NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

TRUST BOARD MEETING (OPEN SESSION)

9 NOVEMBER 2022, 13.00

VIA MS TEAMS

AGENDA

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

OPENING MATTERS				
TB/2022/133	**Chairman's Welcome**	Chairman	v	
TB/2022/134	**Apologies** To note apologies.	Chairman	v	
TB/2022/135	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	Information/ Assurance
TB/2022/136	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 13 July 2022.	Chairman	d✓	Approval
TB/2022/137	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2022/138	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2022/139	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2022/140	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2022/141	**Patient Story** To receive and consider the learning from a patient story.	Interim Chief Nurse	p	Information/ Assurance
TB/2022/142	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the 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/2022/143	**Board Assurance Framework Review** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Director of Corporate Governance	d✓	Information/ Assurance
TB/2022/144	**Patient Safety Incident Response Assurance Report**	Executive Medical Director	d✓	Information/ Assurance

TB/2022/145	**Safeguarding of Patients at ELHT Post Edenfield Documentary**	Interim Chief Nurse	d✓	Information/ Assurance
	ACCOUNTABILITY AND PERFORMANCE			
TB/2022/146	**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: a) Introduction (Chief Executive) b) Safe (Deputy Medical Director and Interim Chief Nurse) c) Caring (Interim Chief Nurse) d) Effective (Executive Medical Director) e) Responsive (Chief Operating Officer) f) Well-Led (Executive Director of HR and OD and Deputy Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2022/147	**Freedom to Speak Up Guardian Annual Report**	Executive Director of HR & OD	d✓	Information
	STRATEGIC ISSUES			
TB/2022/148	**New Hospitals Programme Quarter 2 Board Report**	Programme Director, New Hospitals Programme	d✓	Information
	GOVERNANCE			
TB/2022/149	**EPRR Annual Assurance Statement and Report 2021/2022**	Executive Director of Integrated Care, Partnerships and Resilience	d✓	Information
TB/2022/150	**Finance and Performance Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2022/151	**Quality Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2022/152	**Audit Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2022/153	**Trust Charitable Funds Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2022/154	**Trust Board (Closed Session) Information Report**	Chairman	d✓	Information

	To note the matters considered by the Committee in discharging its duties.			
TB/2022/155	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2022/156	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2022/157	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2022/158	**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/2022/159	**Date and Time of Next Meeting** Wednesday 11 January 2023, 1.00pm, via MS Teams	Chairman	v	

TRUST BOARD REPORT

Item 136

9 November 2022

Purpose Approval

Title	Minutes of the Previous Meeting
Executive sponsor	Mrs T Anderson, Interim Chairman

Summary: The minutes of the previous Trust Board meeting held on 13 July 2022 are presented for approval or amendment as appropriate.

Recommendation: This paper is brought to the Board for information.

Report linkages

Related Trust Goal	As detailed in these minutes
Related to key risks identified on assurance framework	As detailed in these minutes

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

(136) Minutes of the Previous Meeting

NHS
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EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 1.00PM, 13 JULY 2022

MINUTES

PRESENT

Professor E Fairhurst	Chairman	Chairman
Mr M Hodgson	Interim Chief Executive/Accountable Officer	
Mrs P Anderson	Non-Executive Director	
Mrs K Atkinson	Interim Director of Service Development and Improvement	Non-voting
Mr S Barnes	Non-Executive Director	
Mrs M Brown	Executive Director of Finance	
Dr F Dad	Associate Non-Executive Director	Non-voting
Ms C Douglas	Executive Director of Nursing	
Mrs S Gilligan	Chief Operating Officer	
Mr J Husain	Executive Medical Director	
Miss N Malik	Non-Executive Director	
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience	Non-voting
Mr K Moynes	Executive Director of HR and OD	Non-voting
Mrs F Patel	Associate Non-Executive Director	Non-voting
Mr K Rehman	Non-Executive Director	
Mr R Smyth	Non-Executive Director	
Mr M Wedgeworth	Associate Non-Executive Director	Non-voting
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)	Non-voting

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance/ Company Secretary	
Mr D Byrne	Corporate Governance Officer	Minutes
Miss K Ingham	Corporate Governance Manager	
Miss L Le Fao	Junior Consultant, Good Governance Institute	Observer
Mrs J Molyneaux	Deputy Chief Nurse	
Mrs S Philip	Consultant Stroke Nurse	Item: TB/2022/086

Mr M Pugh	Corporate Governance Officer
Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council
Mrs K Quinn	Operational Director of HR and OD

APOLOGIES

Professor G Baldwin	Non-Executive Director

TB/2022/078 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed attendees to the meeting. She extended a special welcome to Dr Dad in his new role as an Associate Non-Executive Director and to Mr Razaq in his role as Director of Public Health. Professor Fairhurst also notified Directors that Miss Le Faou was in attendance to observe proceedings.

TB/2022/079 APOLOGIES

Apologies were received as recorded above.

TB/2022/081 MINUTES OF THE PREVIOUS MEETING

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

RESOLVED: **The minutes of the meeting held on 11 May 2022 were approved as a true and accurate record.**

TB/2022/082 MATTERS ARISING

There were no matters arising from the minutes of the previous meeting.

TB/2022/083 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 the meeting or subsequent meetings.

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

TB/2022/084 CHAIRMAN'S REPORT

Professor Fairhurst informed Directors that she had recently attended a tree planting event at Clitheroe Community Hospital and explained that this had been done in memory of all those that had lost their lives during the COVID-19 pandemic. She also advised that stakeholder meetings had now been reinstated and stressed the importance of such events in maintaining a link between the Trust and the local communities which it served.

Professor Fairhurst confirmed that she continued to be active across the wider Lancashire and South Cumbria (LSC) system and advised that she had recently attended meetings of the Integrated Care System (ICS) Board and the Provider Collaboration Board (PCB). Directors noted that discussions were currently taking place around how the PCB would work together with the Integrated Care Board (ICB) now that it had become a full statutory body earlier in the month.

Professor Fairhurst concluded her update by reporting that she had attended a meeting with colleagues from the University of Central Lancashire (UCLan) to speak with members of their senior leadership team and to view some of their latest facilities.

RESOLVED: Directors received and noted the update provided.

TB/2022/085 CHIEF EXECUTIVE'S REPORT

Mr Hodgson provided updates on national headlines and referred to the recent appointment of The Rt. Hon. Steve Barclay MP as Secretary of State for Health and Social Care. He noted that Mr Barclay would have a number of significant challenges to manage, including the ongoing impact from COVID-19 and the emergence of new and unpredictable variants. Mr Hodgson informed Directors that he had attended the NHS Confederation Expo event on the 15 June 2022 and highlighted that the keynote speech from the Chief Executive of NHS England (NHSE), Amanda Pritchard, had set out the main priorities for Trusts; recovery, resilience, respect and reform.

Mr Hodgson reiterated that the Lancashire and South Cumbria ICB was now a full statutory body and would be working at three separate levels to improve population health and reduce inequalities. He clarified that these were at Integrated Care Partnership (ICP) level, at a place-based level and, crucially at neighbourhood level, at services such as GP practices. Mr Hodgson stressed that the ICB would play a pivotal role in bringing the Trusts in the area together to agree priorities and the mechanisms to ensure that they were delivered. He informed Directors that a number of virtual events had either been held or were planned for

the near future to lay out the work and goals of the ICB in further detail and to provide more clarity around what a greater level of collaboration would mean in practical terms.

Mr Hodgson noted that the meeting would be Ms Douglas' last in her role as Executive Director of Nursing and paid tribute to her many contributions to the Trust over recent years. He reminded Directors that the Trust was currently in the midst of implementing its new Electronic Patient Record (EPR) system as part of a wider East Lancashire Digital Programme. He highlighted that the move to using an EPR would be a significant change for the Trust and stated that the Board would continue to be apprised of its progress at future meetings.

Mr Hodgson stated that he wished to pay special recognition to the Macmillan Cancer Information Support Service, as it had recently been named as North West regional champion for increasing access to cancer services, particularly to those from Asian communities. He went on to inform Directors that there were a number of challenges currently facing the Trust around the reintroduction of car parking charges and the effects of the ongoing cost of living crisis on staff members. He confirmed that several initiatives were currently being considered to ameliorate the pressures on staff.

Mr Hodgson concluded his update by reminded Directors that the Trust's STAR Award ceremony would be taking place virtually the following week and would be livestreamed from a professional broadcasting studio for those wishing to observe the proceedings.

RESOLVED: Directors received the report and noted its contents.

TB/2022/086 STAFF STORY

Ms Douglas explained that the staff story would be presented by Mrs Sheeba Philip, one of the Trust's Stroke Nurse Consultants.

Mrs Philip introduced herself to Directors and explained that she had asked to attend the meeting to share her experiences from participating in the NHSE Getting to Equity Sponsorship Programme. She stated that she had started her career as a band 5 nurse on an elderly medicine ward and, when she had felt confident and capable enough to take the next step in her career, had started to apply for band 6 posts. Mrs Philip reported that there were multiple occasions when she was informed that she had narrowly missed out on roles but was not given any specifics as to why, leading to her feeling that there was a 'glass ceiling' that she was unable to break through. She advised that she was ultimately successful in applying for a band 6 role on a stroke unit but stated that she then experienced similar issues when trying to progress to a band 7 role. Mrs Philip informed Directors that it was not until later when

she had the opportunity to attend regional meetings that she was approached by one of the Trust's senior nursing team, Jane Pemberton, who spoke to her about a Stroke Nurse Consultant post which had recently become available.

Ms Douglas clarified that the Getting to Equity Sponsorship Programme was an opportunity for leaders from a White British background to sponsor the careers of Black, Asian and Minority Ethnic (BAME) staff members. She added that although one in every five midwives or nurses came from minority backgrounds, this was not reflected in senior roles, with only 170 out of 2000 band 8c roles or higher being filled by those from BAME backgrounds. Ms Douglas informed Directors that discussions were taking place around how this work could be taken forward.

Mrs Quinn advised that she had met with Mrs Philip and Ms Douglas earlier in the week to talk through the programme and confirmed that it was one of the key priorities for the Trust, both as part of its People Strategy and as part of its Workforce Race Equality Standard (WRES) action plan. She stated that the learning gathered thus far would be a major help in progressing the Trust's plans in this area.

Mrs Gilligan informed Directors that Mrs Philip's role had made a significant difference to the quality of stroke care provided to patients and had been instrumental in the Trust achieving an overall score of 'A' in the Sentinel Stroke National Audit Programme.

Mr Hodgson commented that the equity programme clearly fell under the 'respect' agenda that was referred to in the Amanda Pritchard's keynote speech and would be crucial to addressing the longstanding concerns around unequal working experiences for NHS staff based on their background.

RESOLVED: Directors received the Staff Story and noted its content.

TB/2022/087 CORPORATE RISK REGISTER (CRR)

Mrs Bosnjak-Szekeres referred Directors to the previously circulated report and advised that Mrs Atkinson would provide a brief overview of the work that had taken place to refresh both the CRR and the Board Assurance Framework (BAF).

Mrs Atkinson explained that work had taken place to refresh the format of the CRR and the BAF, ensuring that there was more alignment between them and to ensure that strategic risks were being informed by the Trust's revised Strategic Framework and goals. She further explained that this had been achieved by utilising the same improvement methodology that had been used to great effect in other areas of the Trust.

Mr Husain reported that there were currently 19 risks in total on the CRR and highlighted that the number of open risks had fallen from 1,700 to 1,512 due to the removal of duplications and general quality improvements. He added that work continued with divisional colleagues to review all remaining open risks. Mr Husain informed Directors that a new Executive Risk Assurance Group (ERAG), chaired by Mr Hodgson, had now been formed to ensure more oversight of risks and confirmed that Executive leads had been assigned to each of the 19 risks currently on the CRR. He advised that some further revisions and corrections would be made in future reports and that risk 7764 (Royal Blackburn Teaching Hospital (RBTH) Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke) and risk 8808 (Burnley General Teaching Hospital (BGTH) Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke) may be merged due to them both being related to fire stopping measures.

In response to a query from Mrs Patel regarding risk 8061 (Management of Holding List) and the reference made to some staff not following the correct procedures for the RAG (Red-Amber-Green) rating of patients, Mrs Gilligan confirmed that these issues had been addressed and that RAG ratings were monitored on a weekly basis in various settings to ensure that they were being done properly.

Mr Hodgson referred to the establishment of the ERAG and stressed the importance of having Executive oversight of the Trust's risks.

Mrs Anderson praised the changes made to the CRR and commented that it was a much more concise, focused and easier to read document.

RESOLVED: **Directors received the report and assurance given.**

TB/2022/088 BOARD ASSURANCE FRAMEWORK

Mr Husain referred members to the previously circulated report and extended his thanks to Mrs Bosnjak-Szekeres and her team for their work in revising it.

Mrs Bosnjak-Szekeres explained that the new risks added to the BAF were set out in section 5 of the report along with their scores. She advised that from September 2022 onwards, all risks would be presented to the Board Sub-Committees, but they would only be asked to review those risks that fell within their remit. Mrs Bosnjak-Szekeres requested confirmation from Directors that they were content to approve the new overarching risk appetite statement and the individual risk appetite scores included in the report and the allocation of each risk to their respective Sub-Committees.

Mrs Atkinson advised that the summary table included in the report clearly showed the alignment of each risk to the Trust's goals and strategies. She added that section 13 of the report also set out the alignment of each risk to the Trust's key delivery programmes.

Mr Barnes acknowledged that the revised BAF was a work in progress but suggested that more information regarding system risks, particularly in relation to its clinical strategy and the proposal for a new corporate hub, should be added to Risk 1 (The partnership arrangements across the ICS for Lancashire and South Cumbria, including the PCB and the place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities).

Professor Fairhurst stated that it was clear that a step change in improvement had occurred in the way in which strategic risks were identified and managed. She requested confirmation from Directors that they were content to agree that there was now clearer alignment between the Trust's activities and that this provided increased assurance.

RESOLVED: **Directors received, discussed and approved the revised Board Assurance Framework, including the overarching risk appetite statement and individual risk statement scores and noted the work on its revision.**

The Board was assured by the process in which strategic risks were identified and managed on the Board Assurance Framework.

TB/2022/089 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) ASSURANCE REPORT

Mr Husain referred Directors to the previously circulated report and requested that it be taken as read. He reminded Directors that the Trust had been one of the early adopters of the Patient Safety Incident Response Framework (PSIRF) and reported that it had recently provided support to a significant number of other organisations across the country to assist them with their implementations. Mr Husain confirmed that the Serious Incidents Requiring Investigation (SIRI) panel had now been replaced with a new Patient Safety Incidents Requiring Investigation (PSIRI) panel and that the detailed reports provided by the PSIRF were feeding into a new Lessons Learned Group. He reported that there were currently eight investigations underway and highlighted that a new flowchart had been included in the report make it clearer how the information from these proceeded through various channels. Directors noted that work was ongoing to close the remaining backlog of 32 open investigations from the previous

Serious Incidents Framework (SIF) and that 20 maternity related incidents had recently been closed by Clinical Commissioning Groups (CCGs).

Mr Husain reported that there were two Never Events currently under investigation and that no harm had been caused to the patients involved.

Professor Fairhurst enquired if any consideration had been given to developing a publication for internal use and for sharing with external colleagues around how the learning form the PSIRF process had been disseminated.

Mr Hodgson suggested that anonymised case studies could be provided at future meetings to demonstrate how the Trust had learned from them and how this learning had improved practice.

Mr Husain proposed inviting the Trust's Deputy Medical Director for Quality and Effectiveness, Dr Chris Gardner, to future meetings to allow him to showcase the improvement work that he had been involved with over recent months.

Mr Rehman commented that while there was a significant volume of quantitative data included in the assurance reports it would be helpful for more information to be included in future reports around the cultural approach to the investigations taking place.

RESOLVED: **Directors received the report and received assurance.**
Case studies from the PSIRF will be provided in future assurance reports.

TB/2022/090 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Mr Hodgson referred directors to the four Rs set out at the recent NHS Confederation (recovery, reform, resilience and respect) and the difficult operating environment that the whole of the NHS remains in, particularly in terms of COVID recovery, vacancy rates and the financial constraints at national, regional and local levels.

He went on to comment that, with that in mind, the performance position of the Trust which was presented to the Board was good. Directors noted that the Trust remained in the upper to mid-quartile in terms of performance.

b) Safe

Mr Husain confirmed that there had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) during the reporting month. He went on to report that the Trust had remained under the tolerance level for Clostridium Difficile (C. diff) during the 2021-22 year, but there

had been six cases of C. diff identified in the reporting month, one of which was community acquired and the remainder hospital acquired.

Mr Husain confirmed that the Trust's Infection Prevention and Control (IPC) team closely monitors progress and reports through to the Trust's Quality Committee on a regular basis. He went on to confirm that there were currently six nosocomial outbreaks of COVID-19 in the Trust and, as a result of this and the increasing levels of COVID-19 across the Trust, the decision had been made to reintroduce the need to wear masks on all Trust sites

Ms Douglas reported that the overall nurse staffing position across the Trust was still challenging, particularly as a result of COVID-19 related staff sickness. She confirmed that work was being undertaken to ensure that wards and departments across the Trust maintained safe staffing levels. Directors noted that, whilst this would allow services to remain safe, it would potentially have a detrimental effect on staff morale.

Ms Douglas went on to provide an update on international recruitment and confirmed that the Trust had begun to see a significant number of new staff commencing in post. She also confirmed that international recruitment was about to commence for Allied Health Professionals.

In response to Dr Dad's request for a better understanding of the trajectories mentioned earlier in the section, Mr Husain commented that his query would likely to be addressed later in the session. Professor Fairhurst provided the rationale for the way in which the IPR was presented to the Board.

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

c) Caring

Ms Douglas referred Directors to the Caring section of the previously circulated report and confirmed that the responses to the Trust's Friends and Family questionnaires were collected following an inpatient stay or a visit to the Emergency Department (ED). She reported that the number of responses from patients who had received care via ED remained below the threshold required but assured Directors that there were a number of other ways to gain feedback on the services provided to patients

Directors noted the number of complaints received into the Trust in the reporting month was 21 and, as such, remained below the threshold of 0.4 complaints per 1,000 patients.

Professor Fairhurst asked Directors to acknowledge the assurance received regarding the caring domain and recognise the work being undertaken to address any shortfalls.

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

d) Effective

Mr Husain reported that the Trust's Summary Hospital Mortality Indicator (SHMI) for May was 1.06, with Hospital Standardised Mortality Ratio (HSMR) at 104, both of which were within expected levels. He added that the Trust currently had two HSMR diagnostic groups with significantly high relative risk scores. These were noted to be acute cerebrovascular disease and septicaemia (except in labour).

Mr Husain provided an overview of the work being undertaken to bring both reporting groups back within the expected range. He highlighted the work being carried out by the Sepsis Taskforce and Trust Mortality Group, including the identification of coding issues that required rectification. Directors noted that, at this point, there had been no evidence found to suggest a cause for concern.

Directors also noted that the Trust's palliative care input rate was lower than the national average, but this did not mean that the care provided was poor, as it also related to a coding issue.

Professor Fairhurst asked for further detail regarding the coding used and what it meant in the wider context. Mr Husain confirmed that the HSMR score for some Trusts was in the high 80s, however these trusts generally had a palliative care service operating 24 hours over 7 days and were able to record deaths as expected during this time. However, for those Trusts who don't have a service operating on a 24/7 basis, deaths that occurred out of hours were classed as unexpected death.

The Directors received assurance regarding the effectiveness of the care given.

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

e) Responsive

Mrs Gilligan reported that, as a result of the COVID-19 pandemic there had been a number of metrics which had been revised and the national recognition that many of the previous targets were no longer feasible. She confirmed that whilst there was no nationally set metric for trolley waits, the Trust was focused on reducing and eliminating them. Directors noted that there had been a total of 233 trolley waits in June, with 83 for the month of July to date.
She provided an overview of the overall Trust performance as set out in the report, including the performance against the four-hour accident and emergency target, which was noted to be 75.2% for the reporting month.

Mrs Gilligan confirmed that the trust had an improvement plan in place for the emergency care pathway, which is monitored on a monthly basis at the Finance and Performance Committee. She went on to confirm that maintaining the flow of patients through the Trust was imperative as this enabled a smooth transition of patients from the Emergency Department (ED) through to wards where appropriate. She provided a short overview of the streaming tool which was in place at the Trust, including the 'Fit to Sit' programme which also assisted in the quicker treatment and discharge of patients.

Directors noted that, in terms of elective care, there were currently 477 patients who had waited in excess of 52 weeks for surgery, and a further patient who had waited in excess of 104 weeks.
Mrs Gilligan reported that there would be an increase in the number of patients on the 52-week wait list in the coming months whilst patient backlogs were managed. She went on to confirm that there was a comprehensive plan in place to eliminate 78-week waits by March 2023.

Mrs Gilligan went on to report that there was a national and Trust level focus on cancer performance, including a drive to reduce the number of patients waiting for cancer diagnosis, within 28 days. She explained that the main reasons for the backlog related to the increased referrals seen over recent months, particularly for certain tumour groups such as skin and urology and the number of consultant vacancies.
She confirmed that an improvement plan was in place and positive movement was being seen. Furthermore, she confirmed that the Trust was on trajectory to achieve the required improvement of having a waiting list no longer than those seen pre-pandemic by the end of the 2022-23 financial year.

