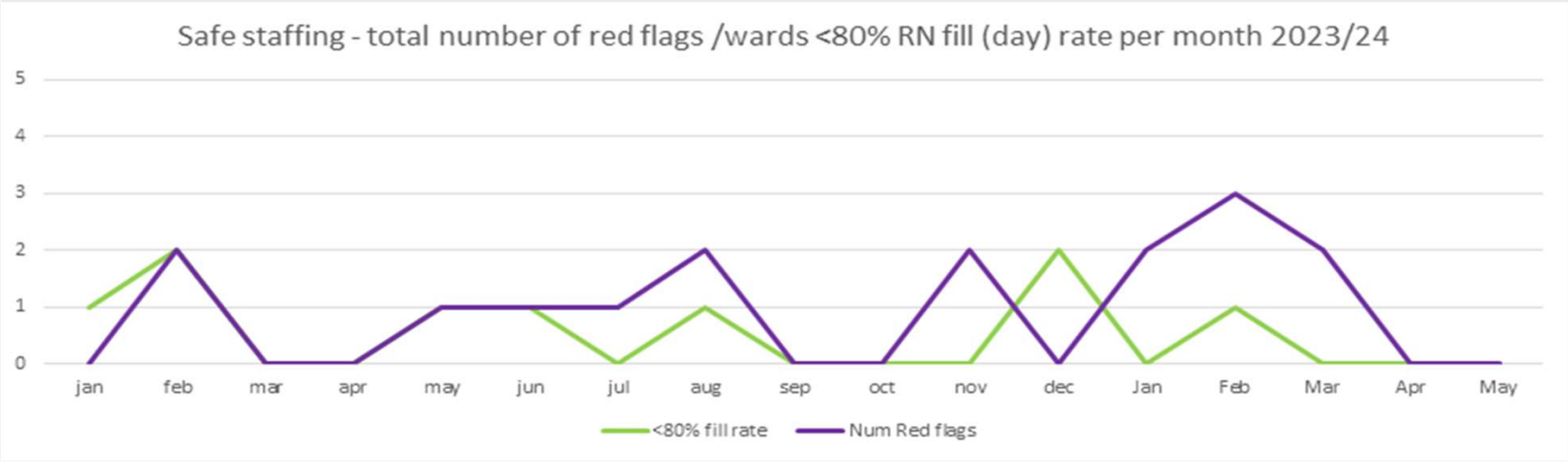
NICU - NICU HCA funded establishment does not cover all shifts. Safely staffed for acuity.

< 80% Registered staff		
Day	-	-
Night	-	-

National Red Flags

No national nursing red flags reported in May.
No maternity red flags reported in May.

The graph below demonstrates the number red flags and wards < 80% per month trend.



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Family Care

Month	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Staffed to full Establishment	01:26	01:26	01:26	01:26	01:26	01:26	01:27	01:26	01:26	01:26
Excluding mat leave	01:26	01:26	01:26	01:26	01:26	01:27	01:26	01:27	01:27	01:27
Maternity leave	3.04	3.04	3.04	5.04	4.40	6.40	6.40	6.40	9.60	9.60
With gaps filled through ELHT Midwife staff bank	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage
Per week	20.74	19.14	22.26	16.12	15.60	24.36	24.19	23.16	28.47	20.65
Midwifery vacancies (Maternity VRS) -11wte	25 wte (11) Backfill for mat leave included	24 wte (11) Backfill for mat leave included	14 wte (11) Backfill for mat leave included	12 wte (11) Backfill for mat leave included	12 wte (11) Backfill for mat leave included	12 wte backfill for Maternity leave incl	10 wte backfill for Maternity leave incl	12 wte backfill for Maternity leave incl	15 wte backfill for Maternity leave incl	15 wte backfill for Maternity leave incl

Maternity- Safe midwifery staffing levels also continue to be reviewed with the appropriate risk assessments 4 times a day at each safety huddles. Additional staffing/ leadership huddles will take place in periods of extreme staffing pressures to mitigate throughout maternity services; midwives are redeployed to other areas to support acuity and activity as and when required. There has been a reduction in bank filled duties which was high last month to cover maternity leave. Maternity have recently recruited 2.44 WTE midwives who have commenced in their role and a recent successful recruitment drive will see 16.25 WTE midwifes commence in September. Local midwifery red flags noted at each handover and reviewed by the local governance team on a weekly basis.

Neonatology –Acuity/ Dependency and activity peaks resulting in both internal and external closures with a small number of transfers out. Staffing levels meet the requirements for the acuity/ activity aligned with the NW connect safe staffing tool. The planned versus actuals meet the safe staffing requirements for the days in month of May 2024, this is equal to the number of infants required intensive, special, and high dependency care. Daily maternity/ Neonatology safety huddles inclusive of safe staffing tool completed twice daily, more frequently if required. Risk assessments prior to agency nurse cover requests are discussed with the Deputy Chief Nurse and Chief Nurse.

Paediatrics – No staffing exceptions. Shortfalls reflect acuity and dependency as reflected in the planned Vs actuals.

Gynaecology – No staffing exceptions, temporary ward move to 16 at BGH due to the Trust regulation fireworks although this work has not yet commenced due to other Trust priorities.

SAFE

Nurse and Midwifery Staffing Data - May

Current vacancies

Vacancies	Establishment	SIP	Vacant	Vacant %
Midwife	284	282	2	0.65%
Nurse	2712	2649	63	2.34%
HCA	1282	1163	119	9.25%
Grand Total	**4278**	**4094**	**184**	**4.30%**

Ethnicity

Ethnicity	HCA	Midwife	Nursing	Grand Total
BME	267	41	842	1150
Not stated	9		9	18
White	1100	313	2147	3560
Grand Total	**1376**	**354**	**2998**	**4728**

The chart above demonstrates that 32% of our nursing and midwifery workforce are of BME origin.

Gender

Gender	HCA	Midwife	Nursing	Grand Total
Female	1215	353	2794	4362
Male	161	1	204	366
Grand Total	**1376**	**354**	**2998**	**4728**

8.3% of our nursing and midwifery establishment are male.

Age Band	HCA	Midwife	Nursing	Grand Total
<=20 Years	31			31
21-25	84	24	165	273
26-30	115	50	411	576
31-35	191	52	543	786
36-40	182	59	446	687
41-45	142	53	343	538
46-50	149	34	344	527
51-55	186	34	345	565
56-60	186	32	234	452
61-65	98	15	146	259
66-70	9	1	15	25
>=71 Years	3		6	9
Grand Total	**1376**	**354**	**2998**	**4728**

28% of nursing and midwifery workforce are over 50.

Safe staffing processes/interventions to mitigate risk

Safe staffing processes/interventions to mitigate risk

Twice daily staffing calls
The Trust has a twice daily (Monday to Friday) and daily (weekends) Trust wide safer staffing review which utilises the safe care software (Safer Nursing Care Tool) to assess staffing levels with current acuity and dependency. This is routinely chaired by a Divisional Director or Heads of Nursing. The meeting is outcome focused and manages the risk across the Trust.

Recruitment/retention nursing and midwifery trust activity overview

International Nursing Recruitment – agreed to temporarily pause the recruitment of International Nurses until April 2024. This was largely due to an evidenced reduction in appropriate band 5 nursing vacancies. Still under review. 20 in April, 18 in May, 20 in June, 20 in July, 20 in August, 20 in September, 16 in October, 16 in November, 11 in December, 8 in January, Paused, 5 due in May, 5 due in July, Paused.

HCA Recruitment / Retention - ESR data 92.87 band 2 WTE HCA vacancies. Direct recruitment to from bank to substantive posts has taken place and for the remaining vacancies a central HCA recruitment event is being planned for mid-May where staff will be directly recruited on the day.

Professional Judgement – formal professional judgement paper to Trust Board.

Trainee Nurse Associate – Agreed to recruit 20 in Sept 2024 and 20 in March 2025.

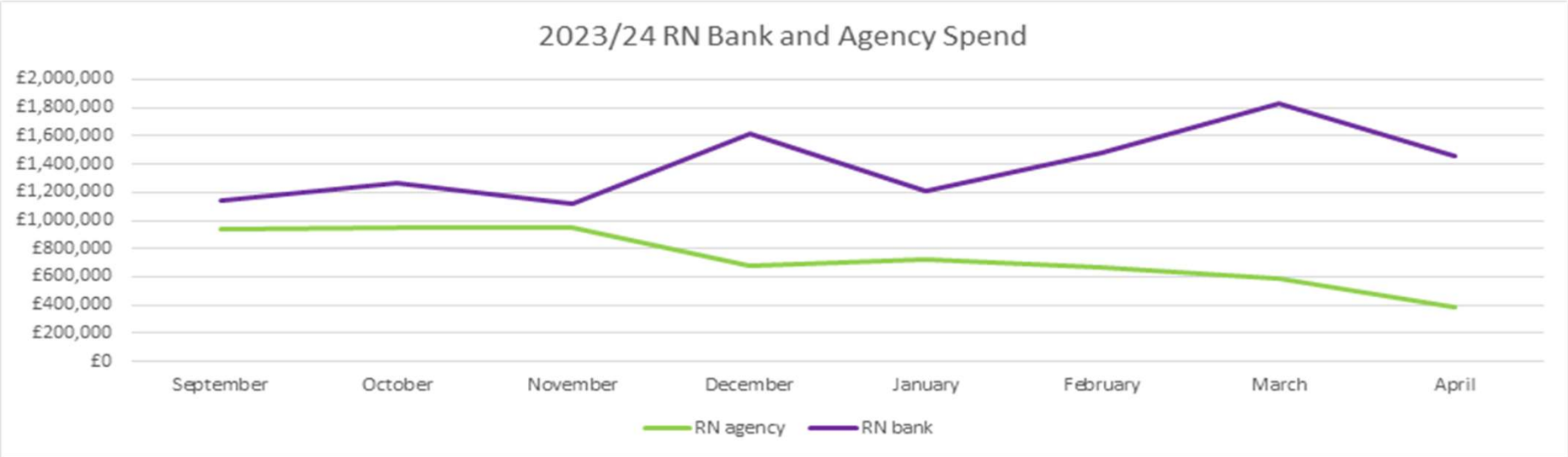
RNDA – Recruit 12 in September 2024 and 20 in September 2025.

District Nursing – Currently 14.91 WTE band 5 vacancies of which 6.5 WTE are recruited and have start dates. Difficult to recruit international nurses due to the requirement to drive. Recent Professional Judgement process agreed to convert some of these posts to band 6s to increase senior nurse and provide career pathways.

ED – Currently 14.91 WTE band 5 vacancies of which 6.5 WTE are recruited and have start dates. Difficult to recruit international nurses due to the requirement to drive. Recent Professional Judgement process agreed to convert some of these posts to band 6s to increase senior nurse and provide career pathways.

SAFE

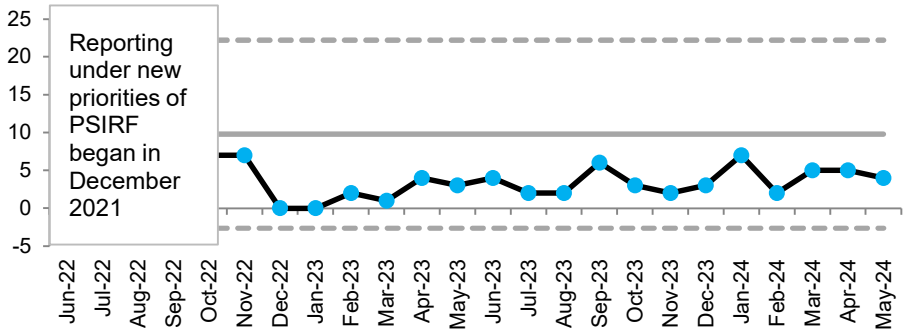
Nursing and Bank and Agency Spend



May bank and agency spend not available at the time of the report.

SAFE

Serious Incidents



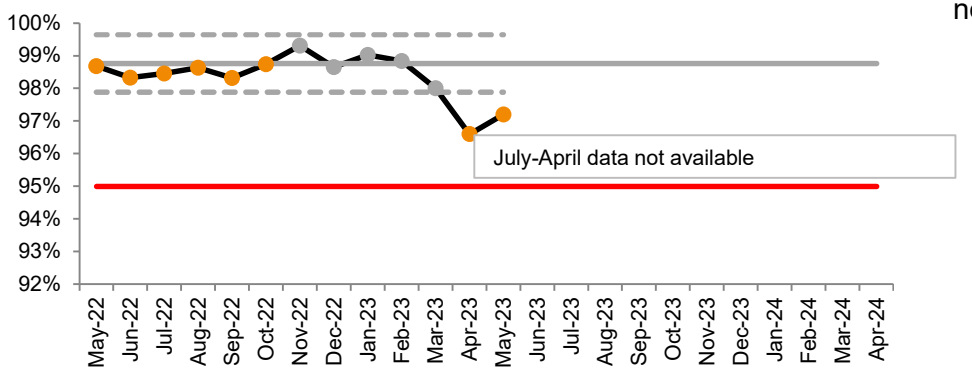
There were no never event reported in May.

Four incidents meeting a national or local priority and whereby a patient safety incident investigation (PSII) are underway, have been reported onto STEIS in April.The Trust started reporting under these priorities on 1st December 2021.

A detailed report providing assurance on the management of each of the STEIS reported incidents is submitted monthly to the Trust Board and Quality Committee.

PSIRF Category	No. Incidents
National priority - incident resulting in death	2
National priority - each baby counts	2

VTE assessment



Venous Thromboembolism (VTE) assessment trend - data not available for July-April.

SAFE

Pressure Ulcers

For May we are reporting the current unvalidated pressure ulcer position, pending investigation, as follows:

Chart not available this month due to technical issues

	Total Number of Incidents developed under ELHT Care		
	2022-2023	2023 - 2024	1.4.2024 – 31.5.2024
	717	852	82
Category of Pressure Ulcer	Total Number of Lapses in Care		
2	73	73	2
3	6	15	6
4	9	10	0
Unstageable	33	30	
DTI	92	112	
TOTAL	**213 (29.7%)**	**240 (28%)**	8

During 2023-2024 the number of reported pressure ulcer incidents increased by 135 however the % of lapses in care has decreased to 28%.

The Trust continues to see increased attendances through the ED department of complex and high acuity patients which has resulted in long waits within the ED department, following a decision to admit, despite increasing the bed base across the inpatient sites. An increase in activity is also reflective within the District Nursing service which is averaging over 900 visits per day..

From the 1st April 2024 ELHT implemented the recommendations of the National Wound Care Strategy removing the categories DTI and Unstageable Category's – which will lead to an increase in the number of moderate incidents being reported.

The 2023-2024 CCG CQUIN Assessment and Documentation of Pressure Ulcer Risk ended in March 2024, however this has been replaced by a Quality Indicator with the same audit measures. In April 2024, the Trust achieved 44% (Target 65-85%). The DDN's & the Pressure Ulcer Steering Group are working together to strive for a more proactive approach with the completion of relevant risk assessments, ensuring individualised care plans are activated which ensures that prevention measures/relevant equipment is in place more timely.

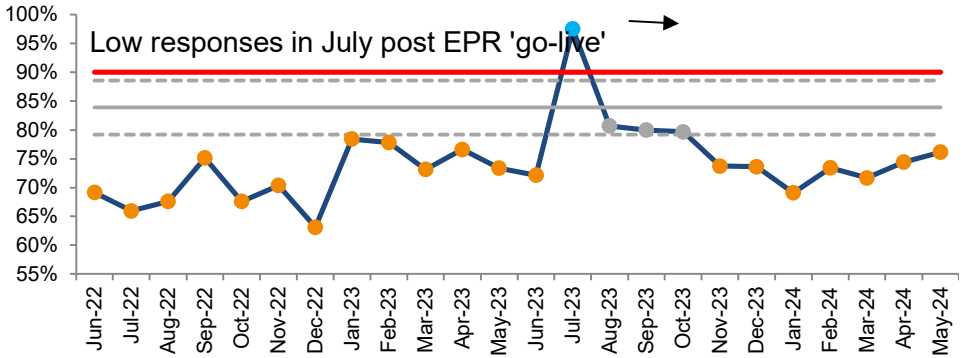
Compliance with the pressure ulcer e-learning is 90.92% and 91.38% for the moisture associated damage e-learning – each Divisional Lead as part of the Pressure Ulcer Steering Group has actions in place to increase the compliance to 95%.

CARING

The Friends & Family Test (FFT) question – “Overall how was your experience of our service” is being used to collect feedback via SMS texting and online via links on the Trust’s website.

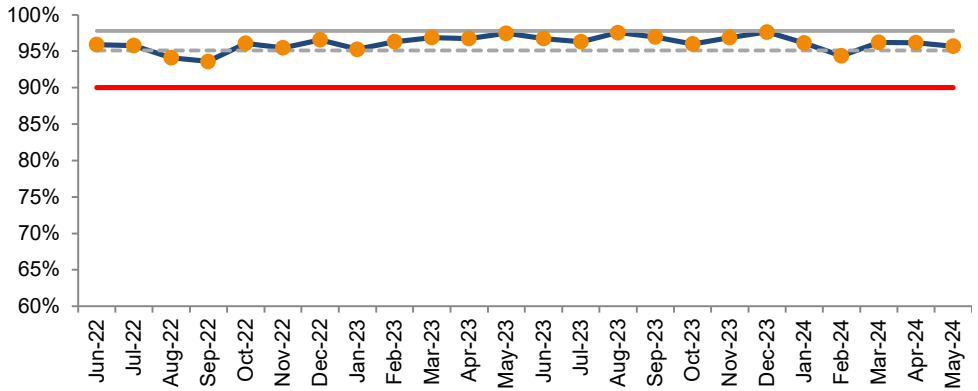
Baseline period for SPC comparison is Apr 18 - Mar 20

Friends & Family A&E



A&E scores are below threshold in March. The trend is showing significant deterioration when compared to the baseline (Apr 18 - Mar 20). Based on current variation this indicator is not capable of hitting the target routinely.

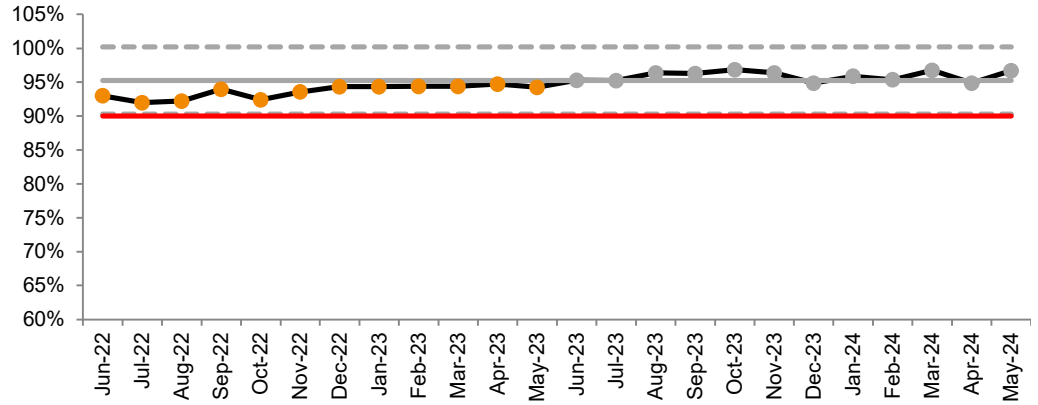
Friends & Family Inpatient



Current performance is above target but is showing significant deterioration from the pre-covid baseline, however based on recent performance will consistently be above threshold.

CARING

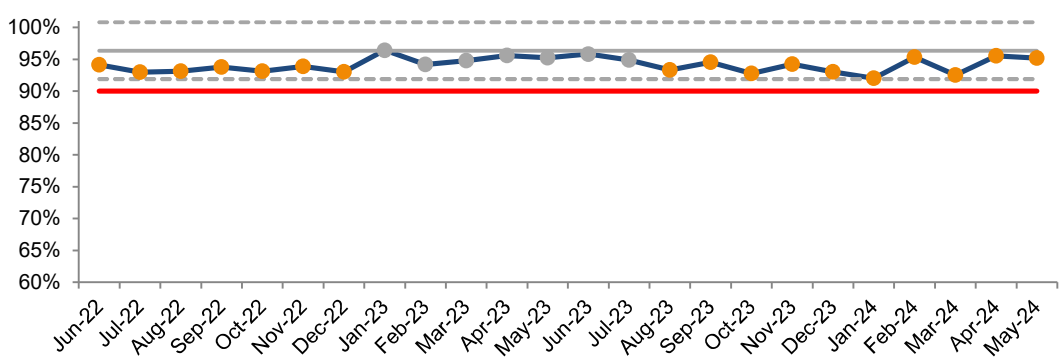
Friends & Family Outpatients



Outpatient scores continue to be above target and are within the normal range when compared to the pre-covid baseline.

Based on current variation this indicator should consistently hit the target.

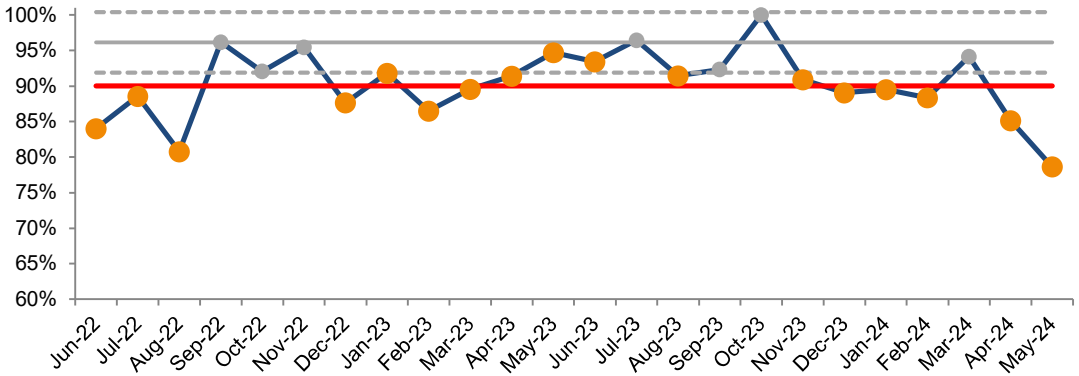
Friends & Family Community



Community scores are above target but showing deterioration when compared with pre-covid levels.

Based on normal variation this indicator should consistently hit the target.

Friends & Family Maternity

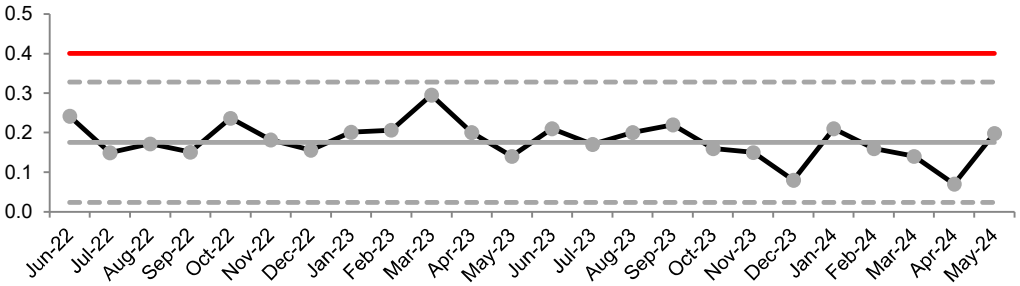


Maternity scores are below target this month and show deterioration when compared to the pre-covid levels.

Based on normal variation this indicator would consistently hit the target.

CARING

Complaints per 1000 contacts



The Trust opened 26 new formal complaints in May.

ELHT is targeted to achieve a threshold of at or less than 0.4 formal complaints per 1,000 patient contacts – made up of inpatient, outpatient and community contacts.

For May the number of complaints received was 0.20 Per 1,000 patient contacts.

The trend is showing usual variation and based on variation will consistently acheive the target.

Patient Experience

		Dignity	Information	Involvement	Quality	Overall
Type	**Division**	Average Score	Average Score	Average Score	Average Score	Average Score
Community	Community and Intermediate Care Services	95.37	92.61	94.69	96.44	95.06
Community	Diagnostic and Clinical Support	100.00	100.00	100.00	100.00	100.00
Community	Family Care	75.00	-	-	75.00	75.00
Community	Surgery	100.00	97.85	-	-	98.45
Delivery	Family Care	100.00	-	100.00	100.00	100.00
Inpatients	Community and Intermediate Care Services	86.67	79.01	85.47	85.36	84.12
Inpatients	Diagnostic and Clinical Support	99.70	94.44	93.60	97.29	96.56
Inpatients	Family Care	95.31	93.88	94.10	93.64	94.25
Inpatients	Medicine and Emergency Care	83.23	70.95	79.05	81.12	78.50
Inpatients	Surgery	97.20	92.55	95.05	95.56	95.02
OPD	Diagnostic and Clinical Support	98.40	95.27	98.75	93.65	96.49
OPD	Family Care	98.41	96.77	98.12	95.75	97.22
OPD	Medicine and Emergency Care	98.71	96.57	98.78	96.47	97.39
OPD	Surgery	100.00	100.00	100.00	100.00	100.00
SDCU	Family Care	96.21	95.16	95.93	98.86	96.32
	Total	**95.32**	**92.63**	**93.30**	**94.75**	**93.88**

The table demonstrates divisional performance from the range of patient experience surveys in May 2024.

The threshold is a positive score of 90% or above for each of the 4 competencies.

The overall Trust performance from the range of patient experience surveys was above the threshold of 90% for all 4 of the competencies.

Divisions are encouraged to review survey feedback to identify areas for improvement.

EFFECTIVE

SHMI Published Trend

There are some issues impacting the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR), including:
- Backlog in coding
- Removal of Same day emergency care (SDEC) from Admitted Patient Care (APC) dataset
- Data quality issues with SUS submission impacting spell counts

A bulk submission of SUS data was made in April which should improve data quality. However, the large backlog in clinical coding and the removal of SDEC will continue to impact mortality figures.

The Trust has an established mortality steering group which meets monthly to review performance and develop specific action plans for any alerting mortality groups identified.