In response to Ms Malik's question regarding patients waiting over 12-hours, particularly those patients with mental health issues, Mrs Gilligan reported that there were examples of days where there were no delays at all, however there was a number of patients with complex needs who required multiple strands of care, often both physical and mental health related. She went on to report that the relations between the Trust and LSCFT had improved, and the two Trusts were in frequent discussion about core pathways.

In response to Dr Dad's query, Mrs Gilligan provided an overview of the mutual aid arrangements that were in place across the ICS and confirmed that whilst the Trust does, on occasion seek aid from other Trusts, in the main it provided more assistance that it requested.

Mr Hodgson commented on the pressure points across the Trust, specifically regarding cancer and histopathology services and commended the support that had been provided to the Trust on the latter.

Directors confirmed that they had received assurance on the work being undertaken to improve areas of underperformance.

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

f) Well-Led

Mrs Quinn referred Directors to the workforce related items within the report, specifically the staff sickness rates and confirmed that they had increased from those reported in the previous IPR to 7.2%. She went on to state that as of 1 July 2022 any staff sickness relating to COVID-19 counted as standard sickness.

In terms of staff turnover, Mrs Quinn reported that whilst the number remained below the threshold of 12%, it had increased to 8.3%. Directors noted the work that was taking place to identify the reasons for the increase in staff turnover and the additional work relating to retention of staff.

Mrs Quinn provided an update on the development of the Care Academy that was being developed to help increase the number of staff employed by the Trust form the local population.

Mrs Quinn reported that there was a continued use of bank and agency staff, although there had been a small reduction in agency use/costs. Directors were informed that a piece of work was being undertaken at ICS level to collectively reduce the use of and spend on agency staff across the whole Lancashire and South Cumbria region.
She also provided a short update on the Trust's appraisal rates and confirmed that significant effort was being put into improving compliance in this area.

Mrs Brown provided an overview of the current financial position and confirmed that the financial position at the end of the reporting month was a deficit position of £4,400,000, which was £1,800,000 behind the planned position. She confirmed that, despite the reported financial position, the Trust had a cash balance at the end of the reporting month of £60,800,000.
Directors noted that the Trust's capital plan stood at around £43,700,000 for the year, with £2,000,000 of the planned £2,700,000 used to date.

At the request of Professor Fairhurst, Mr Hodgson provided an overview of the ICS level finances. He reported that there had been a specific request for a financially balanced system level plan to be submitted. He explained that this was intentional, in order to enable additional levels of income to be secured across the ICS. He went on to agree with the comments made earlier about the need to use a combination of recurrent and non-recurrent savings to achieve the required Waste Reduction Programme target.

RESOLVED: **Directors noted the information provided under the Well-Led section of the Integrated Performance Report.**

TB/2022/091 STAFF HEALTH AND WELLBEING SUMMARY REPORT

Mrs Quinn referred Directors to the previously circulated report and provided an overview of the main points contained within it. She reported that the main focus of work had related to the recent feedback from staff regarding mental health services and financial wellbeing, given the increased cost of living issues being experienced.
Directors were informed that a working group has been set up to consider what support and advice could be offered by the Trust to staff in relation to the ongoing cost of living issues.

Mrs Quinn went on to report that the ICS had launched a health and wellbeing website which is tailored to individual Trusts. The website includes a collection of information for staff and provides assistance through online methods, such as reading and virtual courses.
She went on to confirm that the Trust was leading on the Enhanced Health and Wellbeing Programme at ICS level and it linked to the ICB and PCB ambition to have a unified approach to staff health and wellbeing across the area. Directors noted that in addition to leading on this programme, the Trust had been approached by Lancashire and South Cumbria Foundation Trust (LSCFT) to also provide support to them in this area.

In response to Ms Malik's question, Mrs Quinn confirmed that some of the items within the Trust's ICS Health and Wellbeing website were available to the general public, but there were some specific resources that were only available to staff via logging into the site.

RESOLVED: **Directors received the information within the report and noted the content and assurance provided.**

TB/2022/092 CLINICAL STRATEGY

Mr Hodgson introduced the item and referred members to the previously circulated document. Mrs Atkinson provided a brief summary of the updated Clinical Strategy. She explained that it was the culmination of a significant amount of work by clinical colleagues and set out the Trust's key principles and aims over the next five-year period. Mrs Atkinson highlighted that there was a real focus on system working and health inequalities in the strategy and advised that it would be one of several that would support the Trust's Strategic Framework. She confirmed that it had been through a robust process of development and engagement and that a significant amount of the feedback received had been incorporated into it. Mrs Atkinson informed Directors that teams were already proceeding with the delivery plan for the current year and were in the early stages of development for the next.
Directors confirmed that they were content to approve the Clinical Strategy for 2022-27.

RESOLVED: **Directors received the report and approved the Clinical Strategy for 2022-27.**

TB/2022/093 NHS IMPROVEMENT ANNUAL BOARD SELF-CERTIFICATION

Mrs Bosnjak-Szekeres explained that all NHS providers were required to self-certify on an annual basis to confirm that they were compliant against their obligations. She requested confirmation that Directors were content for Professor Fairhurst and Mr Hodgson to add their

signatures to the certification forms presented prior to them being published on the Trust's website.

Directors confirmed that they were content to accept the documents.

RESOLVED: **Directors approved the annual Board Self-Certification documents.**

TB/2022/094 OCKENDEN FINAL STATEMENT

Ms Douglas informed Directors that the Trust's Ockenden Final Statement was being presented for information. She clarified that this statement confirmed that all immediate and essential actions from the first Ockenden Report had been carried out and that the 15 actions from the second publication were in the process of being completed.

RESOLVED: **Directors received the report and assurance about the steps being taken to implement the recommendations from the Ockenden Reports.**

TB/2022/095 RATIFICATION OF BOARD SUB-COMMITTEE TERMS OF REFERENCE

The revised Terms of Reference for the Trust Charitable Funds Committee and Remuneration Committee were presented to Directors for ratification, following their approval at the most recent meetings of each Committee.

Directors confirmed that they were content to ratify the revised Terms of Reference presented.

RESOLVED: **Directors confirmed that they were content to ratify the revised Terms of Reference for the Trust Charitable Funds Committee and Remuneration Committee.**

TB/2022/096 FINANCE AND PERFORMANCE COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2022/097 QUALITY COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2022/098 AUDIT COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2022/099 TRUST BOARD (CLOSED SESSION) INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB2/2022/100 REMUNERATION COMMITTEE REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2022/101 ANY OTHER BUSINESS

Professor Fairhurst reiterated that the meeting would be Ms Douglas' last. She noted that the Trust was now in the position where it had been rated as 'Good' with a number of areas of outstanding practice and that this was due in large part to the work done by Ms Douglas during her tenure, particularly her efforts to raise and maintain the morale of nursing colleagues.

The Board thanked Ms Douglas for her work and for her contributions during her tenure at the Trust.

TB/2022/102 OPEN FORUM

No questions were submitted prior to the meeting.

TB/2022/103 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst 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.

Mr Hodgson commented that he felt that discussions had reflected the current realities of the system work taking place at different levels, as well as more Trust specific issues such as the cost-of-living issues facing staff.

Professor Fairhurst stated that the discussions around the Trust's revised CRR and BAF were evidence of the Boards focus on providing appropriate assurance.

Miss Malik commented that she had been very impressed by the presentation given my Mrs Philip earlier in the meeting and that it had made her feel proud to be a Non-Executive Director for the Trust.

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

TB/2022/104 DATE AND TIME OF NEXT MEETING

Professor Fairhurst informed Directors that the next Trust Board meeting would be taking place on Wednesday, 14 September 2022 at 13:00, via MS Teams.

Matters arising from the cancelled September 2022 Trust Board Meetings

Following the cancellation of the Trust Board meeting that was scheduled to take place on the 14 September 2022, following the death of Queen Elizabeth II, there were several urgent matters requiring Board approval which were instead agreed by Directors via email. These items were as follows:

a) The awarding of SPEC award status to the Trust's Discharge Lounge and Surgical Ambulatory Emergency Care Unit.

b) The approval of the risk score revisions for:

i. BAF risks 5a: Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce) reduced from 12 (Consequence (C) 4 x Likelihood (L) 3) to 8 (C4 x L 2) and

ii. BAF risk 9: The Trust's Improvement Practice and key delivery programmes do not sufficiently build improvement capability and support delivery on agreed outcomes), reduced from 16 (C4 x L4) to 12 (C4 x L3).

c) Approval of the Health Education England (HEE) Self-Assessment report for placement providers. This was approved and submitted to the regulator.

Mr D Byrne, Corporate Governance Officer

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 138

9 November 2022

Purpose Information

Title	Action Matrix
Executive sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance/ Company Secretary

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

Report linkages

Related Trust Goal	-
Related to key risks identified on assurance framework	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

(138) Action Matrix

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2022/064: Behaviour Framework Implementation Update	A further progress report on the implementation of the Trust's Behavioural Framework will be provided to the Board in 12 months' time.	Executive Director of HR & OD	May 2023	Agenda Item: May 2023
TB/2022/089: Patient Safety Incident Response Framework Assurance Report	Case studies from the PSIRF will be provided in future assurance reports.	Executive Medical Director	TBC	Update: Case studies will be discussed as part of future PSIRF updates provided at meetings of the Quality Committee. Consideration is also being given to providing suitable case studies as part of the patient and staff stories provided to the Board.

Mrs A Bosnjak-Szekeres, Director of Corporate Governance/ Company Secretary
Miss K Ingham, Corporate Governance Manager

TRUST BOARD REPORT

9 November 2022

Item	**140**
Purpose	Information

Title	Chief Executive's Report
Executive sponsor	Mr M Hodgson, Chief Executive

Summary: A summary of national, regional and local updates are provided for information.

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

Report linkages

Related Trust Goal	-
Related to key risks identified on assurance framework	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

(140) Chief Executive's Report

Background
This report is divided into sections covering the following four main elements:

- Major 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
- A summary of the Chief Executive's diary commitments

1. National Updates

New NHS Statutory Operating Framework
On 1 July 2022, Integrated Care Systems (ICSs) were placed on a statutory footing, bringing together different partner organisations across the NHS and local government, Voluntary, Community and Social Enterprise sector and other partners to better integrate services and take a more collaborative approach to agreeing and delivering ambitions for health and wellbeing.

The establishment of ICSs and the new statutory framework, means that NHS England has changed the operating framework to best empower and support local system partners to deliver on their responsibilities. This requires a cultural and behavioural shift towards partnership-based working, creating NHS policy, strategy, priorities and delivery solutions with national partners and with system stakeholders and giving system leaders the agency and autonomy to identify the best way to deliver agreed priorities in their local context.
The new operating framework document sets out in more detail how NHS England will work with systems and outlines purpose and behaviours, medium-term priorities and the accountabilities and responsibilities of the different organisations in the NHS, as well as across the wider health and care system.

It informs how the NHS will become more agile and reduce duplication and deliver the priorities identified within the NHS Long Term Plan alongside the actions needed to respond to the pandemic and wider pressures. The operating framework will be a key input into the design of the new NHS England and further developed alongside the operating models and statutory responsibilities of our new partners, Health Education England and NHS Digital, as part of the new NHS England change programme.

The full operating framework document can be found here.

Next steps on elective care for Tier One and Tier Two providers

In October, NHS England wrote to colleagues across the NHS to outline further plans to boost capacity and resilience for services during winter and a further letter from Sir James Mackey, national director of elective recovery, and Dame Cally Palmer, national cancer director, has been received setting out next steps for the elective recovery programme.

The aim is to ensure that phase two objectives around 78 week waiters and 62 day cancer referral waits are met but the letter acknowledges reductions in patients waiting two years have been delivered alongside the number of people waiting more than 18 months and 62 days respectively.

It accepts also that activity levels compared to pre-pandemic are increasing but is clear that expectations remain to make further progress through a combination of getting the basics right and data-led management and innovation, particularly on outpatient and diagnostic activity.

There are significant learnings from individual organisations across the country which can be shared to support improvements and the update asks all NHS colleagues to complete a Board self-certification, to allow support to be provided to those experiencing the greatest challenges.

Red Cell Shortage – Amber Alert

NHS Blood and Transplant (NHSBT) moved to amber alert status in October when providers were instructed to implement Emergency Blood Management Arrangements for red cells at the amber shortage level.

The team said it had taken action to avert a move to amber alert level but red cell stock levels had reached the point where they were expected to drop below the two-day threshold. The alert will be revoked when stocks reach a sustainable level again, but initial estimations suggest this will take at least a month to achieve.

The Trust immediately implemented a management plan to protect blood stocks and an emergency blood group was set up to support clinical colleagues, which has included optimising patients to avoid transfusion, returning blood that isn't required as soon as possible to prevent wastage and reviewing stock holding and reducing where possible.

NHSBT are continuing to increase frontline staffing numbers so they can increase appointments and build stocks. The Donor Experience team have promoted donation where

capacity is in place and specifically targeted group O donors. Local media is being used alongside direct marketing to ensure the right donors can donate in the right location. Details can be found on www.blood.co.uk

Independent Investigation into East Kent Maternity Services

In February 2020 the Government announced that NHS England and NHS Improvement had commissioned an independent investigation into the maternity and neonatal services provided by East Kent University NHS Foundation Trust. The investigation was led by Dr Bill Kirkup who established an independent investigation including engagement with families involved.

The report entitled Reading the Signals was published on 19 October 2022 and on Friday 21 October East Kent's Board met in public to discuss the report and accepted it and its recommendations in full.

Following the publication of the report a letter was circulated to Trusts Chief Executives, Chairs, ICB Chief executives LMNS chairs and regional leaders outlining expectations to review the findings of the report at public board meetings and be clear about related actions and effectiveness.

The report sets out the devasting consequences of failings and the unimaginable loss and sorrow suffered by families along with clear expectations of the requirements of each trust board to remain focused on delivering personalised, safe maternity and neonatal care and ensure that the voices and experiences of women, babies and families who use these services are listened.

ELHT has collated a response to the report, which is on the agenda for this meeting.

INDUSTRIAL ACTION

On 19 July 2022, the Government announced the 2022/23 pay award for NHS staff, accepting in full the recommendations of the pay review bodies. The pay award was implemented in August 2022 and backdated to 1 April 2022.

In response, trade unions have been holding consultative ballots with members, to decide whether to proceed onto formal, statutory ballots around industrial action. Some trade unions have now progressed onto statutory ballots, with most others expected to follow including those representing ambulance colleagues.

In response to this, ELHT has established an Industrial Action, chaired by the Executive Director of Integrated Care, Partnerships and Resilience, and reporting into the EPRR Committee, with the responsibility to:

- Plan for reduced delivery of services during any industrial action, ensuring that
- Business Continuity Plans are up to date
- Clearly identify the services that must remain unaffected by any industrial action
- Work collaboratively to ensure that all key services remain unaffected
- Agree plans around communication and engagement with staff side colleagues, staff and patients, colleagues, visitors and our community

Meetings will be held every two weeks initially, moving to more frequent when we know the outcomes of the ballots.

24/7 control centres among new plans to step up NHS winter preparations
Rapid response teams to help people who have fallen at home and 24/7 'care traffic control centres' are among new NHS plans to prepare for winter. NHS chief executive Amanda Pritchard said the additional measures would build on the extensive work already underway to prepare for what will be a "very challenging winter."

New 24/7 system control centres are expected to be created in every local area, which will manage demand and capacity across the entire country by constantly tracking beds and attendances – taking stock of all activity and performance for the first time.

Led by teams of clinicians and experts, the centres will enable rapid decisions to be made to any emerging challenges including where hospitals can benefit from mutual aid, or to divert ambulances to another nearby hospital with more capacity. Local areas will also develop new hubs dedicated to serious respiratory infections, with patients receiving same day access to care out of hospital while also creating additional capacity for hospitals and ambulance services.

NHS hits 10 million booster milestone
More than 10 million people in England have now had their autumn Covid-19 booster after bookings for over 50s opened in October. Around 2.3 million people received their autumn booster last week alone with the NHS Covid-19 vaccination programme delivering an average of two million covid jabs per week throughout October.

A record number of sites are delivering autumn boosters since the campaign began, while the flu jab is being offered at thousands of community pharmacies and GP surgeries across England. Approximately 26 million people are eligible for an autumn Covid-19 booster and 33 million people are eligible for a flu vaccine.

NHS launches recruitment drive for tens of thousands of nurses

NHS England has launched a nationwide drive to recruit more nurses. Chief Nurse Ruth May has called on anyone looking for a lifechanging career to consider becoming a nurse, as new figures show that more than six in 10 people are considering a career change over the next year.

Nursing degrees offer strong employment prospects in every part of the country, with 94% of graduates finding jobs within six months and more than 46,828 nursing, midwifery, and health visiting vacancies in the NHS in England alone. The ‘We are the NHS’ campaign adverts will run across on demand services, radio, social media and in cinemas, with two films featuring the powerful stories of patients during their time in hospital and recovery aided by NHS nurses.

The renewed drive comes as a new survey reveals eight in 10 people say nurses have made a positive impact in their life. Alongside increased investment for degrees and placements, NHS recruitment campaigns have prompted a surge in applicants to healthcare degrees in recent years, with more undergraduate nurses than before the pandemic and data showing that nursing applications have increased by more than a quarter, from 40,770 to 52,150*, since 2019.

2. Regional Updates

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

Members of the Lancashire and South Cumbria Integrated Care Board (ICB) met on 12 October 2022. The following key points are summarised from the board meeting and papers. The live stream from the Integrated Care Board meeting is also available to watch online here https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers/previous-board-meetings/12-october-2022-board-meeting

The role of the Integrated Care Board and Provider Collaboration Board

As a system, LSC has been given a System Oversight Framework (SOF) score of SOF 3 by NHS England (NHSE), which is derived from a number of oversight metrics relating to quality of care, access, preventing ill-health, leadership and capability, finance and the use of resources and people. NHSE and government ministers will hold ICBs to account for delivery.

The ICB wants LSC to become a high performing system with a strong community focus with integration of health and care, investment in prevention and improved access to primary care, all delivered with a close eye on health inequalities.

To enable this, there will be a focus on any immediate issues and challenges in the way that the ICB and Provider Collaborative Board (PCB) works together and specialist support will be sought to define roles and responsibilities, links with regional and system level leadership and how it works in practice.

It is anticipated that reviewers will seek to interview key members of the ICB and PCB Boards at executive and non-executive levels and some key people at NHSE.

Lancashire and South Cumbria ICB Constitution

Following the Health and Care Act (2022) the model constitution published by NHSE in May 2022 was reviewed and several small amendments identified for implementation. These changes amount to minor technical references and one clarification on the definition of Health Care Professional and NHSE have advised that the ICB Constitution can be amended and the updated version has been submitted and published on the ICB website.

ICB Governance Handbook, Inclusion of Memorandum of Understanding (MOU)

An MOU with NHSE (North West Region) has been included within the ICB Governance Handbook. The MOU sets out the arrangements between NHSE and the system in respect of

the SOF. It provides clarity on the expected oversight arrangements and support offers and escalations processes in respect of the four segmentations of the framework. In addition, the MOU describes the relationships between the system and NHSE regional team and the interfaces that underpin how the ICB and NHSE will work together to discharge their duties.

It is expected that this relationship will differ according to the system, levels of delegation and maturity. It is anticipated that whilst this document begins to set out these arrangements, a more detailed operating model will further develop these relationships and ways of working for the future. The detailed arrangements will be kept under regular review and the agreement will be updated periodically. The MOU is intended to align and be supported by the NHSE SOF, the ICB Constitution and other published guidance, without duplicating content.

Lancashire and South Cumbria Integrated Care Partnership (ICP)
The first meeting of the ICP was held on 30 September where members acknowledged the tight timescales associated with the development of an LSC Integrated Care Strategy, with a draft strategy required by the end of December, for approval in early 2023. It was agreed a simple approach that builds on existing work will be adopted, acknowledging that it will take two to three years to reach a level of sophistication.

Members agreed to engage residents and staff on the following key themes within a life-course framework for the strategy:

- Starting well - A focus on supporting children and their families in the first 1000 days of a child's life, with a holistic consideration of factors influencing health, wellbeing, and school readiness.
- Living well - A focus on supporting people into employment and staying in work, prevention of ill health, tackling health inequalities, and high-quality care that supports people to stay well in their own home, with radical and innovative approaches to integrating care provision.
- Dying well - A focus on supporting people to choose their preferred place of death

During October 2022, resident and staff engagement will take place on these suggested priority areas, using a combination of online surveys, existing groups sessions and market stalls. Resident engagement will be led by Healthwatch.

Panorama
Following a BBC Panorama programme in September focused on Greater Manchester Mental Health NHS Foundation Trust, NHSE has contacted all ICBs asking for a review of

safeguarding to be urgently undertaken including freedom to speak up arrangements, advocacy provision, complaints, Care, Education and Treatment reviews (CETRs), Integrated Care and Assessment Treatment services (ICATS) and any other feedback on services.

Oversight for the review will sit with the LSC Quality Committee, with a full report provided to the December ICB detailing the findings of this review and any actions required.

Financial Progress

At the end of August, the finances as a whole for Lancashire and South Cumbria were £35.1m worse than planned and although the system continues to forecast a breakeven position, the level of risk for the year remains currently at £70m which has reduced from the £177m of risk identified at planning stage.