HSMR

EFFECTIVE

Structured Judgement Review Summary

	Month of Death																					
Stage 1	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar	Apr 20 - Mar 21	Apr 21 - Mar	Apr 22 - Mar 23	Apr 23 - Mar 24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	TOTAL
Deaths requiring SJR (Stage 1)	47	212	250	262	214	163	231	167	14	12											26
Allocated for review	46	212	250	262	214	163	231	132	2	2											4
SJR Complete	46	212	250	262	214	162	230	94	0	0											0
1 - Very Poor Care	1	1	0	0	1	1	1	1	0	0											0
2 - Poor Care	8	19	22	34	35	22	41	17	0	0											0
3 - Adequate Care	14	68	70	70	65	49	75	23	0	0											0
4 - Good Care	20	106	133	129	103	78	106	49	0	0											0
5 - Excellent Care	3	18	25	29	10	12	7	4	0	0											0
Stage 2																					
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	42	22	1	0											1
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	0	0	1	0											1
Allocated for review	6	18	21	30	35	22	42	22	0	0											0
SJR-2 Complete	6	18	21	30	35	22	42	20	0	0											0
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0											0
2 - Poor Care	3	6	7	13	13	10	21	8	0	0											0
3 - Adequate Care	2	10	13	13	21	10	16	8	0	0											0
4 - Good Care	0	1	0	2	1	1	4	4	0	0											0
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0											0

	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar	Apr 20 - Mar 21	Apr 21 - Mar	Apr 22 - Mar 23	Apr 23 - Mar 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
stage 1 requiring allocation	1	0	0	0	0	0	0	35	12	10											22
stage 1 requiring completion	0	0	0	0	0	1	1	38	2	2											4
Stage 1 Backlog	1	0	0	0	0	1	1	73	14	12											26
stage 2 requiring allocation	0	0	0	0	0	0	0	0	0	0											0
stage 2 requiring completion	0	0	0	0	0	0	10	2	0	0											0
Stage 2 Backlog	0	0	0	0	0	0	10	2	0	0											0

The new structured judgement review process was launched at the beginning of December 2017 for deaths meeting specified criteria. A team of reviewers have been trained on how to complete SJR's and are now undertaking the monthly reviews.

The table shows a breakdown of SJR's completed and the scores allocated. Any death allocated a SJR score of 1 or 2 will have a stage 2 SJR completed.

The stage 2 SJR reviewer will determine whether or not any lapses in care may have contributed to the death and if so a SIRI and RCA will be triggered.

Learning Disability Mortality Reviews

19 reviews outstanding
There are currently reviews 14 outstanding for SJR1
1 for SAR
2 to coroner
3 Deaths notified in May 2024

Issues for escalation from completed review:
Family should have been informed earlier.
Capacity assessment should have been completed earlier.
DOLS should have been completed earlier.
No new actions logged

Commissioning for Quality and Innovation (CQUIN)

ELHT have 15 CQUINs (inclusive of 4 Specialist Service Schemes) relevant to services, 3 are new for 2023-24 (highlighted). The following processes are in place to enable measurement to be undertaken and meet the submission window above:
5/15 CQUINs require data collection of which 5 will be undertaken by the Clinical Audit & Effectiveness Team supported by the relevant specialty leads / service i.e. (500 Case reviews per quarter or all relevant cases where <100 meet the submission criteria). CAE team members have been assigned to support each CQUIN
5/15 CQUINs will be measured locally by the Clinical Teams / services, support from the CAE Team where required
5/15 have existing systems in place for data submission via National data collections / National Clinical Audits etc. performance reports will be shared via the relevant providers

Table 1 identifies how measurement will be undertaken for the relevant CQUINs / PSS schemes, the teams responsible for data collection /collation

Table 1: 2023-24 CCG Schemes

Ref:	Measurement Process Agreed
CCG1	Has an existing process in place for monitoring via monthly provider submission to UK Health Security Agency (UKHAS) via Import
***CCG2**	Clinical Audit of 100 patients (or all patients if <100) to be completed by the CAE Team supported by the Enhanced Recovery Team
***CCG3**	Clinical Audit of 100 patients (or all patients if <100) to be completed by the CAE Team & Antimicrobial Stewardship Group
CCG4	Outcome figures to be obtained via the Somerset Cancer Registry by the Cancer Services Team
CCG5	Clinical Audit of 100 patients (or all patients if <100) to be completed by the CAE Team in liaison with the MfOP Complex Needs & AcMed Management Team
***CCG6**	Monthly report from NHSBSA dataset, which will be made available to providers for checking and (where necessary) challenge.
***CCG7**	Clinical Audit of 100 patients (or all patients if <100) to be completed by the Acute Care Team
****CCG8**	Data to be submitted to the National Vascular Registry within 8 weeks of the end of each quarter. Quarterly reports to be provided from National Vascular Registry (NVR) including a validated assessment against SUS (Secondary Uses Service) data.
****CCG9**	Blueteq data will be assessed by the national team. Data will be validated against the HCV Patient Registry and the HCV Drugs Minimum Dataset.
****CCG10**	Reporting template to be submitted to commissioner each quarter
****CCG11**	SDM9 or CollaboRATE questionnaires to be completed on 50 or more patients across Q2 and Q4. Reporting template to be submitted to commissioner each quarter.
CCG12	Clinical Audit of 100 patients (or all patients if <100) to be completed by the CAE Team supported by the Community Services / Tissue Viability
CCG13	Clinical Audit of 100 patients (or all patients if <100) to be completed by District Nursing Team supported by the CAE Team
CCG14	Clinical Audit of 100 patients (or all patients if <100) to be completed by the CAE Team supported by the Dietetics / Community Services
***CCG15b**	Routine provider submission to the Mental Health Services Data Set (MHSDS). Monthly provider level data will be available approx. 12 weeks after each period – details will be provided via the 'Mental health CQUIN' FutureNHS collaboration platform.

**Incentivised Schemes Highlighted in Green*
***Specialist Service Schemes in Blue*

Data complete up to Q4

The Q4 submission deadline was 28th May and all CQUIN submissions were made wih the exception of CCG11 from Cencer Services, which is being followed up by the Head of Clinical Audit & Effectiveness.

The table below provides detail on the Scheme title, measure indicator, Leads, CQUIN Value (if incentivised or a Specialist Service Scheme), the period of calculation Upper (Max) and Lower (Min) Target percentages and the quarterly outcome and overall performance for each scheme. Compliance is RAG rated by quarter and overall performance in meeting the CQUIN target:

Table 2: 2023-24 CQUIN Schemes (Relevant to ELHT)

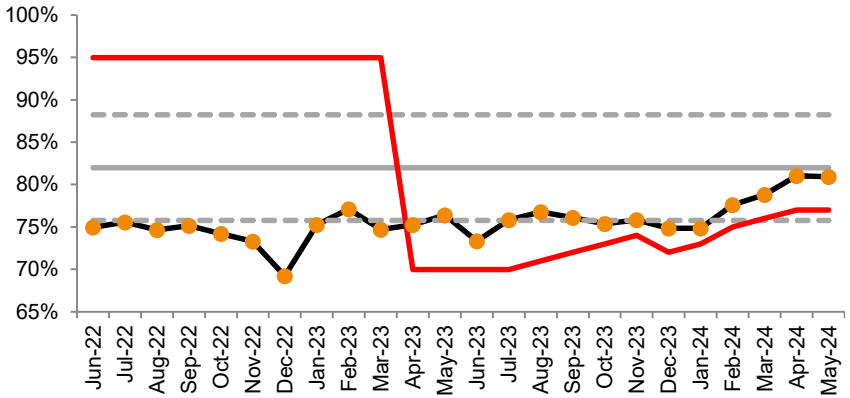
Ref:	Title of Scheme	Indicator	Lead/s	CQUIN Value	Period Calculation	Min (%)	Max (%)	Percentage Compliance (%)				Scheme performance (%)	Travel
								Q1	Q2	Q3	Q4		
CCG1	Staff Flu Vaccinations	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact	S Brewer	NA	All Quarters Quarterly average %	75	80			33	34	34.00	▼
*CCG2	Supporting patients to drink, eat and mobilise after surgery	Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	Prof A Krige C Aherne	1,100k	All Quarters Quarterly average %	70	80	91	92	82	83	87.00	▼
*CCG3	Prompt switching of intravenous to oral antibiotic	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria	Dr H Ziglam K Robinson	1,100k	All Quarters Quarterly average %	60	40	21	21	25	28	23.75	▼
CCG4	Compliance with timed diagnostic pathways for cancer services	Achieving 55% of referrals for suspected prostate, colorectal, lung, oesophago-gastric, head & neck and gynaecological cancers meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	S Hechter V Cole	N/A	All Quarters Quarterly average %	35	55	8.9	11.9	19.9	14	13.70	▼
*CCG5	Identification and response to frailty in emergency departments	Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.	C Finney P McManaman	NA	All Quarters Quarterly average %	10	30	57	68	87	81	73.25	▲
*CCG6	Timely communication of changes to medicines to community pharmacists via the discharge medicines service	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.	E Watson H Robinson	1,100k	All Quarters Quarterly average %	0.5	1.5	15.3	9.5	15.6	14	13.69	▲
*CCG7	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.	A Catterall / T Woods	1,100k	All Quarters Quarterly average %	10	30	85	95	94	95	92.41	▲
**CCG8	Achievement of revascularisation standards for lower limb ischaemia	Percentage of patients that have a diagnosis of CLTI that undergo revascularisation, either open, endovascular or combined within 5 days of a non-elective admission to vascular provider units.	Mrs J Buxton L Taylor	NA	All Quarters Quarterly average %	45	65	92	64	63	100	79.75	▲

**CCG9	Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	The percentage of patients commencing treatment within 4 weeks of referral to ODN	J Grassham	TBC	Quarters 1 to 4	40	75	97	96	93	97	96	▼
**CCG10	Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-1) referred for treatment with curative intent, as per the NICE QS17 recommendation	Dr F M Zaman V Cole	TBC	Whole period %	80	85	83	93	88	87	88	–
**CCG11	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	The level of patient satisfaction with shared decision-making conversations – as measured by patient scores on internationally validated patient questionnaires – at key decision points in specified pathways that are priority areas for recovery around managing /reducing waiting lists, unplanned admissions and keeping vulnerable people out of hospital.	S Hechter J Lishman	TBC	Quarter 2 and 4 (Palliative Chemo + Haemoglobinopathy)	65	75		90*		85*	*Chemo & Chemo combined Q1. No Haemo Clinic in Q4*	
CCG12	Assessment and documentation of pressure ulcer risk	Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.	C Forrest A King	NA	All Quarters Quarterly average %	70	85	34	37	36	48	38.75	▲
CCG13	Assessment, diagnosis, and treatment of lower leg wounds	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.	C Forrest	NA	All Quarters Quarterly average %	25	50	62	68	51	56	59.25	▼
CCG14	Malnutrition screening for community hospital inpatients	Achieving 90% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks	N Robinson J Wilding	NA	All Quarters Quarterly average %	70	90	68	25	45	43	45.25	▼
*CCG15b	Routine outcome monitoring in CYP and community perinatal mental health services	Achieving 50% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measure recorded at least twice.	A Stuart J Fleming	1,100k	Whole period %	20	50	66.2	71.6	70.4	72.7	70.10	▲

- **Incentivised Schemes in Green, **Specialist Service Schemes in Blue*
- *CCG9 NHSE are assuming achievement of the CQUIN for 2023-24 due to issues with extracting data from Blueteq and incorporating this into reporting*

RESPONSIVE

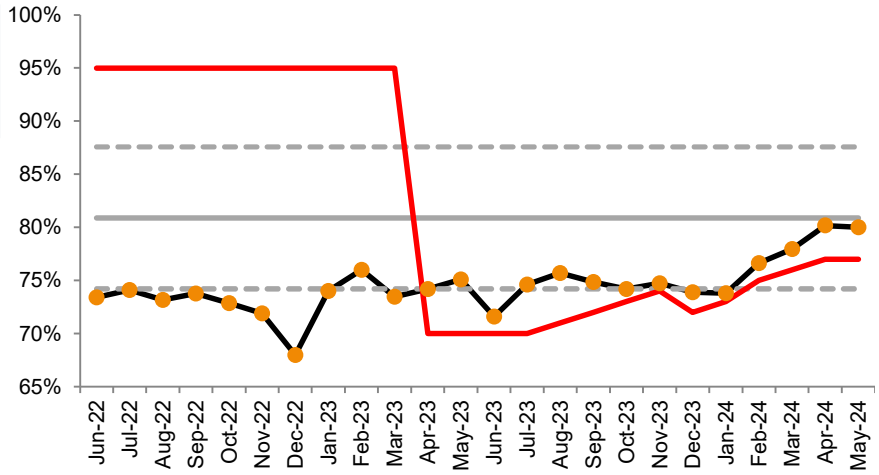
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 80.93% in May, which is above the 77% target.

The trend continues to show a deterioration on previous performance but may deliver the 77% target.

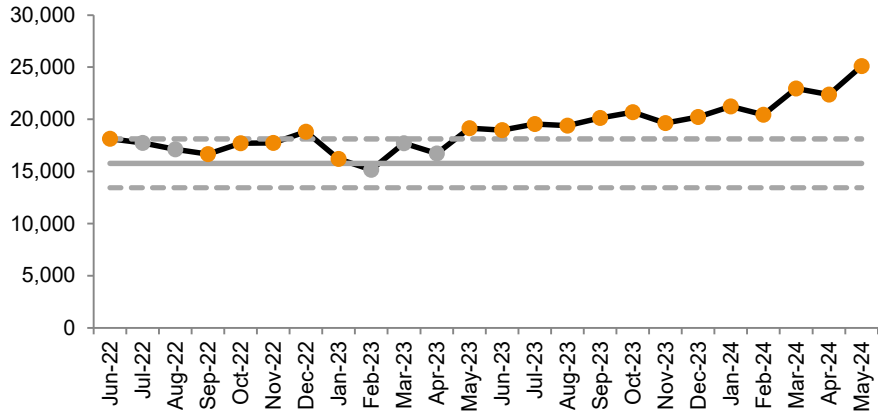
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 80.00% in May, above the 77% trajectory.

The national performance was 74.2% in May (All types).

A&E Attendances - Trust

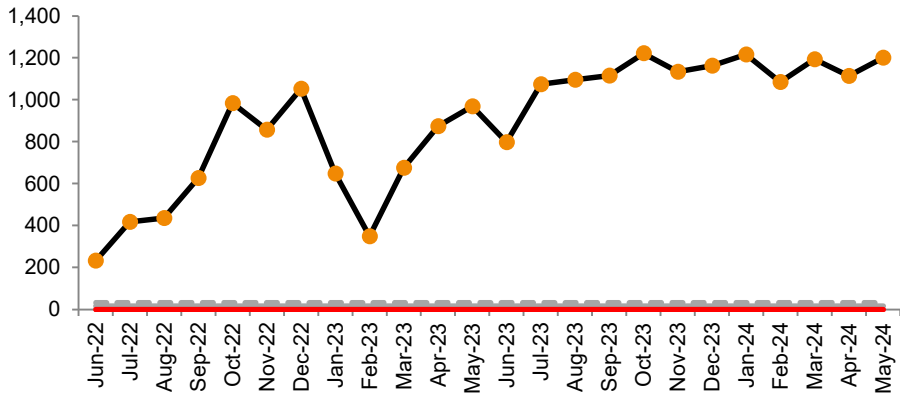


The number of attendances during May was 25,112, which is above the nornal range when compared to the pre-covid baseline.

Following NHSE guidance, the attendance count has been amended in June 23, to include patients who are appointed following inital assessment, which was previously excluded from the count.

RESPONSIVE

12 Hr Trolley Waits

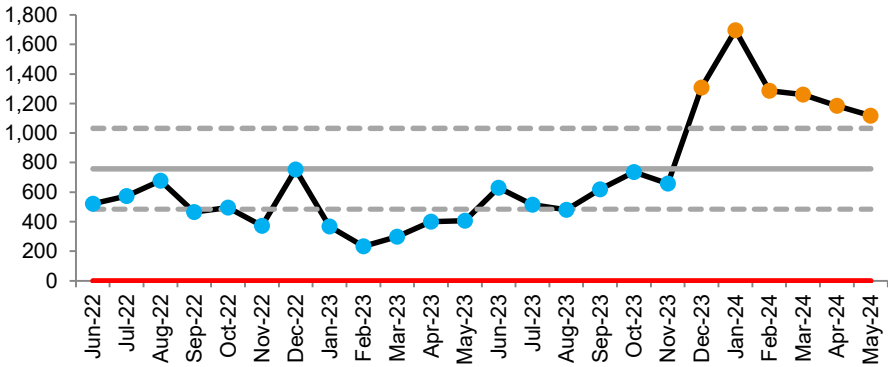


There were 1200 reported breaches of the 12 hour trolley wait standard from decision to admit during May, which is higher than the normal range. 60 were mental health and 1140 were physical health.

Rapid review timelines are completed in accordance with the NHS England Framework for all breaches and a root cause analysis will be undertaken.

	Mental Health	Physical Health
No. 12 Hr Trolley Waits	60	1140
Average Wait from Decision to Admit	40hr 21min	25hr 28min
Longest Wait from Decision to Admit	162hr 0min	70hr 58 min

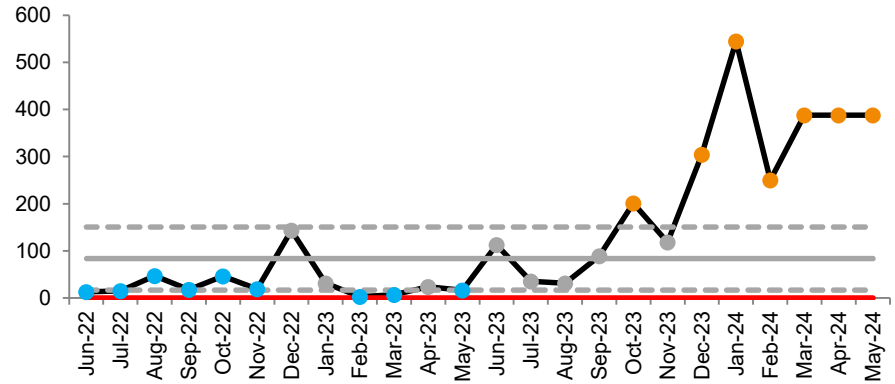
Ambulance Handovers - >30Minutes



There were 1118 ambulance handovers > 30 minutes in May. The trend is higher than pre-covid baseline levels, and based on current variation is not capable of hitting the target routinely.

There were a total of 3146 ambulance attends with 1118 ambulance handovers > 30 minutes and 388 > 60 minutes.

Ambulance Handovers - >60 Minutes



It is no longer possible to split between ED delays and HAS compliance due to the HALO system. Work is ongoing with NWAS to identify a method for reporting this.

The average handover time was 37 minutes in May.

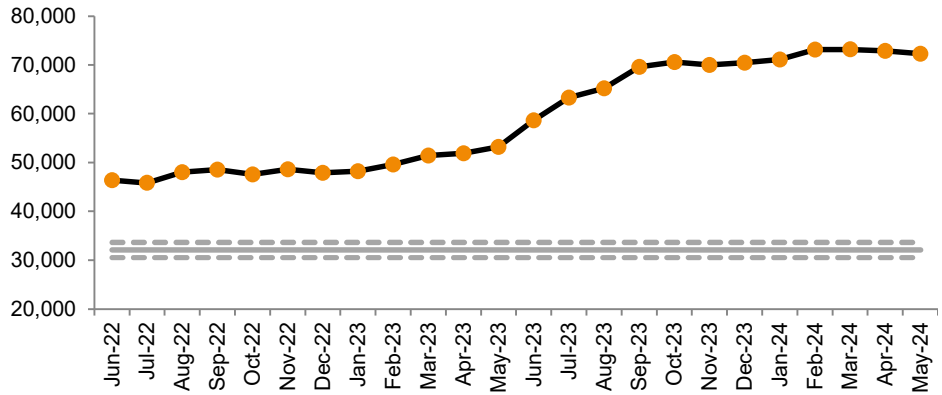
The longest handover in May was reported by NWAS as 7hr 21 minutes. We are working with NWAS to reduce longer waits due to cohorting since the introduction of the HALO system.

RESPONSIVE

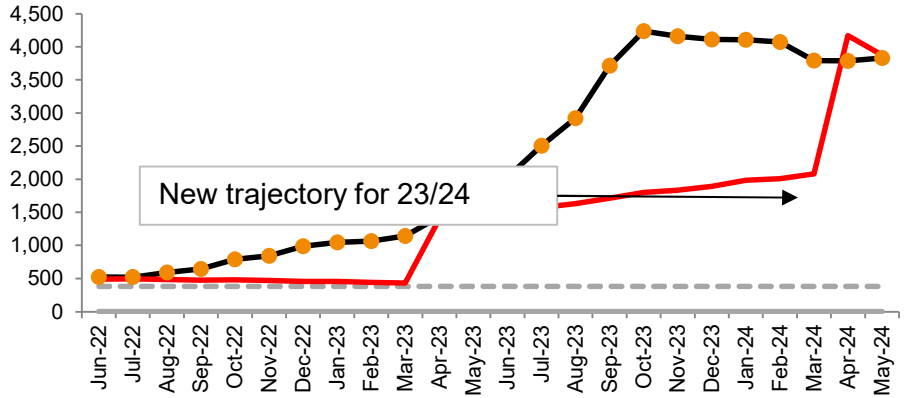
At the end of May, there were 72,283 ongoing pathways, which has reduced on last month but is above pre-COVID levels.

There were 3832 patients waiting over 52 weeks at the end of May which has increased on last month but is below trajectory.
There were 274 patients waiting over 65 weeks at the end of May which has increased on last month but is below trajectory.
We are aware of a number of data quality issues impacting on performance post EPR go live, which the Trust is working on to resolve.
There were 0 patients waiting over 78 weeks.

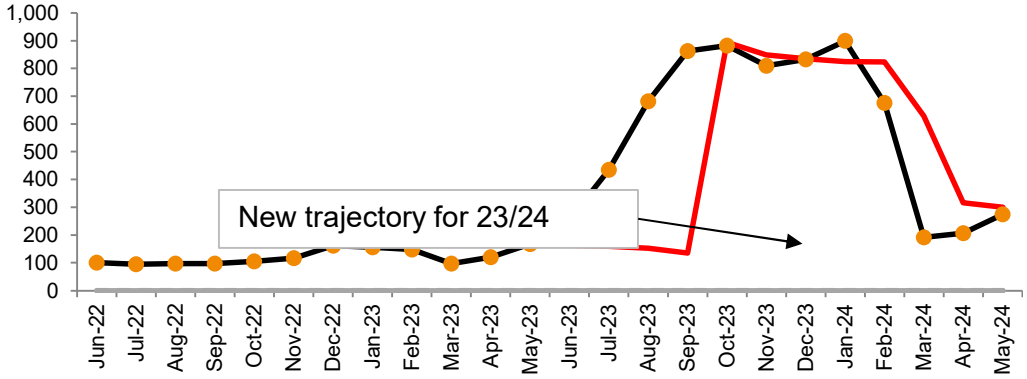
Referral to Treatment (RTT) Total Ongoing



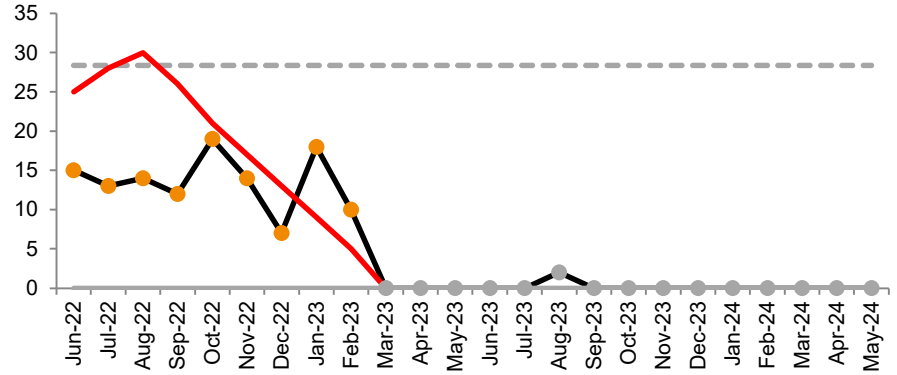
RTT Total Over 52 wks



RTT Total Over 65 wks



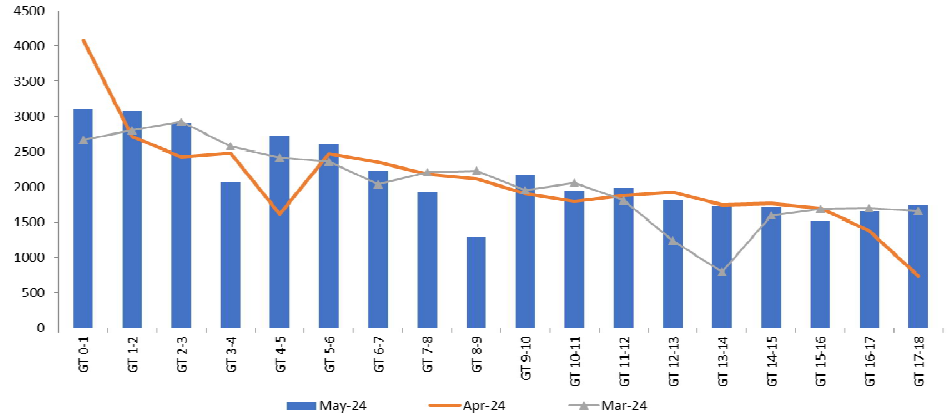
RTT Total Over 78 wks



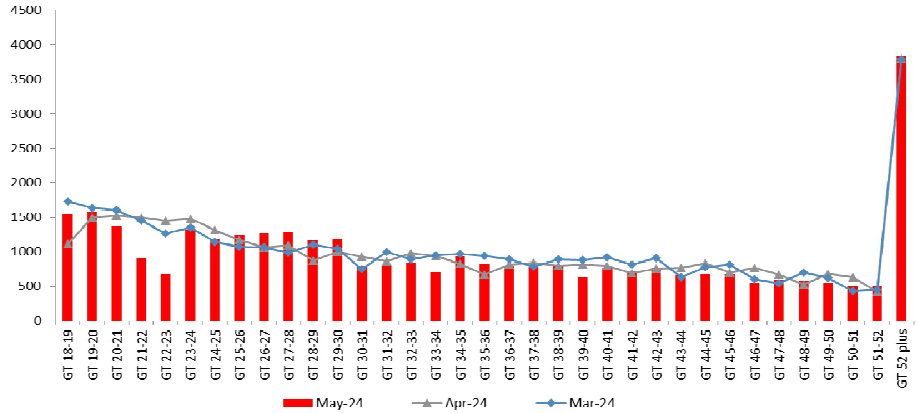
RESPONSIVE

The bar charts show the numbers of RTT ongoing pathways by weekband, compared with previous 2 months.