The level of operational pressures impacted by Covid, which has continued to persist through into the first half of the year, is impacting on the systemwide financial run rate. This is adding challenge to the delivery of the financial targets, but work is continuing to mitigate the risks.

Every organisation has been asked to ensure plans are in place for full delivery of the savings plans and ensure they are delivered recurrently by the final quarter of 2022/23 to avoid pressures emerging in 2022/23.

Urgent and Emergency Care Assurance Framework (Winter Plan)

Winter plans were discussed alongside an acknowledgement and acceptance from NHSE Regional and National Colleagues that the response this year will need to be more agile and innovative than ever before.

In August and in line with the B1449 Guidance for Emergency Departments circular (Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter, and UEC assurance framework) a capacity uplift equivalent to 7,000 extra winter beds was confirmed countrywide and as part of this, the LSC system was awarded £12.5m to achieve the equivalent of 282 extra bed capacity.

In response to this each place-based partnership, including representatives from UEC, Acute, Mental Health, Primary Care Providers and Local Authorities have worked at pace to develop and propose surge schemes.

Collaborative System People Bank and Accelerated Optimisation of Temporary Workforce Systems, Processes and Practices

A recommendation to establish a collaborative system-wide people bank, alongside a targeted programme of work to optimise temporary workforce systems and processes and deliver rapid efficiencies, was approved as one of five priority programmes at the ICB Board in July.

Establishing collaborative system banks and reducing reliance on high-cost agency staff were expressly prescribed within the NHS 2022/23 priorities and operational planning guidance.

A collaborative procurement process was undertaken during October to review the range of potential collaborative bank models, as well as potential delivery partners, against a number of key measures including quality, cost, performance, and delivery (efficiencies), timescales and sustainability. Following the completion of the procurement process a proposal is expected to be presented to the ICB Board and Provider Collaborative Board (PCB) for support and approval for implementation.

After seeking legal advice, the ICB will be the contracting body for this procurement. Potential changes to the PCB governance structures to enable members to make and enact future collective decisions in one place, such as a Committee in Common, will be worked through as part of the wider piece of work.

Getting It Right First Time (GIRFT)

This national NHS programme is designed to improve treatment and care of patients through in-depth review of services, benchmarking and presenting a data-driven evidence base to support change.

Four high-volume clinical pathways for Lancashire and South Cumbria have been agreed. These are respiratory, frailty, cardiac and orthopaedics and ambitions in relation to each of these have been set for 2023 and 2024. An LSC GIRFT clinical ambassador has been appointed to take this work forward.

Senior Leadership Structure

Interviews for the chief officer for health and care integration took place in early September and a conditional offer made to the successful candidate. More details will be provided in due course. This concludes the recruitment to executive level positions and the ICB is confident all executive directors should be in post by November 2022.

Inaugural Meetings

The first meeting of the new ICB People Board took place on 27 September, Chaired by Professor Ebrahim Adia, with James Fleet the ICB chief people officer as Executive lead.

The first meeting of the new ICB Quality Committee took place on 21 September, Chaired by Sheena Cumiskey, with Sarah O'Brien the systems chief nurse as Executive lead.

Innovative New Test to Detect Oesophageal Cancer Launched in Lancashire and South Cumbria

The ICB, working with partners including the Innovation Agency, has secured £500,000 funding from the Small Business Research Initiative Healthcare fund to pilot an innovative new test called Cytosponge, which helps to detect oesophageal cancers. This procedure is offered to people classed as high risk on current endoscopy waiting lists, delivered in community settings, via GP practices.

The test is a quicker procedure than an endoscopy in hospital and can identify the 80 to 85 per cent of patients who do not have cancerous cells, giving peace of mind and avoiding unnecessary hospital visits, whilst also ensuring that the 15 to 20 per cent of patients who need to attend hospital for an endoscopy go onto much shorter waiting lists. A video with a case study of a patient undergoing the test is available here: https://www.lancashireandsouthcumbria.icb.nhs.uk/news-andmedia/latest-news/sponge-string-cancer-test-launches-gp-practices

3.2 Updates from the Lancashire and South Cumbria Provider Collaboration Board (PCB)

Governance

The five provider NHS trusts in Lancashire and South Cumbria continue to work collaboratively to ensure patients have equal access to the same high-quality care wherever they live and colleagues have the same high-quality experience wherever they work.

To support this, the PCB, which consists of the chairs and chief executives of the five trusts, last month (October) reviewed the Board's terms of reference and the operating process of accountability to the Integrated Care Board (ICB). As the system architecture is now in place, the Board will move towards having an agenda focused on decision making and assurance.

PCB Committee Chairs

There has been a change of chair arrangements across a number of committees as follows:

- Professor Mike Thomas, chair of University Hospitals of Morecambe Bay, was ratified as the new chair of the PCB at its August meeting. He takes over from

David Flory, chair of the ICB, who has stepped away from his PCB role now that the ICB has been established as a statutory organisation

- The Clinical Integration Group will be chaired by Martin Hodgson, Chief Executive of East Lancashire Teaching Hospitals
- The Corporate Collaboration Board will be chaired by Aaron Cummins, Chief Executive of University Hospitals of Morecambe Bay
- The acute provider representative at the LSC People Board will be Trish Armstrong-Child, Chief Executive of Blackpool Teaching Hospitals Foundation Trust
- The lead on the clinical strategy for physical and mental health integration will be David Fearnley, Deputy Chief Executive and Medical Director of Lancashire and South Cumbria Foundation Trust

Joint Clinical Vision

To support the aim to ensure joined-up sustainable services that improve health outcomes across the whole of Lancashire and South Cumbria, work has been continuing to develop a joint clinical vision.

The developing strategy describes we can be more effective, efficient and resilient through a networked approach to service delivery.

A communications and engagement plan is being developed through a time-limited task and finish group which contains representatives from all of the trusts. This aims to ensure colleagues, the public and other stakeholders have an opportunity to shape developments.

Pathology collaborative

Following a significant re-engagement exercise that took place over the summer months, face-toface sessions have now been arranged for all pathology teams across the system with Professor Anthony Rowbottom MBE, Clinical Director for the project.

Sessions have been held in Royal Blackburn Teaching Hospital and at Burnley General Teaching Hospital and will be the first of many conversations which will draw on the expertise and experience from colleagues and within teams to shape the development of future services and to collectively work towards strategic, network and departmental goals.

3. Local and Trust specific updates

Important news and information from around the Trust which supports our vision, values and objectives.

Use of the Trust Seal

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

- The amendment of an indemnity letter between ELHT and Project Co. regarding the removal of Reinforced Autoclaved Aerated Concrete (RAAC), signed by Martin Hodgson and Michelle Brown.

Goodbye to the Chairman

The Trust said goodbye to Chairman Professor Eileen Fairhurst in October after more than eight years at the helm of ELHT.

She took up the role in 2014 after the Trust had been placed in 'special measures' and during a tough and challenging time for everyone. Since then, the change in the Trust itself, in Pennine Lancashire and in the wider health and social care system in Lancashire and South Cumbria has been immense and ELHT has progressed to an organisation that is now rated 'good' with large pockets of 'outstanding' and a clear and proud ambition to further build on that overall position.

In addition, ELHT is the only Trust in Lancashire and South Cumbria to be ranked as 'SOF2' in the NHS System Operating Framework and has retained that position for more than five years. The Trust Board acknowledge the Chairman's contribution to these achievements and her consistent and positive influence to colleagues across all settings and services as well as the wider system.

Professor Fairhurst has joined Northern Care Alliance as Chairman.

New Chair to be announced

In line with the NHS constitution a new Chair will be appointed to ELHT by NHS England who held two stakeholder panels and a formal interview process in October, involving colleagues from the Trust and the wider health and social care system including GPs, public health specialists, local authority Chief Executives and from the team at UCLan who support us in training our workforce of the future.

The interview panel was chaired by the Regional Director of NHSE in the North West Richard Barker and including esteemed system colleagues who have made a recommendation for the appointment.

At the time of writing, the announcement was yet to be made but colleagues will be updated as soon as possible with details about the successful candidate.

The Chair is an important role for the Trust and within the Lancashire and South Cumbria system, including the Integrated Care Board and Provider Collaborative.

New Chief Nurse

The Trust has appointed a new Chief Nurse who will join the Board and Executive Team in the New Year.

Peter Murphy currently holds a similar role at Blackpool Teaching Hospitals NHS Foundation Trust and is the senior responsible officer (SRO) for nursing on the Provider Collaborative Board.

The recruitment process included two stakeholder panels and a formal interview, including a range of colleagues from ELHT, Pennine Lancashire, the Lancashire and South Cumbria system as a whole and partners with interest in the portfolio.

Electronic Patient Record (EPR) Update

The Trust announced a delay to the planned ‘go live’ date for the implementation of the Electronic Patient Record (EPR) system in the summer and continues to work towards agreeing a new date for this important project to be implemented.

The programme remains broadly on track and the team continues to be focused on having everything working effectively before we switch it on. It is critical to both patient safety and in supporting colleagues to provide safe, personal and effective care.

A new ‘go live’ date will be rescheduled as soon as possible and there is new communications and marketing collateral ready to share once released, including demo videos of the system, a new brochure and a variety of flyers and posters.

A series of ‘ward walkarounds’ at all hospital sites re-started in September with the aim to visit every ward and department before December. The Ambassadors are helping to spread the word and will be joining the visits, where colleagues can see the system in action, ask

questions and raise any concerns. So far, anecdotal feedback is mostly positive and colleagues are looking forward to the benefits the EPR will bring.

Supporting colleagues with the cost of living

The Trust remains mindful of the impact of the rise in the cost of living on all colleagues and a working group including both clinical and non-clinical roles, supported by specialists from corporate support teams including finance, occupational health and the Well team, continues to meet regularly.

A new initiative launched in November aims to support colleagues. The Money Worry Tree will see experts from different organisations visit the Trust so colleagues can receive advice and information. The first of five themed events took place on 1 November focused on financial wellbeing.

So far the Trust has also offered to pay mileage up front for those who use their cars for their work and the overall mileage rate has also increased. In addition, a system has been introduced which allows colleagues to draw down their wages at different times of the month called Wagestream. More colleagues than expected have joined the system and given positive feedback about the way it supports people to manage their money more effectively. This is particularly effective for those taking up extra shifts who can then access wages quicker than by waiting for payroll. Free tea, coffee, juice, cup-a-soup and breakfast snacks have also been distributed, funded through ELHT&Me through an NHS Charities Together grant. All ideas and tips will be provided in a booklet for colleagues.

Improvement activity to support patient flow

The Trust continues to be very busy and pressured across all services, with a high number of people being seen through our Urgent and Emergency Care (UEC) pathways each day and large numbers of attendees needing to be admitted into hospital for treatment and care.

Colleagues from across the Trust, including on wards, in specialities and community teams, have focused on maximising discharges as soon as it is clinically safe to do so and there has been significant activity delivered to support optimum flow.

Teams have worked flexibly, collaboratively and creatively to meet the challenges. A Discharge Week campaign to coincide with August Bank Holiday was supported by messages and video content produced in house every day.

The aim was to highlight the benefits of the Discharge Lounge and encourage more colleagues to use the facility. This was a Trust-wide effort with clinical colleagues working on the wards to physically promote the use of the lounge, supported by communications activity promoting the lounge to both colleagues and patients.

It received positive feedback internally and achieved over 190 discharges ahead of the weekend. The activity, including daily bulletins with information, updates and reminders, along with social media promotion via our colleague Facebook page. |Patient stories, including video content of patients who were looking forward to returning home, were used as a reminder that the campaign was all about improving the patient experience.

The Trust hosted its first Facebook Live broadcast which focussed on the discharge lounge, with Matron Natalie Bradley talking about what the discharge lounge is, why we have it and how it helps patient flow. This was well engaged with reaching nearly 5,000 people.

The best practice and lessons learned have helped create a template for future bank holiday communications plans. A series of improvement weeks have been launched to review all activity, identify best practice and embed this across the Trust. The work is being undertaken as the Trust starts to implement plans for winter and outcomes will be reported in due course.

Reducing pressure on UEC campaign

The communications team has developed and delivered a campaign with colleagues in the Trust and across the system to reduce pressure on colleagues by reducing the number of people attending the emergency department and urgent care centres inappropriately.

Social media has created immediate conversations with local communities. More use has been made of personal stories from teams highlighting the patient journey, different services and what they do and the impact demand has, with an emphasis on the positive difference choosing the right pathway has.

Our social media statistics show that people engage most with posts that feature Trust colleagues, so more videos of colleagues within the Emergency Department talking openly about the pressures they face have been produced. Our first in September reached over 7,500 people and was picked up by local media, further increasing our reach and engagement.

We have been working with local partners to identify ways messages can be further shared via third party social media pages, newsletters and digital screens to help amplify key messages further. This will educate more of the community about different pathways, reduce unnecessary footfall to ED whilst also helping manage expectations around ED wait times and highlight work being done by colleagues to improve the patient experience.

Infection Prevention Control (IPC)

The Trust reintroduced mandatory mask wearing across all services, sites and settings in October, which means all staff, patients and visitors must wear a face mask in all areas at all times unless they are able to social distance.

The decision was made in response to an escalation of Covid infection rates in the community and rising sickness absence among colleagues.

Trusts across Lancashire and South Cumbria have agreed a standard protocol for when to introduce compulsory mask wearing or lift restrictions. It takes into consideration the number of Covid positive patients, colleague sickness and prevalence of Covid in the community.

IPC measures at ELHT continue to be monitored on a day to day basis and any changes communicated along with the relevant rationale immediately.

Covid testing

In keeping with national guidance and to help standardise practice across Lancashire and South Cumbria, changes have been made to Covid testing. They were introduced into the Trust in October.

The key differences are:

- Testing is not required for any colleague who is asymptomatic, unless they are asked to by the Infection Prevention Control team
- Symptomatic or immunocompromised elective patients will need to do a lateral flow test prior to day case or admission
- Any patient being transferred between hospitals needs a PCR test
- Any immunocompromised patient being transferred between wards needs a PCR test.

Vaccination campaign

The vaccination team at the Trust have administered over 2,500 COVID and 2,000 flu jabs since the autumn booster campaign began in September. A mixture of drop-in clinics and

walk-around sessions across all sites, including weekend and evening sessions, have helped ensure the vaccines are accessible to anyone working at ELHT.

The mass vaccination site at Blackburn Cathedral closed on 4 September after delivering almost 200,000 COVID-19 jabs to the community. It was one of the first mass vaccination sites in the country. The vaccination hub has now moved to new premises, at the nearby Barbara Castle Way Health Centre.

Investment in equipment

As part of a £1.6 million programme of investment and improvements in technology across the ELHT sites, new equipment has been introduced.

This includes:

- Six bladder scanners that use technology safely and accurately to assess bladder dysfunction and evaluate the need for catheterisation.
- Interacoustics eclipse systems to support hearing screens at birth to enable early access to support for babies who have hearing loss and their families.
- Hand therapy equipment to support patients who need resistive upper extremity exercise in Occupational Therapy
- Patient cooling equipment for neonates who need total body cooling in the Neonatal Intensive Care Unit

This investment was part of the Trust's capital equipment replacement programme which ensures teams have access to the best medical equipment available to create a better patient experience.

Survey launched

The national NHS Staff Survey for 2022 launched in September and is one of the largest workforce surveys in the world. The survey is an important way of understanding how colleagues feel about working in the NHS and at the Trust. where change is needed as well as what it working well.

In the past, ELHT has encouraged record numbers of colleagues to take the time to complete the survey and provide their feedback. This makes a real difference to how ELHT works and to the working lives of colleagues and a number of actions have been taken as a result of previous feedback. The survey closes at the end of November with results expected in the New Year. Full details will be provided in due course.

New Pennine Lancashire Intensive Home Support Service (IHSS)

The Intensive Home Support Service (IHSS) has joined with colleagues from the neighbouring Lancashire and South Cumbria NHS Foundation Trust (LSCft) IHSS team to enable more patients to access treatment from home.

The new Pennine Lancashire IHSS will help to further reduce avoidable hospital admissions by supporting patients across East Lancashire and Blackburn with Darwen to stay well at home by offering a full assessment service, treatments and medical reviews, all from their usual place of residence.

The service, which has been running separately across both Trusts for a number of years, is offered to patients aged 18+ through a referral from a health professional and helps to avoid hospital admissions, easing pressure on both Emergency Departments and ambulance callouts. The service also works within the hospital, with members of the team identifying patients who could be discharged, and their treatment continued at home. Those patients that have already been looked after by the service can self-refer back in – thus ensuring they can have quick access to an expert service that they are familiar with.

Through the new joint approach, patients across the area will now experience equal health provisions and targeted support by having more choice about where they access their care, with the benefit of avoiding disruption through unnecessary hospital visits.

HM the Queen's funeral

An enormous amount of activity took place in the aftermath of the death of Her Majesty Queen Elizabeth II s the country entered a period of mourning. Key information was quickly shared so that colleagues, patients and the public were aware of what was happening.

Publicly this included information about work taking place to keep services running during the State Funeral and Bank Holiday. Internally information was shared across all channels about Bank Holiday arrangements, wellbeing support, books of condolences, and details of how to watch the funeral within the hospitals. Posts on the ELHT People Facebook Group reached an audience of 1,400 colleagues and collectively achieved 190 engagements.

Books of condolence were available at all sites, flags flew at Half Mast and patients and colleagues were given the opportunity to watch the funeral, as TVs were made available free of charge.

Considerable work took place to ensure as many services as possible remained open on the Bank Holiday and thousands of patients were contacted to determine if they would still attend appointments. As a result, hundreds of appointments went ahead that would normally be cancelled on a public holiday.

Festival of Inclusion

The Trust's annual Festival of Inclusion was held at the end of September and involved an exciting array of events and activities to celebrate diversity and inclusion across the Trust.

As part of the week, the Trust invited keynote speakers to come and talk to colleagues about their experiences, including talks from diversity and inclusion Architect, Toby Mildon, Blackburn with Darwen's Director of Public Health and Shaka Hislop, a football legend and commentator and analyst for ESPN. These talks were attended by over 100 colleagues at each event and included an in-depth Q&A with each speaker.

A calendar of events and supporting material was created by the Communications team to promote the week-long campaign and encourage participation. This included five podcasts, each looking at a different staff network across the Trust. They were listened to over 180 times during the week and continue to be streamed on the ELHT Audio channel.

The podcasts were promoted in a daily bulletin which also had a statement from an Executive Director, information about events taking place day, including details of a new Safe Space initiative, which Executive Directors were holding that day for colleagues to share their lived experience and feedback. In addition, new welcome banners have been installed at Blackburn and Burnley Hospitals, showcasing colleagues and promoting our diverse workforce.

Stakeholder event

The Trust held its first virtual stakeholder event on Thursday 7 July and the second event was scheduled for Monday, November 7, 2022, when Executive colleagues were planning to share updates on services provided by the Trust, the challenges faced and the improvements made over the past year.

Those invited included health and social care partners, third sector providers, community organisations, local authorities and education organisations and the event format encourages people to ask questions for the panel to answer during the session. Feedback from the event will be provided verbally during the meeting.

Recruitment focus

The Trust continues to explore ways of improving our approach to recruitment with the aim of filling all vacancies and becoming a leading employer of choice both in the NHS and locally in Pennine Lancashire.

Thanks to some improvement work, there has been a noticeable increase in the number of people clicking through to the recruitment page of the website as a direct result of social media posts.

This has included posts on LinkedIn supporting a recruitment event for the Intensive Home Support Service that led to 284 clicks, promotion of an administrative role in the Incidents and Policies Team that led to 351 clicks and informaion about the Trust's search for a new Chairman that led to 221 clicks.

A Working Group of key people from around the Trust has been set up to look at improvements to the recruitment pages in order to improve the candidate experience. As part of that activity, the Communications team is reviewing all content, making more use of multimedia content and adding additional elements that promote the East Lancashire area and showcase This has included connecting with Marketing Lancashire to make use of existing materials to help support place marketing, in order to attract applications from outside the area.

A survey has also been created that is being sent to all new starters to understand key reasons for applying, how people learn about the Trust and any gaps in information provided. Feedback is being used to influence future content.

We are producing content about specific roles within the Trust to encourage further job applications to help fill vacancies. Videos were created to showcase careers with the Intermediate Care Allocation Team, Intensive Home Support Service and District Nursing. Collectively these have been viewed over 12,000 times.

Award winning teams

The fantastic work being done by colleagues across the Trust has been recognised through a number of awards over the past couple of months.

HSJ Patient Safety Awards The Health Journal Awards for Patient Safety took place in October. The Trust were finalists in two categories:

- The End of Life and Bereavement Care Team were shortlisted for Quality Improvement Initiative of the Year
- The Intermediate Care Access Team were part of a system-wide Healthier Pennine Lancashire Partnership nomination for Improving Care for Older People Initiative of the Year in recognition of work done with the Care Sector to improve access to community health services.

The awards recognise and reward the hard-working teams and individuals who are striving to deliver improved patient care.

National Safeguarding Star for Outstanding Practice Midwives Louise Slater and Natalie Woodruff were given a National Safeguarding Star for Outstanding Practice from NHS England after helping create connection boxes for women who are at risk of being separated from their baby at birth. The boxes help families capture important memories prior to separation and promote ongoing connection between them and their baby post-separation whilst the court proceedings consider longer term plans for the child.