RTT Ongoing 0-18 Weeks

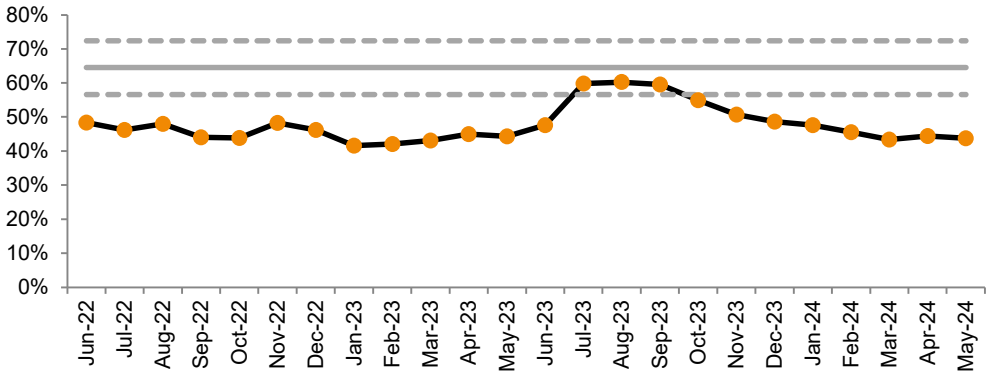


RTT Over 18 weeks

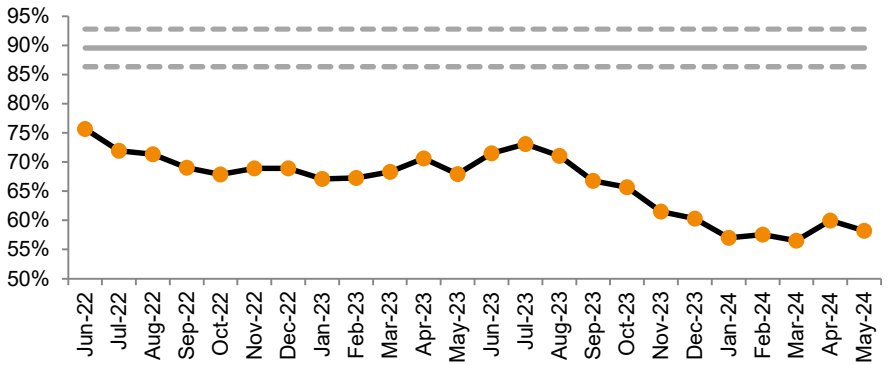


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted



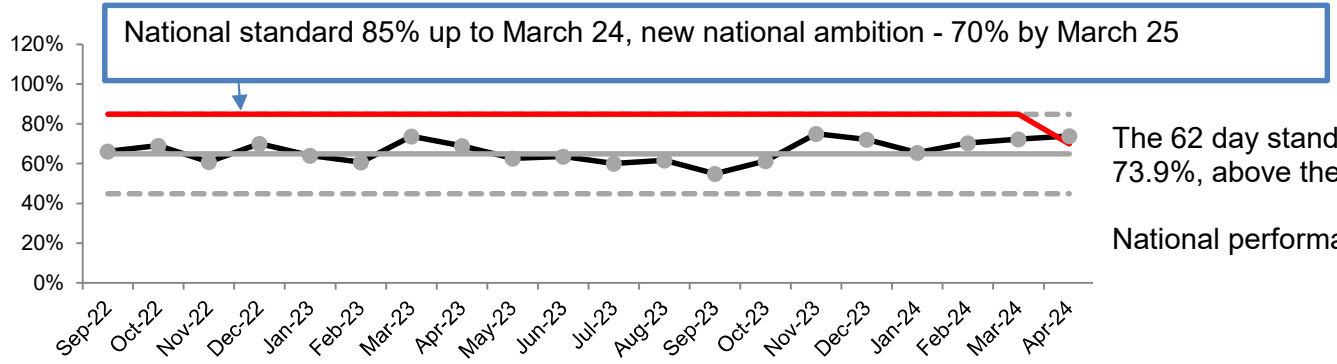
RTT Non-Admitted



RESPONSIVE

Three new national cancer standards were introduced from 1st October 23. Previously there were 10 standards, which were simplified down to 3. Although graphs show what performance would have been against the new standards, trusts were not being monitored against them prior to October

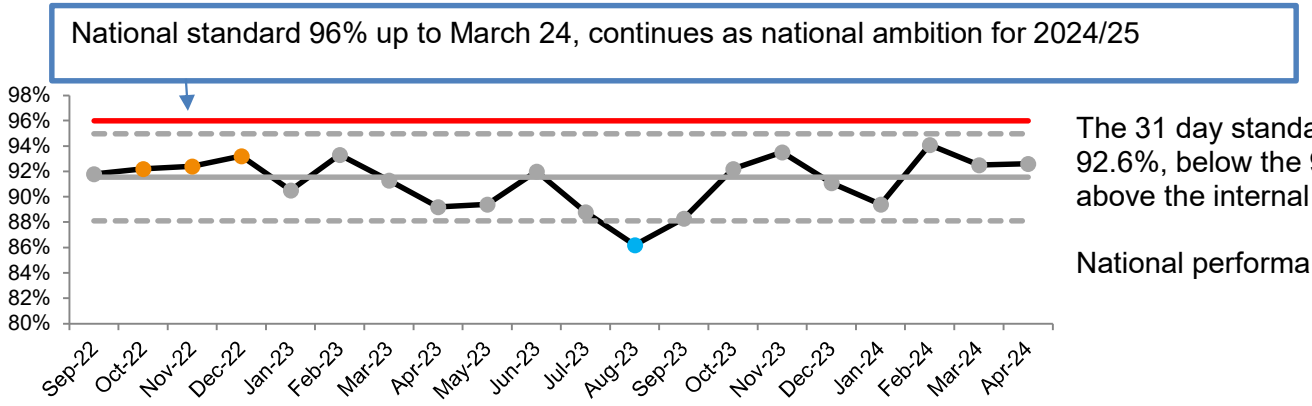
Cancer 62 day general



The 62 day standard was acheived in April at 73.9%, above the 70% trajectory.

National performance April - 66.6%

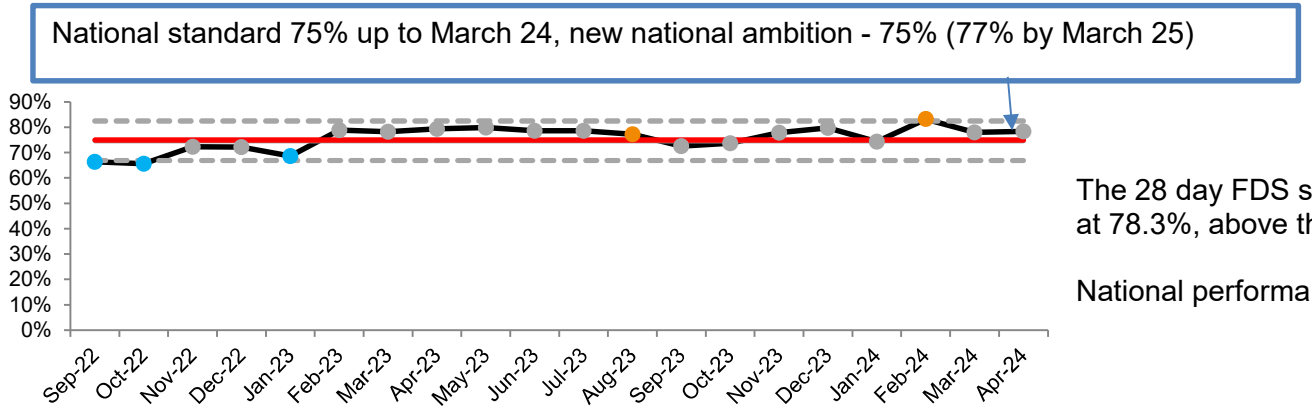
Cancer 31 day general treatment



The 31 day standard was not achieved in April at 92.6%, below the 96% trajectory. However this is above the internal trajectory of 90%.

National performance April - 89.2%

28 day general FDS

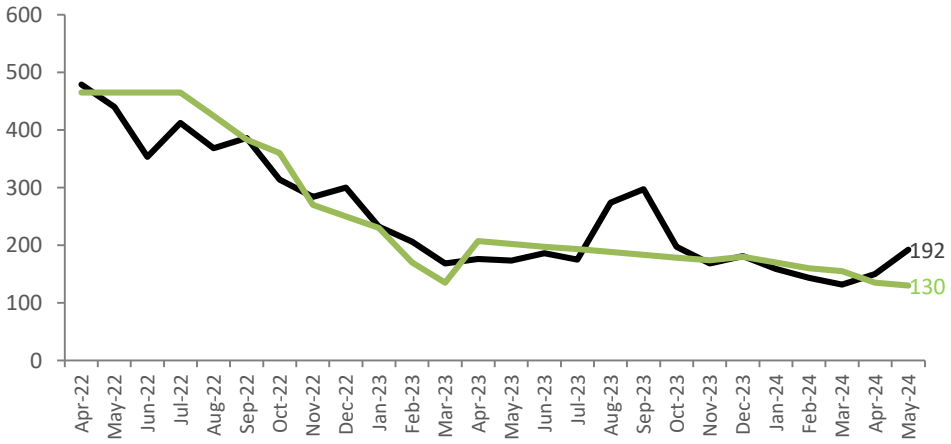


The 28 day FDS standard was achieved in April at 78.3%, above the 75% trajectory.

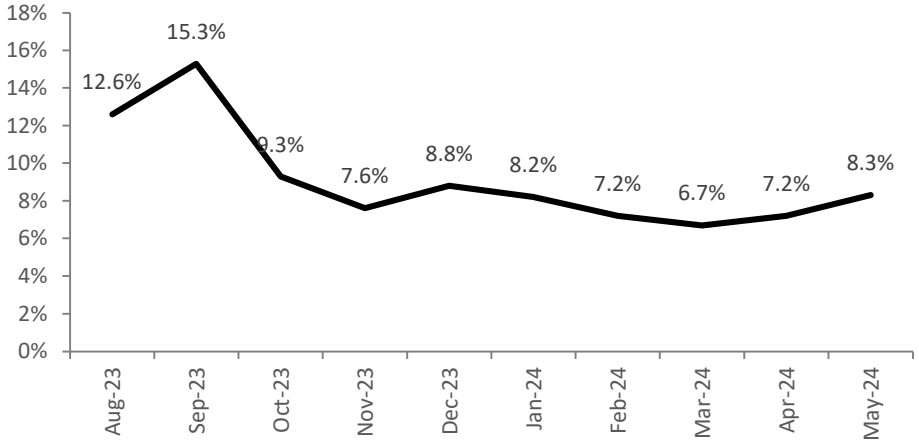
National performance April - 73.5%

RESPONSIVE

Cancer >62 day vs trajectory



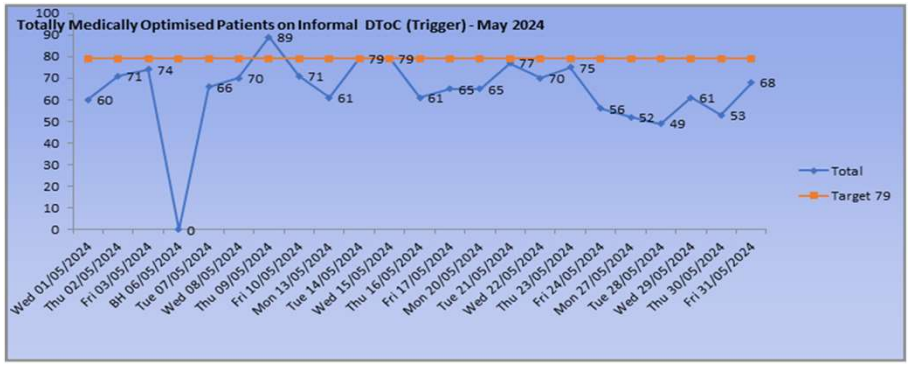
Cancer % Waiting >62days (Urgent GP Referral)



At the end of May the number of patients >62 days was 192 vs 130 trajectory. This was 8.3% of the total wait list.

RESPONSIVE

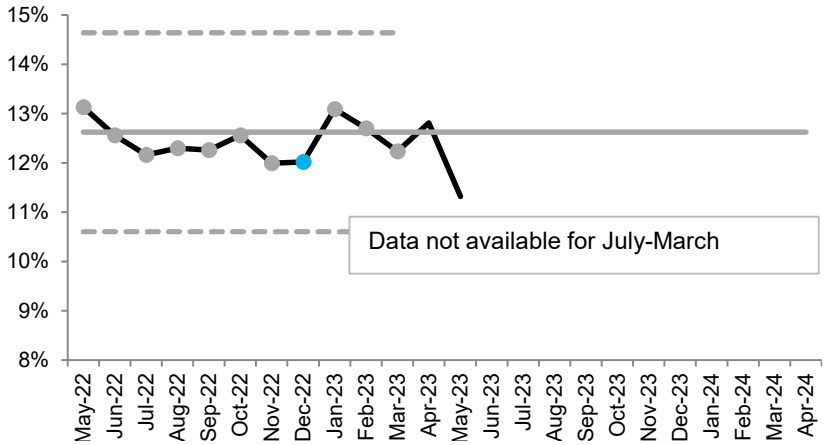
Delayed Discharges



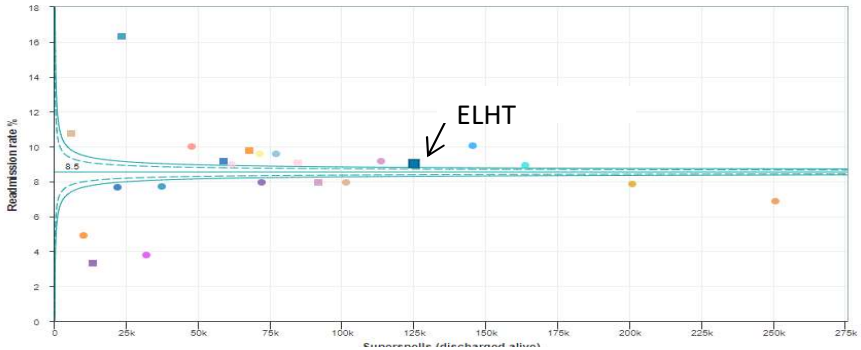
We continue to discharge patients using the rapid discharge principles set out in the Hospital discharge and community support: policy and operating model government guidance, utilising pathways 0-3. Pathways are being used to ensure patients have a discharge plan identified from admission, with pathway 0 and 1 being our strongest and most rapid response.

Dr Foster benchmarking shows the ELHT readmission rate is higher than the North West average. There are data quality issues with missing spells in the current HES dataset which means more recent data is not available.

Emergency Readmissions

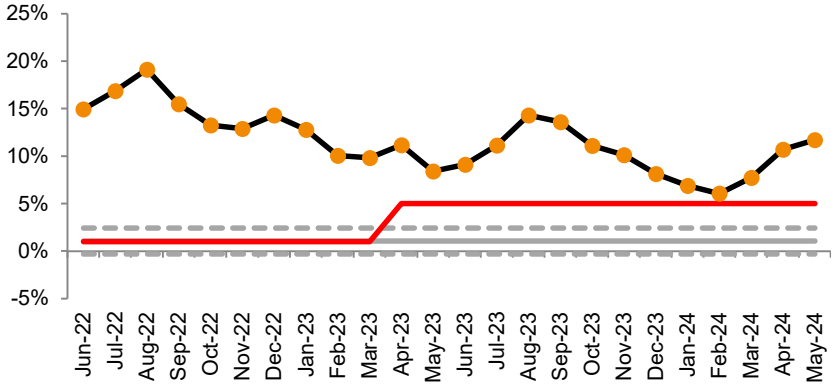


Readmissions within 30 days vs North West - Dr Foster
June 2022 - May 2023



Data not available for emergency readmissions.

Diagnostic Waits



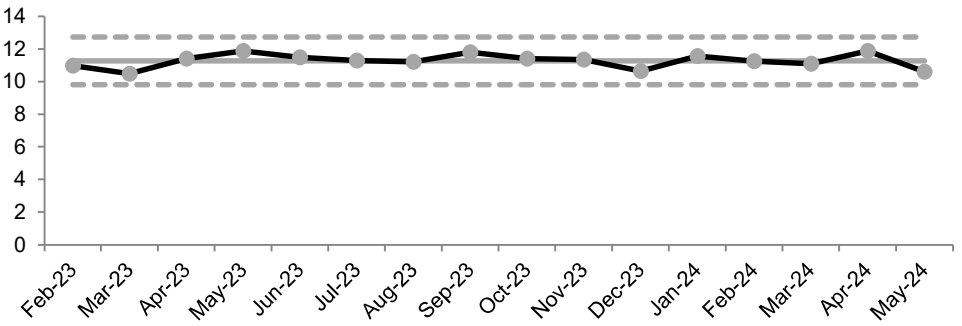
In May, 11.7% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is above the 5% threshold. (95% of patients to receive a diagnostic test within 6 weeks by March 2025)

The trend remains significantly higher than baseline, however there are issues with data quality post EPR implementation, impacting on performance.

Nationally, the performance is failing the 5% target at 23.0% in April.

RESPONSIVE

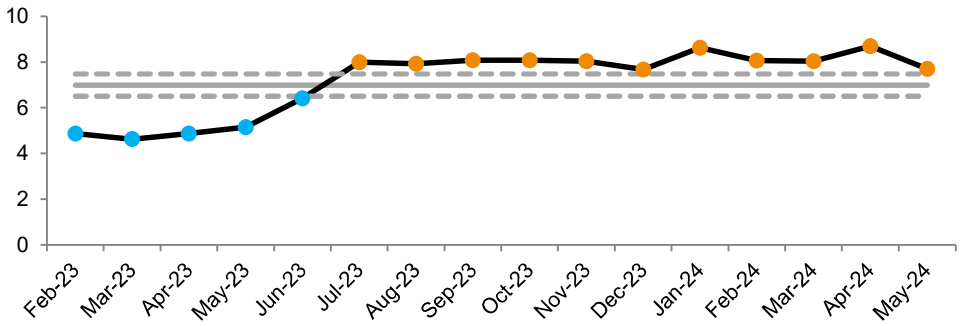
Emergency average length of stay - excluding 0 and 1



Emergency average length of stay methodology in model health excludes 0 and 1 days. Using this methodology, May 24 is within normal variation for this time period.

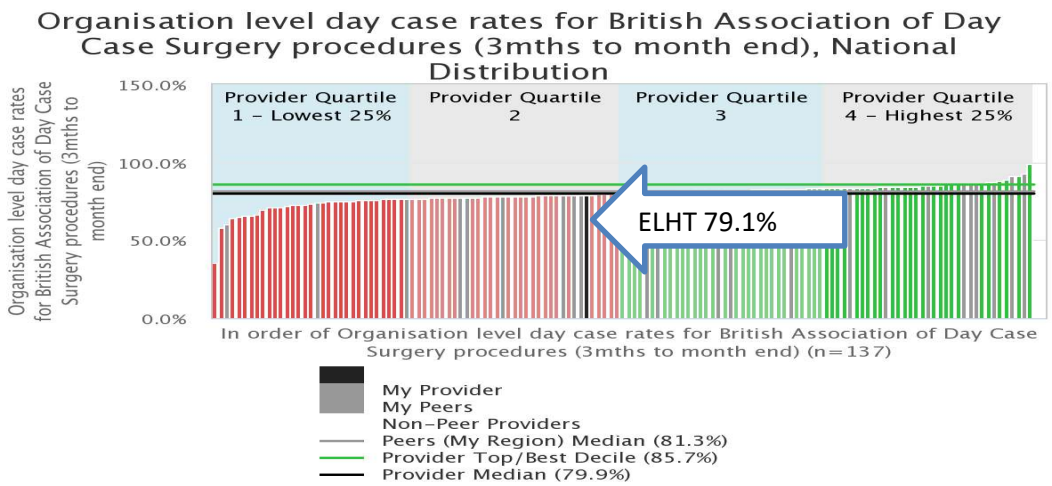
Please note, there are known data quality issues with recorded discharge date after true discharge discharges.

Emergency average length of stay - including 0 and 1



Step change from June 23 is due to the removal of Same Day Emergency Care (SDEC) activity which was previously recorded as a non-elective admission and is now recorded as a type 5 A&E attendance.

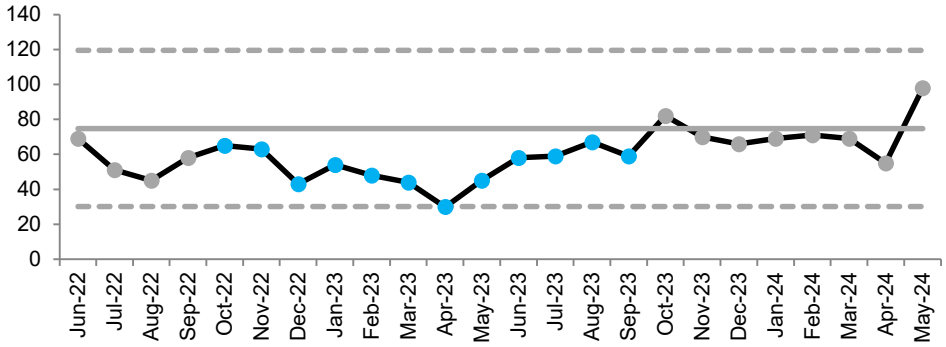
Daycase Rate



Model health system data based on latest 3 months up to June 23, shows ELHT in the second quartile for daycase rates at 79.1%. Data is for adults only

RESPONSIVE

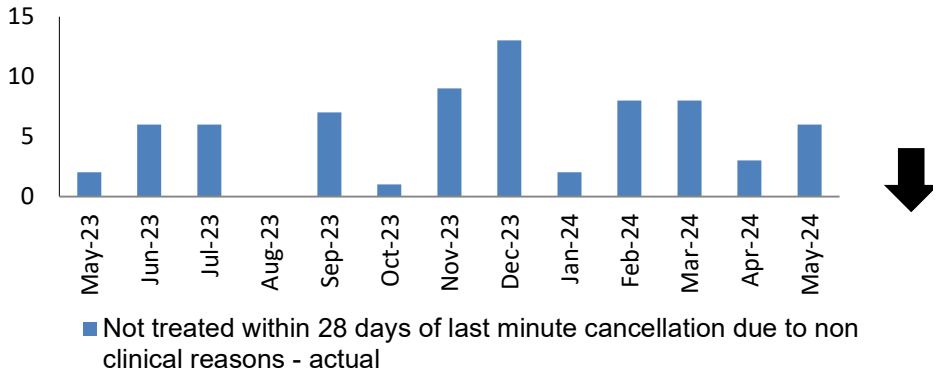
Operations cancelled on day



There were 98 operations cancelled on the day of operation - non clinical reasons, in May.

The trend is similar to pre-covid levels.

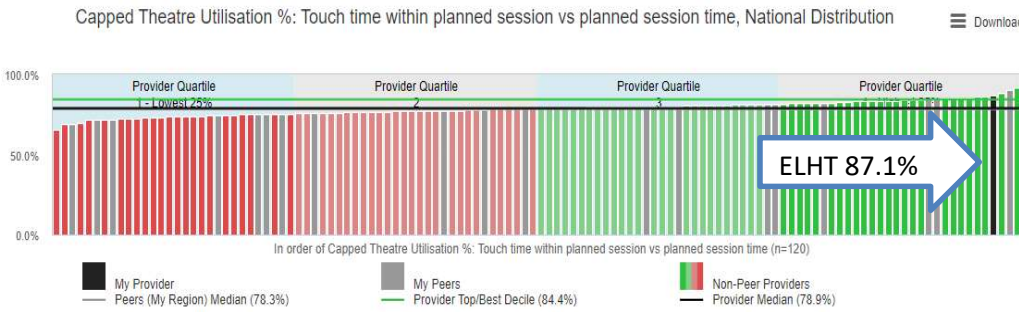
Operations cancelled on day - breaches of 28 day



There were 6 ‘on the day’ cancelled operations not rebooked within 28 days in May.

Patients that had procedures cancelled on the day are monitored regularly to ensure dates are offered within the 28 days. Risks are escalated to senior managers and escalated at the weekly operations meeting.

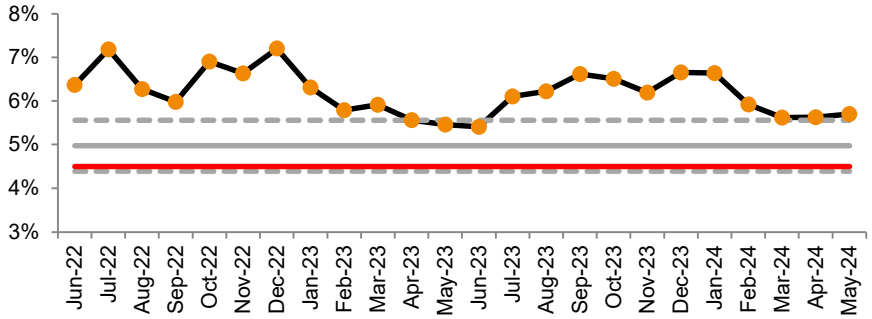
Theatre Utilisation



Data taken from 'The model hospital' shows capped theatre utilisation at 87.1% for the latest period. This is in the fourth quartile nationally, with 4 being the highest and 1 the lowest.

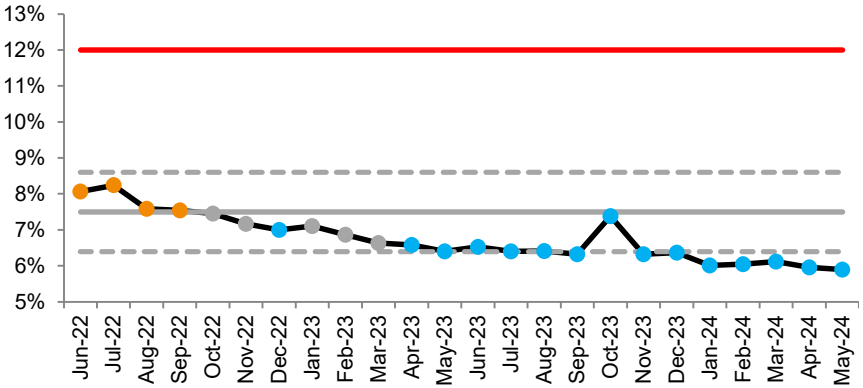
WELL LED

Sickness



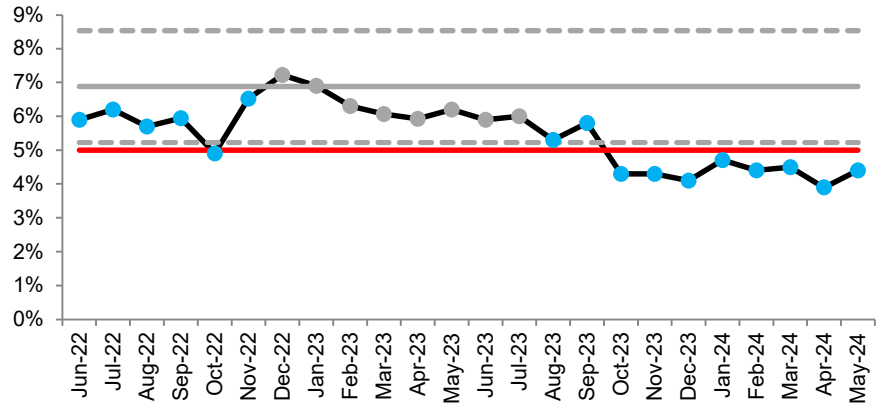
The sickness absence rate was 5.7% for May which is above the threshold of 4.5%. The trend is significantly higher than the pre covid baseline and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 5.9% in May and remains below threshold. This is showing a significant reduction when compared with baseline. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



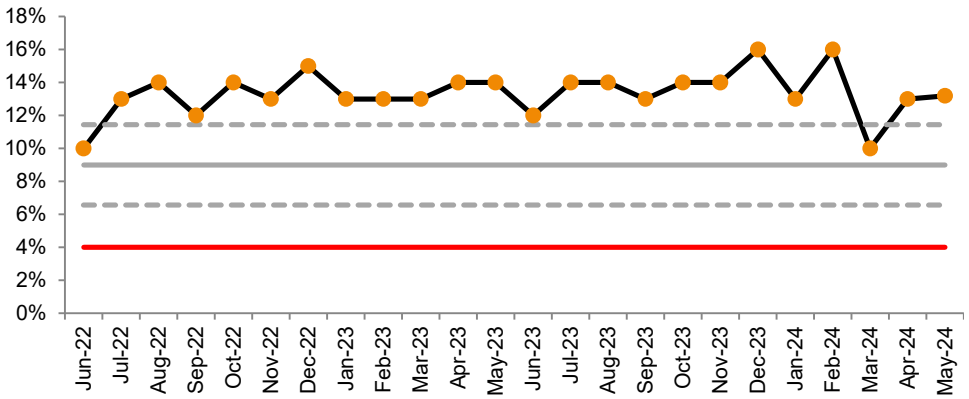
The vacancy rate is 4.4% for May which is below the 5% threshold.

The trend is showing improvement but based on current variation this indicator is not capable of hitting the target routinely.

A detailed action plan has been developed and a quarterly progress update will be provided to the Trust Board.

WELL LED

Temporary costs and overtime as % total pay bill



In May 2024, £5.8 million was spent on temporary staff, consisting of £1.1 million on agency staff and £4.7 million on bank staff.

WTE staff worked (10,084 WTE) was 28 WTE less than is funded substantively (10,112 WTE).

Pay costs are £2.0m less than budgeted establishment in May 2024.

At the end of May 24 there were 430 vacancies.

The temporary staffing cost trend shows a significant increase when compared to pre covid levels and is not capable of hitting the target.

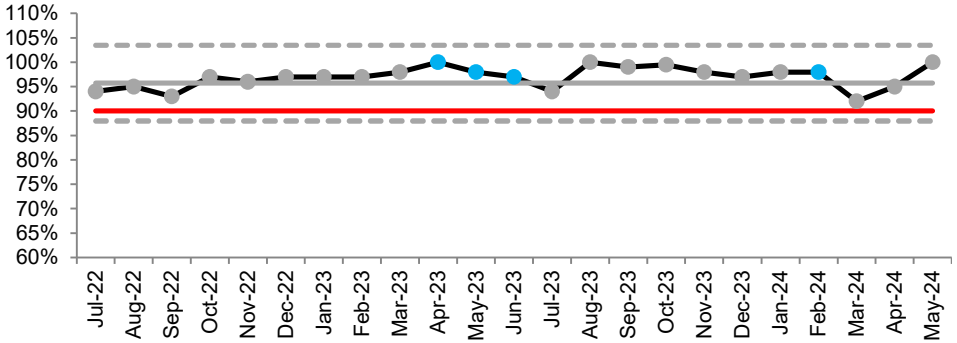
Job Plans

Stage	Consultants	Non consultant grades
Awaiting Signatures	194	61
Complete	26	2
Due Soon	22	11
In Progress	120	23
No Current Job Plan	17	8
Not Started	1	0
Referred Back	4	1
Uploaded	4	0
Total	388	106

As at May 2024, the table shows the numbers in each stage of the job planning process.

WELL LED

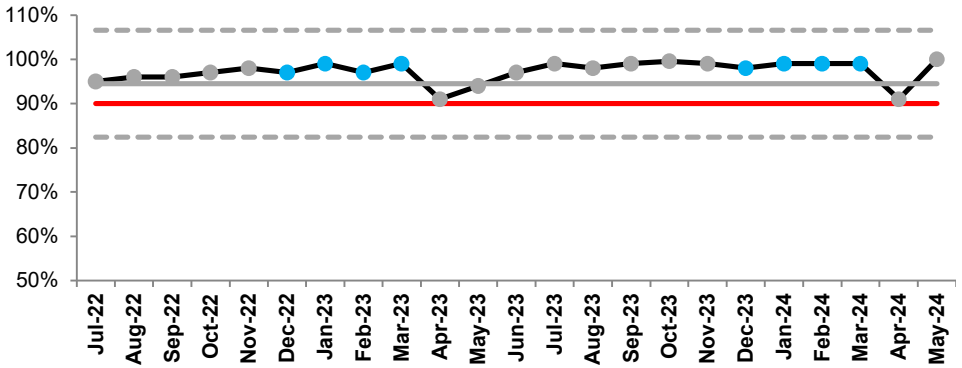
Appraisals, Consultant



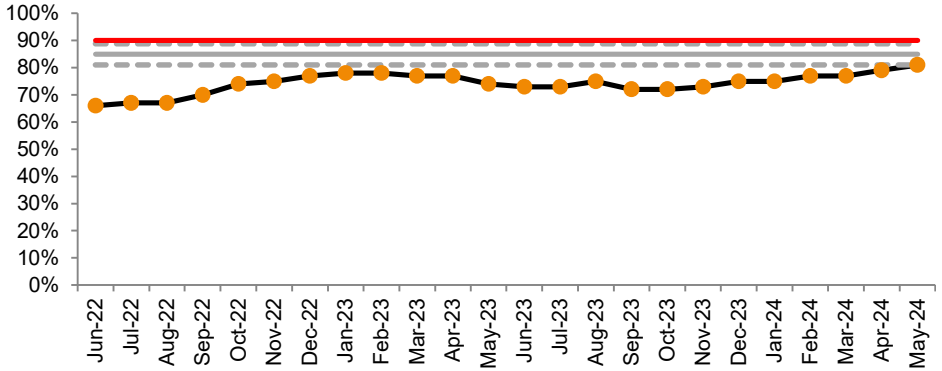
The appraisal rates for consultants and career grade doctors are reported for May 24 and reflect the number of reviews completed that were due in this period.

They both continue to be above target with 100% completed that were due in the period.

Appraisals, Other Medical



Appraisals Agenda for Change (AFC) Staff



The AFC appraisal rate continues to be reported as a rolling 12 month figure and remains below threshold. Appraisals were suspended until March 21, due to COVID pressures.

The trend is significantly lower than previous levels and based on current variation the indicator is not capable of achieving the target

There has been a range of Trust wide actions to support compliance which are on-going. These actions are monitored through the Finance & Performance Committee.

WELL LED

Core Skills Training % Compliance

	Frequency	Target	Compliance at end May
Basic Life Support	2 years	90%	89
Conflict Resolution Training L1	3 years	90%	97
Equality, Diversity and Human Rights	3 years	90%	96
Fire Safety L1	2 years	95%	94
Health, Safety and Welfare L1	3 years	90%	97
Infection Prevention L1	3 years	90%	98
Infection Prevention L2	1 year	90%	91
Information Governance	1 year	95%	92
Preventing Radicalisation Level 1	3 years	90%	95
Preventing Radicalisation Level 3 †	3 years	90%	94
Safeguarding Adults L1	3 years	90%	95
Safeguarding Adults L2	3 years	90%	96
Safeguarding Adults L3*	3 years	90%	78
Safeguarding Children L1	3 years	90%	94
Safeguarding Children L2	3 years	90%	96
Safeguarding Children L3	3 years	90%	85
Safeguarding Children L4	3 years	90%	100
Safer Handling Level 1	3 years	95%	96
Safer Handling Level 2 (Patient Handling)	3 years	95%	88

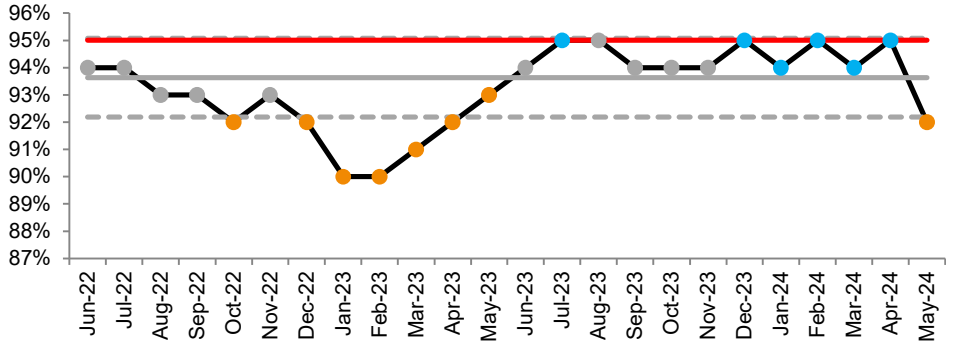
The core skills framework consists of eleven mandatory training subjects, with 19 modules in total. Training is via a suite of e-learning modules and knowledge assessments on the learning hub.

The threshold has been set at 90% for all areas except Information Governance, Fire Safety and Safer Handling which have thresholds of 95%

6 of the 19 modules are below threshold in April. Preventing Radicalisation Level 3 and Safeguarding Adults Level 3 are new mandatory requirements for some staff from April 23.

New starters are now being requested to complete as much of their Core Skills e-Learning requirements as possible prior to attending the Trust Induction training programme via the e-Learning for Healthcare platform. Additionally, there will be a limited amount of time for new starters to undertake any incomplete Core Skills e-Learning/training during the one-day Trust Induction training programme.

Information Governance Toolkit Compliance

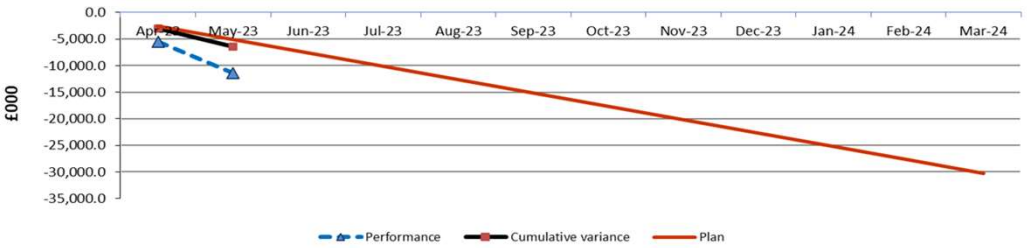


Information governance toolkit compliance is 92% in May which is below the 95% threshold. The trend is at risk of not meeting the target.

WELL LED

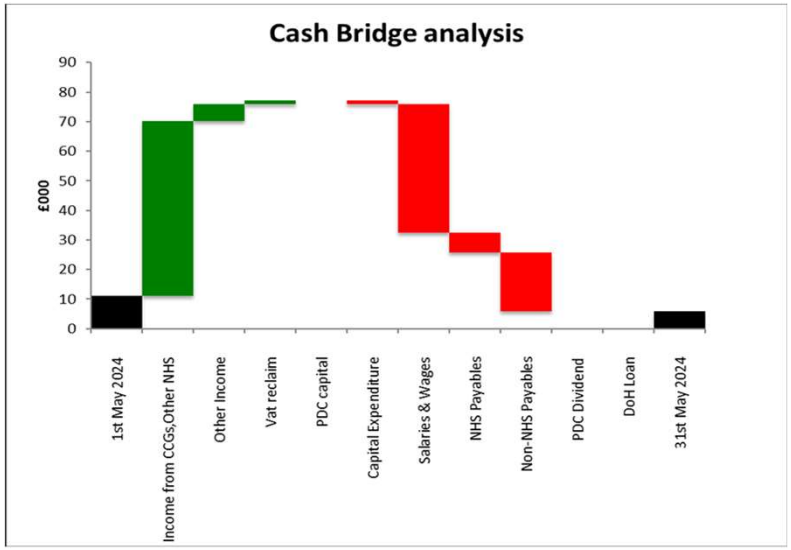
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



The Trust is reporting breakeven against a deficit plan of £5.0m at Month 2, however our current run rate is showing a deficit of £6.4m against this plan.

Cash



The Trust's cash balance is £5.9m as at 31st May 2024.

The Trust is reporting breakeven against a deficit plan of £5.0m at Month 2, however our current run rate is showing a deficit of £6.4m against this plan.

Working to a £36.2m capital programme for the 2024-25 financial year, the Trust is less than £0.1m ahead of planned capital spend as at 31st May 2024.

The cash balance on 31st March was £5.8m, a reduction of £5.2m compared to the previous month. This position is supported by £9.2m of Provider Revenue Support Public Dividend Capital (PDC).

The Trust is currently meeting the Better Payment Practice Code (BPPC) target to pay 95% of invoices on time by value and volume for both NHS and non-NHS invoices.

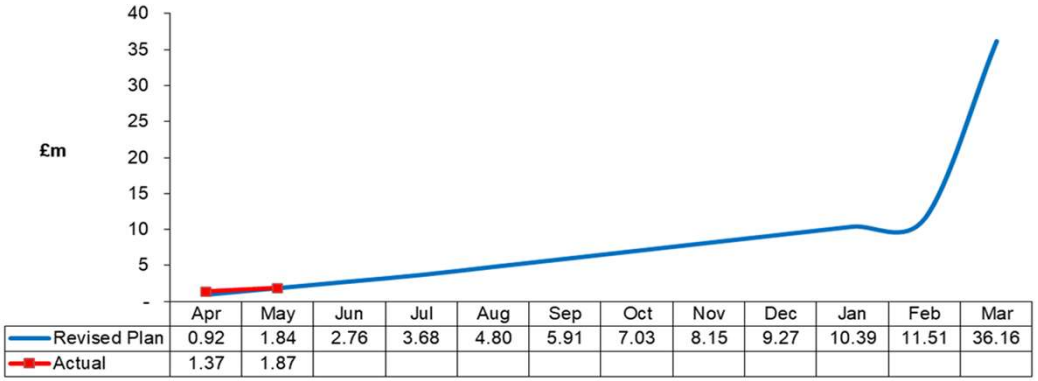
Spend on agency staff was at 2.4% of pay in month 2, well below the ceiling of 3.2% set by NHSE for 2024-25.

The Waste Reduction Programme for the 2024-25 financial year is £57.8m, of which £2.4m has been delivered recurrently for the financial year to date, £7.2m behind plan.

WELL LED

Capital expenditure

Capital expenditure profile



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	0.92	1.84	2.76	3.68	4.80	5.91	7.03	8.15	9.27	10.39	11.51	36.16
Actual	1.37	1.87										

The The Trust is less than £0.1m ahead of planned capital spend as at 31st May 2024.

Waste reduction programme

WRP schemes analysis

2024-25 Divisional Performance to Date

Division	Annual Target £000s	Identified £000s	To Identify £000s	Number of Schemes	Annual Achieved £000s	Annual To Achieve £000s	Year to Date Target £000s	Year to Date Achieved £000s	Year to Date Variance £000s	Recurrently Achieved £000s	Next Year Identified £000s
Trust Wide Schemes	5,835	52,951	(47,116)	33	2,427	(3,408)	1,288	2,427	1,139	2,427	0
Medicine & Emergency Care	11,620	40	11,581	10	0	(11,620)	1,937	0	(1,937)	0	0
Community & Intermediate Care	3,358	2,566	792	5	0	(3,358)	560	0	(560)	0	0
Surgical & Anaes Services	11,649	242	11,407	11	0	(11,649)	1,942	0	(1,942)	0	0
Family Care	7,302	79	7,223	9	0	(7,302)	1,217	0	(1,217)	0	0
Primary Care	261	3	258	1	0	(261)	44	0	(44)	0	0
Diagnostic & Clinical Support	8,485	1,208	7,277	33	0	(8,485)	1,414	0	(1,414)	0	0
Estates & Facilities	4,498	674	3,824	13	0	(4,498)	750	0	(750)	0	0
Corporate Services	3,604	0	3,604	0	0	(3,604)	601	0	(601)	0	0
Education, Research & Innov'N	1,175	25	1,150	1	0	(1,175)	196	0	(196)	0	0
Total	57,787	57,787	(0)	116	2,427	(55,360)	9,946	2,427	(7,520)	2,427	0

Schemes to the value of £2.4m have been transacted in the year to date. Additional identified schemes will be assessed for delivery throughout

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **103**

10 July 2024 **Purpose** Assurance Information

Title	Freedom to Speak Up Report
Report Author	Mrs N Bamber, Freedom to Speak Up Guardian
Executive sponsor	Mrs K Quinn, Executive Director of People and Culture

Summary: This report has been prepared to advise the Board of progress made since the last bi-annual report in January 2024. It includes number of staff who have raised concerns in 2023-24, emerging themes, actions taken, service updates and national updates. This report has also been shared and approved by People & Culture Committee in May 2024.

Recommendation: To note and approve the content of the report. Once approved the report will be made available to managers and staff.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Healthy, diverse and highly motivated people
Related to key risks identified on Board Assurance Framework	1 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 2 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Freedom to Speak Up Review Assignment Report 2022/23 Report Ref: 127ELHT_2223_013

Impact

Legal	No	Financial	No
Equality	Yes	Confidentiality	Yes

Background

1. The importance of listening to staff cannot be overemphasised. When staff raise concerns, they want to know that they are encouraged and supported to do so and can do it safely in a protected environment. Following on from the Sir Robert Francis Review, it is a requirement of the NHS Standard Contract that Trusts appoint a Freedom To Speak Up (FTSU) Guardian with the organisation who is "someone to whom staff can go to, who is recognised as independent and impartial, has authority to speak to anyone within or outside the Trust, is expert in all aspects of raising and handling concerns, has the tenacity to ensure safety issues are addressed and has dedicated time to perform this role".

Introduction

2. This report has been prepared to advise the Board of progress made since the last bi-annual report in January 2024 and includes a yearly summary of 2023/24. It includes number of staff who have raised concerns, emerging themes, actions taken, service updates and national updates. This report has also been shared and approved by People & Culture Committee in May 2024.

Summary of Progress

3.

a) 237 concerns have been raised through the service in 2023/24, meaning over 1500 colleagues have spoken up since the role was introduced at the Trust in April 2016.
b) FTSU training of all levels has now been mandated for all staff.
c) 20 FTSU Ambassadors have been recruited, trained and launched across multiple sites and services in the Trust.
d) As a result of the Staff Survey results, we are facilitating Trust-wide Big Conversations on speaking up, what the barriers are and what can be put in place to help staff feel safe to speak up at work.
e) FTSU information has been reported at divisional level at DMB meetings and will continue to be expanded across all divisions during the coming year.

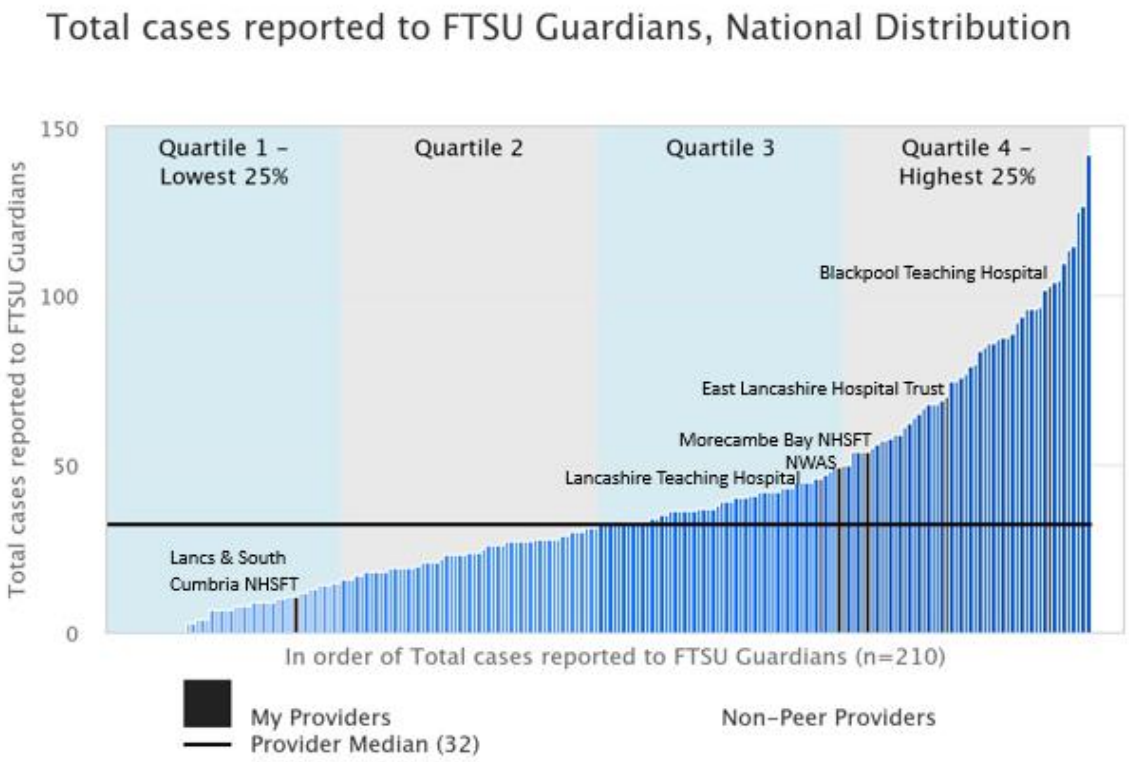
Freedom to Speak Up – Number of cases, themes and actions taken

4. During 2023/24, 237 concerns have been raised. This is an increase of 32 concerns from last year's figure of 205. The following table shows the figures submitted to the National Guardian's Office (NGO).

			Q1	Q2	Q3	Q4
Total no			**55**	**62**	**71**	**49**
Raised anonymously			0	1	2	0
Element of patient safety			5	14	5	4
Element of bullying and harassment			12	13	15	7
Element of worker safety or well-being			27	23	34	11
Element of inappropriate behaviours and attitudes			31	21	31	16
Staff member suffered detriment as a result of raising a concern			0	0	2	0
Concern raised by:	**AHP**		5	4	6	1
	Medical and Dental		6	4	6	5
	Ambulance		0	0	0	0
	Nurses & Midwives		16	9	19	14
	Administrative and Clerical		14	32	25	16
	Additional Professional Scientific		2	1	3	4
	Additional clinical services		6	6	5	6
	Estates and Ancillary		5	5	6	1
	Healthcare Scientists		0	0	0	0
	Students		0	0	0	1
	Not Known		1	0	0	1
	Other		0	1	1	0
No. of staff providing feedback about the service			0	8	11	10
Given their experience would they speak up again?		**yes**	0	8	7	8
		no	0	0	2	1
		maybe	0	0	2	1
		I don't know	0	0	0	0

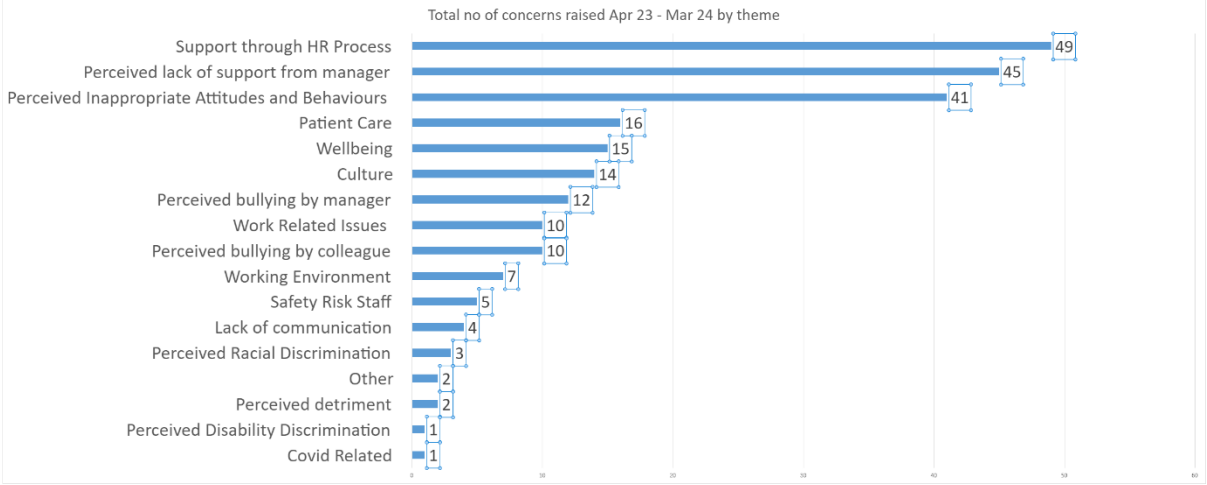
5. We saw an increase in Q3 during Freedom to Speak Up Month in October with increased promotion and comms. We've only had 3 cases raised anonymously which shows the trust staff have in the service and that the promise of confidentiality is honoured. Of those that responded to feedback about the service, we have had

consistent positive feedback that they found the process helpful, the service approachable and appreciated in depth feedback being provided. Negative feedback stemmed from difficult, complex cases where staff were frustrated as a whole, despite intervention taken by several support services.