NIHR Greater Manchester Health and Care Research Awards The Trust's Research and Development team were announced winners at the NIHR Greater Manchester Health and Care Research Awards. They came out top in both the 'Transforming Research Delivery' category and the 'Collaborating Working Accomplishment' category, which the team won alongside North West Ambulance Service (NWAS) NHS Trust and Lancaster University. The awards recognise and celebrate research delivery achievements.

Rising Star Awards Foundation Year 2 Doctor, Chanelle Smith was a Rising Star Winner in Healthcare at the Rising Star Awards, which focus on the achievements of women below Senior Management or Director level. She was recognised for a number of different initiatives within healthcare which have helped both colleagues, and members of the wider community, including striving to improve healthcare inequalities for mothers who identify as Black, Asian or Minority Ethnic and newborns through her role as an ambassador for BAME Maternity, as well helping students with their medical school applications through her role as a Chief mentor of Medic Mentor.

RCN North West Award for Outstanding Contribution to Equality, Diversity and Inclusion Barry Williams, Assistant Director Patient Experience, has received the RCN North West Award for Outstanding Contribution to Equality, Diversity and Inclusion. The awards recognise and celebrate the outstanding contribution of nursing staff from BAME backgrounds who work in health and social care across the region.

NHS Chef of the Year Two Chefs from the Trust reached the national finals of the NHS Chef of the Year competition. Dylan Lucas and Ebrahim Lorgat won the regional heats. They had 90 minutes to prepare, cook and present a three-course meal, which had to be suitable for generic NHS patients and costing no more than £5-6. The meal also had to reflect Government Buying Standards for Food and Catering Services, the Department of Health and Social Care's Obesity Strategy and nutritionally balanced in accordance with the British Dietetic Association (BDA) guidance.

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

9 November 2022

Item	**142**
Purpose	Information Action Monitoring

Title	Corporate Risk Register
Executive sponsor	Mr J Husain, Executive Medical Director

Summary: The purpose of this report is to provide members with an overview of risk management performance activity, of risks presented onto the corporate risk register (CRR) and to outline the next steps for the continuous development and quality improvement of open risks held.

Recommendation: Members are asked to note and approve the contents of this report and seek assurances of progress on risk management outcomes in line with legislation, best practice and guidance.

Report linkages

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 assurance framework

1. The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
2. The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter.
3. The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive.
4. The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.
5. The volume of activity that the Trust is able to deliver is insufficient to achieve the required targets and eradicate backlogs.

(142) Corporate Risk Register Report

6. The Trust is unable to see, treat and discharge/admit/transfer patients within the prescribed timeframes due to:
    - the volume and complexity of their needs
    - the unavailability of alternative consistent services in the community
    - lack of workforce (links to BAF 5b)
    - lack of flow within the organisation
7. Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce.
8. Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy).
9. 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.
10. The Trust fails to deliver the strategic objectives set out in its NHS Green Plan.
11. The Trust’s transition towards increased digitisation of records and communication disrupts the current clinical and operational service delivery to such a degree that it increases the risk of harm to patients. The reliance on digital systems also increases the impact upon the services should the Trust be subject to a Cyber-attack or significant infrastructure failure.
12. The Trust's Improvement Practice and Management System (including strategy deployment framework and associated key delivery and improvement programmes) do not sufficiently build improvement capability and support delivery on agreed outcomes.

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by:

N/A

Executive Summary

1. This report provides members with an overview of risk management performance, of risks presented onto the corporate risk register (CRR) and outlines next steps for the continuous development and quality improvement of risks held.
2. Key points of note since the last meeting.
   a) Total numbers of open risks held on the risk register continue to reduce.
   b) Strengthening strategic and operational risks in line with organisational strategy, objectives, targets and business assurance frameworks remains ongoing.
   c) Following feedback received from the Executive Risk Assurance Group (ERAG) and the Audit Committee, a full quality improvement review of a number of risks held on the CRR is to take place before the next meeting
3. Members are asked to note and approve the contents of this report and seek assurances of risk management outcomes in line with legislation, best practice and guidance.

Introduction

4. East Lancashire Hospitals NHS Trust operates a risk management framework that reflects the basic principles of risk management as summarised below.

Principle	Description
Proportionate	Risk management activities must be proportionate to the level of risk faced by the organisation
Aligned	Risk management activities need to be aligned with other activities in the organisation
Comprehensive	Risk management approach must be comprehensive in order to be fully effective
Embedded	Risk management activities need to be fully embedded within the organisation
Dynamic	Risk management activities must be dynamic and responsive to emerging and changing risks

Risk Management Performance Activity (CRR)

5. Key points of note since the last meeting.

   a) Two additional risks have been approved by members of the Risk Assurance Meeting (RAM) and ERAG for inclusion onto the CRR, increasing the total number of risks held on the CRR from 19 to 21 risks.

   b) The two additional risks relate to DATIX ID 9251 *recurrent gaps in junior surgical staff rota* and DATIX ID 9557 *patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provider* with the latter replacing the following risks held on the risk register.

      - DATIX ID 7067 *failure to obtain timely mental health treatments impacts on patient care, safety and quality* which has been subsequently removed from the CRR.
      - DATIX ID 7582 *inability to meet the needs of high risk mental health patients on inpatient wards* which had a risk score of 8 and was being managed by the Medicines and Emergency Care (MEC) Division.
      - DATIX ID 5083 *failure to have a robust system to assess and manage patients with mental health needs* which had a risk score of 9 and was being managed by the MEC Division.
      - DATIX ID 8538 *patients with mental health problems potentially being detained for their own safety outside of the Mental Health Act* which had a risk score of 16 and was awaiting review and approval at the RAM.

   c) Following feedback received from the ERAG and the Audit Committee, a full quality improvement review of the following risks held on the CRR is to take place before the next meeting:

      - DATIX ID 9251 *recurrent gaps in junior surgical rota*.
      - DATIX ID 8441 *managing the risk of coronavirus (COVID-19) outbreak*.
      - DATIX ID 8257 *loss of transfusion service*.
      - DATIX ID 8126 *risk of compromising patient care due to lack of an advanced Electronic Patient Record (EPR) system*.
      - DATIX ID 7165 *failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations*.
      - DATIX ID 8941 *delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology* and DATIX ID 2636 *inability to maintain*

establishment of consultant histopathologists are to be amalgamated and rescored accordingly.

d) The RAM and ERAG continue to scrutinise and monitor risks approved as scoring 15 and above. Executive Leads are appointed by the ERAG to monitor and review these risks and ensure they are being well managed or mitigated in accordance with the risk management framework.

Risk Management Performance Activity (Trust Wide)

6. Key points of note since the last meeting.

a) Whilst risk management activity remains continuous, desired outcomes are becoming more visible as a result of improvement works to avoid duplication, improve standardisation and the quality and quantity of open risks held, with further challenging work remaining.

b) Total numbers of open risks held on the risk register continue to reduce, from 1,709 risks in January 2022 to 1,276 risks at present, a percentage reduction of 26%. For the same period, numbers of closed risks continue to increase, from 7,100 risks to 7,869 risks.

c) Work in challenging and improving risk profiles continues to steer the movement of levels of risk from being high/extreme, moderate or significant to low.

d) A targeted review of all 1,276 open risks held, whereby the current risk score has met its target score, and of seeking confirmation control measures and assurances are being well managed, sustained and or mitigated against so the risk can be closed down or tolerated, has been completed.

e) Whilst highest numbers of open risks continue to remain within Surgical and Anaesthetic Services (27%), closely followed by Diagnostic and Clinical Support (25%) and Corporate Services (23%), there has been a significant reduction in numbers of open risks held across Divisions.

f) Numbers of open risks held across Divisions are expected to significantly reduce further as more focused attention is given to improving risk profiling and mapping of strategic and operational risks, along with better utilisation of lead specialisms and or subject matter experts regarding the identification and management of risks held within their own areas of responsibility, expertise and control.

g) Clinical risks remain the highest risk type category, comprising 53% of the total number, followed by health and safety risks with a percentage of 28%.

h) A further breakdown of clinical risks shows patient safety risks (32%) continue to remain the highest sub type category, followed by risks associated with medical devices (16%).
i) Work to improve health and safety risk sub type categories and the assimilation of these risks has been completed. This will act as a benchmark of performance for all other risk types.
j) Work has commenced with lead specialists or subject matter experts within the fields of medical devices, infection control, medication, information governance, finance and radiation to review and improve risk profiles and the quantity and quality of risks held within their areas of work activity.
k) A review of workforce/staffing risks has highlighted the majority relate to staffing levels, recruitment and retention issues and gaps in skills or competency levels and provide further opportunity to strengthen and improve the integrity of risks held.
l) All services have been supported to ensure risks of coronavirus have been reviewed and accurately reflect the level of risk and scoring against changes in legislation, guidance and recovery and restoration stages.
m) Work remains continuous in addressing numbers of risks remaining overdue. Less than 1% of overdue tolerated risks have surpassed their review date.
n) The RAM Terms of Reference has been strengthened to include better thematic review of risk management performance and more frequent review of tolerated risks as part of the standardised reporting criteria.
o) The sub type category of ‘other’ does not add any real value to the risk identification or management process and provides further opportunity to strengthen the quality and integrity of data. This will be further remedied upon the introduction of RADAR.
p) The performance management and monitoring of risks scoring 15 and above not identified on the CRR is undertaken at the RAM, with escalation by exception as required.
q) The risk management framework and process of escalation has been reaffirmed to all members of the RAM, Divisional Quality and Safety Leads, Risk Handlers and Leads.

Conclusion of report

7. The importance of risk profiling and mapping, improving the quality and quantity of risks held, better utilisation of lead specialisms and or subject matter experts,

increasing awareness and understanding of the operating risk management framework and compliance with the process regarding the escalation of risks remains a key focus area and has been reaffirmed across all Divisions and with risk handlers and or leads. This is heavily impacting on the quality and quantity of risks held.

Next actions

8. A summary of key focused activity due for completion before the next meeting.
   a) Work is to take place within the Q3 financial period with lead specialists or subject matter experts within the fields of manual handling, fire safety, radiation, security and sharps management to review and improve risk profiles and the quality and quantity of risks held within their areas of responsibility and work activity.
   b) Work to complete the action plan of recommendations from a review of risk management by Mersey Internal Audit Agency (MIAA) is nearing completion, with one outstanding action regarding identified training needs remaining on course for completion within the Q3 financial year period.
   c) The review of all open risks held across Surgical and Anaesthetic Services and Estates and Facilities Divisions.
   d) Work with services in addressing the 933 foreseeable risks due for review over the next three months.
   e) Continuation of strengthening strategic and operational risks in line with organisational strategy, objectives, targets and business assurance frameworks etc.

How the decision will be communicated internally and externally

9. Progress in monitoring the quality and integrity of open risks held, in particular, those with a current risk score of fifteen or above, is undertaken at the monthly Risk Assurance Meeting, Senior Leadership Group and Executive Risk Assurance Group meetings.

Appendices

10. Summary of risks held on the CRR
11. Detailed information of risks held on the CRR

J Houlihan, Assistant Director of Health, Safety and Risk Management

01 November 2022

Summary of risks held on the Corporate Risk Register

Corporate Risk Register						
No	**ID**	**Where is the risk being managed**	**Title**	**Rating (current)**	**Effectiveness of Controls (taken from Datix)**	**Changes since last report**
1	9557	Trust Wide	Aggregated risk – patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provision	**20**	**Inadequate**	
2	9439	Trust Wide	Failure to meet internal and external financial targets for the 2022-23 financial year	**20**	**Limited**	
3	9336	MEC	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery	**20**	**Limited**	
4	8126	Corporate	Aggregated risk - risk of compromising patient care due to lack of an advanced Electronic Patient Record (EPR) System	**20**	**Limited**	
5	8061	Trust Wide	Management of Holding List	**20**	**Limited**	
6	9296	DCS	Inability to provide routine or urgent tests for biochemistry requests	**16**	**Limited**	
7	9251	SAS	Recurrent gaps in junior surgical staff rota	**16**	**Limited**	
8	9222	Trust Wide	Failure to implement the NHS Green Plan	**16**	**Limited**	
9	8941	Trust Wide	Delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology	**16**	**Limited**	
10	6190	SAS	Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales	**16**	**Limited**	
11	2636	DCS	Inability to maintain establishment of consultant histopathologists	**16**	**Limited**	
12	8960	FC	Risk of undetected foetal growth restriction and preventable stillbirth due to non-compliance with pulsatility index ultrasound guidance	**15**	**Limited**	
13	8839	SAS	Failure to achieve performance targets	**15**	**Limited**	
14	8441	Trust Wide	Managing the risk of coronavirus (COVID-19) outbreak	**15**	**Adequate**	
15	8257	DCS	Loss of transfusion service	**15**	**Limited**	
16	8808	Corporate	BGH - breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke	**15**	**Adequate**	
17	7764	Corporate	RBH - breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke	**15**	**Adequate**	
18	7165	Corporate	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	**15**	**Limited**	
19	7008	Trust Wide	Failure to comply with 62 day cancer waiting time target	**15**	**Limited**	
20	5791	Corporate	Aggregated risk - failure to recruit to substantive nursing and midwifery posts may impact on patient care and finance	**15**	**Adequate**	
21	4932	Trust Wide	Patients who lack capacity to consent to placements in hospital may be being unlawfully detained	**15**	**Limited**	

Corporate Risk Register Detailed Information

No	ID	Title
1	9557	Aggregated risk – patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provision

Lead		Current score		Score Movement	
Lead	Risk Lead: Alison Brown Exec Lead: Julie Molyneaux	Current score	20	Score Movement	↑

Description	Clinical staff working within our Emergency Pathway and wider Trust wards increasingly report patients in their care require psychiatric assessment or potentially may be suitable to be detained under the Mental Health Act (MHA). These patients often experience delayed assessment of their mental health needs and those identified as requiring detention under the MHA experience delayed transfers as the availability of specialist beds is limited. The Trust is not currently registered or resourced to provide this specialist care with no standard training package for this specialist group routinely provided, with incidents of staff and patient harm resulting from this situation continuing to be reported.	**Actions**	1. Review and formalise service level agreement with LSCFT. 2. Medical staff require relevant training and supervision to enable them to effectively utilise Section 5.2 of the MHA and on the prescription/monitoring of mental health medications 3. Consideration to be given to levels of control and restraint / de-escalation training required for staff. 4. Additional and significant training requirements for all staff in relation to the care of patients with mental health disorders to develop confidence and competence across the workforce 5. There would be roles required by the MHA, specially to "administer" and oversee the implementation of the MHA, in line with Approved Codes of Practice. 6. No capital funding allocated. 7. Ongoing inquests contain issues related to this risk. 8. The Trust must formally and consistently demonstrate it is providing care in the best interests of patients (including patients with capacity or are assessed by a practitioner as requiring detention whilst being unable to apply the MHA. 9. The Trust does not have the estate or relevant infrastructure to safely enable the detention under the MHA, such as areas suitable for seclusion where indicated (both within AMU and across the Trust). 10. Ligature risk assessments not completed across the Trust only within high risk ward areas. 11. Staff safety dashboard not yet in place 12. Liaison nurse support remains unclear.
Top Controls	1. Joint working arrangements exist between East Lancashire Hospitals NHS Trust (ELHT) and Lancashire and South Cumbria Foundation Trust (LSCFT). 2. Development of pathway for the management of mental health patients in Emergency Care. 3. Management of challenging behaviours training available in DERI, but not mandatory. 4. Safeguarding Team available for advice regarding the management of patients at risk. 5. Enhanced care assessments undertaken. 6. The Care Quality Commission (CQC) are supporting the Trust to register for the provision and treatment under the Mental Health Act. 7. Ligature Risk Assessments completed on annual basis in line with national guidance. 8. Security staff on site with protocol for supporting challenging patients. 9. Staff Safety Group monitors incidents. 10. Wellbeing reporting and conversations in place. 11. Mental Health Liaison Nurses based within the Emergency Department 12. Visibility of inquest closure forms at Trust Wide Quality Governance meetings and in Executive Slides. 13. CQC and Integrated Care Board (ICB) awareness of current ongoing process to risk assess application for registration. 14. Daily Gold call escalates concerning cases at system level. 15. Health and Safety Team monitor incidents of environmental harm to patients. 16. Mental Health Unit Assessment Centre (MHUAC) functional since February 2021		

Update since the last report					
New Risk **Next Review Date 11/11/2022**	Date Last reviewed	**10/10/2022**			
	Risk by Quarter 2022	Q1	Q2	Q3	Q4
				20	
	8-week score projection	20			
	Current issues	System wide external influences			

<table>
<tr><th>No</th><th>ID</th><th colspan="8">Title</th></tr>
<tr><td>2</td><td>9439</td><td colspan="8">Failure to meet internal and external financial targets for the 2022-23 financial year</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Charlotte Henson
Exec Lead: Michelle Brown</td><td>Current score</td><td>20</td><td colspan="3">Score Movement</td><td colspan="2">↔</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">Failure to meet the Trust financial plan and obligations, together with the wider Lancashire and South Cumbria Integrated Care Systems (LSCICS) financial plan and obligations, may lead to imposition of special measures, limiting ability to invest in services. A continuous failure to meet financial targets may also lead to the Trust being acquired by another service provider.

The financial risk is made up of:
1. A lack of control. Monies are currently allocated to Integrated Care Systems to agree allocation to system partner organisations.
2. A 5% efficiency target has been set for the 2022/23 financial year to reduce costs by £28.8 million - a level that has never been achieved.
3. The unknown extent of increased living costs and inflation rates.
4. The unknown impact of COVID within the 2022/23 financial year.
5. A system financial gap that still needs to be closed.</td><td rowspan="2">Actions</td><td colspan="5" rowspan="2">1. There remains a £19.9m system risk within the breakeven financial plan with mitigations being worked through. In addition, there is a 5% workforce recovery plan of £28.8m and a risk attached to elective recovery of monies of £16.3m.
2. A higher efficiency target than has ever been achieved in the past has been put in place to ensure all services are fully engaged and playing a role in reducing inefficiencies.
3. The financial regime is now being managed at system level not just the Trust.
4. Financial gaps are identified at system level not just the Trust.
5. Other financial risks emerging associated with temporary workforce due to vacancies and sickness absence, increasing service pressures within ED, numbers of COVID cases and the impact of the EPR system go live date.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. The Trust and LSCICS have agreed a 2022-23 breakeven revenue financial plan.
2. The Trust has met its financial plan at month 3 other than for the system risk.
3. Robust financial planning to ensure targets are achievable and agreed, based on accurate financial forecasts.
4. Financial performance reports distributed across the Trust to allow senior management and service managers to monitor against financial plans, supported by the finance department.
5. Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments incurred are made within delegated limits.
6. Monitoring and improving delivery of waste reduction programme.
7. Provision of training and guidance for budget holders.
8. Presence of senior financial lead as part of external and internal conversations influencing direction of travel.
9. Frequent, accurate and robust financial reporting and challenge by way of:
a) Trust Board reports
b) Finance and Performance Committee finance reports
c) Audit Committee reports
d) Integrated performance reporting
e) Divisional and Directorate finance reports
f) Budget statements
g) Staff in posts lists
h) Financial risks
i) External reporting and challenge</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 11/10/2022
The Trust is reporting a deficit year to date of one third of the system planning risk (£3.3m) and a forecast breakeven revenue financial plan. There is a continued risk regarding achievement of the 5% workforce recovery plan, elective recovery monies and of mitigating the system planning gap, with additional financial risks emerging that include associated costs relating to temporary workforce, vacancies and meeting the elective recovery plan along with continued pressures within the Emergency Department, costs associated with the EPR system, a shortfall in funding the pay award and potential industrial action.

Next Review Date 14/11/2022</td><td>Date Last reviewed</td><td colspan="5">11/10/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3</td><td colspan="2">Q4</td></tr>
<tr><td>20</td><td>20</td><td>20</td><td colspan="2"></td></tr>
<tr><td>8-week score projection</td><td colspan="5">20</td></tr>
<tr><td>Current issues</td><td colspan="5">System wide external influences</td></tr>
</table>

Safe | Personal | Effective

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>3</td><td>9336</td><td colspan="6">Lack of capacity across the Trust can lead to extreme pressure resulting in a delayed care delivery</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Michelle Montague
Exec Lead: Sharon Gilligan</td><td>Current score</td><td>20</td><td>Score Movement</td><td colspan="2"></td></tr>
<tr><td colspan="2">Description</td><td colspan="2">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.</td><td rowspan="2">Actions</td><td colspan="3" rowspan="2">1. Discussions ongoing with commissioners in providing health economy solutions and help with attendance avoidance.
2. System partners ability to flex and meet demands of local and ICS health population can be compounded with offer of mutual aid, with support to ICS with inter hospital diverts increasing risk.
3. Once OPEL triggers are met and actioned there is no escalation strategy.
4. Code black standard operating process highly dependent on flow.
5. Bed meeting actions can be person dependent e.g. consultant or commissioners discharge or release patients.
6. No additional plan once high observation beds on AMUB supporting patients requiring higher levels of care are full.
7. Ambulance turnaround times have improved but rely on capacity of ED to accept.
8. Staff allocation and skills mixes remain an issue.
9. Capacity and demand can be benchmarked but remains unpredictable.
10. People dependency and delays obtaining adequate swabs e.g. MRSA, POC, COVID etc may increase risk of infection.
11. Year on year increase in volume of complaints with family and friends results highlighting concerns of waiting times.
12. Patient experience strategy reliant on capacity and demand.
13. COVID and future reconfiguration has limited numbers of specialist cardiology beds.
14. Corridor Care Standard Operating Procedure only manageable if no severe overcrowding and staff are available to complete the task.
15. No call bells within corridor areas so patients cannot call for assistance increasing risk of further delays.
16. Daily meeting with Executive Team continue with concerns of winter resilience based on current pressures raised by Head of Nursing.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Operational Pressures Escalation Levels (OPEL) triggers and actions completed for Emergency Department (ED) and Acute Medical Units (AMU).
2. Code black standard operating process reviewed and redesigned.
3. All divisions have a divisional flow rep so escalation of ‘pull through’ can be much clearer, along with actions.
4. Bed meetings held x4 daily with divisional flow reps.
5. Escalation trolleys implemented for extreme pressure.
6. ED, AMU and Urgency Care Centre (UCC) taking stable assessed patients out of trolley space/bed to facilitate putting unassessed patients into bed/trolley.
7. Corridor care standard operating procedure embedded.
8. Hourly rounding by nursing staff embedded in ED.
9. Review of processes across acute and emergency medicine in line with coronial process and incidents.
10. Established 111/GP direct bookings to UCC.
11. 111 pathways from GP/North West Ambulance Service (NWAS) directly to Ambulatory Emergency Care Unit (AECU).
12. 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.
13. Segregation of ED in line with COVID risk reducing likelihood of cross contamination. Risk assessments completed.
14. Daily staff capacity assessments completed.
15. Workforce redesign aligned to demands in ED.
16. Full recruitment of established consultants.
17. Safe Care Tool designed for ED.
18. Daily consultant ward rounds done at cubicles so review of care plans are undertaken.
19. Matrons have undergone coaching and development on board rounds.
20. Daily ‘every day matters’ meetings with head of clinical flow and all patient flow facilitators.</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td colspan="2" rowspan="4">Update 28/10/2022
The risk score has been reviewed and remains the same. Service demand continues and overcrowding remains, with patients being seen on corridors, increasing delays for patients to be seen and increasing pressures to meet ambulance handover times of 30 mins. Whilst delays regarding triage have improved, delays still remain and complaints and concerns remain high in this regard along with an increasing number of incidents of moderate harm.</td><td>Date last reviewed</td><td colspan="3">28/10/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3</td></tr>
<tr><td>20</td><td>20</td><td>20</td></tr>
<tr><td>8 week score projection</td><td colspan="3">20</td></tr>
</table>

Note: the Risk by Quarter 2022 row also has a Q4 column, which is blank.

<table>
<tr><td colspan="2"></td><td colspan="2">Next Review Date 30/11/2022</td><td>Current Issues</td><td colspan="5">Impact of COVID-19 pandemic and restoration pressures</td></tr>
<tr><td>No</td><td>ID</td><td colspan="8">Title</td></tr>
<tr><td>4</td><td>8126</td><td colspan="8">Aggregated Risk - Potential to compromise patient care due to the lack of a Trust-wide advanced Electronic Patient Record (EPR) System</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Mark Johnson
Exec Lead: Michelle Brown</td><td>Current score</td><td>20</td><td colspan="3">Score Movement</td><td colspan="2">↔</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">The absence of an EPR system, the reliance on paper case notes, assessments, prescriptions and multiple minimally interconnected electronic systems in the Trust could compromise patient care and patient outcomes, lead to poor data quality and management and increased organisational costs.</td><td rowspan="2">Actions</td><td colspan="5" rowspan="2">1. The WinDIP Electronic Document Management System does not cover all specialities and case note groups.

2. EMIS system only supports community activity, with no significant system within an acute setting.

3. Not all systems are registered (or known about).

4. Contracts for current systems being ‘rolled over’ annually cannot identify specific ‘switch over’ dates.

5. Inability to rapidly flex the current system to emerging demands from NHS Improvement for additional information.

6. Limited capital budget to invest in additional hardware or software as clinical requirements develop.

7. Whilst many reports are produced, the Trust does not always have enough administrative or clinical resource to action.

8. Unable to plan infrastructure as new technology and clinical techniques develop in isolation from the main EPR.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Stable Patient Admission System (PAS) albeit 25+ years old.
2. Extra-med patient flow software which includes the capture of nursing documentation.
3. Use of Integrated Clinical Environment (ICE) and EMIS Group healthcare software systems and information technology.
4. The use of the Winscribe Digital Dictation System allows clinicians to quickly streamline and automate dictation and transcription workflow.
5. The WinDIP Electronic Document Management System assists with the digitalisation of paper records
6. The Orion Health and Social Care Clinical Portal provides a single view of patient information across different IT systems.
7. 24/7 system support services and additional administrative staff.
8. Paper contingencies in place for data capture.
9. All critical systems managed by informatics or services with direct links to Informatics.
10. Register of non-core systems capturing patient information (feral systems) in place.
11. Improved infrastructure (including storage) to maintain and manage existing systems.
12. Consistent monitoring of current clinical systems and support via helpdesks and informatics services.
13. Significant amount of business intelligence system data quality and usage reports.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 27/09/2022
Due to interface challenges, the EPR system go live date has been extended from November 2022 to Spring 2023. A business case for continued support is being submitted, with plans remaining in place and a new go live date is to be agreed by the Board in September 2022.

Next Review Date 27/10/2022

A full quality improvement review of this risk is to be undertaken before the next meeting.</td><td>Date Last reviewed</td><td colspan="5">27/09/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3</td><td colspan="2">Q4</td></tr>
<tr><td>20</td><td>20</td><td>20</td><td colspan="2"></td></tr>
<tr><td>8 week score projection</td><td colspan="5">20</td></tr>
<tr><td>Current issues</td><td colspan="5">Work remains ongoing with Cerner on implementation.</td></tr>
</table>

<table>
<tr><th>No</th><th>ID</th><th colspan="5">Title</th></tr>
<tr><td>5</td><td>8061</td><td colspan="5">Aggregated Risk - Management of Holding List</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Victoria Hampson
Exec Lead: Sharon Gilligan</td><td>Current score</td><td>20</td><td>Score Movement</td><td>↔</td></tr>
<tr><td colspan="2">Description</td><td>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.</td><td rowspan="2">Actions</td><td colspan="3" rowspan="2">1. Holding list remains high due to backlog from COVID-19.
2. Patients currently booked into appointments not RAG rated will drop onto the holding list if appointments are cancelled and do not have a RAG rating identified.
3. Patients added to the holding list from other sources such as theatres, wards etc. will not have a RAG identified.
4. Specialities continue to review patients waiting over 6 months and those rated as red to ensure they are prioritised appointments.
5. General lack of capacity across many specialities impacting on reducing holding list numbers.
6. Not all staff follow the standard operating procedures for RAG rating of patients leaving some patients without a rating.
7. Updates provided weekly to Executive Team.</td></tr>
<tr><td colspan="2">Top Controls</td><td>1. Suitable Red, Amber, Green (RAG) ratings included on all outcome sheets in outpatient clinic.
2. Daily holding list report circulated to all Divisions to show the current and future size of the holding list.
3. Updates provided at weekly Patient Transfer List (PTL) meetings.
4. Restoration plan in place to restore activity to pre-covid levels.
5. Individual specialities undertaking their own review of the holding list to identify if patients can be managed in alternative ways.
6. Meetings held between Divisional and Ophthalmology Triads to discuss current risk and agree next steps.
7. Requests sent to all Directorates requesting all patients on holding list to be initially assessed for any potential harm that could have been caused due to delays being seen, with suitable RAG ratings applied to these patients.
8. 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.
9. Meetings held with Directorate Managers from all Divisions to understand position of all holding lists.
10. 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.
11. 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. Process has been rolled out and is monitored daily.
12. 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.</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td rowspan="4">Update 01/11/2022
The size of the holding list remains a challenge with significant numbers of patients still overdue an appointment - 3,091 within ophthalmology, 1,429 in urology, 1,347 in ear, nose and throat services, 1,403 in general surgery and 1,435 in oral and maxillofacial surgery.

A new band 3 administrator has recently commenced in post to review all unknown and uncoded patients requesting clinical input and micromanagement of red patients in chronological order to find available slots.

Next Review Date 01/12/2022</td><td>Date last reviewed</td><td colspan="3">01/11/2022</td></tr>
<tr><td>Risk by Quarter 2022</td><td colspan="3">Q1: 20 | Q2: 20 | Q3: 20 | Q4: </td></tr>
<tr><td>8 week score projection</td><td colspan="3">20</td></tr>
<tr><td>Current issues</td><td colspan="3">Impact of COVID-19 pandemic and restoration pressures</td></tr>
</table>

No	ID	Title
6	9296	**Inability to provide routine or urgent tests for biochemistry requests**

Lead	Risk Lead: Dayle Squires Exec Lead: Jawad Husain	Current score	16	Score Movement	⟷

Description	Ortho Clinical Diagnostics are the company which supply the bulk of the general chemistry reagents to the department. Recently, as contracts up and down the country have been awarded to other suppliers, the department has been left as the sole 'large' laboratory in the country being supplied by Ortho Clinical Diagnostics. Consequently, the company is finding it difficult to provide and deliver reagents in suitable quantities to satisfy departmental orders, leaving the department chasing reagents on a daily basis which has now become intolerable. If supply does not improve, urgent requests will be affected as there are no contingencies in place.	**Actions**	1. Delayed results impacting on treatment. 2. No early intervention for urgent requests as tests referred out take significantly longer to produce. 3. Increase in staff workloads due to referring out more samples than anticipated. 4. Urgent requests will be treated as routine as referral out cannot be in agreed turnaround time. 5. No feasible option to send high volume of samples for certain tests. 6. Senior staff time is limited resource. 7. Laboratory has no control regarding the allocation of reagents or their arrival.
Top Controls	1. Certain non-urgent tests referred out due to reagent shortages 2. Senior members of staff chasing reagents daily via email and phone. 3. Monitoring via operations and department. 4. Risk is being monitored by Divisional Quality and Safety Meetings.		

Update since the last report	
	Update 07/10/2022 The supply of key reagents and consumables to the department by Ortho Clinical Diagnostics is becoming increasingly worse, with heavy reliance on suppliers to improve their supply chains. **Next Review Date 07/11/2022**

Date last reviewed	**07/10/2022**			
Risk by Quarter 2022	**Q1**	**Q2**	**Q3**	**Q4**
		16	16	
8 week score projection	16			
Current issues	Heavy reliance on supplier improving the supply chain			

No	ID	Title				
7	9251	**Patient harm due to recurrent gaps in junior surgical staff rota**				

Lead	Risk Lead: Susan Anderson Exec Lead: Jawad Husain	**Current score**	**16**	**Score Movement**	↑

Description	Recurrent gaps in the junior surgical staff rota, with no resilience in managing these gaps when episodes of sickness absence occur. Insufficient staffing levels to cover emergency on call and provide adequate support for FY1's on surgical wards leading to potential delays in assessing, arranging appropriate investigations, instigating treatment and managing both newly admitted and existing inpatients on the wards. If delays occur, this may further lead to adverse complications of patients or death. Recurrent gaps in the junior surgical staff rota affects morale, with increased sickness absence exacerbating the challenges of filling the surgical staff rota.	**Actions**	1. Should step down policy be enacted this would impact on elective activity the following day. 2. Agency staff unfamiliar with Trust policies and the work environment. 3. Overstretched workforce leading to complaints by trainees to the Deanery. 4. Concerns from trainees to share workload due to impact this has on their own ability to manage own workload and training. 5. Concerns from specialty middle grades in supporting overnight gaps due to contracts being non-resident and having activity booked the following day.
Top Controls	1. Hospital at Night and Step Down Policies in place. 2. Active internal and external recruitment to fill gaps. 3. Development of business case to expand rota. 4. Process of escalation in place to registrars and consultants regarding gaps. 5. A standard operating procedure in place within Surgical and Anaesthetic Division. 6. Action plan in place to deal with gaps and any ongoing issues. 7. Meetings regularly held between divisional management team and medical staffing.		

Update since the last report	**Update 10/10/2022** All 6 doctors being recruited to additional posts have withdrawn. The additional posts have been offered out to follow up candidates living outside of the UK who will require visas etc. prior to commencing in post. Decision taken to roll out new rota with 7 gaps on it. The performance manager and rota manager for the Surgical and Anaesthetics Division are working through each of the gaps for on call and will get these out to agency, bank and internal locums. Recruitment remains ongoing. Interviews planned in September/October 2022 to cover gaps within the rota. **Next Review Date: 03/11/2022** **A full quality improvement review of this risk is to be undertaken before the next meeting.**	**Date last reviewed**	**10/10/2022**			
		Risk by Quarter 2022	**Q1**	**Q2**	**Q3**	**Q4**
				16	16	
		8 week score projection	**16**			
		Current issues	National shortages in recruitment and COVID19 restoration pressures adding to demand			

No	ID	Title
8	9222	**Failure to implement the NHS Green Plan**

Lead	Risk Lead: Sue Chapman Exec Lead: Michelle Brown	Current score	16	Score Movement	⟷

Description	The Health and Social Care Act has been amended to support existing environmental legislation and the NHS England sustainability strategy which places duties on NHS Trusts in meeting carbon reduction strategies as part of the NHS Green Plan.	**Actions**	1. Buildings will need resources to bring them up to standard e.g. insulated walls and adequate windows etc. 2. Long term target of reaching carbon neutral targets will require huge investment to buildings to meet minimum standards under BREEAM. 3. Review of staff resources, knowledge, skills, experience and training etc. to be able to deliver actions required. 4. Review of energy efficiency equipment e.g. gas boilers before 2032, heating and ventilation units etc. 5. Funds for capital projects and increased costs of materials and services required to meet NHS sustainability strategy needs. 6. Budget commitments to deliver zero carbon plan is significant but will need to be factored into wider plans. 7. Lack of full carbon emissions monitoring. 8. Lack of compliance with Greenhouse Gas Emissions Trading Scheme Order 2020.
Top Controls	1. Full review of legislative requirements, organisational arrangements, processes, equipment and competences. 2. Development and implementation of a new Green Plan. 3. Link of Green Plan with other necessary plans e.g. travel plan, care plans etc. 4. All building work done to Building Research Establishments Environmental Assessment Method (BREEAM) standards 5. Purchase of EV fleet vehicles where possible. 6. Review of energy and waste processes for reduction / greener strategies. 7. Local leadership, raised awareness of actions, understanding and inspiring action. 8. Working with neighbouring Trusts to identify improvement and compliance strategies.		
Update since the last report	**Update 06/10/2022** No change to risk scoring. Green Plan data, NHS England data reporting processes, UK ETS emissions reporting management and Estates Returns Information Collection (ERIC) returns will provide a baseline for the Trust. First step implemented on 01 April 2022 by means of 10% weighting of sustainability requirement in procurement contracts. **Next Review Date 01/11/2022**	**Date last reviewed**	**06/10/2022**
		Risk by Quarter 2022	Q1: 16 / Q2: 16 / Q3: 16 / Q4:
		8 week score projection	16
		Current issues	Commitment of adequate resources to deliver the NHS Green Plan

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>9</td><td>8941</td><td colspan="6">Potential delays to cancer diagnosis due to inadequate reporting and staff capacity in cellular pathology</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Neil Fletcher
Exec Lead: Kevin Moynes</td><td>Current score</td><td>16</td><td colspan="2">Score Movement</td><td>↔</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">The cellular pathology department is not able to meet existing turnaround times (TAT's) due to inadequate consultant reporting capacity and laboratory staffing levels with difficulties in recruitment of appropriately skilled staff causing potential delays to patient diagnosis and treatment of serious illnesses such as cancers.</td><td rowspan="2">Actions</td><td colspan="3" rowspan="2">1. Lack of equipment is being partially addressed by capital funding.
2. COVID19 related absences.
3. Continuing difficulties in recruiting highly skilled, permanent consultant staff.
4. Increasing TAT due to volume and complexity of work.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Monthly monitoring of TATs against targets.
2. Locum laboratory biomedical staff members in post.
3. Locum consultants in post.
4. Sample tracking software installed.
5. Ongoing recruitment of additional substantive and locum histopathologists.
6. Risks monitored via Quality Assurance and Operations meetings.
7. Increasing volume of tests sent to external providers at additional cost.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 07/10/2022
No change to risk score. There continues to be a national shortage of histopathologists. TATs continue not to be met. There is a risk that potential delays to patient diagnosis and treatment of serious illnesses such as unexpected cancers may be waiting in backlogs.

A total of 3 consultants have now been appointed awaiting clearance, contracts of employment and start dates.

Next Review Date 07/11/2022

This risk is to be amalgamated with DATIX ID 2636 and scored accordingly.</td><td>Date last reviewed</td><td colspan="3">07/10/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3 | Q4</td></tr>
<tr><td>16</td><td>16</td><td>16 |</td></tr>
<tr><td>8 week score projection</td><td colspan="3">16</td></tr>
<tr><td>Current issues</td><td colspan="3">National shortage of histopathologists</td></tr>
</table>

No	ID	Title				
10	6190	**Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale**				
Lead		Risk Lead: Victoria Hampson 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, with the requirement for social distancing meaning less patients can be accommodated in waiting areas. 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.	Actions	1. Insufficient staff numbers to provide capacity. 2. Insufficient estates capacity and outpatient space to provide required clinics and comply with social distancing. 3. Ability to flex theatres to outpatient departments and vice versa but opportunities are limited. 4. Funding and difficulties recruiting additional medical staff and equipment so as to be able to increase activity e.g. medical, nursing, admin etc. 5. Locums introduced but only a short term fix as there is a tendency to bring patients back for further review which impacts longer term on increasing the holding list. 6. Getting It Right First Time (GIRFT) report not yet created for patient waiting times above 25% within recommended timescales for review.		
Top Controls		1. A failsafe officer is in place who validates the holding list and focuses on appointing red rated patients and those longest waiting. 2. Capacity sessions held where doctors are willing and available. 3. Increased flexibility of staff and constant review and micro management of each sub specialty. 4. Integrated Eye Care Service in place for specific pathways, keeping relevant patients out of hospital eye services where possible. 5. Use of clinical virtual pathways where appropriate. 6. Expanded non-medical roles e.g., orthoptists, optometrists, specialised nurses etc. 7. Action plan and ongoing service improvements identified to reduce demand. 8. All holding list patients are reviewed weekly by administrative staff, with patients highlighted where required to clinical teams. 9. Weekly operational meetings challenge outpatient activity and recovery.				
Update since the last report		**Update 07/10/2022** No change in risk scoring. Due to service demands a decision has been made to close routine new referrals for glaucoma patients and are currently on month 2 of a 3 month closure plan. Whilst the plan has supported the service, numbers of urgent glaucoma patients are still being received. The holding list remains a major concern with similar numbers awaiting review of appointments which are unable to be accommodated. **Next Review Date 07/11/2022**	Date last reviewed	07/10/2022		
			Risk by Quarter 2022	Q1: 16	Q2: 16	Q3: 16 / Q4:
			8 week score projection	16		
			Current Issues	Impact of COVID-19 pandemic and restoration pressures		

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No	ID	Title
11	2636	**Inability to maintain establishment of consultant histopathologists**

Lead	Risk Lead: Yacoob Nakhuda Exec Lead: Kevin Moynes	Current score	16	Score Movement	⟷

Description	A national shortage of histopathologists and increasing service demand is leading to delays in cancer diagnosis and targets.	Actions	1. Process mapping and pathways continue to be reviewed. 2. Demand outstripping capacity and turnaround times. 3. Impact from staff annual leave and sickness 4. Two consultants are now employed in substantive posts working as locums part time with one consultant covering skin MDT. 5. Locum CV's sent by agencies are not meeting expertise required.
Top Controls	1. Cases are triaged on reception and divided into; - Urgent i.e. cases marked urgent or with a specific target e.g. two week rule. - Allocated i.e. surgical cancer resections allocated to a named pathologist. - Routine i.e. cases reported on site but not in the above categories. - Referred i.e. cases of a non-urgent nature which can be sent to an external reporting service. 2. Workloads over capacity are reported via capacity lists on weekends, or sent to an external reporting service dependent on clinical need. 3. Medical staffing looking to fill all vacancies on a permanent or locum basis. Workload allocated via a system based on clinical priority to prioritise cancer cases. Non reported routine work available for capacity list reporting at weekends. Lowest priority work identified at triage and sent to external reporting service. 4. Capacity provided by external reporting services has reduced over the summer months but has picked up again with a scheduled plan in place to export work. 5. Since January 2022 the entire gynae / cancer pathology workload is now reported by Lancashire Teaching Hospital (LTH) and the entire breast cancer pathology workload now shared by LTH and University Hospitals Morecambe Bay (UHMB). 6. Continuous monitoring of situation by Clinical Director from LTH and Trust Divisional Director and via Clinical Leadership Meetings. 7. Weekly consultants meeting chaired by new histopathology lead. 8. Two overseas locums started end February 2022 and May 2022 and are 'bedding' in. They are contracted to the Trust for 12 months. 9. Continued use of outsourcing companies to keep up with backlog.		