6. Data available on Model Hospital for Quarter 3 2023/24 shows where East Lancashire Hospital Trust sits alongside our peers for total cases reported through FTSU. We are in quartile 4 for the highest 25% of reported cases. We hope this shows that staff have the confidence to use the service, that concerns are listened to, acted upon and feedback provided.

Total number of concerns raised by theme 2023 / 24



7. The highest number of concerns raised is for support through a HR process – 49 cases. Followed by 45 reporting a perceived lack of support from managers and 41 reporting perceived inappropriate attitudes and behaviours.

8. Staff seeking support through a HR process can range from a pay or pension query, support through the resolution process or queries about policies and procedure such as flexible working. We work extremely closely with HR and Union colleagues to resolve these concerns for the individual. We can also be involved in policy updates to improve processes.

9. Often the individual seeks confidential support about a situation or incident which has occurred. At which point we can signpost to the appropriate service such as Occupational Health or mediation, escalate the matter on their behalf, or empower them to raise it themselves following an in-depth conversation.

10. Through concerns raised, we are hearing that staff of all grades are feeling the recent system and financial pressures evident throughout the Trust. This is manifesting in staff feeling a lack of support, increased inappropriate behaviours and low morale. Managers are struggling to find the time to support staff as they usually would, meaning traditional routes of speaking up are becoming impaired. Many staff comment they are currently part of the sickness absence process or are thinking about leaving due to current morale.

11. Though low in numbers, it is also important to note that we are encouraged to see staff being able to raise concerns about perceived discrimination. In light of the 'Too Hot to Handle' report and 'Sexual Safety Charter' we have asked to be involved in any conversations and 'Task & Finish' groups so we can feed in staff's experiences and become better allies.

12. To demonstrate some of the actions that have taken place this year because of staff speaking up, we have summarised some anonymised cases below:

a) Two individuals raised concerns about the culture and management style in one department, despite repeated attempts to raise internally. The FTSU Guardian arranged a meeting with the senior manager who listened to both concerns openly and without judgment. This has now resulted in an action plan for the department to address both processes and culture. Feedback has been provided to the individuals who report an improvement, and this will continue to be monitored.

b) A concern was raised in relation to the change in car salary sacrifice scheme. The staff member had been trying to get answers and getting frustrated and lost in the process. Following speaking up, their individual concern was resolved, the process was reviewed and guidance and documentation was updated.

c) The lack of confidentiality in open plan offices was highlighted by one member of staff following an incident of breach in confidentiality. As they wanted to remain anonymous this resulted in a Trust-wide comms campaign to remind staff of the importance of confidentiality, as well as posters being placed in open plan areas.

Freedom to Speak Up Mandatory training

13. FTSU training Levels 1 and 2 became mandatory for all staff on 18 October 2023. FTSU training Level 3 became mandatory for Band 9 and above on 26 February 2024.

Level	Name	Audience	Compliance rate (as of 01/05/24)
Level 1	Speak Up	All staff	83.1%
Level 2	Listen Up	All staff	78.9%
Level 3	Follow Up	Band 9 and above	34.2%

14. Compliance has increased from 0.8% to 83.1% (Level 1) and 0.7% to 78.9% (Level 2). However this has fallen short of the 90% target. We are addressing this by individually targeting those who are non-compliant to encourage completion.

15. Compliance for Level 3 has increased from 0% to 34.2% in 10 weeks. The grace period for completing Level 3 is still on going until 26 May 2024 and we ask that any staff Band 9 and above who have not yet completed this training to do so.

Freedom to Speak Up Ambassadors

16. During October 2023 we relaunched and recruited to the existing the FTSU Champions role and renamed them FTSU Ambassadors. We are pleased to announce we have now trained/retrained 20 Ambassadors who have been officially launched in January 2024 who have been selected from a variety of roles, departments and sites within the organisation.
17. A comprehensive campaign was launched to introduce the FTSU Ambassadors explaining their roles and how staff can engage with them. Clear governance, pathways and guidance has been established for FTSU Ambassadors to ensure confidentiality and protection for those who speak up. Quarterly meetings have been set up to provide support and guidance for the FTSU Ambassadors with the FTSU Guardians. Staff have already started using this route and we are pleased that staff now have an additional route for speaking up.

Big Conversations

18. In the 2023 NHS Staff Survey:
    a) 6.76 out of 10 agreed or strongly agreed that we each have a voice that counts at ELHT, which is above the national average.
    b) 71% said they would feel secure raising concerns about unsafe clinical practice but only 62% said they would feel safe to speak up about anything that concerned them in the organisation.
    c) And only 51% felt that if they spoke up they were confident that the Trust would address their concerns.
19. As a result of gradually declining results, we are holding a Trust-wide Big Conversation in May 2024 to understand what barriers colleagues feel there are to raising concerns and what we can do to tackle them, in order to contribute proactively to creating a safe speak up culture. The results of which will be shared widely when available.

National Updates

20. Since January 2024 some significant reports have been published including ‘Too Hot to Handle’, NHS England’s culture review into Ambulance Trusts and ‘HSSIB investigation report into temporary workers’. They showed how racism, sexual harassment and bullying are unfortunately still a real experience for many NHS staff and that vulnerable groups such as temporary workers, are struggling to have a voice, losing vital information and learning.

21. The National Guardian's Office (NGO) responded saying "These reports amplifies our observation, that regulators and leaders must put staff experience on an equal footing with patient outcomes…When leaders actively listen and take action, it strengthens organisations, and fosters a culture of ongoing improvement and innovation in delivering healthcare…Leaders themselves need to listen to understand and amplify the voices of their workers to politicians and policy makers."
22. As FTSU Guardians we want to help the Trust break down some of the barriers that staff face and improve the speaking up experience. We have started to look at the recommendations included in the reports which includes the following:

    a) 'Too Hot to Handle' recommends that Guardians should have training in understanding systemic racism and in noticing how patterns of discrimination are often overlooked and reproduced. We will seek to undertake this training to better understand staff experience and become a better ally.
    b) To avoid the fear of reprisal and allow staff to report discrimination and harassment, we will ask the Board to give assurance that colleagues who seek to dissuade staff from raising concerns or who seek to victimise staff as a result of raising concerns will face gross misconduct proceedings.
    c) We will target temporary workers and deliver bespoke FTSU training to ensure that everyone, no matter their contract terms, understand they are encouraged to speak up.

Next Steps

23. In the last report we mentioned that we were submitting a business case to outline resources required to improve the current service offered and concentrate more on the proactive side of the role including responding to staff survey results, cultural reviews, staff engagement, culture, training, and directorate focused interventions. The business case was rejected and therefore we need to seek clarity on the requirements for the service going forward.
24. To feed in the actions from the Big Conversations into the outcome of the Breaking Barriers survey to produce an action plan on how to tackle the barriers to speaking up.
25. To individually target those who have not completed FTSU training to reach the 90% target for completion.

26. To source training for FTSU Guardians to better understand systemic racism and how best to support staff who raise these concerns.
27. Working closely with the staff networks to deliver bespoke training to groups with known barriers in the Trust such as temporary workers and internationally educated colleagues.
28. Continue to work closely with each division regarding specific areas of concern.

Recommendation

29. To approve to note and approve the content of the report. Once approved the report will be made available to managers and staff.
30. To commit to completion of the Level 3 FTSU Follow Up training for staff members Band 9 and above.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **104**

10 July 2024 **Purpose** Approval

Title	Standing Orders and Standing Financial Instructions Annual Review
Report Author	Mrs M Brown, Executive Director of Finance Mrs A Bosnjak-Szekeres, Director of Corporate Governance

Summary: The revised Standing Orders and Standing Financial Instructions have been reviewed and presented to the Audit Committee for discussion and recommendation to the Board.

The Chair of the Audit Committee will make the recommendation to the Board on behalf of the Audit Committee and the Executive Director of Finance and Director of Corporate Governance will update the Board on any changes that have been requested to the documents in addition to those set out in the documents presented.

Recommendation: The Board is asked to ratify the revised documents.

Report linkages

Related Trust Goal	Deliver safe, high quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	Provider Collaborative Waste Reduction Programme
Related to ICB Strategic Objective	Enhance productivity and value for money.

Impact

Legal	Yes/No	Financial	Yes/No
Equality	Yes/No	Confidentiality	Yes/No

Previously considered by:

Audit Committee will discuss the documents at their meeting on 8 July 2024.

	TRUSTWIDE
Delete as appropriate	**Policy**
DOCUMENT TITLE:	**Standing Orders**
DOCUMENT NUMBER:	**ELHT/F24 Version 3.3**
DOCUMENT REPLACES Which Version	**ELHT/F24 Version 3.2**
LEAD EXECUTIVE DIRECTOR DGM	**Chief Executive**
AUTHOR(S):Note should not include names	**Director of Corporate Governance/Company Secretary**

TARGET AUDIENCE:	**All Trust Personnel**
DOCUMENT PURPOSE:	**Identify the standing orders for the Trust.**
To be read in conjunction with (identify which internal documents)	Standing Financial Instructions Scheme of Delegation

SUPPORTING REFERENCES	

CONSULTATION		
	Committee/Group	**Date**
Consultation	**Audit Committee**	
Approval by:	**Trust Board**	
Ratification date at Policy Council:	**N/A, to be sent for publication following Board approval**	
NEXT REVIEW DATE:	**March 2025**	

Contents

STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

(1) The East Lancashire Hospitals NHS Trust (the Trust) is a statutory body which came into existence on 1st April 2003 under The East Lancashire Hospitals NHS Trust (Establishment) Order 2002 No. 2073 (the Establishment Order) as amended by the East Lancashire Hospitals National Health Service Trust (Establishment) and the Blackburn, Hyndburn and Ribble Valley Health Care National Health Service Trust and Burnley Health Care National Health Service Trust (Dissolution) Amendment Order 2011 No 2223.

(2) The principal place of business of the Trust is The Royal Blackburn Teaching Hospital, Haslingden Road, Blackburn.

(3) NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995 and the Health Act 1999 and subsequent amendments.

(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

(5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

(6) The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

(1) In addition to the statutory requirements the Secretary of State through the Department of Health and Social Care issues further directions and guidance.

(2) The Code of Accountability requires that Boards, inter alia, draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the

establishment of Audit and Remuneration Committees with formally agreed terms of reference. The Codes of Conduct prescribe various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness in the NHS and the provisions of the Freedom of Information Act 2000 set out the requirements for public access to information on the NHS.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. Standing Orders 4 and 5 set out the detail of these arrangements. Delegated powers are covered in the Schedule of Matters reserved for the Board and Scheme of Delegation.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with the National Health Service Trusts (Membership and Procedure) Regulations 1990 and the Trust's Establishment Order as amended by The East Lancashire Hospitals National Health Service Trust (Establishment) and the Blackburn, Hyndburn and Ribble Valley Health Care National Health Service Trust and Burnley Health Care National Health Service Trust (Dissolution) Amendment Order 2011 No 2223 and The East Lancashire Hospitals National Health Service Trust

(Establishment) and the Blackburn, Hyndburn and Ribble Valley Health Care National Health Service Trust and Burnley Health Care National Health Service Trust (Dissolution) (Amendment) Order 2017 no.61 made on 26 January 2017, that came into force on 10 February 2017 the composition of the Board shall be:

(1) The Chairman of the Trust (appointed by NHS England);

(2) 7 Non- Executive Directors (appointed by the NHS England);

(3) 5 Executive Directors including:

- Chief Executive
- Executive Director of Finance
- Executive Medical Director
- Executive Director of Nursing
- Chief Operating Officer

The Trust shall have no more than 13 and no less than 8 voting members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

(4) Other Executive Directors (e.g People and Culture, Services Development and Improvement, Communications and Engagement, and Integrated Care, Partnerships

and Resilience) will also form part of the Board membership but shall have no voting rights.

(5) NHS England or the Trust can appoint Associate Non-Executive Directors, who shall be expected to observe the roles and responsibilities of Non-Executive Directors, apart from the statutory obligations which only apply to Non-Executive Directors. All Associate Non-Executive Directors must adhere to the Nolan Principles of Public Life, the Fit and Proper Persons Regulations and all relevant legislative, regulatory and Trust level requirements. They will form part of the Board membership but shall have no voting rights and will not count towards the quorum at the Trust Board meetings. The Associate Non-Executive Directors will have a vote at the Board Sub-Committee level and count towards the quorum.

2.2 Appointment of Chairman and Members of the Trust Board

Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chairman is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chairman and members are set out in the National Health Service Trusts (Membership and Procedure) Regulations 1990 as amended.

2.3 Terms of Office of the Chairman and Members

The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in Sections 7 to 9 of the National Health Service Trusts (Membership and Procedure) Regulations 1990 as amended.

2.4 Appointment and Powers of the Deputy Chair(s)

(1) Subject to Standing Order 2.4 (2) below, the Chairman and members of the Trust Board may appoint one or two of their numbers, who is/are a Non-Executive member(s), to be Deputy Chair(s), for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

(2) Any member so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another member as Deputy Chair(s) in accordance with the provisions of Standing Order 2.4 (1).

(3) Where the Chairman of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Deputy Chair(s) shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to

perform those duties, be taken to include references to the Deputy Chair(s).

2.5 Role of Board Members

The Board will function as a corporate decision-making body, Executive and Non-Executive Members will be full and equal members (provided they have full voting rights). Their role as members of the Trust Board will be to consider the key strategic issues facing the Trust in carrying out its statutory and other functions.

(1) Executive Members

Executive Members shall exercise their authority within the terms of these Standing Orders and the Standing Financial Instructions and the Scheme of Delegation.

(2) Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. They are the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) Executive Director of Finance

The Executive Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) Non-Executive Members

The Non-Executive Members shall not be granted, nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) Chairman

The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall liaise with NHS England over the appointment of Non- Executive Directors and once appointed, shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments and their performance.

The Chairman shall work with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the East Lancashire Hospitals NHS Trust – Policies & Procedures, Protocols Guideline debate and ultimate

resolutions.

2.6 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as Corporate Trustee.

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3.

(4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.6.1 Schedule of Matters reserved for the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved for the Board' that forms part of the Standing Financial Instructions and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.7 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Director of Corporate Governance/Company Secretary to the Board will publish the dates, times and locations of the meeting of the Board in advance.

(2) The Chairman of the Trust may call a meeting of the Board at any time.

(3) One third or more members of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

(4) In case of emergencies or the need to conduct urgent business, the Director of Corporate Governance/Company Secretary shall give to all members as much notice as is considered reasonable by the Chairman or the Deputy Chair(s) of the Trust, of the date, time and place of the meeting by whatever means of communication is considered appropriate by the Chairman or the Deputy Chair(s) of the Trust.

(5) In the event of an emergency or the need to conduct urgent business, the Chairman, Deputy Chair(s) or Director of Corporate Governance/Company Secretary may, in calling the meeting, authorise the meeting to be held in private as a Part 2 meeting of the Trust Board, if the nature of the business to be conducted is commercially sensitive or would otherwise not be in the public interest to disclose at that time. The fact that such a meeting has been held shall be reported to the next Board meeting.

2.8 Notice of Meetings and the Business to be transacted

(1) Save in the case of emergencies or the need to conduct urgent business, before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. Want of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under the Standing Orders.

(4) A member desiring a matter to be included on an agenda shall make their request in writing to the Chairman at least 15 calendar days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 calendar days before a meeting may be included on the agenda at the discretion of the Chairman.

2.9 Agenda and Supporting Papers

The agenda will be sent to members 7 calendar days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in exceptional circumstances

2.10 Notices of Motion

A director desiring to move or amend a motion shall send a written notice thereof at least 10 calendar days before the meeting to the Chairman and Director of Corporate Governance/Company Secretary, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

2.11 Withdrawal of Motions or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

2.12 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any

resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the director who gives it and also the signature of 4 other directors. When any such motion has been disposed of by the Trust, it shall not be competent for any director other than the Chairman to propose a motion to the same effect within 6 months; however, the Chairman may do so if they consider it appropriate.

2.13 Motions

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

2.14 Chairman of meeting

(1) At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Deputy Chair(s), if present, shall preside.

(2) If the Chairman and the Deputy Chair(s) are absent, such member (who is not also an Executive Member of the Trust) as the members present shall choose shall preside.

2.15 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders, at the meeting, shall be final.

2.16 Quorum

(1) No business shall be transacted at a meeting unless at least one-third of the whole number (rounded up) of the Chairman and voting members (including at least one member who is also an Executive Member of the Trust and one member who is a Non-Executive Member) is present.

(2) An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

(3) If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.5) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next item of business.

2.17 Voting

(1) Save as provided in Standing Orders 2.18 - Suspension of Standing Orders and 2.19

- Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting) shall have a second, and casting vote.

(2) At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(3) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(4) If a member so requests, their vote shall be recorded by name.

(5) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

(6) A deputy who has been formally appointed to act up for an Executive Director Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director Member.

(7) A deputy attending the Trust Board meeting to represent an Executive Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director Member. A deputy's status when attending a meeting shall be recorded in the minutes.

2.18 Suspension of Standing Orders

(1) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 2.16), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the voting members of the Board are present (including at least one member who is an Executive Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes. No formal business may be transacted while the Standing Orders are suspended.

2.19 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under these Standing Orders
- no fewer than half of the Trust's total Non-Executive Directors in post vote in favour of the amendment; and
- at least two thirds of the voting Board members are present at the meeting where the

variation or amendment is being discussed, and

- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

2.20 Record of Attendance

The names of the Chairman and Directors/members present at the meeting shall be recorded.

2.21 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

2.22 Admission of public and the press

(1) Meetings of the Board of Directors will be open to members of the public. At any meeting of the Board of Directors open to members of the public the Chairman may exclude any member of the public if they are interfering with or preventing the proper conduct of the meeting. Members of the public may be excluded from a meeting of the Board of Directors on the grounds that publicity of the matters being reviewed would be prejudicial to public interest, by reason of the confidential nature of business.

(2) Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

3.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health and Social Care, the Trust Board may appoint committees of the Trust; or together with one or more health organisations appoint joint committees.

The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State for Health and Social Care or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

3.2 Applicability of Standing Orders to Committees

The Standing Orders of the Trust, as far as they are applicable, shall as appropriate, apply to meetings and any committees established by the Trust. (There is no requirement to hold meetings of committees established by the Trust in public.)

3.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State for Health and Social Care. Such terms of reference shall have effect as if incorporated into the Standing Orders.

3.4 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees, they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

3.5 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State for Health and Social Care. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

3.6 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State for Health and Social Care, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State for Health and Social Care.

3.7 Committees established by the Trust Board

The committees, sub-committees, and joint committees established by the Board are:

a) Audit Committee and Auditor Panel
b) Remuneration Committee
c) Trust Charitable Funds Committee
d) Finance and Performance Committee

e) Quality Committee

f) People and Culture Committee

The Board approves the terms of reference for these committees, and they are reviewed on at least an annual basis.

3.8 Other Committees

The Board may also establish such other committees as required to discharge the Trust's responsibilities. The Board has established an Ethics Committee.

4. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

4.1 Delegation of Functions to Committees, Officers or other bodies

Subject to such directions as may be given by the Secretary of State for Health and Social Care, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub- committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body, in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.8) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

4.3 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub- committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

Delegation to Provider Collaboration Board (PCB) Joint Committee

The provider Boards, within the Lancashire and South Cumbria (LSC) Integrated Care System (ICS) have agreed to delegate the following functions to the PCB Joint Committee, where such matters affect the Trusts and can benefit the population of Lancashire and South Cumbria. This includes key decisions regarding:

a) service transformation priorities as defined by the ICS and commissioners;

b) priorities for provider productivity improvement
c) opportunities for developing standardised approaches to service change and delivery
d) Shared clinical services for community services
e) Shared corporate services for: bank and agency workers; procurement;
f) Pathology Collaboration Network strategic decisions
g) And other matters as determined from time to time.

In exercising delegated functions the PCB shall provide a single, collective view of the Provider Trusts and agree an annual work programme, each year, relating to the delegated functions, that promotes the best interests of the whole population.

The Trust Board will ensure that it is fully involved in the decision making and engagement process in relation to the strategic collaborative items and this will be enacted through an Executive function with representation from the Non-Executive contingent of directors.

4.4 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Executive Director of Finance to provide information and advise the Board in accordance with statutory or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Executive Director of Finance shall be accountable to the Chief Executive for operational matters.

The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" shall have effect as if incorporated in these Standing Orders.

4.5 Duty to report non-compliance with Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Trust Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Director of Corporate Governance/Company

Secretary as soon as possible.

5. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

5.1 Declaration of Interests

5.2 Requirements for Declaring Interests and applicability to Board Members

The NHS Code of Accountability and the Trust's Standard of Conduct policy requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

5.3 Interests which are relevant and material

Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of Authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services;

f) Research funding/grants that may be received by an individual or their department;

g) Interests in pooled funds that are under separate management.

Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in this document) have any pecuniary interest, direct or indirect, the Board member shall declare their interest by giving notice in writing of such fact to the Director of Corporate Governance/Company Secretary as soon as practicable.

5.4 Advice on Interests

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust or with the Trust's Director of Corporate Governance/Company Secretary.

Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including

general practitioners should also be considered.

5.5 Recording of Interests in Trust Board minutes

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

5.6 Publication of declared interests in Annual Report

Board members' declarations of interest are entered into the Directors' Register of Interests and published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

5.7 Register of Interests

The Director of Corporate Governance/Company Secretary will ensure that a Directors' Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by executive and non-executive Trust Board members.

These details will be kept up to date by means of a regular review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

The Register will be available to the public and the Director of Corporate Governance/Company Secretary will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

Exclusion of Chairman and Members in proceedings on account of pecuniary interest

5.8 Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

a) "Spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

b) "Contract" shall include any proposed contract or other course of dealing.

c) "Pecuniary interest" – an amount or an interest related to money or that which can be measured in money

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:

a) they, or a nominee of theirs, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

b) they are a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:

a) neither they or any person connected with them have any beneficial interest in the securities of a company of which they or such person appears as a member, or

b) any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence them in relation to considering or voting on that contract, or

c) those securities of any company in which they (or any person connected with them) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Orders.

5.9 Exclusion in proceedings of the Trust Board

Subject to the following provisions of this Standing Order, if the Chairman or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Secretary of State may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to them in the interests of the National Health Service that the disability should be removed. (See SO 5.11 on the 'Waiver' which has been approved by the Secretary of State for Health).

The Trust Board may exclude the Chairman or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which they have a pecuniary interest is under consideration.

5.10 Waiver of Standing Orders made by the Secretary of State for Health and Social Care

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure) Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chairman' for the purpose of interpreting this waiver

The "relevant chairman" is:

(a) at a meeting of the Trust, the Chairman of that Trust;

(b) at a meeting of a Committee:

(i) in a case where the member in question is the Chairman of that Committee, the Chairman of the Trust;

(ii) in the case of any other member, the Chairman of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest. It will apply to:

(i) A member of the East Lancashire Hospitals NHS Trust ("the Trust"), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of:

(a) services under the National Health Service Act 1977; or

(b) services in connection with a pilot scheme under the National Health Service Act 1997;

for the benefit of persons for whom the Trust is responsible.

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as they provide or perform, or assists in the provision or performance

of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question

(2) (b) above, except where that member is the Chief Executive;

(c) in the case of a meeting of the Trust:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) in the case of a meeting of the Committee:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

5.11 Standards of Conduct

The Trust has adopted the Standards of Conduct which are applicable to all staff and those acting on behalf of the Trust.

5.12 Standards of Conduct, Trust Policy and National Guidance

All Trust staff and members of must comply with the Trust's Standards of Conduct and procedures on receipt of hospitality and gifts and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff', the provisions of the Bribery Act 2010 and the NHS England guidelines on declarations of interest issued on 1 June 2017.

(1) Interest of Officers in Contracts

i) Any officer or employee of the Trust who comes to know that the Trust has entered into, or proposes to enter into, a contract in which they or any person connected with them have any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Trust's Director of Corporate Governance/Company Secretary as soon as practicable.

ii) An Officer should also declare to the Trust Director of Corporate Governance/Company

Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

(2) Canvassing of and Recommendations by Members in Relation to Appointments

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

iii) Pre-interview visits or questions from applicants for an advertised vacancy or from shortlisted candidates prior to interview are permitted to take place, providing this is undertaken through the appropriate channels and is not intended as a form of canvassing.

(3) Relatives of Members or Officers

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose through the application process, whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

ii) The Chairman and every member and officer of the Trust shall disclose to the Trust Board any relationship between themself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chairman and members in proceedings on account of pecuniary interest' shall apply.

5.13 Fit and Proper Person Declaration

(1) In addition to being of good character, persons appointed to the post of Executive or Non-Executive Director must, as laid out in the Trust's Policy (HR73: Fit and Proper Persons policy):

- Have the qualifications, competence, skills and experience necessary to undertake the role
- Be able by reason of their health to properly perform the role's intrinsic tasks after any reasonable adjustment
- Not be prohibited from holding the position under any other legislation
- "not have been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity"

They must not be:

- an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
- a person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- a person included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
- part of an Employment Tribunal as a named party where they have been implicated and which relates to the requirements of the Fit and Proper Persons Regulations.
- managed their social media presence in such a way as to contrast the ethos of the Fit and proper Persons Regulations.

5.14 Declarations

The Board requires Executive and Non-Executive Directors to declare on appointment and thereafter on an annual basis that they remain a Fit and Proper Person to be employed as a Director. If Board members have any doubt about the declaration, this should be discussed with the Chairman of the Trust or with the Trust's Director of Corporate Governance/Company Secretary.

Failure to comply with this requirement or failure to meet the necessary elements of the Fit and Proper Person test will be addressed under the Trust's HR Policies and Procedures for

Executive Directors and will be reported to NHS England.

6. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

6.1 Custody of Seal

The common seal of the Trust shall be kept by the Director of Corporate Governance/Company Secretary in a secure place.

6.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed by the Director of Corporate Governance in the presence of two Executive Directors, preferably the Chief Executive and Executive Director of Finance.

They must be duly authorised by the Chief Executive, and not from the originating department, and shall be attested by them. If another voting Executive Director is to sign a sealed document, it must have been reviewed and approved by the Executive Director of Finance in the first instance.

6.3 Register of Sealing

The Director of Corporate Governance/Company Secretary shall keep a register in which they shall enter a record of the sealing of every document.

6.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or the Executive Director of Finance. If one or both of the named Directors are not available when the documents need to be executed the Deputy Chief Executive or any other Executive Board Director with Board level voting rights will be able to execute the documents.

In land transactions, the signing of certain supporting documents will be delegated to managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

7. MISCELLANEOUS (see overlap with SFIs)

7.1 Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority

using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health-related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999. See overlap with Standing Financial Instruction.

Scheme of Reservation and Delegation

Decisions Reserved to the Board
General Enabling Provision 1. The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
Regulations and Control 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session 5. Approve a scheme of delegation of powers from the Board to committees. 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Receive reports from committees including those that the Trust is required by the Secretary of State and Social Care or other regulation to establish and to take appropriate action on. 9. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 10. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 11. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 13. Receive report on the use of the seal. 14. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Director of Corporate Governance/Company Secretary's attention 15. Appoint the External Auditors on the recommendation of the Auditor Panel 16. Agree any powers to be delegated to the Provider Collaboration Board Joint Committee (PCBJC)
Appointments/ Dismissal 1. Appoint the Deputy Chair(s) of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, discipline and dismiss Executive Directors 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
Strategy, Plans and Budgets 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State and Social Care. 3. Approve, or delegate approval to one of its sub-committees, the Trust's policies and procedures for the management of risk.

Decisions Reserved to the Board
4. Approve Outline and Final Business Cases for Capital Investment with the value of £1 million and above 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1 million 10. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Executive Director of Finance (for losses and special payments) previously approved by the Board. 11. Approve individual non-clinical compensation payments. 12. Approve proposals for action on non- clinical litigation against or on behalf of the Trust.
Annual Reports and Accounts 1. Receipt and approval of the Trust's Annual Report and Annual Accounts/delegate it to the Audit Committee
Monitoring 1. Receive of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and Social Care and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from Executive Director of Finance on financial performance against budget and Trust Annual Business Plan.

Scheme of Delegation Derived from the Accountable Officer Memorandum

Delegated To	Duties Delegated
Chairman	Implement requirements of corporate governance.
Chief Executive	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
Chief Executive	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.
Chief Executive	*Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers:* "have a clear view of their objectives and the means to assess achievements in relation to those objectives be assigned well defined responsibilities for making best use of resources have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
Chief Executive	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the External Auditors and the National Audit Office (NAO).
Chief Executive	Primary duty to see that Executive Director of Finance discharges this function.
Chief Executive	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
Chief Executive	If the Chief Executive considers the Board or Chairman is doing something that might infringe probity or regularity, he should set this out in writing to the Chairman and the Board. If the matter is unresolved, they should ask the Audit Committee to inquire and if necessary NHS England and Department of Health and Social Care.
Chief Executive	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is that they are overruled, it is normally sufficient to ensure that their advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform NHS England and the Department of Health and Social Care. In such cases, the Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting.
Chief Executive and Executive Director of Finance	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State for Health and Social Care. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs.

Delegated To	Duties Delegated
Chief Executive and Executive Director of Finance	Chief Executive, supported by Executive Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
Executive Director of Finance	Operational responsibility for effective and sound financial management and information. Approve the opening of bank accounts.

Scheme of Delegation Derived from the Codes of Conduct and Accountability

Delegated To	Authorities/Duties Delegated
Chairman	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board and other Board sub-committees; 7. advise the Secretary of State on the performance of Non-Executive Board members.
Chairman and Directors	Declaration of conflicts of interest
Chairman and Non-Executive/Officer Members	Chairman and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
The Board	Approve procedure for declaration of hospitality and sponsorship/delegate approval to the Audit Committee.
The Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Standards of Conduct, and other ethical concerns.
The Board	The Board has seven key functions for which it is held accountable by the Department of Health and Social Care on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer-term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and

Delegated To	Authorities/Duties Delegated
	that these are responsive to the community's needs. 7. to work in collaborative ways with partner organisations across the system and wider NHS as set out in section 75 of the Health and Social Care Act 2022.
The Board	Board members share corporate responsibility for all decisions of the Board.
The Board	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board. 7. to work in collaborative ways with partner organisations across the system and wider NHS as set out in section 75 of the Health and Social Care Act 2022.
The Board	NHS Boards must comply with legislation and guidance issued by the Department of Health and Social Care on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.
All Board members	Subscribe to Standards of Conduct.
Chief Executive	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.

Delegated To	Authorities/Duties Delegated
Non-Executive Directors	Non-Executive Directors are appointed by NHS England to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health and Social Care to Ministers and to the local community.

Scheme of Delegation from Model Standing Orders

Delegated to	Authorities/Duties Delegated
Chairman	Final authority in interpretation of Standing Orders (SOs).
Chairman	Call meetings
Chairman	Chair all Board meetings and associated responsibilities
Chairman	Give final ruling in questions of order, relevancy and regularity of meetings
Chairman	Having a second or casting vote
The Board	Appointment of Deputy Chair(s)
The Board	Suspension of Standing Orders
The Board	Variation or amendment of Standing Orders
The Board	Formal delegation of powers to sub-committees or joint committees and approval of their constitution and terms of reference. (Delegation of powers includes approval of corporate policies on behalf of the Board)
The Board	Declare relevant and material interests
Chairman and Chief Executive	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members
Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion
Chief Executive/ Executive Director	Approve and sign all documents which will be necessary in legal proceedings
Director of Corporate Governance/Company Secretary	Maintain Register(s) of Interests
Director of Corporate Governance/Company Secretary	Keep seal in safe place and maintain a register of sealing
All Staff	Disclosure of non-compliance with Standing Orders to the Director of Corporate Governance/Company Secretary as soon as possible
All Staff	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”

All Staff	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board)

TRUST WIDE / DIVISIONAL DOCUMENT

Delete as appropriate	Policy
DOCUMENT TITLE	STANDING FINANCIAL INSTRUCTIONS
DOCUMENT NUMBER	ELHT/F25 Version 4.3
DOCUMENT REPLACES Which Version	4.2
LEAD EXECUTIVE DIRECTOR DGM	ELHT/F25 Version 4.2
AUTHOR(S): Note should not include names	Executive Director of Finance Director of Corporate Governance/Company Secretary

TARGET AUDIENCE	All Trust Personnel
DOCUMENT PURPOSE	Identify the reservation and delegation of powers and standing financial instructions for the Trust.
To be read in conjunction with (identify which internal documents)	Standing Orders
SUPPORTING REFERENCES	NA

CONSULTATION		
	Committee/Group	Date
Consultation	**Audit Committee**	
Approval Committee	**Audit Committee**	

Document ratification date	
NEXT REVIEW DATE:	31 March 2025
AMENDMENTS	

STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust, Hosted organisations and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Executive Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Executive Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non- compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Executive Director of Finance as soon as possible.

1.2 Responsibilities and delegation

1.2.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/ overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

1.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Matters Reserved to the Board' document. All other powers have been delegated to such other committees as the Trust has established or individuals as indicated in the scheme of delegation or these Standing Financial Instructions.

1.2.3 **Delegation to Provider Collaboration Board (PCB) Joint Committee**

The provider Boards, within the Lancashire and South Cumbria (LSC) Integrated Care System (ICS) have agreed to delegate the following functions to the PCB Joint Committee, where such matters affect the Trusts and can benefit the population of Lancashire and South Cumbria.

a) service transformation priorities as defined by the ICS and commissioners

b) priorities for provider productivity improvement

c) opportunities for developing standardised approaches to service change and delivery

d) Shared clinical services for community services

e) Shared corporate services for: bank and agency workers procurement

f) Pathology Collaboration Network strategic decisions

g) And other matters as determined from time to time

In exercising delegated functions, the PCB shall provide a single, collective view of the Provider Trusts and agree an annual work programme, each year, relating to the delegated functions, that promotes the best interests of the whole population.

The Trust Board will ensure that it is fully involved in the decision making and engagement process in relation to the strategic collaborative items and this will be enacted through an Executive function with representation from the Non-Executive contingent of directors.

1.2.4 The Chief Executive and Executive Director of Finance

The Chief Executive and Executive Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.5 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.6 The Executive Director of Finance

The Executive Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Executive Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.7 Board Members and Employees

All members of the Board and employees, severally and collectively are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.2.8 Contractors and their employees

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this. For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Executive Director of Finance.

2. AUDIT

2.1 Audit and Risk Committee

2.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board;

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

(g) Review and approve corporate policies on behalf of the Board

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health and Social Care (to the Executive Director of Finance in the first instance).

2.1.3 It is the responsibility of the Executive Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

2.1.4 As a host and partner organisation of One LSC ELHT has a pivotal role in relation to central services collaboration. The Audit and Risk Committee will have a standing item on its agendas on One LSC and will provide assurance to the Board about the appropriateness of the governance arrangements and risk management systems. It will also consider matters in relation to collaborative working of providers and other stakeholders.

2.1.5 As a host organisation the Trust's Audit and Risk Committee will be responsible for receiving at least an annual report, but more frequently if required, from the Managing Director of One LSC in relation to the total remuneration packages of the One LSC Directors, specifically setting out the confirmation that the correct governance and decision making processes have been followed by the PCBJC and CSEC as the decision making bodies in this matter, before any implementation instructions are delivered to payroll.

2.2 Executive Director of Finance

2.2.1 The Executive Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring the following reports are prepared for the consideration of the Audit Committee:

(i) an internal audit plan for the forthcoming year;

(ii) regular progress reports against that plan;

(iii) an internal audit annual report that must cover:

- a clear opinion on the effectiveness of internal control in accordance with Public Sector Internal Audit Standards;
- details of any major internal financial control weaknesses discovered;
- progress on the implementation of internal audit recommendations; and
- progress against plan over the previous year;

2.2.2 The Executive Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;

(ii) waste, extravagance, inefficient administration;

(iii) poor value for money or other causes.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Executive Director of Finance must be notified immediately.

2.3.3 The Internal Audit Engagement Lead will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The Internal Audit Engagement Lead shall be accountable to the Executive Director of Finance. The reporting system for internal audit shall be agreed between the Executive Director of Finance, the Audit Committee and the Internal Audit Engagement Lead in the form of an Internal Audit Charter. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least annually.

2.4 External Audit

2.4.1 The External Auditor is appointed by the Trust Board on the recommendation of the

'Auditor Panel', which is a sub-set of the Audit Committee. The Executive Director of Finance is responsible for ensuring the selection and appointment process is compliant with the audit framework established under the Local Audit and Accountability Act 2014 and that suitable contract management arrangements are in operation. The Audit Committee should review and monitor the external auditor's independence and objectivity.

2.5 Fraud and Corruption

2.5.1 In line with their responsibilities, the Trust Chief Executive and Executive Director of Finance shall monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on fraud and corruption.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS), as specified by the NHS Counter Fraud Manual and guidance NHS Counter Fraud Authority (NHSCFA).

2.5.3 The Local Counter Fraud Specialist shall report to the Trust Executive Director of Finance and shall work with staff in the NHSCFA.

2.5.4 The Local Counter Fraud Specialist will provide a written report quarterly to the Audit Committee, on counter fraud work within the Trust.

2.6 Security Management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health and Social Care guidance on NHS security management.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed LSMS.

3. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board an Annual Business Plan (ABP) which takes into account financial targets and forecast limits of available

resources. The ABP will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in activity, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Executive Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the local delivery plan;

(b) accord with activity and workforce plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

3.1.3 The Executive Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Executive Director of Finance to enable budgets to be compiled.

3.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.1.6 The Executive Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service;

(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Executive Director of

Finance.

3.3 Budgetary Control and Reporting

3.3.1 The Executive Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) Financial reports to the Board and reports to the Finance and Performance Committee in a form approved by the Board containing:
  (i) income and expenditure to date showing trends and forecast year-end position;
  (ii) balance sheet position showing movement from previous month and movement year to date
  (iii) movements in working capital;
  (iv) movements in cash and capital;
  (v) capital project spend and projected outturn against plan;
  (vi) explanations of any material variances from plan;
  (vii) details of any corrective action where necessary and the Chief Executive's and/or Executive Director of Finance's view of whether such actions are sufficient to correct the situation;
  (viii) Patient level information and costing system.

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, activity and workforce budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the ABP and a balanced budget.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 1.2).

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Executive Director of Finance, on behalf of the Trust, will ensure that the annual accounts and other prescribed financial returns are:

(a) prepared and certified in accordance with the accounting requirements of the Department of Health and Social Care's Group Accounting Manual;

(b) submitted to the Department of Health and Social Care and audited by the Trust external auditor in accordance with prescribed timetables;

4.2 The Trust will publish and present at a public meeting an annual report, prepared in accordance with the Department of Health and Social Care's Group Accounting Manual, and including the Trust's audited annual accounts.

5. BANK AND GBS ACCOUNTS

5.1 General

5.1.1 The Executive Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by the Department of Health and Social Care. In line with 'Cash Management in the NHS' Trusts should minimise the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

5.1.2 The Board shall approve the banking arrangements.

5.2 Bank and GBS Accounts

5.2.1 The Executive Director of Finance is responsible for:

(a) bank accounts and GBS accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts

to be overdrawn.

(e) monitoring compliance with DHSC guidance on the level of cleared funds.

5.3 Banking Procedures

5.3.1 The Executive Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Executive Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review

5.4.1 The Executive Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

5.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Executive Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Executive Director of Finance is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow the advice in the NHS Operational Planning and Contracting guidance in setting prices for NHS service agreements.

6.2.2 The Executive Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care/ NHS England or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered

the guidance in the Department of Health and Social Care's Commercial Sponsorship – Ethical standards in the NHS and the provisions of the Bribery Act 2010 shall be followed.

6.2.3 All employees must inform the Executive Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 The Executive Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Executive Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines as prescribed by the Trust approved procedure (Procedure Notes for Petty Cash Payments (F04)**)**;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Director of Finance.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7. TENDERING AND CONTRACTING PROCEDURE

(i) The Trust's policy is to seek to maximise value for money in the procurement of goods and services whilst ensuring that operational requirements are fulfilled and statutory obligations met. Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

7.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with the Standing Orders and the Standing Financial Instructions (except where the Suspension of Standing Orders is applied).

7.2 World Trade Organisation's (WTO) Government Procurement Agreement (GPA)

The WTO's GPA is a voluntary trade agreement that governs public procurement. Procurement in the UK post-Brexit followed rules set by OJEU; these rules will now shift to be in line with the GPA. The GPA includes both EU member states and non- EU states. It also outlines procurement principles, thresholds and rules that all those in agreement must adhere to. This agreement will allow the UK to have access to international public procurement.

7.3 Capital Investment Manual, NHSE and Department of Health and Social Care and Social Care capital investment guidance

The Trust shall comply as far as is practicable with the requirements of Capital regime, investment and property business case approval guidance for NHS providers issued by NHS England and the Department of Health and Social Care and Social Care, "Capital Investment Manual" and Efficient Management of Healthcare Estates and Facilities in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with the requirements of guidance issued by NHS England on Consultancy spending approval criteria Department of Health guidance "The Procurement and Management of Consultants within the NHS".

7.4 Formal Competitive Tendering

7.4.1 Trust Officers will as a matter of course seek to use NHS or other Public Body Contracts. In cases where they are not available or are inappropriate for use the following rules by value apply. All values are for the total procurement value over the life of the goods/services.

7.4.2 Both quotations and tenders are formal requests from the Trust to potential suppliers to provide prices/costs against a defined procurement.

7.4.3 Tenders representing a value greater that the GPA level and more complicated

procurements will comprise a range of standard documentation as advised by the Department of Health and Social Care and Government.

7.4.4 In cases where the Trust, by prior agreement, uses another Public Body to undertake procurement then the Statutory Framework of that Body will apply to the procurement – the Trust having agreed and documented this in advance.

7.4.5 In cases where the Trust, by prior agreement, undertakes procurement on behalf of another Public Body the Trust's Statutory Framework will apply – all parties having agreed and documented this in advance.

7.5 General Applicability

7.5.1 The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);

(c) For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

7.6 Health Care Services

7.6.1 Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 16.

7.7 Exceptions and instances where formal tendering need not be applied

7.7.1 Trust Procurement will advise budget holders as to how compliance can be achieved.

7.7.2 Formal tendering procedures need not be applied where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed **£10,000**;

(b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 16.13.

7.7.3 Formal tendering procedures **may be waived** in the following circumstances:

(a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(b) where the requirement is covered by an existing contract;
(c) where a government agreement is in place and have been approved by the Board;
(d) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(e) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
(f) where specialist expertise is required and is available from only one source;
(g) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(h) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
(i) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.
(j) Where the pre-procurement estimate has been exceeded and would have required an alternative procurement route or has exceeded the estimate by more than 25%.

7.7.4 The Executive Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

7.8 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure. All proposed waivers will be requested by means of the Trust approved formal Waiver Form and in line with the Trust's Scheme of Delegation.

7.8.1 Trust Procurement will consider all requests to waive tendering and quotation requirements as set out in these Standing Orders and Standing Financial Instructions based upon both the information presented and appropriate research. Approval will be granted or declined in the first instance by Trust Procurement and the form will then be submitted to the Executive Director of Finance. If either party declines the waiver request the Trust Procurement Officer will brief and advise the commissioning officer of the reason.

7.8.2 Where it is decided that competitive tendering is not applicable and should be waived,

the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee on an annual basis

7.9 Fair and Adequate Competition

7.9.1 Except where the exceptions set out in SFI No. 7.7 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.10 Building and Engineering Construction Works

7.10.1 Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with GPA, Procure21+/ Procure22 and Private Finance Initiatives) without Department of Health and Social Care approval.

7.11 Items which subsequently breach thresholds after original approval

7.11.1 Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported via a waiver to the Executive Director of Finance and be recorded in an appropriate Trust record.

7.12 Contracting/Tendering Procedure

7.12.1 Trust Procurement will support budget holders in sourcing and identifying potential suppliers. Sources of potential suppliers will include but not be limited to:

(a) Via posting on the Government website and per the Public Contracts Regulations 2015 contracts finder
(b) NHS or other Public Body Contractors
(c) Respondents to Notices placed on Find a Tender
(d) Respondents to Notices placed in appropriate Journals
(e) Those advised by Trust Officers based upon their operational and technical knowledge

7.12.2 A pre-selection process will usually be undertaken including, where appropriate, indicative costing methodologies.

7.12.3 Tender documents will be issued according to one of three methods the following method:

a) Electronically via the Trust Tender Management (TM) system.

This involves giving Tenderers electronic access to Tender Documents and their return electronically. The Trust may also elect to utilise the Electronic Auction option as part of this method which involves facilitating an online reverse auction where against an agreed range of products/ services tenderers submit prices within a timescale with an expectation that suppliers submitting the lowest prices will achieve the highest score for the pricing elements of the Tender. The trust may also invite non price Tender submissions in addition to the Electronic Auction.

Electronic Auctions will be operated in accordance with the protocols of the TM System provider and the Trust Procurement/E-Commerce Department.

7.13 Opening tenders and Register of tenders

7.13.1 Tenders issued electronically via the TM System should be submitted and opened in accordance with the TM System protocols. These protocols having been agreed with the system provider and having been approved by the Trust's Internal Audit System prior to implementation. The Tenders will remain within the TM System under a password controlled and time locked secure electronic environment.

7.14 Admissibility

7.14.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive or Executive Director of Finance.

7.14.2 Where only one tender is sought and/or received, the Chief Executive and Executive Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.15 Late Tenders

7.15.1 Tenders received after the due time and date, but prior to the opening of the other tenders may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.

7.15.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

7.15.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential,

recorded, and held in safe custody by the Chief Executive or his nominated officer.

7.15.4 The TM System will require the Trust's authorised Officers to approve the opening of Tenders received past the Tender Return date – until this is agreed they will be stored securely online

7.16 Acceptance of formal tenders

7.16.1 The Tender Document will normally state that the awarded is to be based on the most economically advantageous bid. This will normally include full life cycle costs.

7.16.2 In cases where the GPA Thresholds apply, the Award Criteria must be included in either the Notice on Find a Tender or in the Tender.

7.16.3 Contract Award criteria are agreed by Trust Officers as part of the procurement process. In projects of significant value/risk this will include budget holders, finance staff and procurement officers along with any other appropriate Trust Officers.

(a) The procurement process must allow sufficient time for pre- offer (tender) engagement with potential suppliers including the application of indicative pricing methodologies. These will be conducted in accordance with Department of Health and Social Care / Government Guidance. Post tender negotiation /pre contract negotiation is not permitted within the GPA tendering process. In exceptional cases at the discretion of Trust Procurement it may be undertaken for below GPA threshold tendering exercises. Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender. These clarifications will be conducted in accordance with Department of Health and Social Care/ Office of Government Commerce Crown Commercial Services/Cabinet Office Guidance.

(b) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record. The Trust will award all tenders on the basis of the most economically advantageous tender taking into account both cost and quality measures.

(c) It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(i) experience and qualifications of team members;

(ii) understanding of client's needs;

(iii) feasibility and credibility of proposed approach;

(iv) ability to complete the project on time.

(v) Where other factors are taken into account in selecting a tenderer, these factors and their weighting in the award process must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(vi) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(vii) The use of these procedures must demonstrate that the award of the contract was:

(viii) not in excess of the going market rate / price current at the time the contract was awarded;

(ix) that best value for money was achieved.

7.16.4 All tenders should be treated as confidential and should be retained for inspection.

7.16.5 All tender awards need to be posted on the contracts finder website as per the Public Contracts Regulations 2015.

7.17 Tender reports to the Trust Board

7.17.1 Reports to the Trust Board will be made on an exceptional circumstance basis only.

7.17.2 Building and Engineering Construction Works

(a) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Efficient Management of Healthcare Estates and Facilities guidance (Health Notice HN(78)147).

(b) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

(c) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

7.17.3 Financial Standing and Technical Competence of Contractors

The Executive Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

7.18 Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Executive Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.19 Quotations: Competitive and non-competitive

7.19.1 General Position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed
£10,000 but not exceed £30,000.

7.19.2 Competitive Quotations

Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Quotations will usually comprise a single document.

Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

All quotations should be treated as confidential and should be retained for inspection. The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made, and the reasons why should be recorded in a permanent record.

7.19.3 Non-Competitive Quotations

(a) Non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) miscellaneous services, supplies and disposals;

(d) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: and (ii) of this SFI) apply.

7.19.4 Quotations to be within Financial Limits

8. 7.22.4.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Executive Director of Finance.

8.1 Authorisation of Tenders and Competitive Quotations

8.1.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

Designated budget holders	up to	£25,000
Divisional Directors of Operations	up to	£75,000
Executive Directors	up to	£250,000
Executive Director of Finance	up to	£500,000
Deputy Chief Executive	up to	£500,000
Chief Executive	up to	£1,000,000
Trust Board	over	£1,000,000

8.1.2 These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

8.1.3 Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

8.2 Instances where formal competitive tendering or competitive quotation is not required (Referred to elsewhere in document)

(a) The Trust shall use the NHS Logistics Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented. Where it has been deemed inappropriate to utilise NHS Supply Chain approval should be sought from Trust Procurement in the first instance and then the Executive Director of Finance.

(b) If the Trust does not use the NHS Supply Chain - where tenders or quotations are not required, because expenditure is below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Executive Director of Finance.

8.3 Private Finance for capital procurement

8.3.1 The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health and Social Care for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

8.4 Compliance requirements for all contracts

8.4.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Efficient Management of Healthcare Estates and Facilities, Capital regime, investment and property business case approval guidance for NHS providers and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.5 Personnel and Agency or Temporary Staff Contracts

8.5.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

8.6 Disposals

8.6.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £5,000 this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DHSC guidance has been issued but subject to compliance with such guidance.

8.7 In-house Services

8.7.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

8.7.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical

support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Executive Director of Finance representative. For services having a likely annual expenditure exceeding £500,000, a Non-Executive member of the Board should be a member of the evaluation team.

8.7.3 All groups should work independently of each other, and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of tenders.

8.7.4 The evaluation team shall make recommendations to the Board.

8.7.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.8 Applicability of SFIs on Tendering and Contracting to funds held in trust

8.8.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust charitable funds and private resources.

9. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

9.1 Service Level Agreements (SLAs)

9.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

9.1.2 All SLAs should aim to implement the agreed priorities contained within the Annual Business Plan (ABP) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

(a) the standards of service quality expected;

(b) the relevant national service framework (if any);

(c) the provision of reliable information on cost and volume of services;

(d) the NHS National Performance Assessment Framework;

(e) that SLAs build where appropriate on existing Joint Investment Plans;

(f) that SLAs are based on integrated care pathways.

9.2 Involving Partners and jointly managing risk

9.2.1 A good SLA will result from a dialogue of clinicians, service users, carers, public health professionals and non-clinical staff. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with

all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

9.3 Reports to Board on SLAs

9.3.1 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services; all parties should agree a common currency for application across the range of SLAs.

10. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

10.1 Remuneration Committee

10.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.) The Committee will:

(a) agree the appropriate remuneration and terms of service for the Chief Executive and Executive Directors including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) Review the salary of Very Senior Managers (VSM's) and ensure arrangements for any other staff not covered with a current pay review body, are reviewed through an appropriate Executive led operational committee. The operational performance of VSM's will be monitored through the appropriate Executive Director lead.

(c) Advise the Board of the remuneration and terms of service of the Executive Directors to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(d) Monitor the performance of individual Executive Directors via the annual appraisal report of the Chief Executive for the Non-Executive Directors and the Chairman's

appraisal report for the Chief Executive.

(e) Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

(f) Carry out duties under the Trust's Fit and Proper Person Test Policy and receive an annual report confirming compliance with the FPPT regulations for all ELHT Trust Board members and One LSC Directors;

10.1.2 The Remuneration Committee and Non-Executive Directors will be involved in the recruitment of Executive Directors through focus groups that form part of the selection process.

10.1.3 The Committee shall report in writing to the Board. The Board shall remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Remuneration Committee meetings should record such decisions.

10.1.4 The Remuneration Committee will receive a report by the Chief Executive on the remuneration and conditions of service for those employees who are not Executive Directors or employed under the terms of Agenda for Change.

10.1.5 Where there are joint Executive Director posts with other NHS organisations, there will be, once per year, a joint meeting of the Remuneration Committees of each organisation to discuss and agree the remuneration of any and all joint Executive Director posts.

10.1.6 The Trust will pay allowances to the Chairman and Non-Executive Directors (including Associate Non-Executive Directors) of the Board in accordance with instructions issued by the Secretary of State for Health and Social Care.