Update since the last report					
Update 07/10/2022 Recruitment remains ongoing and very challenging. Contingency plans are well established. Assistance with workload provided by external agencies, LTH and UHMB. Outsourcing companies struggling to cope with national shortages, sickness and annual leave amongst their own pathologists. A trial is to begin with an external service provider using digital slide scanning to reduce or remove transport times for slides which will reduce overall turnaround times. **This risk is to be amalgamated with DATIX ID 8941 and scored accordingly.**	Date last reviewed	07/10/2022			
	Risk by Quarter 2022	Q1	Q2	Q3	Q4
			16	16	
	8 week score projection	16			
	Current Issues	National shortages in recruitment and COVID19 restoration pressures adding to demand			

	Next Review Date 07/11/2022		

<table>
<tr><th>No</th><th>ID</th><th colspan="4">Title</th></tr>
<tr><td>12</td><td>8960</td><td colspan="4">Risk of undetected foetal growth restriction and possible preventable stillbirth given non-compliance with national ultrasound guidelines</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Tracy Thompson
Exec Lead: Julie Molyneaux</td><td>Current score</td><td>15</td><td>Score Movement</td></tr>
<tr><td colspan="2">Description</td><td>Diagnosis of intrauterine growth restriction could be missed due to inability to report/action pulsatility index on uterine artery doppler measurement.

The introduction of national/international recommendations will require investment of resources including the obstetric reporting package, increase in sonography and midwife sonography hours currently allocated and an update of ultrasound machines within maternity services.</td><td rowspan="2">Actions</td><td colspan="2" rowspan="2">1. There is no capacity to increase the current workload within the midwifery sonography or general ultrasound teams or allow trained staff the hours required to fulfil this task.

2. The existing system allows for detection of some cases of foetal growth restriction. Of the women who pass through general sonography, there will be a cohort who develop undetected foetal growth restriction or it will be detected late and has the potential for stillbirth that could otherwise be prevented.

3. The viewpoint reporting software has been introduced as part of the radiology reporting system in obstetrics which includes pulsatility index as standard along with appropriate reference charts. Whilst progress has been made regards a new ultrasound machine and reporting software, there has been no progress to enable management of cases with an abnormal pulsatility index.</td></tr>
<tr><td colspan="2">Top Controls</td><td>1. Additional funding and implementation of ultrasound machine. Equipment available and ready to undertake the task.
2. Staff trained in measuring and interpreting pulsatility index.
3. Rollout of viewpoint reporting software allowing interpretation and reporting of pulsatility index.
4. Reporting of umbilical artery end diastolic flow, absent or reversed, with no measurement of the pulsatility index which will identify some babies with foetal growth restriction less sensitive than the recommended pulsatility index
5. Babies demonstrating foetal growth restriction are referred to the placenta clinic for further management.
6. Women at very high risk of early-onset growth restriction are offered an appointment within the placenta clinic where an umbilical artery doppler and pulsatility index is part of the first assessment.
7. Full recruitment to the midwifery sonography team now in place.
8. Review of risk assessment and update of control measures has been completed.
9. Audit to assess pulsatility index within midwifery sonography services so as to understand potential volumes of demand moving forwards has now been completed.
10. Midwifery sonography staffing model and service provision to be implemented pending Ockenden outcomes and availability of monies.</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td rowspan="4">Update 19/10/2022
Risk reviewed. No change in risk scoring. There has been no progress with the introduction of pulsatility index into current clinical practice. New guidance issued by the Royal College of Obstetricians and Gynaecologists is due for publication shortly which recommends the use of pulsatility index for umbilical artery doppler assessment.

Next Review Date 16/11/2022</td><td>Date Last reviewed</td><td colspan="2">19/10/2022</td></tr>
<tr><td>Risk by Quarter 2022</td><td colspan="2">Q1: 15 | Q2: 15 | Q3: 15 | Q4: </td></tr>
<tr><td>8-week score projection</td><td colspan="2">15</td></tr>
<tr><td>Current issues</td><td colspan="2">Capacity issues and operational pressures have impacted on the mitigation of the risk.</td></tr>
</table>

No	ID	Title				
13	8839	**Failure to meet performance targets**				
Lead		Risk Lead: Victoria Hampson Exec Lead: Sharon Gilligan	**Current score**	**15**	**Score Movement**	⟺
Description		There is a risk regarding the ability to meet national performance targets set for referral to treatment times, with non-achievement of standards impacting on delays in patient treatment. Due to the COVID-19 pandemic, all surgical specialities are currently significantly challenged for meeting Referral to Treatment (RTT). The failure of this standard means that individual patient care is impacted as patients will have to wait an extended length of time for treatment which will further impact on patient experience and treatment plans. Patients may also deteriorate waiting for treatment for extended lengths of time. As this standard is externally monitored failure may lead to organisational reputational damage and patients choosing not to be treated by the Trust.	**Actions**	1. Impact of coronavirus pandemic has significantly increased backlogs and it remains unknown how targets will be managed in the future. 2. Theatre staff supporting critical care has reduced availability of theatre sessions, capacity and ability to clear backlogs. 3. Capacity has also been impacted by patient choice i.e. reluctance of patients attending clinic or theatre, delays and cancellations etc., theatre flow and other work pressures. 4. New pension rules and workforce challenges have reduced numbers of consultants offering additional capacity sessions to manage demand. 5. Inability to recruit within some specialities is impacting on referral to treatment (RTT) performance.		
Top Controls		1. Weekly Patient Treatment List (PTL) meetings held within division of awareness of current position and ensure suitable controls remain in place to focus on achievement of the standard. 2. Bi-weekly meetings held with Directorate Managers, led by the Director of Operations, to monitor and review performance and trajectories. 3. Recovery plans updated weekly by Directorate Managers. 4. Attendance of Divisional Information Manager (DIM) at Directorate meetings to provide updates on current position. 5. Exception reports provided by DIM where standards are not being met. 6. Regular performance monitoring and challenge at Divisional Management Board (DMB) and Senior Management Team. 7. Addition of priority code monitoring now forms part of PTL meetings. This control enables all clinically urgent patients to be tracked for dates. 8. Additional waiting list initiatives for theatres and clinics to close gaps and maximise capacity. 9. Monthly meetings held with commissioning teams to work on demand management and explore options for mutual aid and outsourcing. 10. Outpatient Transformation Group tracking outpatient redesign.				
Update since the last report		**Update 01/11/2022** Risk reviewed. No change in risk scoring. There are currently 626 52 week breaches within Surgical and Anaesthetic Services the majority of which are within general surgery. A significant gap between demand and capacity still remains within surgical specialities with a heavy reliance on additional activity. Micromanagement of all 52 week breaches remains ongoing at weekly PTL meetings and patients continue to be seen in order of clinical priority. A revised clinical harm process is being implemented to ensure patient safety. **Next Review Date 01/12/2022**	**Date Last reviewed**	**01/11/2022**		

	Q1	Q2	Q3	Q4
Risk by Quarter 2022	15	15	15	
8 week score projection	15			
Current issues	Increased COVID-19 prevalence has impacted on workforce activities across the elective pathway and patient availability for surgery			

<table>
<tr><th>No</th><th>ID</th><th colspan="5">Title</th></tr>
<tr><td>14</td><td>8441</td><td colspan="5">Managing the risk of coronavirus (COVID-19) outbreak</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Alison Whitehead
Exec Lead: Tony McDonald</td><td>Current score</td><td>15</td><td>Score Movement</td><td>↔</td></tr>
<tr><td colspan="2">Description</td><td>There is a risk of increased infection rates of staff and patients following coronavirus (COVID-19) outbreak</td><td rowspan="2">Actions</td><td colspan="3" rowspan="2">1. The use of face masks in clinical and non-clinical areas across all sites and settings has been reintroduced due to the escalation of infection rates within community and clinical settings, numbers of positive patients within wards and a rise in coronavirus related staff sickness absence and is being closely monitored and reviewed by the infection, prevention and control team in line with infection prevention control guidance.</td></tr>
<tr><td colspan="2">Top Controls</td><td>1. UK COVID-19 alert level has been downgraded.
2. Regular external and internal communications issued to keep staff and patients informed.
3. Numbers of coronavirus cases are communicated and reviewed daily and included as part of routine infection prevention control reporting, with escalation, as appropriate, via the Senior Leadership Group and Quality Committee.
4. NHS 111 referral measures including home testing and support to alleviate work pressures within Urgent Care and Emergency Department.
5. Set up of command and control centres to enable management and implementation of plans, processes and procedures etc.
6. Responsive communication of COVID-19 bulletins in accordance with frequency of activity.
7. Plans and processes in place to relocate staff in providing additional support within areas of need.
8. Vaccination and booster programme in place for all staff and population groups.
9. Weekly compliance figures regarding vaccination and boosters provided within regular communications such as newsletters and senior management reports.
10. Establishment of vaccination centres and deployment of mobile vaccination units across the local region made available for staff and public access
11. Mobilisation of COVID-19 wards across acute and community settings and use of additional wards, where necessary.
12. Asymptomatic testing in place i.e. use of LFT/LAMP etc.
13. Why not home, why not today campaign to maximise discharges, patient flow and bed capacity.
14. Regular performance monitoring and review of incidents.</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td rowspan="4">Update 07/10/2022
Risk reviewed. No change in risk score.

Next update 07/11/2022

A full quality improvement review of this risk is to be undertaken before the next meeting.</td><td>Date Last reviewed</td><td colspan="3">07/10/2022</td></tr>
<tr><td>Risk by Quarter 2022</td><td colspan="3">Q1: 20 | Q2: 15 | Q3: 15 | Q4:</td></tr>
<tr><td>8 week score projection</td><td colspan="3">12</td></tr>
<tr><td>Current issues</td><td colspan="3">Impacted by COVID-19 pandemic, recovery and restoration stages.</td></tr>
</table>

No	ID	Title				
15	8257	**Loss of Transfusion Service**				
Lead	Risk Handler: Lee Carter Exec Lead: Jawad Husain	Current score	15	Score Movement	⟷	

Description	Denial of the laboratory premises at Royal Blackburn Teaching Hospital (RBTH), especially blood transfusion, due to: 1. Planned evacuation due to fire alarm test. 2. Unplanned evacuation, in response to local fire alarm activation. 3. Evacuation due to actual fire within the laboratory. 4. Evacuation due to flooding within the laboratory. In all 4 scenarios above there would be no access to the blood stocks or issuable blood stocks within the laboratory. The hospital site currently operates 2 blood bank units situated within the laboratory area and the effects of no access to units of blood or blood components are of the inability to supply: 1. Routine transfusions. 2. Blood for surgical procedures. 3. Blood for major haemorrhages. In the latter of the two instances, this would have a profound clinical, organisational and reputational impact.	**Actions**	1. Fridges remain within the testing phase and subsequently the laboratory remains prone to the risk until the blood track system has been fully rolled out and implemented. 2. The purchase of a single unit, under bench blood fridge, in a remote site would reduce this risk but would raise other risks regarding monitoring and maintenance of stock levels, increasing staff time and resource, limited numbers of units stored or available for transfusions weighted against delivery timescales, units needing to be 0+ and 0- and issues of track and traceability of bloods.
Top Controls	1. Meetings held with project lead for haemonetics. 2. Emergency bloods can be stored in temporary insulated boxes for a period of time. 3. The Bio-Medical Scientist (BMS) would station themselves outside the entrance to the laboratory where they could issue emergency units out. 4. If level 0 was out of bounds, clinical flow room would be the point of contact for skilled staff. 5. As testing of the system is rolled out changes to IT processes will occur to meet plans for the electronic release of blood from remote fridges. 6. On the Burnley General Hospital (BGH) site the fridge has been enabled and label print runs have been successfully carried out with a room opposite AMU at RBTH available awaiting fridge installation and testing.		

Update since the last report	**Update 09/10/2022** Risk reviewed. No change to risk scoring. The risk is expected to reduce in score as the Trust overall plan for electronic release of blood from remote fridges is rolled out. **Next Review Date 09/11/2022** **A full quality improvement review of this risk is to be undertaken before the next meeting.**	**Date Last reviewed**	**09/10/2022**			
		Risk by Quarter 2022	Q1	Q2	Q3	Q4
			15	15	15	
		8 week score projection	15			
		Current issues	System requires installation and validation which can take up to 12 months			

No	ID	Title
16	8808	**Burnley General Teaching Hospital (BGTH) - Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke.**

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

Description	Breaches to fire stopping in compartment walls and fire door frame surrounds due to poor workmanship or incorrect product usage may result in the faster spread of smoke or fire between compartments within a timescale lower than an hour or 30 mins that these compartments and doors are designed to provide.
Top Controls	1. Fire alarm system throughout building providing early warning of fire. 2. Evacuation procedures in place. 3. Staff fire wardens are in most areas. 4. All staff trained in awareness of alarm and evacuation methods. 5. Fire safety awareness training modules are a core and statutory training requirements for all staff. 6. Fire safety policy and performance monitoring regularly reviewed by the Health and Safety Committee. 7. Provision of on-site fire safety team response. 8. Agreement of external response times with Lancashire Fire and Rescue Service (LFRS). 9. External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place. 10. Contractual arrangements in place between PFI and ELHT in establishing duty holder responsibilities regarding building controls, the regular servicing of systems and planned preventative maintenance programmes. 11. Collaborative working arrangements in place between ELHT, Consort and third parties to address remedial works and correct defects around fire doors and frame sealings. 12. Total Fire Safety Ltd have commenced program of work on phases 1-4 with Balfour Beatty undertaking work in phase 5. 13. Project team established to manage passive fire protection remedial works throughout phase 5. 14. Random sampling and audit of project works of fire stop door surrounds in phase 5 and phases 1-4. 15. Estates and Facilities team working closely with Consort and third parties to address high risk areas e.g., plant rooms etc. 16. Additional fire wardens provided by ENGIE to patrol common areas of hospital, maintain extra vigilance and undertake basic fire safety checks. 17. All before and after photographic evidence of remedial works being recorded and appropriately shared. 18. Independent advice established to oversee process, materials and methods used.
Actions	1. Monthly Executive and Senior Management meetings held with Finance, PFI Partners, Estates and Facilities and Health and Safety (Fire) to review position and suspension of work due to COVID-19 pandemic activity. 2. Fire Cell created and led by Executive Director of Finance and the Executive Director of Integrated Care, Partnerships and Resilience to frequently monitor actions and restoration works
Update since the last report	**Update 14/10/2022** No change to risk scoring. LFRS have issued enforcement action. Improvement works being monitored and reviewed at the weekly Fire Safety Meetings. **Next Review Date 14/11/2022**

Date Last reviewed	14/10/2022			
Risk by Quarter 2022	**Q1**	**Q2**	**Q3**	**Q4**
	15	15	15	
8 week score projection	15			
Current issues	Impact of COVID-19 pandemic and restoration pressures			

o	ID	Title				
17	**7764**	**Royal Blackburn Teaching Hospital (RBTH) Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke**				
Lead		Risk Lead: John Houlihan Exec Lead: Tony McDonald	**Current score**	**15**	**Score Movement**	⟷
Description		Breaches to fire stopping in compartment walls and fire door frame surrounds due to poor workmanship or incorrect product usage may result in the faster spread of smoke or fire between compartments within a timescale lower than an hour or 30 mins that these compartments and doors are designed to provide.	**Actions**		1. Monthly Executive and Senior Management meetings held with Finance, PFI Partners, Estates and Facilities and Health and Safety (Fire) to review position and activity. 2. Fire Cell created and led by Executive Director of Finance and the Executive Director of Integrated Care, Partnerships and Resilience to frequently monitor actions and restoration works.	
Top Controls		1. Fire alarm system throughout building providing early warning of fire. 2. Evacuation procedures in place. 3. Staff fire wardens are in most areas. 4. All staff trained in awareness of alarm and evacuation methods. 5. Fire safety awareness training modules are a core and statutory training requirements for all staff. 6. Fire safety policy and performance monitoring regularly reviewed by the Health and Safety Committee. 7. Provision of on-site fire safety team response. 8. Agreement of external response times with Lancashire Fire and Rescue Service (LFRS). 9. External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place. 10. Contractual arrangements in place between PFI and ELHT in establishing duty holder responsibilities regarding building controls, the regular servicing of systems and planned preventative maintenance programmes. 11. Collaborative working arrangements in place between ELHT, Consort and third parties to address remedial works and correct defects around fire doors and frame sealings. 12. Total Fire Safety Ltd have commenced program of work on phases 1-4 with Balfour Beatty undertaking work in phase 5. 13. Project team established to manage passive fire protection remedial works throughout phase 5. 14. Random sampling and audit of project works of fire stop door surrounds in phase 5 and phases 1-4. 15. ELHT Estates and Facilities team working closely with Consort and third parties to address high risk areas e.g., plant rooms etc. 16. Additional fire wardens provided by ENGIE to patrol common areas of hospital, maintain extra vigilance and undertake basic fire safety checks. 17. All before and after photographic evidence of remedial works being recorded and appropriately shared. 18. Independent advice established to oversee process, materials and methods used.				

Update since the last report					
Update 14/10/2022 No change to risk scoring. LFRS have issued enforcement action. Improvement works being monitored and reviewed at the weekly Fire Safety Meetings. **Next Review Date 14/11/2022**	**Date Last reviewed**	**14/10/2022**			
	Risk by Quarter 2022	**Q1**	**Q2**	**Q3**	**Q4**
		15	**15**	**15**	
	8 week score projection	**15**			
	Current issues	Impact of COVID-19 pandemic and restoration pressures			

Lancashire and
South Cumbria
Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

<table>
<tr><th>o</th><th>ID</th><th colspan="4">Title</th></tr>
<tr><td>18</td><td>7165</td><td colspan="4">Failure to ensure legislative compliance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: John Houlihan
Exec Lead: Tony McDonald</td><td>Current score</td><td>15</td><td>Score Movement</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">Failure to provide quality assurance of legislative compliance regarding duties to report certain types of injuries, diseases and dangerous occurrences to the HSE within set timescales</td><td rowspan="2">Actions</td><td rowspan="2">1. Process of determining RIDDOR reportable incidents and ensuring legislative compliance is let down by deficiencies in the incident management process and of utilising specialisms more effectively. This will be remedied upon the introduction of RADAR.

2. A more robust process is now in place to provide assurances cases of medically diagnosed occupational disease, infections or ill health are being identified or reported.

3. More in-depth review of accidents and incidents and their investigation is highlighting gaps in existing systems e.g. sharps, falls, manual handling, violence and aggression etc.

4. Demonstrable evidence of increasing awareness and activity from external bodies regarding RIDDOR e.g. HSE, CQC etc.

5. Challenges arising as a result of the recovery and restoration stages of coronavirus have significantly impacted on service provision and delivery. This, together with increasing demands and competing priorities, increasing numbers of accidents and incidents and time spent completing investigations, some of which are very complex, have impacted on RIDDOR performance and of timescales being met.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Full review of legislative requirements and of measuring and reviewing performance.
2. Inclusion of RIDDOR reporting requirements within the scope of the incident management policy and or procedures.
3. Better utilisation of the incident management module of DATIX and improvements made to the quality of accident and incident investigations.
4. Targeted RIDDOR awareness training provided to members of the Health and Safety Committee, Divisional Quality and Safety Leads and Occupational Health, with cascade training across Divisions and Groups etc.
5. Increased management and staff awareness and understanding of RIDDOR i.e. what is and what is not reportable, consequences and timescales involved in reporting externally to the HSE, relevant work examples and issue of guidance.
6. Improved working relationships with clinical services and other relevant specialisms e.g. human resources, occupational health, infection prevention control, manual handling, security, falls, legal, estates and facilities etc. should any significant trends be identified.
7. Improved sickness absence monitoring, more robust health surveillance and employee assistance programmes, utilisation of occupational health services and ‘fast physio’
8. More in depth thematic review and monitoring of all accidents and incidents undertaken by the health and safety team.
9. A process of escalation has been agreed across Divisions to ensure consistency in approach and improve service responses.
10. RIDDOR performance included as a standalone agenda item of the Health and Safety Committee, with escalation and or exception reporting to Trust Wide Quality Governance and Quality Committee.</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td colspan="2" rowspan="4">Update 14/10/2022
This risk is to be presented back to members of the Health and Safety Committee in December 2022 to review existing controls and risk scoring following an increase in compliance rates as a result of quality improvements made and a reduction in total numbers of RIDDOR reportable incidents compared to previous financial year to date totals.

Next Review Date 14/11/2022

A full quality improvement review of this risk is to be undertaken before the next meeting.</td><td>Date Last reviewed</td><td>14/10/2022</td></tr>
<tr><td>Risk by Quarter 2022</td><td>Q1: 15   Q2: 15   Q3: 15   Q4: </td></tr>
<tr><td>8 week score projection</td><td>12</td></tr>
<tr><td>Current issues</td><td>COVID pandemic and restoration pressures</td></tr>
</table>

<table>
<tr><th>No</th><th>ID</th><th colspan="7">Title</th></tr>
<tr><td>19</td><td>7008</td><td colspan="7">Failure to comply with the 62 day cancer waiting time targets.</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Matthew Wainman
Exec Lead: Sharon Gilligan</td><td>Current score</td><td>15</td><td colspan="2">Score Movement</td><td colspan="2">↔</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">There is a risk that the Trust will fail to meet its key performance indicator in achieving the national target for all cancer treatment pathways which is set for at least 85% of patients starting their first treatment for cancer within two months (62 days) of an urgent GP referral which may result in patient harm if treatment is delayed and reputational damage.</td><td rowspan="2">Actions</td><td colspan="4" rowspan="2">1. Medical Vacancies - Many areas suffering with excessive waiting times are resulting from vacancies for key posts. Vacancies for posts that are notoriously difficult to recruit to due to national shortages.

2. Unavoidable Breaches - some breaches are outside of ELHT control, patients breaching targets because of complexities in their pathway, comorbidities, or patient choice can at times eat into the tolerance we have.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. ELHT Cancer Action Plan – a document summarising all key actions aimed at improving performance, quality, or patient experience in relation to cancer care. This is monitored bi-weekly through the Cancer Performance Meeting.
2. Cancer Performance Meeting – a weekly meeting aimed at reviewing all patients at risk of breaching a National Cancer Waiting Times Treatment Standard chaired by the Director of Operations.
3. Tumour Site Patient Treatment List (PTL) Meetings – meetings held weekly per tumour site with key individuals present. In these meetings the PTL is reviewed patient by patient identifying actions as they go through the list.
4. External Funding – Regular investment of the Lancashire and South Cumbria (L&SC) Cancer Alliance & NHS England funding into problem areas.
5. Cancer Reporting – “Hot List” representing all patients at risk of breaching distributed twice weekly and reviewed in detail at the Cancer Performance Meeting. Cancer Performance Pack issued once weekly to all key stakeholders in Cancer and additional report of in month. Performance issues to all key stakeholders weekly.
6. Breach Analysis Process – each month all breaches or near misses of a 62-day standard are mapped out in a template, delays identified, and then reviewed by the responsible directorate to identify areas for learning and improvement that will feed into their Action Plan.
7. External Meetings – L&SC Cancer Alliances Rapid Recovery Team, key stakeholders from across the cancer alliance attend and discuss performance, progress, and ideas for improvement. Pennine Lancashire Cancer Tactical Group, the Trust and Clinical Commissioning Group (CCG) colleagues discuss performance, progress, and ideas for improvement.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 07/10/2022
Risk reviewed. No change in risk scoring. Increased COVID-19 prevalence has impacted on the workforce across the elective pathway and patient availability for investigation and surgery. Significant challenges within endoscopy, lower gastrointestinal demand, clinical oncology, pathology and outpatient capacity across all specialities. Weekly micro-management undertaken at specialty level.

Next review date 07/11/2022</td><td>Date Last reviewed</td><td colspan="4">07/10/2022</td></tr>
<tr><td rowspan="2">Risk By Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>15</td><td>15</td><td>15</td><td></td></tr>
<tr><td>8 week score projection</td><td colspan="4">15</td></tr>
<tr><td>Current issues</td><td colspan="4">COVID pandemic, restoration pressures and local, national and international recruitment and retention remains an issue</td></tr>
</table>

No	ID	Title					
20	5791	Aggregated Risk - **Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance.**					
Lead		Risk Handler: Jane Pemberton Exec Lead: Kevin Moynes	**Current score**	**15**	**Score Movement**	⟷	
Description		Difficulties in the recruitment and retention of substantive nursing and midwifery posts is resulting in continued use of agency and or bank staff, which, in turn, is financially challenging and does not support continuity of patient care.	**Actions**	1. Although temporary staffing and recruitment into the Trust continues, along with active progression of recruitment programmes identified in areas, it may not be able to staff to agreed levels due to gaps created by vacancies, compounding sickness absence, unplanned absence, maternity leave, unfilled bank or agency shifts, the effects of the COVID pandemic, increasing pressures in relation to non-elective activity and continued overcrowding with the Emergency Department (ED).			
Top Controls		1. Daily staffing teleconference held with the Director of Nursing and repeated throughout the day, as required. 2. Formal review and exercising of professional clinical judgement to allocate or reallocate staff appropriately and address deficits in skills shortages and or numbers. 3. Appointment of Lead Recruitment Nurse with focus on ongoing local, national and international recruitment of registered nurses and healthcare support workers. 4. Use of e-rostering, both actual and planned, staffing numbers recorded daily and reported monthly as part of quality assurance processes. 5. A robust system is in place regarding internal bank staff arrangements, senior authorisation of agency usage and the management and utilisation of temporary staff, including overtime worked. 6. Monitoring of red flags, incident reporting (IR1's), complaints and other patient experience data. 7. Monthly financial reporting and non-medical agency group review of spending. 8. Regular dashboard review of good rostering compliance along with use of the Safe Care Tool within Allocate to support decision making regarding acuity, dependency and staffing levels. 9. Business continuity plans remain in place. 10. Regular performance reporting of actual and planned staffing levels at the Quality Committee and at Trust Board meetings.					
Update since the last report		**Update 03/10/2022** Risk reviewed. No change in risk score. Nurse staffing levels continue to remain extremely challenging. Recruitment action in place, with international recruitment bids being submitted in October 2022. **Next review date 02/11/2022**	**Date Last reviewed**	**03/10/2022**			
			Risk by Quarter 2022	**Q1**	**Q2**	**Q3**	**Q4**
				15	**15**	**15**	
			8 week score projection	**15**			
			Current issues	COVID pandemic, restoration pressures and local, national and international recruitment and retention remains an issue			

No	ID	Title
21	4932	**Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained.**

Lead	Risk Lead: Rebecca Woods Exec Lead: Julie Molyneaux	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.	**Actions**	1. The Local Authority, acting as the 'Supervisory Body', has been made aware of the risk, but is unable to process assessments within the statutory provisions set. This action remains outside the control of the Trust, who are, consequently, unable to extend urgent authorisations beyond the required timescales set at 14 days. 2. In the absence of assessments being undertaken by the Supervisory Body, patients will not have a DoLS authorised and will not have had the relevant checks undertaken to ensure they are being legally detained. This can lead to patients being detained without authorisation as not doing so would pose an even greater risk. 3. Plans to change DoLS to Liberty Protection Safeguards (LPS) remains ongoing, with no date set for their implementation or subsequent publication of new national codes of practice.
Top Controls	1. The policy relating to the Mental Capacity Act (MCA) and the procedure for DoLS has been updated to reflect the 2014 Supreme Court judgement ruling. 2. The arrangements contained within the policy and or procedure are being adhered to by wards, along with applications being made in a timely manner. 3. Applications continue to be tracked by the Safeguarding Team, with any changes in patient status relayed back to the Supervisory Body. 4. Mandatory training on the MCA and DoLS is available to all clinical professionals. 5. Additional support and training is available for all ward based staff and is provided by the MCA Lead and members of the Safeguarding Team. 6. Legal advice and support is readily available. 7. A quarterly review of risk is being undertaken by the Internal Safeguarding Board. 8. The ability to extend urgent authorisations for all patients up to 14 days in total provides some defence to the Trust. 9. Despite the legal framework, it is anticipated patients will not suffer any adverse consequence or delays in treatment etc. and that the principles of the MCA will still apply.		

Update since the last report	**Update 12/10/2022** Risk reviewed. No change in risk score. A continuous increase numbers of DoLS applications is adding to workforce pressures on the Safeguarding Team to manage the process for each individual. The mitigation of this risk remains outside of the control of the Trust. **Next review date 11/11/2022**	**Date Last reviewed**	**12/10/2022**			
		Risk by Quarter 2022	Q1	Q2	Q3	Q4
			15	15	15	
		8-week score projection	15			
		Current issues	External influences regarding mitigation of risk beyond the control of ELHT			

TRUST BOARD REPORT

9 November 2022

Item	**143**
Purpose	Information Action Monitoring

Title	Board Assurance Framework
Director sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance

Summary: The Executive Directors have reviewed the BAF and it has been presented to the Finance and Performance Committee, Quality Committee and Executive Risk Assurance Group (ERAG) for review and discussion.
In revising the BAF, they have reviewed the risk scoring and Risk Appetite for each of the risks, including updates to the actions due in this reporting cycle.

On 12 August 2022 NHS England (NHSE) issued a letter which links the winter resilience plans to the obligations of accountability, based on the implementation of the new legislation and the formation of the Integrated Care Boards. This has been considered when reviewing the BAF with the Executive Directors and there are a number of new actions which relate to the contents of the letter.

The cover report sets out the changes made to the document, including updates on actions and the addition of assurances where actions have been completed. Despite the consideration of the risk ratings and risk appetite scores, there have been no changes to either in this round of reviews.

Section 41 of the report sets out the linkages between the BAF risks and the risks on the Corporate Risk Register (CRR).

Recommendation: The Board is asked to review and approve the revised BAF.

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 assurance framework	1. The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2. The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter.

3. The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive.
4. The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.
5. The volume of activity that the Trust is able to deliver is insufficient to achieve the required targets and eradicate backlogs.
6. The Trust is unable to see, treat and discharge/admit/transfer patients within the prescribed timeframes due to:
    - the volume and complexity of their needs
    - the unavailability of alternative consistent services in the community
    - lack of workforce (links to BAF 5b)
    - lack of flow within the organisation
7. Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce.
8. Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy).
9. 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.
10. The Trust fails to deliver the strategic objectives set out in its NHS Green Plan.
11. The Trust’s transition towards increased digitisation of records and communication disrupts the current clinical and operational service delivery to such a degree that it increases the risk of harm to patients. The reliance on digital systems also increases the impact upon the services should the Trust be subject to a Cyber-attack or significant infrastructure failure.
12. The Trust's Improvement Practice and Management System (including strategy deployment framework and associated key delivery and improvement programmes) do not sufficiently build improvement capability and support delivery on agreed outcomes.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by:
Quality Committee, 26 October 2022
Executive Risk Assurance Group, 27 October 2022
Finance and Performance Committee, 31 October 2022

Introduction

1. The Executive Directors with BAF risks assigned to them have met individually with the Corporate Governance Manager to review and revise the individual risks.
2. This document sets out the changes that have been made to the BAF since the Committee meetings that took place in August 2022, including any updates to the actions, assurances and controls.
3. The full BAF has been presented to the Committees for completeness and information, however, the Committees are only asked to discuss the risk scores, mitigations and actions for the risks that are within their remit as follows:
   a) **Finance & Performance Committee:** BAF 1, BAF 3, BAF 4a and 4b, BAF 5b, BAF 6, BAF 8 and BAF 9.
   b) **Quality Committee**: BAF 2a and 2b, BAF 3, BAF 5a.
   c) **Audit Committee**: BAF 7.
4. The BAF now includes, where appropriate, references to the 8 steps for increasing capacity and operational resilience in urgent and emergency care ahead of winter. The 8 core objectives are:
   a) Prepare for variants of COVID-19 and respiratory challenges
   b) Increase capacity outside acute Trusts
   c) Increase resilience in NHS 111 and 999 services.
   d) Target category 2 response times and ambulance handover delays
   e) Reduce crowding in A&E departments and target the longest waits in ED
   f) Reduce hospital occupancy
   g) Ensure timely discharge
   h) Provide better support for people at home.
5. For ease of reference and we have produced the following heat map of the BAF risks for 2022-23 below.

		LIKELIHOOD				
		Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
CONSEQUENCE	Catastrophic 5			BAF 2a BAF 2b BAF 7	BAF 6	
	Major 4		BAF 5a	BAF 1 BAF 3 BAF 9	BAF 4a BAF 5b BAF 8	BAF 4b
	Moderate 3					
	Minor 2					
	Negligible 1					

Risk 1: The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities.

6. **Risk Score:** remains at 12 (Consequence (C) 4 x Likelihood (L) 3).
7. **Updates to Assurances:** there have been two updates to the assurances section in relation to the reflection of system delivery plans in the Trust's key delivery programmes and the Trust's Chief Executive being the Chair of the Provider Collaboration Board (PCB) Clinical Improvement Group.
8. **Updates to Gaps in Control:** there have been a number of updates to the gaps in control and associated actions, including:
   a) The presentation of the developing PCB Clinical Strategy with the Trust Board members and the work at system level to align it with the ICB plans and strategies.
   b) A new action has been included regarding the need for clarification of the PCB workstreams to ensure alignment to wider Integrated Care Board (ICB)/organisational strategies. The action being taken to mitigate and address this gap are the scoping of the workstreams and development of a common approach with the PCB Corporate Collaboration Group.

c) There have been a number of updates on progress against other actions as indicated in red on the detailed BAF risk sheet, particularly the confirmation of further development of out of hospital services in relation to the new winter planning guidance.

Risk 2a: The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter.

9. **Risk Score:** remains at 15 (C5 x L3).
10. **Updates to Assurances:** there has been one new source of assurance included, this being the co-ordination of GIRFT to identify Trust wide efficiency and effectiveness gains, which is reported to the Quality Committee on a regular basis.
11. **Updates to Gaps in Control:** there have been updates to the majority of the actions relating to the gaps in control. The updates include, but are not limited to:

a) Now that the mitigations have been established in relation to the histopathology staffing issues the Trust is concentrating efforts on delivering on both timeliness an quality of the service provided, and a review of progress will take place in March 2023.

b) The Executive Team have agreed to the proposed option for registration with the CQC to provide assessments for patients under Section 5.2 of the Mental Health Act and a business case is now in development. An update will be provided to the Board in November 2022.

c) The role descriptors and business case for the Patient Safety Partners has been completed and public engagement is taking place with a view to securing applicants.

d) Two new actions have been included, both relate to the actions being taken to address the issues raised in the letter from NHS England (NHSE) on 12 August 2022 regarding the core objectives and key actions for operational resilience. The first action relates to the development of the Trust's Integrated Home Support Service (IHSS) across the Pennine Lancashire area and its co-location with the Intermediate Care Allocation Team (ICAT) for operation seven days per week in the Trust's ED. The second action relates to the work being undertaken to ensure that bed capacity is sufficient throughout the winter period.

Risk 2b: The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as the Health and Safety Executive.

12. **Risk Score:** remains at 15 (C5 x L3).
13. **Updates to Controls and Assurances:** These sections have been extensively revised to provide a greater depth of information. The revisions can be seen in red in the detailed BAF risk sheet.
14. **Updates to Gaps in Control:** there have been a small number of updates to this section, including:
    a) The completion of action 3a: the terms of reference for the Health and Safety Committee have been completed.
    b) In relation to action 3b, the deadline for completion has been extended to March 2023, based on the new Health, Safety and Risk Manager now being in post who will oversee the completion of the work.
    c) Action 5a has also been completed and the Trust and Consort now meet on a two-weekly basis.

Risk 3: The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.

15. **Risk Score:** remains at 12 (C4 x L3).
16. **Updates to Gaps in Control:** there have been a number of updates to the progress of actions. Actions 2 and 8 have been completed and will move to the assurances section of the report in the next round of updates. The remainder of the updates to this section can be found highlighted in red text in the detailed BAF sheet.

Risk 4a: The volume of activity that the Trust is able to deliver is insufficient to achieve the required targets and eradicate backlogs.

17. **Risk Score:** Remains at 16 (C4 x L4).
18. **Updates to Controls:** the second half (H2) of the financial year plan has been revised to take into account the impact of Targeted Investment Funding (TIF), efficiency gains and the delay in the implementation of the Trust's Electronic Patient Record (EPR) system.

19. **Updates to Assurance:** the actions that had been marked as complete in the last round of updates have now been moved to the assurances section. These relate to the submission, implementation and monitoring of specialty level plans for demand and capacity regarding the 104% elective delivery and the plans to improve performance against the 6-week diagnostic standards.
20. **Updates to Gaps in Control:** there have been a number of updates to the progress sections of the gaps in controls, including confirmation that the actions 3, 5 and 6 have now been completed. One new action has been added regarding the willingness of medical staff to undertake additional activity at the current pay rates and the associated discussions that are being undertaken. It is anticipated that this action will be completed by the end of November 2022.

Risk 4b: The Trust is unable to see, treat and discharge/admit/transfer patients within the prescribed timeframes due to: the volume and complexity of their needs, the unavailability of alternative consistent services in the community, lack of workforce (links to BAF 5b) and lack of flow within the organisation.

21. **Risk Score:** Remains at 20 (C4 x L5).
22. **Updates to Controls:** There have been two new additions to the controls section, one relates to the development of the direct pathways into Older Peoples Rapid Assessment (OPRA) with North West Ambulance Service (NWAS). The second inclusion relates to the agreement of a standard operating procedure (SOP) between the Emergency Department (ED) and acute medicine to utilise the Ambulatory Care Unit for appointed patients out of hours to ease pressure on ED.
23. **Updates to Assurances:** There has been one addition to the section, which confirms the review and strengthening of compliance for the flow of patients into Same Day Emergency Care (SDEC) to help with overcrowding in ED.
24. **Updates to Gaps in Control:** There have been three new actions added. All three seek to address the actions set out in the recent NHS England letter on the core objectives and key actions for operational resilience. Two relate to the winter planning, and the third relates to the work being carried out to reduce bed occupancy, reduce overcrowding in the ED and support people at home to reduce the need for admissions.

Risk 5a: Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce.

25. **Risk Score:** There is a proposal to reduce the risk from 12 (C4 x L3) to **8 (C4 x L2).**
26. **Updates to Controls:** The amended date of the commencement of the Workforce Assurance Group has been added.
27. **Updates to Assurances:** minor updates to four of the assurances have been made. The updates can be seen in red in the main BAF sheet.
28. **Updates to Gaps in Control:** There have been progress updates and/or revisions to the timelines for all of the actions within this risk. The development of the Leadership Strategy has been delayed due to a combination of capacity within the team and overarching organisational pressures, although progress is being made.

Risk 5b: Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy).

29. **Risk Score:** remains at 16 (C4 x L4).
30. **Updates to Gaps in Control:** There have been a number of updates to the action section of the risk, including:
    a) The outcome of the previously submitted bids for funding, circa £110,000 has been allocated to the Trust from Health Education England (HEE) for upskilling.
    b) The ongoing work with Provider Collaboration Board (PCB) colleagues to identify wider system workforce opportunities as the PCB Clinical Strategy emerges.

Risk 6: 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.

31. **Risk Score:** Remains at 20 (C5 x L4).
32. **Updates to Assurances:** There have been two new sources of assurance included, one being the establishment and staffing of a Benefits Realisation Team and the second being the implementation of additional financial controls.
33. **Updates to Gaps in Control:** There have been a number of updates to the actions and the inclusion of a new action. The new action relates to the identification of additional financial pressures that have been identified which relate to, but are not

limited to, the delay to the implementation of the EPR programme, impacts of the pay award and non-pay inflation.

Risk 7: The Trust fails to deliver the strategic objectives set out in its NHS Green Plan.

34. **Risk Score:** Remains 15 (C5 x L3).
35. **Updates to Gaps in Control:** There had been a number of updates to the actions being undertaken, including:
    a) The completion of the establishment of the Benefits Realisation Team and the commencement in post of some of its staff members.
    b) The revision of the completion dates for actions 4 and 5, which have been delayed until the end of November 2022 due to operational pressures.

Risk 8: The Trust's transition towards increased digitisation of records and communication disrupts the current clinical and operational service delivery to such a degree that it increases the risk of harm to patients, The reliance on digital systems also increases the impact upon the services should the Trust be subject to a Cyber-attack or significant infrastructure failure.

36. **Risk Score:** Remains at 16 (C4 x L4).
37. **Updates to Gaps in Control:** There have been updates to two of the actions, one being an update to the progress of recruitment to the cyber team and the second being the confirmation of the recruitment of a new ICB Digital Lead who will review the co-ordination and corporate collaboration between Trusts.

Risk 9: The Trust's Improvement Practice and Management System (including strategy deployment framework and associated key delivery and improvement programmes) do not sufficiently build improvement capability and support delivery on agreed outcomes.

38. **Risk Score:** Remains at 12 (C4 x L3).
39. **Updates to Controls:** There have been a small number of revisions to the assurances section and are highlighted in red in the detailed BAF risk sheet. There have also been two new additions to this section:
    a) The completion of level two and three improvement practice training, with level one and four training in development, as well as the completion of a training plan.

b) The successful completion of 2022-23 planning to sign off key strategies, agree operational plans and identify key delivery and Improvement programmes.

40. **Updates to Gaps in Control:** there have been a number of updates to the actions within the risk, including:

a) The completion of action 2 regarding the alignment of the Improvement Hub, including improvement priorities and key delivery programmes.

b) The completion of action 4a regarding the Engineering Better Care for Lancashire and South Cumbria for Frailty workshop.

Connection with the CRR

41. Following feedback from the Board we are connecting the BAF risks with those on the CRR. The table below shows the individual CRR risks and their links to the BAF.

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
2a: Quality and Safety	**ID 9557:** Patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provision.	20
	ID 9336: Lack of capacity across the Trust can lead to extreme pressure resulting in delayed care.	20
	ID 8126: Risk of compromising patient care due to lack of electronic patient record (EPR) system.	20
	ID 9296: Inability to provide routine or urgent tests for biochemistry requests.	16
	ID 9251: Recurrent gaps in junior surgical staff rota.	16
	ID 8960: Risk of undetected foetal growth restriction and preventable stillbirth due to non-compliance with pulsatility index ultrasound guidance.	15
	ID 8441: Managing the risk of coronavirus (COVID-19) outbreak.	15

BAF Risk	Linked CRR Risks	CRR Score
	ID 4932: Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained.	15
2b: Health and Safety	**ID 9222:** Failure to implement the NHS Green Plan. **ID 8808:** Burnley General Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke. **ID 7764:** Royal Blackburn Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke. **ID 7165:** Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	16 15 15 15
3: Health Inequalities	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 3.	N/A
4a: Elective Recovery	**ID 8061:** Management of Holding Lists. **ID 8941:** Delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology. **ID 6190:** Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales. **ID 8257:** Loss of transfusion service. **ID 7008:** Failure to comply with 62-day cancer waiting time target.	20 16 16 15 15
4b: Emergency Care Pathway	**ID 8839:** Failure to achieve performance targets.	15
5a: Culture	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 5a.	N/A
5b: Workforce Planning/Redesign	**ID 5791:** Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance. **ID 2636:** Inability to maintain establishment of consultant histopathologists.	15 15

BAF Risk	Linked CRR Risks	CRR Score
6: Financial Sustainability	**ID 9439:** Failure to meet internal and external financial targets for the 2022-23 financial year	20
7: Wider Sustainability	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 7.	N/A
8: Digital Agenda	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 8.	N/A
9: SPE+ Improvement Practice and Key Delivery Programmes	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 9.	N/A

Recommendation

42. The Board is asked to review and recommend the BAF risks to the Board for approval.

Mrs A Bosnjak-Szekeres, Director of Corporate Governance

Miss K Ingham, Corporate Governance Manager

BAF Risk 1

Risk Description: The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities.