10.2 Funded Establishment

10.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or the Executive Director of Finance on behalf of the Chief Executive.

10.3 Staff Appointments

10.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or

(b) Executive Director of Finance within the limit of their allocated budget and funded establishment;

10.3.2 The Chief Executive will ensure that a process is in place for approval of commencing pay rates, condition of service, etc., for employees. Except with the prior permission of the Chief Executive, no agency staff shall be employed at rates in excess of those advised by NHS England (NHSE).

10.3.3 Where the Trust is planning to engage with an agency to facilitate with the recruitment of staff; a copy of the proposed contract must be reviewed by the Head of Procurement prior to commitment. Any deviation from the following standard must be approved by the Executive Director of Finance due to financial risk:

(a) 100% rebate if the worker leaves within 4 weeks
(b) 80% rebate if the worker leaves between 4 and 12 weeks
(c) 75% rebate if the worker leaves between 12 and 26 weeks
(d) 50% rebate if the worker leaves between 26 and 52 weeks

An official order must be raised once the terms of any such agreement have been agreed via delegated authority through the Executive Director of Finance.

10.4 Processing Payroll

10.4.1 The Executive Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay and allowances;
(c) making payment on agreed dates;
(d) agreeing method of payment.

10.4.2 The Executive Director of Finance will issue instructions regarding:

(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;
(f) authority to release payroll data under the provisions of the Data Protection Act;
(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

10.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Executive Director of Finance's instructions and in the form prescribed by the Executive Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Executive Director of Finance must be informed immediately.

10.4.4 Regardless of the arrangements for providing the payroll service, the Executive Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

11. NON-PAY EXPENDITURE

11.1 Delegation of Authority

11.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

11.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

(c) The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

11.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Lancashire Procurement Cluster (Hosted Service) shall be sought. Where this advice is not acceptable to the requisitioner; the Executive Director of Finance (and/or the Chief Executive) shall be consulted.

11.2.2 System of Payment and Payment Verification

The Executive Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

11.2.3 The Executive Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(iv) A list of Board employees (including specimens of their signatures) authorised to certify invoices.

(v) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are

of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(vi) A timetable and system for submission to the Executive Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(vii) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 10.2.4 below

11.3 Prepayments

11.3.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 3.5%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Executive Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed;

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11.4 Official orders must:

(a) be in a form approved by the Executive Director of Finance;

(b) be in a form approved by the Executive Director of Finance and Head of Procurement, which state Terms and Conditions compliant with the Trust's statutory obligations

(c) be authorised, in line with the Scheme of Delegation, prior to committing expenditure on goods or services

11.4.1 Duties of Managers and Officers

12.4.1.1 Managers and officers must ensure that they comply fully with the Lancashire Procurement Cluster Procurement Policy, guidance and limits specified by the Executive Director of Finance in advance of any commitment and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Executive Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with GPA rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits; (This provision needs to be read in conjunction with Standing Orders and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff") and the Bribery Act 2010;

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services included on the exemption list detailed in the Procurement Policy and purchases from petty cash,

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order" issued via the Lancashire Procurement Cluster department

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) Any equipment on loan or trial to the Trust and/or on Trust property must be notified to the Executive Director of Finance, Head of Procurement and Medical Equipment Services Department; together with any conditions attached to the loan of that equipment.

(k) changes to the list of employees and officers authorised to certify invoices are notified to the Executive Director of Finance;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Director of Finance as set out in the procedure (Procedure Notes for Petty Cash Payments (F04));

(m) petty cash records are maintained in a form as determined by the Executive Director of Finance.

(n) all attempts to bribe or otherwise induce members of staff to procure products or services from a particular supplier are reported immediately to the Executive Director of Finance.

12.4.1.2 The Chief Executive and Executive Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within GPA regulations, Procure21+/Procure22, Private Finance Initiative and Efficient Management of Healthcare Estates and Facilities. The technical audit of these contracts shall be the responsibility of the relevant Director.

12.4.1.3 Under no circumstances should goods or services be ordered through the Trust for personal or private use.

12.4.1.4 The Head of Procurement shall ensure that;

(a) a register of all waivers of tender is maintained

(b) all waivers of tender are reported to the Audit Committee.

12. Joint Finance Arrangements with Local Authorities and Voluntary Bodies

12.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Executive Director of Finance which shall be in accordance with these Acts.

13. REVENUE AND CAPITAL SUPPORT

13.1 The Executive Director of Finance will advise the Board concerning the Trust's ability

to pay dividend on and repay Public Dividend Capital (PDC) and any proposed new capital support, within the limits set by the Department of Health and Social Care. The Executive Director of Finance is also responsible for reporting periodically to the Board concerning the level of PDC held and all loans and overdrafts.

13.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make applications for revenue and capital support on behalf of the Trust. This must include the Chief Executive and the Executive Director of Finance.

13.3 The Executive Director of Finance must prepare detailed procedural instructions concerning applications for revenue support and overdrafts.

13.4 All applications for revenue support must be approved by the Trust Board and should be consistent with the overall cash flow position and comply with the latest guidance from the Department of Health and Social Care.

13.5 The Board must be made aware of all applications for capital support at the next Board meeting.

14. INVESTMENTS

14.1.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

14.1.2 The Executive Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

14.1.3 The Executive Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

15. FINANCIAL FRAMEWORK

15.1 The Executive Director of Finance should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the Trust must follow. The Executive Director of Finance should also ensure that the direction and guidance in the framework is followed by the Trust.

16. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

16.1 Capital Investment

16.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon

business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

(d) Shall ensure that for every capital expenditure proposal that a business case (in line with Capital regime, investment and property business case approval guidance for NHS providers) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangements;

(e) that the Executive Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

(f) For capital schemes where the contracts stipulate staged payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Efficient Management of Healthcare Estates and Facilities document.

16.1.2 The Executive Director of Finance:

(a) shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

(b) shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

16.1.3 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

16.1.4 The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with other sections of SFI's);

(c) approval to accept a successful tender (see overlap with other sections of SFI's).

16.1.5 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with Efficient Management of Healthcare Estates and Facilities document guidance and the Trust's Standing Orders.

16.1.6 The Executive Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes.

16.2 Private Finance

16.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Executive Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health and Social Care or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

16.3 Asset Registers

16.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Executive Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

16.3.2 The Trust shall maintain an asset register for capital accounting purposes, which records:

a) Asset identification and description
b) Asset location
c) Date of acquisition
d) Method of acquisition
e) Initial capital expenditure
f) Gross replacement cost (for equipment)
g) Depreciated replacement cost (for buildings)
h) Cumulative depreciation charged (including buildings since date of acquisition or revaluation)
i) Indexation adjustments
j) Revaluation adjustments
k) Impairments
l) Assessed life

16.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

16.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

16.3.5 The Executive Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

16.3.6 Each asset is to be appropriately valued in accordance with agreed accounting policies

16.3.7 The Executive Director of Finance of the Trust shall calculate and pay capital charges as specified by the Department of Health and Social Care.

16.4 Security of Assets

16.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

16.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Executive Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

16.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Executive Director of Finance.

16.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

16.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

16.4.6 Where practical, assets should be marked as Trust property.

17. STORES AND RECEIPT OF GOODS

17.1 General position

17.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take or agreed cycle count system

(c) valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method

17.2 Control of Stores, Stocktaking, condemnations and disposal

17.2.1 Subject to the responsibility of the Executive Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Executive Director of Finance. The control of any pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

17.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

17.2.3 The Executive Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

17.2.4 Stocktaking arrangements shall be agreed with the Executive Director of Finance and there shall be a physical check covering all items in store at least once a year.

17.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Director of Finance. The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Executive Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Executive Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 16 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

17.3 Goods supplied by NHS Supply Chain

17.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Executive Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

18. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

18.1 Disposals and Condemnations

18.1.1 Procedures

18.1.1.1 The Executive Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers. The process is set out in Trust policy (F03): Procedure for Transfer, Disposal and Sale of Surplus Assets.

18.1.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Executive Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

18.1.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Executive Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Executive Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Executive Director of Finance.

18.1.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Executive Director of Finance who will take the appropriate action.

19.1 Losses and Special Payments

19.1.1 Procedures

19.1.1.1 The Executive Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

19.1.1.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Executive Director of Finance or inform an officer charged with

responsibility for responding to concerns involving loss. This officer will then appropriately inform the Executive Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Executive Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Executive Director of Finance must inform the LCFS and NHSCFA team in accordance with Secretary of State for Health and Social Care's Directions.

19.1.1.3 The Executive Director of Finance must also notify the External Auditor of all frauds.

19.1.1.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Director of Finance must immediately notify:

(a) the Audit Committee,

(b) the External Auditor

(c) in the event of theft or arson, the police.

19.1.1.5 The Executive Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations. For any loss, the Executive Director of Finance should consider whether any insurance claim can be made.

19.1.1.6 The Executive Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

19.1.1.7 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

19.1.1.8 All losses and special payments must be reported to the Audit Committee on an annual basis

20 INFORMATION TECHNOLOGY

20.1 Responsibilities and duties of the Executive Director of Finance

20.1.1 The Executive Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

20.1.2 The Executive Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

20.1.3 The Head of Information Governance shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner.

20.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

20.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Executive Director of Finance:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

20.3 Contracts for Computer Services with other health bodies or outside agencies

20.3.1 The Executive Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

20.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Executive Director of Finance shall periodically seek assurances that adequate controls are in operation.

20.4 Risk Assessment

20.4.1 The Executive Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to

mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

20.5 Requirements for Computer Systems which have an impact on corporate financial systems

20.5.1 Where computer systems have an impact on corporate financial systems the Executive Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Executive Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

21 PATIENTS' PROPERTY

21.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

21.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

(a) notices and information booklets; *(notices are subject to sensitivity guidance)*

(b) hospital admission documentation and property records;

(c) the oral advice of administrative and nursing staff responsible for admissions,

(d) that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

21.3 The Executive Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

21.4 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Executive Director of Finance.

21.5 In all cases where property of a deceased patient is of a total value in excess of

£5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

21.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

21.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

22 FUNDS HELD ON TRUST

22.1 Corporate Trustee

8.1.2 Standing Order No. 2.6 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust. For further information in relation to the requirements in relation to Charitable Funds please see the Standing Orders and Standing Financial Instructions for Charitable Funds.

22.1.1 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non- charitable purposes.

The Executive Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

22.2 Accountability to Charity Commission and Secretary of State for Health and Social Care

22.2.1 The trustee responsibilities must be discharged separately, and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

22.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

22.2.3 Applicability of Standing Financial Instructions to funds held on Trust

(a) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

(b) The over-riding principle is that the integrity of each Trust must be maintained, and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

23 ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF CONDUCT (see overlap with Standing Orders)

23.1 The Executive Director of Finance and Director of Corporate Governance/Company Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health and Social Care circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and the NHS England Managing Conflicts of Interest guidance published in June 2017 (https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf) and is also deemed to be an integral part of the Standing Orders and the Standing Financial Instructions.

24 RETENTION OF RECORDS

24.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines.

24.2 The records held in archives shall be capable of retrieval by authorised persons.

24.3 Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

25 RISK MANAGEMENT AND INSURANCE

25.1 Programme of Risk Management

25.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

(c) a process for identifying and quantifying risks and potential liabilities;

(d) engendering among all levels of staff a positive attitude towards the control of risk;

(e) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance

cover, and decisions on the acceptable level of retained risk;

(f) contingency plans to offset the impact of adverse events;

(g) audit arrangements including; Internal Audit, clinical audit, health and safety review;

(h) a clear indication of which risks shall be insured;

(i) arrangements to review the Risk Management programme.

25.1.2 The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health and Social Care guidance.

25.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

25.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

25.3 Insurance arrangements with commercial insurers

25.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) Trusts may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(b) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(c) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for an NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Executive Director of Finance should consult the Department of Health and Social Care.

25.4 Arrangements to be followed by the Board in agreeing Insurance cover

25.4.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Executive Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Executive Director of Finance shall ensure that documented procedures cover these arrangements.

25.4.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Executive Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self- insured as a result of this decision. The Executive Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

25.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Executive Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

25.5 HOSTED BODIES, PARTNERSHIPS AND COLLABORATIONS

25.5.1 Hosted bodies are organisations for which ELHT provide services under a service level agreement (SLA). ELHT also works in partnership and collaboration with other organisations under service level agreements, memoranda of understanding or similar documents.

25.5.2 Dependent on the terms of the SLA, memorandum of understanding or equivalent, these standing financial instructions may or may not be applicable. Individual SLAs, memorandum of understanding or equivalent should be referred to on a case-by-case basis.

DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions, which may have a far-reaching effect, must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior officers as appropriate. All items concerning Finance must be carried out with Standing Financial Instructions and Standing Orders.

	Delegated Matter	Authority Delegated To
1	**Responsibility of keeping expenditure within budgets:** • At individual budget level (pay and non-pay) • At service level • For all other areas	Budget holder Divisional Directors of Operations or service managers Departmental Directors and Managers
2	Maintenance/Operation of bank accounts	Executive Director of Finance
3	Non-pay revenue requisitioning/ordering/receipting of goods and services. Budgets are spent consistent with their purpose	Budget holders
	Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement	Chief Executive / Executive Director of Finance
	Orders exceeding 12-month period	Executive Director of Finance / Divisional Director of Operations / Departmental Directors
	All contracts for goods and services and subsequent variations to contracts	Executive Director of Finance / Divisional Director of Operations / Departmental Directors
4	**Capital schemes** Selection of architects, quantity surveyors, consultant engineer and other professional advisors within WTO GPA	Executive Director of Finance

	Delegated Matter	Authority Delegated To
	Financial monitoring and reporting on all capital scheme expenditure	Executive Director of Finance
5	**Quotation, Tendering and Contract Procedures**	
	All contracts prior to signing must be approved by Lancashire Procurement Cluster	
	A minimum of 1 quote retained by the requisitioner to establish best value for goods/ services/works up to £10,000	Head of Procurement or delegated officer
	A minimum of 3 written quotes retained by the requisitoner to establish value for money for goods/ services/works from £10,000 to £30,000	Head of Procurement or delegated officer
	Sourcing options to be agreed with Procurement and compliance with SFIs for expenditure over £30,000	Head of Procurement or Executive Director of Finance or Chief Executive
	All contracts over the value of £25,000 should be advertised accordingly on the Contracts Finder utilised for tenders	Head of Procurement or delegated officer
6	**Setting of Fees and Charges**	
	Private patients, overseas visitors, income generation & other patient related services	Executive Director of Finance
	Charges for all NHS service level agreements and non-NHS services	Executive Director of Finance
7	Engagement of staff not on the establishment	Chief Executive or Executive Director of Finance
	Engagement of Trust solicitors	Executive Director of Finance, Director of HR and OD, Associate Director of Quality and Safety
	Booking of bank or agency staff	Director of HR and OD
	Medical locums	Director of HR and OD
	Nursing	Director of HR and OD

	Delegated Matter	Authority Delegated To
	Clerical	Director of HR and OD
8	**Expenditure on charitable and endowment funds**	
	Up to £3,000 per request	Fund holder
	From £3,001 - £10,000 per request	Fund holder plus Executive Director of Finance
	Over £10,000 per request	Three members of the Trust Board, one Executive Director who is a member of the Charitable Funds committee, one being the Executive Director of Finance, plus the Charitable Funds Chairman.
9	Agreements/ Licenses	Facilities Manager
	Preparation and signature of all tenancy agreements/licences for staff subject to Trust policy on accommodation for staff Extension to existing leases	Executive Director of Finance
	Letting of premises to outside organisations	Executive Director of Finance or Chief Executive
	Approval of rent based on professional assessment	Executive Director of Finance
10	**Condemning and Disposals** ***Items obsolete, obsolescent, irreparable or cannot be repaired cost effectively*** With current/ estimated purchase less than £50	Budget holder
	With current purchase new price greater than £50	Divisional Directors of Operations or service managers
	Disposal of x-ray films (subject to estimated income of less than £1,000 per sale)	Service Manager – Radiology Service Manager
	Disposal of x-ray films (subject to estimated income exceeding £1,000 per sale)	Service Manager – Radiology Service Manager
	Disposal of mechanical and engineering plant (subject to estimated income of	Executive Director of Finance or Director of Estates

	Delegated Matter	Authority Delegated To
	less than £3,000 per sale)	
	Disposal of mechanical and engineering plant (subject to estimated income exceeding £3,000 per sale)	Executive Director of Finance or Director of Estates
11	**Losses, Write Off and Compensation** Losses and cash due to theft, fraud, overpayment and others up to £50,000	Chief Executive or Executive Director of Finance
	Fruitless payments (including abandoned capital schemes) up to £250,000 chief Executive or Executive Director of Finance Bad debts and claims abandoned, private patients, overseas visitors and others up to £50,000	Chief Executive or Executive Director of Finance Chief Executive or Executive Director of Finance
	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson) or other up to £50,000	Chief Executive or Executive Director of Finance
	Compensation payments made under legal obligation Chief Executive or Executive Director of Finance	Chief Executive or Executive Director of Finance
	Extra contractual payments to contractors up to £50,000	Chief Executive or Executive Director of Finance
	Ex-gratia payments to patients and staff for loss of personal effects Less than £500 Over £500 and up to £50,000 Over £50,000	 Budget Holder / Associate Director of Safety & Quality Chief Executive / Executive Director of Finance Trust Board
	Ex-gratia payments to patients and staff for clinical negligence claims	

	Delegated Matter	Authority Delegated To
	For clinical negligence up to £1,000,000 (negotiated settlements through NHS Resolution). For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £1,000,000 including plaintiff's costs. Any other cases over £1,000,000.	Associate Director Safety & Quality / Deputy Chief Executive (Executive Medical Director) Chief Executive or Executive Director of Finance Trust Board
	Write-Offs Write off NHS Debtors Write off non-NHS Debtors	 Executive Director of Finance Executive Director of Finance
12	**Reporting of Incidents to the Police where a criminal offence is suspected** Criminal offence of a violent nature Other where fraud is involved	 Chief Executive, Executive Directors Executive Director of Finance
13	**Receiving Hospitality** Applies to both individual and collective hospitality receipt items, in excess of £50.00 per item received	Declaration required in the Trust's Register
14	Implementation of internal and external audit recommendations	Executive Director of Finance
15	Maintenance & update on Trust financial procedures	Executive Director of Finance
16	**Investment of Funds**	
	Exchequer/Trust funds	Executive Director of Finance
	Charitable and Endowment	Per Section 8 and Charitable Funds Committee
17	**Personnel and Pay**	
	Authority to fill funded post on the establishment with permanent staff	Budget holder
	Authority to appoint staff to post not on the formal establishment The granting of additional increments to staff within budgeted establishments	Chief Executive, Executive Director of Finance

Delegated Matter	Authority Delegated To
All requests for upgrading or regarding shall be dealt with in accordance with Trust procedures	
Additional staff to the agreed establishment with specifically allocated Finance	Budget holder
Additional staff to the agreed establishment without specifically allocated finance	Executive Director of Finance
Pay: Authority to complete standing data forms effecting pay, new starters, variations and leavers	Divisional Directors of Operations, Departmental Directors
Authority to authorise overtime	Director of HR and OD and Executive Director of Finance
Authority to authorise travel and subsistence expenses	Budget holder
Leave: Approval of annual leave	Divisional Directors of Operations, Departmental Directors, Service Managers
Approval of carry forward up to a maximum of 5 days or as defined in the initial conditions of service	Divisional Directors of Operations, Departmental Directors, Service Managers
Approval of carry over in excess of 5 days but less than 10 days	Divisional Directors of Operations, Departmental Directors, Service Managers
Approval to carry forward 10 days or more	Chief Executive, Executive Director of Finance
Compassionate leave up to 5 days - Special leave arrangements	Divisional Directors of Operations, Departmental Directors, Service Managers
paternity leave up to 5 days	Divisional Directors of Operations, Departmental Directors, Service Managers
carers leave up to 3 days	Divisional Directors of Operations, Departmental Directors, Service Managers
carers leave up to 5 days Leave without pay	Divisional Directors of Operations, Departmental

	Delegated Matter	Authority Delegated To
		Directors, Service Managers
	Time off in lieu	Divisional Directors of Operations, Departmental Directors, Service Managers
	Maternity leave – paid and unpaid Sick leave	Divisional Directors of Operations, Departmental Directors, Service Managers
18	**Study Leave** Study leave outside the UK Medical staff study leave (UK) All other study leave Authorisation of payment of removal expenses incurred by officers taking up new appointments providing consideration was given at interview.	 Chief Executive or Executive Director of Finance Divisional Director of Operations, Divisional Clinical Leads Divisional Director of Operations, Departmental managers Executive Director of Finance
	Grievance Procedure • All grievance cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Head of HR must be sought when the grievance reaches the level of Service Manager • Authorised car and mobile phone users • Requests for new posts to be authorised as car users • Request for new posts to be authorised as mobile telephone users • Renewal of Fixed Term contract Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances Redundancy • Ill Health Retirement	 Director of HR and OD Executive Director of Finance Executive Director of Finance Executive Director of Finance Executive Director of Finance or Director of HR and OD Chief Executive, Executive Director of Finance

	Delegated Matter	Authority Delegated To
	• Decision to pursue retirement on the grounds of ill health • Dismissal	Director of HR and OD Director of HR and OD
19	**Authorisation of New Drugs** Estimated total yearly cost up to £25,000 Estimated total yearly cost above £25,000	 Deputy Chief Executive/Divisional Directors of Operations Drugs Committee & Chief Executive, Executive Director of Finance
20	Authorisation of sponsorship deals	Chief Executive, Medical Director and Executive Director of Finance
21	Authorisation of research projects	Chief Executive, Medical Director and Chairman of Research Committee
22	Authorisation of clinical trials	Research & Development Committee, Chief Executive and Medical Director
23	Insurance policies and risk management	Chief Executive, Executive Director of Finance
24	Patients and Relatives Complaints - Overall responsibility for ensuring that all complaints are dealt with effectively	Deputy Chief Executive and Associate Director of Safety & Quality
	Responsibility for ensuring complaints relating to a directorate area are investigated thoroughly Medico-legal complaints – co-ordination of their manager	Divisional Directors of Operations and Associate Director of Safety & Quality
25	Review Trust compliance with the GDPR	Executive Director of Finance (as SIRO), and Data Protection Officer
26	Review of the Trust's compliance with the Code of Practice for Handling Confidential Information in the Contracting Environment and compliance with	Executive Director of Finance (as SIRO), and Data Protection Officer

	Delegated Matter	Authority Delegated To
	Safe Haven per EL92/60	
27	The keeping of a Register of Interests	Director of Corporate Governance/ Company Secretary
28	Attestation of Sealings in accordance with Standing Orders Signing and Sealing of documents:	Director of Corporate Governance/Company Secretary Two voting Directors, preferably the Chief Executive and Director of Finance. Another voting Director may sign a sealed document; however the document must have been reviewed and approved by the Executive of Finance in the first instance.
29	The keeping of a Register of Sealings	Director of Corporate Governance/Company Secretary
30	The keeping of the Hospitality Register	Director of Corporate Governance/Company Secretary
31	Retention of Records	Chief Executive or Executive Director of Finance as SIRO

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Executive Director of Finance	Approval of all financial procedures.
Executive Director of Finance	Advice on interpretation or application of SFIs.
All Members of The Board and Employees	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Executive Director of Finance as soon as possible.
Chief Executive	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
Chief Executive & Executive Director of Finance	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
Chief Executive	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
Executive Director of Finance	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) Maintaining such accounts, certificates etc. as are required for the Trust to carry out its statutory duties.
All Members of the Board and Employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
Chief Executive	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Audit Committee	Provide independent and objective view on internal control and probity.
Audit Committee	Ensure cost-effective External Audit.
Auditor Panel	Provide advice and recommendation on the appointment of the External Auditor.
Board	Appoint External Auditor
Chair of Audit Committee	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
Executive Director of Finance	Ensure an adequate internal audit service, for which he/she is accountable, is provided
Executive Director of Finance	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
Director Of Internal Audit	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
Chief Executive & Executive Director of Finance	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
Chief Executive	Monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management including appointment of the Local Security Management Specialist.
Chief Executive	Compile and submit to the Board an Annual Business Plan (ABP) which takes into account financial targets and forecast limits of available resources. The ABP will contain: • a statement of the significant assumptions on which the plan is based; details of major changes in workload, delivery of services or resources required to achieve the plan.
Executive Director of Finance	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
Executive Director of Finance	Ensure adequate training is delivered on an ongoing basis to budget holders.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Chief Executive	Delegate budget to budget holders.
Chief Executive and Budget Holders	Must not exceed the budgetary total or virement limits set by the Board.
Executive Director of Finance	Devise and maintain systems of budgetary control.
Budget Holders	Ensure that: a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
Chief Executive	Identify and implement cost improvements and income generation activities in line with the Annual Business Plan.
Chief Executive	Submit monitoring returns
Executive Director of Finance	Preparation of annual accounts and reports.
Executive Director of Finance	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. Board approves arrangements.
Executive Director of Finance	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
All Employees	Duty to inform DoF of money due from transactions which they initiate/deal with.
Chief Executive	Tendering and contract procedure.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Chief Executive	Waive formal tendering procedures.
Chief Executive	Report waivers of tendering procedures to the Audit Committee.
Executive Director of Finance	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
Chief Executive	Responsible for the receipt, endorsement and safe custody of tenders received.
Chief Executive	Shall maintain a register to show each set of competitive tender invitations dispatched.
Chief Executive and Executive Director of Finance	Where one tender is received will assess for value for money and fair price.
Chief Executive	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
Chief Executive	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
Chief Executive	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
Chief Executive or Executive Director of Finance	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
Chief Executive	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
Board	All PFI proposals must be agreed by the Board.
Chief Executive	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Chief Executive	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
Chief Executive	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
Chief Executive	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
Chief Executive	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
Chief Executive	As the Accountable Officer, ensure that regular reports are provided to the Board by the DoF detailing actual and forecast income from the SLA
Board	Establish a Remuneration Committee
Remuneration Committee	Agree the remuneration and terms of service of the CE, and Executive Directors and VSMs to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; NHS England and evaluate the performance of Executive Directors
Remuneration Committee	Report in writing to the Board its decisions
Board	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
Chief Executive	Approval of variation to funded establishment of any department.
Chief Executive	Staff, including agency staff, appointments and re-grading.
Executive Director of Finance	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; final determination of pay and allowances;
Nominated Managers*	Submit time records in line with timetable.

<table>
<tr><th>DELEGATED TO</th><th>AUTHORITIES/DUTIES DELEGATED</th></tr>
<tr><td></td><td>Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.</td></tr>
<tr><td>Executive Director of Finance</td><td>Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.</td></tr>
<tr><td>Nominated Manager*</td><td>Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
Deal with variations to, or termination of, contracts of employment.</td></tr>
<tr><td>Trust Board
Chief Executive</td><td>Determine, and set out, level of delegation of expenditure/ Commitment of expenditure within budget to individuals within the Trust
<table>
<tr><th></th><th>Authorisation of invoices & credit notes within budget</th><th>Commitment of expenditure within budget</th></tr>
<tr><td>Board</td><td>Over £5,000,000</td><td>Over £1,000,000</td></tr>
<tr><td>Chief Executive</td><td>£5,000,000</td><td>£1,000,000</td></tr>
<tr><td>Executive Director of Finance</td><td>£3,000,000</td><td>£500,000</td></tr>
<tr><td>Executive Director</td><td>£250,000</td><td>£250,000</td></tr>
<tr><td>Divisional Directors of Operations/ Other Directors</td><td>£75,000</td><td>£75,000</td></tr>
<tr><td>Business Managers</td><td>£25,000</td><td>£25,000</td></tr>
<tr><td>Budget Holder/ Assistant Business Manager</td><td>£10,000</td><td>£10,000</td></tr>
</table></td></tr>
<tr><td>Chief Executive</td><td>Set out procedures on the seeking of professional advice regarding the supply of goods and services.</td></tr>
<tr><td>Requisitioner*</td><td>In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.</td></tr>
</table>

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Executive Director of Finance	Shall be responsible for the prompt payment of accounts and claims.
Executive Director of Finance	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Executive Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
Appropriate Executive Director	Make a written case to support the need for a prepayment.
Executive Director of Finance	Approve proposed prepayment arrangements.
Budget Holder	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
Chief Executive	Authorise who may use and be issued with official orders.
Managers And Officers	Ensure that they comply fully with the guidance and limits specified by the Executive Director of Finance.
Chief Executive/ Executive Director of Finance	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within GPA regulations, Procure21+ / Procure22 (P21+ / P22), Private Finance Initiatives and Efficient Management of Healthcare Estates and

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	Facilities. The technical audit of these contracts shall be the responsibility of the relevant Director.
Executive Director of Finance	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
Executive Director of Finance	The DoF will advise the Board on the Trust's ability to pay dividend on Public Dividend Capital (PDC) and report, periodically, on the level of PDC, loans and overdrafts.
Board	Approve a list of employees authorised to make applications for revenue and capital support on behalf of the Trust. (This must include the CE and DoF).
Executive Director of Finance	Prepare detailed procedural instructions concerning applications for capital and revenue support, as well as overdrafts.
Executive Director of Finance	Will advise the Board on investments and report, periodically, on performance of same.
Executive Director of Finance	Prepare detailed procedural instructions on the operation of investments held.
Executive Director of Finance	Ensure that Board members are aware of the Financial Framework and ensure compliance
Chief Executive	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
Executive Director of Finance	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
Chief Executive	Issue procedures for management of contracts involving stage payments.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Executive Director of Finance	Assess the requirement for the operation of the construction industry taxation deduction scheme.
Executive Director of Finance	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
Chief Executive	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
Executive Director of Finance	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
Executive Director of Finance	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
Board	Proposal to use PFI must be specifically agreed by the Board.
Chief Executive	Maintenance of asset registers (on advice from DoF).
Executive Director of Finance	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
Executive Director of Finance	Calculate and pay capital charges in accordance with Department of Health and Social Care requirements.
Chief Executive	Overall responsibility for fixed assets.
Executive Director of Finance	Approval of fixed asset control procedures.
Board, Executive Members and All Senior Staff	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
Chief Executive	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Executive Director of Finance	Responsible for systems of control over stores and receipt of goods.
Designated Pharmaceutical Officer	Responsible for controls of pharmaceutical stocks
Designated Estates Officer	Responsible for control of stocks of fuel oil and coal.
Nominated Officers*	Security arrangements and custody of keys
Executive Director of Finance	Set out procedures and systems to regulate the stores.
Executive Director of Finance	Agree stocktaking arrangements.
Executive Director of Finance	Approve alternative arrangements where a complete system of stores control is not justified.
Executive Director of Finance	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
Nominated Officers*	Operate system for slow moving and obsolete stock, and report to Executive Director of Finance evidence of significant overstocking.
Chief Executive	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
Executive Director of Finance	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
Executive Director of Finance	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
All Staff	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Executive Director of Finance.
Executive Director of Finance	Where a criminal offence is suspected, Executive Director of Finance must inform the police if theft or arson is involved. In cases of fraud and corruption Executive Director of Finance must inform the LCFS and

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	NHSCFA in line with SoS directions.
Executive Director of Finance	Notify External Audit of all frauds.
Executive Director of Finance	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
Board	Approve write off of losses (within limits delegated by DHSC).
Executive Director of Finance	Consider whether any insurance claim can be made.
Executive Director of Finance	Maintain losses and special payments register.
Executive Director of Finance	Responsible for accuracy and security of computerised financial data.
Executive Director of Finance	Be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
Director of Corporate Governance / Company Secretary	Shall publish and maintain a Freedom of Information Scheme.
Relevant Officers	Send proposals for general computer systems to Executive Director of Finance
Executive Director of Finance	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.
Executive Director of Finance	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
Executive Director of Finance	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies;

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) Executive Director of Finance and staff have access to such data; d) Such computer audit reviews are being carried out as are considered necessary.
Chief Executive	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
Executive Director of Finance	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
Departmental Managers	Inform staff of their responsibilities and duties for the administration of the property of patients.
Executive Director of Finance	Ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
Executive Director of Finance	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
Chief Executive	Retention of document procedures in accordance with NHS Code of Practice for Records Management
Chief Executive	Risk management programme.
Board	Approve and monitor risk management programme.
Board	Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
Executive Director of Finance	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Executive Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Executive Director of Finance shall ensure that documented procedures cover these arrangements.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Executive Director of Finance	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

Lancashire and South Cumbria Provider Collaborative

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TRUST BOARD REPORT | **Item** | **105a**

10 July 2024 | **Purpose** | Assurance / Information

Title	Triple A Report from Finance and Performance Committee
Report Author	Mrs L Sedgley, Non-Executive Director

Summary: This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 3 June 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	10082 - Failure to meet internal & external financial targets for 2024-25

Related to recommendations from audit reports	Assurance Framework Key Financial Controls Risk Management Core Controls
Related to Key Delivery Programmes	Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	Finance and Performance Committee
Date of Meeting:	3 June 2024
Committee Chair:	Mrs L Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting Improvement Update Priorities for 2024/25 Integrated Performance Report Community Services Transfer including Albion Mill Surgical Hub Business Case Corporate Risk Register Contract over £1,000,000 Private Finance Initiative Update System Issues

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter

- The Committee was alerted to the risk to the 24/25 capital plan due to the revised financial plan agreed between the system and NHSE. This has meant that we are £2.8m above plan at the start of the financial year and this will put additional pressure on the teams to deliver the agreed projects.
- The review of the block contracts by the Lancashire and South Cumbria (LSC) Integrated Care System (ICS) is still ongoing and therefore there are potential financial risks for ELHT in this financial year.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee noted that there are now fortnightly meetings with the divisions to monitor the Waste Reduction Programme (WRP), and there was excellent engagement across the whole organisation.
- These meetings are helping to identify Whole Time Equivalent (WTE) reductions where possible and clinically safe to do so.
- The Committee reiterated the commitment made by the Trust Board that despite the continuing financial pressures that patient safety will not be compromised.
- The Committee was pleased to note that despite the continued high attendances in the emergency pathways that the Trust is on trajectory to deliver all the key performance targets. It acknowledged that given the ongoing pressures, the patient experience was not always what was aspired to deliver.
- The Committee received a verbal update on the joint working with the North West Ambulance Service (NWAS) regarding ambulance conveyancing and the benefits that this joint working is bringing to ensure that where appropriate patients are receiving care in the community rather than the acute hospital.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee was advised that further industrial action will be undertaken by junior doctors. Teams will work through the implications of this to minimise the disruption to patients wherever possible.
- The Committee approved the Surgical Hub Business Case and noted the potential financial risks and the controls put in place to minimise those. Despite those risks, the Committee noted the benefits to patients in East Lancashire and LSC in reducing waiting times and reducing health inequalities.
- The Committee received an update on the ongoing work of the improvement team in supporting the organisation to enact change and drive out waste and inefficiencies within our systems and processes.
- The Committee noted that the transfer of Adult Community Services and the Albion Mill project were on track and any ongoing issues were being worked through ahead of the transfer date of 1 July 2024.

- The Committee received the Performance metrics for May 2024 and noted that A & E attendances were still at the levels usually seen in the Winter periods as post covid patients were experiencing complex health issues. This was resulting in continuing pressure on the bed base on all sites despite a continued focus on discharge of medically fit patients.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **105b**

10 July 2024 | **Purpose** | Assurance / Information

Title	Triple A Report from Finance and Performance Committee
Report Author	Mrs L Sedgley, Non-Executive Director

Summary: This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 24 June 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability	
Related to key risks identified on Board Assurance Framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
	2	The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
	3	A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
	4	The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	10082 - Failure to meet internal & external financial targets for 2024-25	

Related to recommendations from audit reports	Assurance Framework Key Financial Controls Risk Management Core Controls
Related to Key Delivery Programmes	Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	Finance and Performance Committee
Date of Meeting:	24 June 2024
Committee Chair:	Mrs L Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting National Cost Collection Update Board Assurance Framework Improvement Update Integrated Performance Report Community Services Transfer including Albion Mill Corporate Risk Register Contract over £1,000,000 Tender Update Private Finance Initiative Update System Issues Sign Off of Board Digital Maturity Assessment

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter

- The Committee approved the revised annual budget of a deficit of £21.9m and the increased Waste Reduction Programme (WRP) of £59.7m however noting the inherent risks within this very challenging plan given that the level of demand for services especially via UEC pathways was not decreasing despite the success of a number of work streams to deflect demand to more appropriate care settings.
- The revised financial plan has also meant a reduction in the allocation of capital by £1.3m to £32.6m which will put further pressure on the capital plans for 2024/25

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee discussed the assurance processes in place to monitor progress against the WRP programme.
- The Committee re-iterated the commitment made by the Trust Board that despite the continuing financial pressures that patient safety will not be compromised.
- The Committee approved the process to complete the mandated costing submission for 2023-24.
- The Committee ratified the Trust's Digital Maturity Assessment.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee approved delegated authority to the Chair of the Committee, the CEO and Chair of the Trust to review and sign off a bid should the initial assessment support a bid for the ACCT Service, if the dates of the submission fall outside scheduled meetings.
- The Committee supported the Maternity services decision not to bid for 2 contracts commissioned by Blackburn with Darwen Council, given that this would not support the values of the Trust to provide equitable services to all patients and their families across the whole of East Lancashire.
- The Committee were advised that there had been no confirmation of the level of financial support that would be available to support the organisation during the next round of industrial action.
- The Committee were advised of the ongoing review of the Board Assurance Framework and also the mechanisms which would be put in place to update the Committee of the progress of the One LSC programme.
- The Committee noted the reduction in staff turnover and vacancy rates within the Emergency Department and that this, together with the ongoing improvement work and the commitment of all the teams involved had contributed to the achievement of 80% for the Emergency 4-hour care standard in May. It was acknowledged that there were still exceptionally long waits in ED and the experience that large numbers of patients had, was not at the level the Trust aspired too. However, given the continuing high demand for emergency care and the increased acuity of patients this is a significant achievement. A & E attendances at ELHT have increased by 23.9% from 2018/19 to 2023/24, whilst the national average for the same period is 5.8%.
- The Trust has received legal advice that the MoU with the BwD council re Albion Mill is replaced with a legal agreement and is currently working through this with partners, but this may affect the go live date of 1 July.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **106a**

10 July 2024 | **Purpose** | Assurance / Information

Title	Triple A Report from Quality Committee
Report Author	Mrs C Randall, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Quality Committee meeting held on 22 May 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal	Deliver safe, high quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	Quality Committee
Date of Meeting:	21 May 2024
Committee Chair:	Catherine Randall
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update Never Events Update Patient Safety Incident Response Framework Report Nursing Assessment and Performance Framework Update CQC Update Strategic Priorities 2024-25

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter

- Never Events and Regulation 28 Notice from Coroner
- Coroners request for CQC to inspect the Trust's Consent processes. The Trust has included an audit of consent processes to the Internal Audit Plan 2024-25.
- UEC Pathway Demand: increasing attends to ED and Urgent Care: England - 5.8% growth, LSC - 19.2% growth, ELHT - 23.9% growth. Increasing non-elective admissions: England - 0.7%, LSC (excl. ELHT) - 18%, ELHT - 6.4%.
- PSC Rapid diagnostic emerging findings, including: Mortality and morbidity is up for Pennine Lancashire especially Blackburn with Darwen (BwD), BwD has 2nd highest age standardised mortality rate in LSC (after Blackpool) and annual deaths have growth by 5.6% between 2019-2023 which is faster than growth in the weighted population and indicative of rising acuity, Covid legacy and delays in health seeking likely to impact on mortality and morbidity as well as growths in UEC attends and NEL admissions.
- Hospital actions taken include: Bed modelling to right size our acute medical bed base and this will take account of population need and demographic changes, flexing Ward B18 capacity whilst completing fire remediation works, additional UEC

medical and nursing staffing to respond to increased demand, mobilisation of significant escalation and surge capacity including additional patients on wards, reviewing our IHSS/OPRA/Front Door therapy pathways to further maximise the impact of these and, ensuring our internal processes are as slick as possible including:

- Timely completion of discharge summaries and TTO medications
- Increase the use of discharge lounge to create bed capacity earlier each day
- Transfers to community hospitals (by 2pm each day) and care home discharges by 4pm
- Focus on reducing length of stay especially longer stay patients.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- Patient Story about Long COVID which provides assurance that the Trust is working effectively with partners
- Clinical, quality and health inequalities strategy
- Reflection on patient safety investigations
- Community actions with system partners (Place): Mobilising UEC Capacity investments for community services including:
    - Respiratory Hubs
    - Intermediate care (to support alternatives to hospital admission)
    - Hospices and advance care planning
- Mobilising Albion Mill beds from 1st July (15 beds)
- Supporting care homes in terms of training, education and development and referring to IHSS/ICAT as first responder rather than NWAS
- BwD Adult Physical Health Community Services transfers to ELHT on 1st July - this will support integration and alignment of clinical pathways and service delivery
- Working with NWAS to support alternative to hospital conveyance via integrated community hub and community services
    - IHSS/ICAT launched a new pilot in collaboration with NWAS whereby paramedics on scene are able to refer directly into the IHSS service as a

trusted assessment - results: as at 13/05/24, 88 referrals have been received and 70 conveyances (80%) have been avoided

- From 12/04/24 IHSS worked with the District Nursing Service to develop an escalation pathway to direct District Nurses to refer to the service as an alternative to an ambulance conveyance. Results: as at 10/05/24, 16 referrals have been received and 12 conveyances (75%) have been avoided
- Progressing plans with NWAS for directing lower acuity category calls (Cat 3,4 and 5) to IHSS/ICAT for first response rather than despatching an ambulance

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee will receive an update on performance against mortality indicators at its meeting in July and September 2024.
- It will also consider ways in which deep dives of QIRAs can be undertaken at the meetings.
- The committee wishes to advise the Board of the increase in the number of incidents being reported which have resulted in moderate harms, however this was noted to be largely as a result of the changes to the way that pressure ulcers are reported.
- Finally there is a need to make the Board aware of the changes to the CQC's Quality Standards.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **106b**

10 July 2024 **Purpose** Assurance

Information

Title	Triple A Report from Quality Committee
Report Author	Mrs C Randall, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Quality Committee meeting held on 26 June 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal	Deliver safe, high quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	Quality Committee
Date of Meeting:	26 June 2024
Committee Chair:	Catherine Randall
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update Never Events Update Patient Safety Incident Response Framework Report Nursing Assessment and Performance Framework Update CQC Update Strategic Priorities 2024-25

ALERT

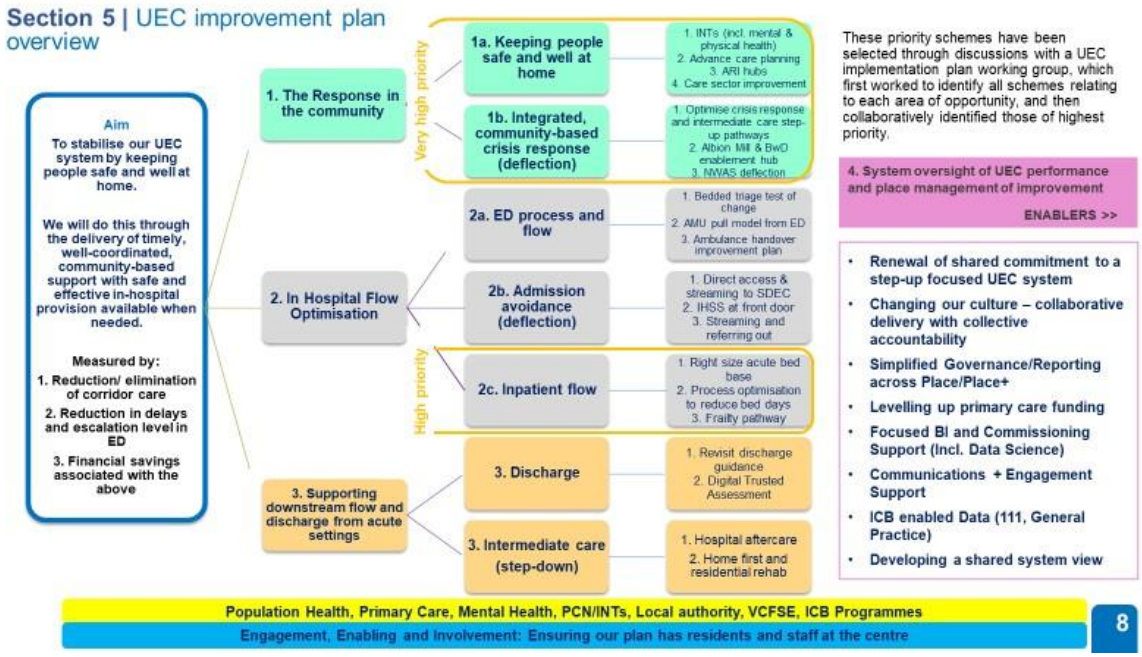
Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The recent Dispatches 'Undercover A&E: NHS in Crisis' episode and its findings.
- Recent increases in patient flow issues in the Trust.
- Surges in attendances and concerns around increased challenges regarding discharges.
- The patient story presented to the Committee indicated a potential rise in the fragmentation of care being delivered to some patients.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- It was reported that wide range of work was taking place across the system to relieve pressures on urgent and emergency care pathways, optimise patient flow in hospitals and ensure that the acute medical bed base met the needs of local populations. A detailed overview of some of urgent and emergency care improvement work can be seen below:



- Around 120 newly qualified nurses will be joining the Trust over the coming weeks.
- New care plans and a number of new beds will be put in place to help alleviate the pressures being seen in urgent and emergency care pathways.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee was informed that a number of new beds were due to be opened on the Royal Blackburn Teaching Hospital site in the near future and that although sufficient nurse staffing was available, additional work was needed to ensure that appropriate medical staffing would also be available. Members were informed that Executive Directors would be discussing this topic in more detail at a meeting the following week.
- The Committee received an overview of a new approach to the management of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents. It was explained that this new approach was intended to share the responsibility for identifying RIDDOR incidents with divisional leads, reduce the amount of incidents requiring review by the Trust's Health and Safety team and

improve the Trust's RIDDOR reporting compliance. The Board will receive an update on RIDDOR reporting compliance levels at the end of Q4.

Lancashire and South Cumbria Provider Collaborative

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TRUST BOARD REPORT **Item** **107**

10 July 2024 **Purpose** Information

Title	Triple A Report from People and Culture Committee
Report Author	T Anderson, Chair of People and Culture Committee

Summary: This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 1 July 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	-

Related to recommendations from audit reports	-
Related to Key Delivery Programmes	-
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	**Audit Committee**
Date of Meeting:	**1 July 2024**
Committee Chair:	**Trish Anderson**
Attendance:	Quorate
Key Items Discussed:	Board Assurance Framework Corporate Risk Register Workforce Inclusion Report Staff Health and Well Being Report DERI Q1 Strategy Update Mutually Agreed Resignation Scheme People Promise Exemplar Progress Pathology Improvement Plan Workforce Update Guardian of Safe Working Hours Industrial Action Update

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter

- The Committee received the Corporate Risk Register Report. 2 new risks were highlighted to the Committee relating to Theatre Capacity due to high demand, and a concern in relation to criticism of some new health roles e.g. Physician Associates. The Committee discussed the pressures on staff and the risk of 'moral injury' due to the pressures. We are also seeing more staff suffering mental health issues and a rise in sick leave.
- The Committee received the Workforce and Inclusion Report. This looks at 3 areas Race Equality, Disability Equality, Gender Pay Gap. The standards have been benchmarked over 5 years and there is little evidence of a shift in culture.

ASSURE
Please include items that have been discussed at the Committee that the Board can be gain assurance from. • The Committee received the Staff Health and Well Being Report. There are 7 themes and 59 actions. Whilst good progress has been made 15 actions remain Red and are the focus of the ongoing activity. • The Committee was updated on the good progress being made with the People Promise Exemplar Programme and supports the wider roll out. • The Committee received a detailed report from the Guardian of Safe Working Hours and an update on relevant issues.
ADVISE
Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing. • The Committee received a verbal update on the Pathology Improvement Plan. The business plan has been improved and new automated equipment went live in July which will deliver improvements to the service and develop staff skills and confidence. • The Committee received minutes from the Joint Negotiating and Consultative Committee, and the Joint Local Negotiating Committee.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **108**

10 July 2024 **Purpose** Information

Title	Triple A Report from Audit Committee
Report Author	K Rehman, Chair of Audit Committee

Summary: This report sets out the summary of the items discussed at the Audit Committee meeting held on 8 April 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	-

Related to recommendations from audit reports	-
Related to Key Delivery Programmes	-
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	**Audit Committee**
Date of Meeting:	**8 April 24**
Committee Chair:	**Khalil Rehman**
Attendance:	Quorate
Key Items Discussed:	

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter

- Internal audit is impacted by a large number of reports due in Q4. Head of internal audit opinion currently amber but committee assured that trajectory is towards green. Committee to review any learning lessons post finalisation of HOIA opinion.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The committee noted the assurances and progress from executive regarding an internal audit report on Risk Management.
- An update on Cerner EPR – committee raised an issue of the keeping the risk score assessed regularly.
- Update on international recruitment.
- The main part of the meeting focussed on Internal Audit where committee approved the FY24/25 internal audit plan subject to review in light of the work on 1LSC and service transfers into community health as the year progresses.
- Alongside the committee approved the FY24/24 counter fraud plan.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The second part of the committee's agenda focussed on reviewing and subsequently approving draft documents relating to the FY23/24 annual audit – in particular the going concern statement, accounting policies and Annual Governance Statement. The committee acknowledged the rationale for an increase in fees from the external auditors.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**109**
10 July 2024		**Purpose**	Assurance Information
Title	Triple A Report from Trust Charitable Funds Committee		
Report Author	Mrs L Sedgley, Non-Executive Director		

Summary: This report sets out the summary of the items discussed at the Trust Charitable Funds Committee meeting held on 4 June 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability	
Related to key risks identified on Board Assurance Framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
	2	The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
	3	A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
	4	The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	10082 - Failure to meet internal & external financial targets for 2024-25	

Related to recommendations from audit reports	Assurance Framework Key Financial Controls Risk Management Core Controls
Related to Key Delivery Programmes	Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	Trust Charitable Funds Committee
Date of Meeting:	4 June 2024
Committee Chair:	Mrs L Sedgley
Attendance:	Quorate
Key Items Discussed:	Report of the Investment Manager Use of Charitable Funds for Long Service Awards & Retirement Gifts Financial Performance Report for April 2023 – March 2024 Charity Strategy Proposal 2024 - 27 ELHT&Me Fundraising and Performance Report ELHT&Me Charity Hub and Retail Outlet Update

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter

- The Committee noted the potential risks to the charity through payroll giving with the move towards One LSC

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee noted the completion of the financial statements to March 2024 with a potential audit date in late summer.
- The Committee received an update on the fundraising activities and thanked all those involved in contributing to the continuing success of ELHT&Me.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee received the annual report from the Investment Manager and agreed that a review of the risk tolerance level for the investment portfolio should be reviewed with all the trustees.
- Members were pleased to note the continuing success of the Charity Hub and retail outlet and the number of fundraising activities involving communities across the whole of East Lancashire.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **110**

10 July 2024 **Purpose** Information

Title	Trust Board (Closed Session) Summary Report
Report Author	Miss K Ingham, Corporate Governance Manager
Executive sponsor	Mr S Sarwar, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 15 May 2024.

As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders would not be applicable in this instance.

Report linkages

Related Trust Goal	Deliver safe, high quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.

	5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to here.
Related to ICB Strategic Objective	State which ICB Strategic Objective the paper relates to here.

Impact

Legal	Yes/No	Financial	Yes/No
Equality	Yes/No	Confidentiality	Yes/No

Previously considered by:

Meeting: **Trust Board (Closed Session)**

Date of Meeting: **15 May 2024**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 13 March 2024 were approved as a true and accurate record.

The minutes of the Extraordinary Trust Board held on 20 March 2024 were also approved as a Trust and accurate record.

ITEMS DISCUSSED

At the meeting of the Trust Board on 10 January 2024, the following matters were discussed in private:

a) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.
b) Budget 2024-25
c) Paediatric Audiology Services
d) National Planning Guidance 2024-25 and Trust Priorities
e) Central Services Update
f) Pathology Update
g) Fire Remediation Programme Update: Burnley General Teaching Hospital
h) Fire Remediation Programme Update: Royal Blackburn Teaching Hospital
i) Responsible Officers Report regarding Doctors with Restrictions

ITEMS RECEIVED FOR INFORMATION

None.