Executive Director Lead: Chief Executive

Strategy: ELHT Strategic framework (Partnership Working)

Date of last review: Executive Director: 19 October 2022

ERAG: 27 October 2022

Links to Key Delivery Programmes: Care Closer to Home Place-based Partnerships

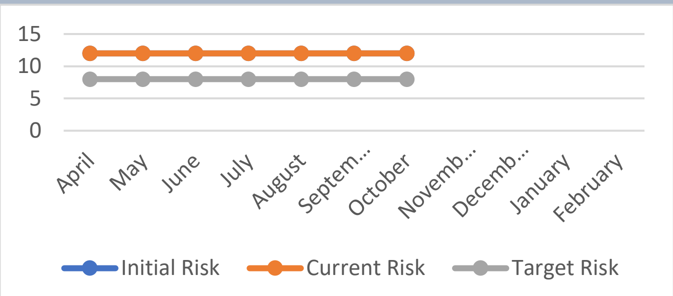
Lead Committee: Finance and Performance Committee

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

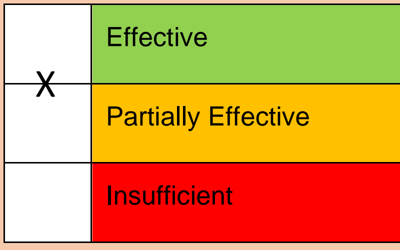
Current Risk Rating: C4 x L3 = 12

Initial Risk Rating: C4 x L3 = 12

Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:



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):

- ELHT has strong representation at all levels across existing ICS and emerging ICB structures and working 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.
- Place-based partnership review complete and place-based leaders confirmed.

Provider Collaborative Board (PCB):

- The PCB is developing a robust governance and delivery structure, with investment from all partners, and has developed key aims and objectives and PCB Business Plan.
- 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 at PCB Co-ordination Group, 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 PCB is developing a Quality Management System to ensure a consistent approach to planning, a consistent approach to system-level improvement work via a single overarching improvement model and co-ordination of key operational and service development work streams e.g. Elective Recovery, Pathology Collaborative etc
- A PCB Clinical Strategy is in development.

Pennine Lancashire Place-Based Partnership (PBP):

- A strong PBP delivery model has been established with Partnership Leader's Forum, Chairs and Chief Officers Advisory Group and an overarching Delivery Co-ordination Group.
- The PBP has formal place-based Collaborative Delivery Boards, with responsibility for planning and delivery of an integrated approach to key workstreams with identified priorities for 2022-23. There is strong leadership and representation from ELHT and all partners on the Delivery Boards.
- Place based partnership review complete and place-based leaders confirmed.

ELHT:

- ELHT Strategic framework has been developed to ensure clear alignment of organisational aims to wider system aims.
- Key organisational strategies have been developed/in development to clearly outline ELHT priorities for development as a partner in the wider system.

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.
- Reports from PCB SROs. Programme Update reports to the PCB Co-ordination Group and PCB Board.
- PBP Programme Boards workplans and progress reports developed and signed off by PBP and monitored via Programme Delivery Co-ordination Group.

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 Programmes
- Pennine Lancashire ICP Memorandum of Understanding (MoU) agreed by stakeholders workplan in place after Tripartite Board session. Revised governance and delivery standards.
- Chief Executive is the Chair of the Clinical Improvement Group for the PCB.

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.

- Key delivery programmes have been identified to ensure delivery against organisational aims and objectives and aligned to wider system programmes.
- Strategy deployment framework/process will support development and delivery of organisational plans aligned to wider system.
- ELHT is a provider of community and primary care services and well represented at Primary Care Networks.

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 delivery plans developed are yet to deliver tangible outcomes and progress not always consistently clear.	Work with partners to ensure plans improve assurance on action, progress, outcomes, inter-dependencies and risk and build into ELHT Key Delivery Programme Reporting arrangements (refer to BAF 9).	Interim Director of Service Development and Improvement with SRO leads	End March 2023	Ongoing review of progress of plans and monitoring impact. Ongoing review of how forming ICB plans need to be integrated into existing plans.	G
2.	PCB Clinical Strategy development process needs clarifying to ensure clear alignment to wider ICS, New Hospitals programme, organisational strategies.	Work with PCB via Clinical Integration Group and Directors of Strategy Group to clarify plans for development.	Executive Medical Director/ Interim Director of Service Development and Improvement	End March 2023	A Clinical strategy presentation has now been developed by PCB and shared with all Trust Boards. Clinical strategy still in development and requires alignment to new ICB-level plans and strategies. New timescales currently being reviewed and agreed but will require aligning to national timescales for planning by March 2023. Review of the PCB Clinical Integration Group underway alongside development of clear programme plan to deliver key clinical change programmes. The Trust's Chief Executive is the Chair of this group.	A
3.	ICB review of place-based partnerships boundary review may impact on current Pennine Lancashire PBP arrangements/ progress.	Participate in review to ensure opportunities and risks appropriately identified.	Interim Chief Executive/ Executive Director of Integrated Care, Partnerships and Resilience	March 2023	New place-based Directors currently taking up new positions. A Place Development Programme has been commissioned by the Integrated Care Board with an initial series of design workshops will be held across October 2022 to January 2023 to determine the future operating model and relationships between Integrated Care Board, Provider Collaborative Board, Place-Based Partnerships, Provider organisations and others. Work with partners to continue to review implications of the boundary review outcome on current place-based partnership working arrangements.	G
4.	Community service provision in Pennine Lancashire sits across 2 providers which can impact equity of provision.	Continue to engage with ICB and PBP leaders to mitigate inequities so far as possible and reunify provision.	Interim Chief Executive/ Executive Director of Integrated Care, Partnerships and Resilience	No date yet agreed Position to be reviewed in September 2022	Successful transfer of urgent community response service to ELHT completed on 3 October 2022. Further review of community services provision to continue from September 2022 with timescales thereafter to be confirmed.	G
5.	ICB Programme(s) for community, discharge and intermediate care including virtual wards and hospital at home.	Continue to lead and engage in programmes to support transformation and mobilisation of pathways.	Executive Director of Integrated Care, Partnerships and Resilience	March 2023	Work programmes either in development or on track as expected. Winter planning guidance requires further development of the out of hospital service offer to provide resilience to the urgent and emergency care pathway during Winter 2022-23.	G
6.	Quality Management System in early stages of development. System Improvement Model developed and in early stages of testing.	Active participation in development of QMS and Model for Improvement. Testing of Improvement Model on Frailty/Respiratory.	Interim Director of Service Development and Improvement	March 2023	Work plan in place for development of Model for Improvement. Recruitment of teams underway. External support from David Fillingham and University of Cambridge.	G
7.	Capacity to support all workstreams both for ELHT staff, due to system architecture changes and emerging delivery structures at PCB.	Continue to review demand and capacity and shape discussions on best way to configure system resources to support delivery	Senior Responsible Officers	March 2023	Discussions ongoing to verify programme priorities and resources required to support delivery and agreed outcomes. Capacity requirements not yet fully understood.	A
8.	PCB Corporate Collaboration workstreams need clarifying to ensure alignment to wider ICB and organisational strategies.	Work with PCB via Corporate Collaboration Group to clarify development plans, methodology, consultation and sign off mechanisms.	Senior Responsible Officers	March 2023	Workstreams currently being scoped and a common approach in development.	A

BAF Risk 2a

Risk Description: The Trust is unable to 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 Interim Executive Director of Nursing
Strategy: Quality Strategy	**Date of last review:** Executive Director: 11 October 2022 ERAG: 27 October 2022
Links to Key Delivery Programmes: Quality and Safety Improvement Priorities	**Lead Committee:** Quality Committee

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

Current Risk Rating: C5 x L3 = 15

Initial Risk Rating: C5 x L3 = 15

Target Risk Rating: C5 x L1 = 5

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.

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 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.
- All Divisions (including Estates and Facilities) have Quality and Safety meetings which coordinate Directorate assurance reports and escalation. Divisional reports are provided to the Trust Wide Quality Governance (TWQG) Group and 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 and Experience, Clinical Effectiveness Committee, Infection Prevention and Control Steering Group, Safeguarding Board, Medicines Management Committee, Trust Wide Quality Governance Group, 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 Framework, Patient Experience Framework, Risk Management Framework and Clinical Effectiveness Framework coordinate the operational implementation of the priorities which are reported and monitored through respective assurance groups, and exceptions reported to Quality Committee via TWQG.

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 Walk rounds including Executive and Non-Executives
- Complaints review process which is chaired by a Non-Executive Director
- Nursing Assessment Performance Framework (NAPF) Process ongoing and reports to Quality Committee
- Safe, Personal, Effective Care (SPEC) process and the ratings of green/silver 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.

Specialist support, policy and procedure setting, oversight responsibility:

- Clinical Commissioning Group Quality Assurance Meetings – awaiting Integrated Care Board (ICB) reporting structure.
- Health Safety Incident Board (HSIB) 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
- 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.

Independent challenge on levels of assurance, risk and control:

- Annual organisational appraisal report.
- CQC inspections and preparation/evidence gathering ongoing.
- Mersey Internal Audit Agency (MIAA) audits (Risk/Incidents/Duty of Candour) and improvement actions plan reporting to Audit Committee.
- Engagement meetings with General Medical Council (GMC) and e-Learning Anaesthesia (e-LA).
- 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.

BAF Risk 2a

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 workforce (medical and nursing). Health and wellbeing of the workforce (Refer to BAF 5a and BAF 5b)	To strengthen the Patient Safety Culture in line with the Workforce Plan and a Just Culture Approach	Executive Medical Director/ Executive Director of Nursing/ Director of HR and OD	November 2022	Initial metrics agreed between HR, members of Staff Safety Group and Quality Governance. Agreed proposal re staff safety dashboard and reporting/escalation of themes identified to be agreed at Staff Safety Group.	G
2	Provision of histopathology within the Trust (medical and healthcare scientists)	Work is taking place across providers via mutual aid and exploration of outsourcing and open recruitment. Ongoing improvement work to identify internal efficiency opportunities.	Executive Medical Director/ Executive Director of Nursing/ Director of HR and OD	March 2023	Appointed three consultants, however there are still 4 vacant posts Task and Finish Group with Diagnostics and Clinical Services (DCS) team and Chief Operating Officer. Early evidence of improvement work having impact on Histopathology turnaround times. Quality Committee received assurance report on progress July 2022 Ongoing mutual aid from LTHTR and UHMB and the Trust continues to use eternal providers to clear backlogs. The matter has been escalated to the national team as it impacts on cancer performance and if required work would be sent outside the region. Having established the mitigations, we are now delivering on time and quality standards and ongoing monitoring takes place. A review will take place on this action in 6 months.	G
3	Lack of electronic governance management system	Implement RADAR as new governance system	Executive Medical Director	September 2022 start date met. Staged approach now in place to support full implementation by April 2023.	RADAR purchased and implementation plan under development. The implementation of Radar is underway. Audit planned for September 2022 and Events workstream has commenced. Planned go live early 2023. Development of Documents/Policies Management modules commenced. Twice monthly meetings with RADAR have been established to support the implementation 6-month extension for current Datix license requested in order to allow for co-running, staff training and current governance activity to be closed down.	G
4	Continued requirement to manage patients who are waiting for placement under the Mental Health Act (MHA) Sections 2/3	Continued working with Integrated Care System (ICS) partners to commission mental health provision (refer to BAF 4b)	Executive Director of Nursing/ Executive Medical Director/ Executive Director of Integrated Care, Partnerships and Resilience	March 2023	Interaction at local level with mental health teams. Need to develop a formal agreement with Lancashire and South Cumbria Foundation Trust (LSCFT) re support available to assist our staff to safely manage patients who may be a risk to themselves or others in an acute setting. Executive Team have agreed to the proposed option for registration with CQC. The business case for personnel top support the process is being developed. An update will be provided to the closed session of the Board in November 2022.	A
5	Increased requirement to manage patients who require detention under section 5 2 of the MHA, or who display challenging behaviour	Application to the CQC for the Trust to provide assessments and detail for patients under Section 5.2 of the MHA.	Executive Director of Nursing/ Executive Medical Director/	March 2023	Mental Health Urgent Assessment Centre (MHUAC) service implemented Mental Health Liaison nurses supporting ED	G

					Urgent and Emergency Care (UEC) MH admission pathway 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. – please refer to the action above (4).	
6	Unprecedented demand on the Quality Governance team	a) Implement PSIRF and PHSO Complaints standards as an early adopter.	Executive Director of Nursing/ Executive Medical Director/	April 2023	PSIRF implemented through additional funding for focused team. 2 of these posts are 12 months and permanent funding required from Nov 22. Review of funding report being completed on PSII teams capacity for 2 x 12 months to be made permanent. PSIRF process change embedding. Further improvement work taking place with process to support Divisions and PSIRI panel. PSIRF ELHT Trust Review booked for 11th November to identify what is working well and what areas may require further work. Updating PSIRF and incident policies in line with final publication documents from NHSE due to be completed and approved late Nov/early Dec 2022. Attending Northwest PSIRF workshops over next 6 months to ensure all Trusts and ICBs are working to same standards PHSO standards monitoring process still under development with RADAR representatives. Training will be required for both programmes of work, with staff difficult to release	A
		b) COVID-19 Independent Inquiry will require significant resource to coordinate.	Executive Director of Nursing/ Executive Medical Director/	November 2022	Terms of Reference now confirmed nationally. Meetings with Hempsons indicate likely significant focus on ELHT and likely significant assurance evidence required to be co-ordinated and checked prior to submission. Formal NHS focus may be later than initially anticipated. Task and Finish group established internally with evidence gathering commenced in preparation. The system rather than individual Trusts will be assessed. The webinar from Hempsons, the expectation is for a system level response and not from individual Trusts.	A
		c) Introduction of Liberty Protection Safeguards.	Executive Director of Nursing/ Executive Medical Director/	Before April 2023	Awareness raising ongoing Nationally the implementation of LPS has been delayed until April 2024, allowing greater time to prepare Potential significant workload associated to cover approx. 260 annual applications.	R
7	Need to increase patient/public engagement and influence	Introduction of Patient Safety Partners.	Executive Director of Nursing	November 2022	Funding for these permanent posts will be required Role Descriptions completed A business case to fund the posts completed. Submission to Finance Department expected 31/10/22. Project Lead briefed Trust staff groups and some external organisations regarding the role and how to apply. Public engagement to continue until 2023, at which point it will be reviewed. Project Lead and the Trust's Communications Team have created a draft website in respect of communication package.	A

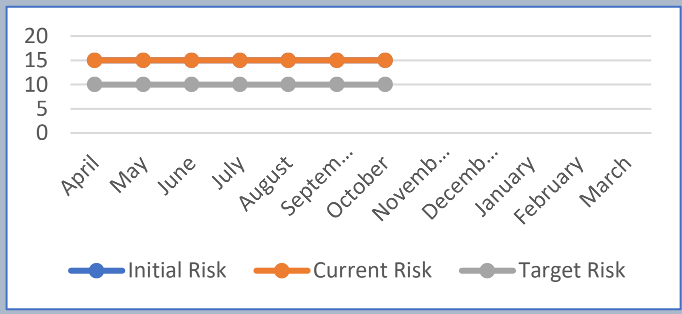
					to support the implementation of PSPs. Website to 'go live' if business case agreed.	
8	Failure to achieve the required cancer performance target.	Need to improve cancer performance	Executive Medical Director/ Chief Operating Officer	March 2023	Tumour site cancer plan in place (includes colorectal) Focus on colorectal as the biggest gain to include referral management pathways with primary care, step down of patients due to non-cancer and continue treating capacity. Continue to work closely with the cancer alliance, ICB and NHSE Weekly meeting with the national team and the Trust in place Currently ahead of trajectory. The Trust is on tier one assessment by the NHSE national team. Initially the meetings with the national team were held weekly, they have now been moved to 2 weekly review meetings as the Trust is on trajectory. Support is in place from the cancer alliance as is mutual aid at ICS level.	G
10	The need to reduce hospital occupancy, reduce overcrowding in ED and support people at home (addresses issues raised in NHSE letter on Core objectives and key actions for operational resilience dated 12 August 2022)	Development of the IHSS model and the development of a Pennine Lancashire IHSS service, collocated in a community hub with the intermediate care allocation team (ICAT) and as part of these developments to ensure an IHSS front door team operating 7 days per week within the ED.	Executive Medical Director/ Chief Nurse/ Chief Operating Officer/ Executive Director of Integrated Care Partnerships and Resilience	November 2022	Mobilisation of 24/7 IHSS service complementing the 24/7 ICAT service and 8 am – 10pm IHSS front door service 7 days er week.	A
11	Bed capacity during winter (addresses issues raised in NHSE letter on Core objectives and key actions for operational resilience dated 12 August 2022)	Maintain Ward 22 for winter escalation	Executive Director of Integrated Care Partnerships and Resilience	November 2022	Funding secured for ward 22 from the ICB	B

BAF 2b

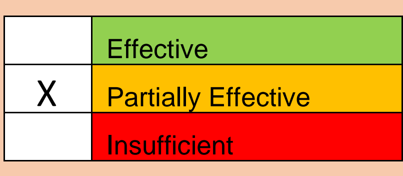
Risk Description: The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive	**Executive Director Lead:** Executive Director of Integrated Care, Partnerships and Resilience
Strategy: Quality Strategy / Health and Safety Framework as enabler to the Safe priorities	**Date of last review:** Executive Director: 3 October 2022 ERAG: 27 October 2022
Links to Key Delivery Programmes: Quality and Safety Improvement Priorities	**Lead Committee:** Quality Committee

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

Initial Risk Rating:	**C5 x L3 = 15**
Current 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: Minimal

Controls: (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the risk)

Strategy and Planning:

- A new organisational Health and Safety at Work Policy and accompanying Statement of Intent was approved by members of the Health and Safety Committee and ratified in March 2022, providing strategic and operational direction for the effective management of health and safety across services and of driving expected safety behaviours. The policy also strengthens and compliments assurances in relation to the CQC 'safe' and 'well led' criteria.
- As part of its annual work programme, the Health and Safety Committee regularly reviews external drivers that may influence strategic direction and operational planning e.g. new or proposed changes in legislation or guidance, case law review, key consultative documents and the influence of external regulators i.e. enforcement activity etc.

Health and Safety Governance Arrangements:

- The Health and Safety Committee reports directly to the Quality Committee, via the Trust Wide Quality Governance Group, with the main purpose of providing assurance of legislative compliance on the systems and processes by which the Trust leads, directs and controls its core corporate and clinical functions for the effective management of health and safety across all its services and of working closely with other Committees and or Groups to ensure all issues relating to health and safety are considered in a holistic and integrated way.
- A robust incident management process is in place regarding the review and investigation of all health and safety related incidents, along with the identification of gaps, trends, thematic review and any external reporting to regulatory bodies such as the HSE under RIDDOR. The review and monitoring of RIDDOR performance forms part of the standing agenda item of the Health and Safety Committee, with any concerns of performance escalated through existing governance and risk management systems i.e. risk register etc.
- Executive overview of health, safety and risk management themes, trends and activity is included as part of the fortnightly Quality Governance data pack.
- A number of health and safety training courses are included as part of the core and statutory framework for all staff, clinical and non-clinical, to attend and or complete, where necessary. These include health and safety awareness, fire safety, risk management, manual handling (e-learning and practical), conflict resolution (e-learning and practical) etc. which outline the key obligations and responsibilities of staff, with compliance monitored and reviewed by the Health and Safety Committee and as part of divisional core skills training monthly reports.
- The Risk Assurance Meeting and Executive Risk Assurance Group continue to monitor, review and challenge risks scoring 15 or above that are held on the corporate risk register.

Assurances: (Evidence that the controls/ systems which we are placing reliance on are effective)

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

- The Trust has nominated the Executive Director of Integrated Care, Partnerships and Resilience to be the responsible lead for health and safety at Board level.
- The Assistant Director of Health, Safety and Risk is the named 'competent person' as required by statutory legislation providing strategic and operational direction for the effective management of health and safety.
- Total numbers of open risks held on the risk register continue to decrease, with further significant reductions expected as a result of collaborative working with lead specialisms / subject matter experts within the fields of medical devices, infection control, medication, information governance, finance, radiation, security management etc. so as to avoid unnecessary duplication, improve standardisation and the quantity and quality of strategic and or operational risks held within their areas of responsibility.
- Challenging and improving risk profiles is helping steer the movement of risks from being high/extreme, moderate or significant to low. Since January 2022, there has been a 64% reduction in numbers of overdue live risks and less than 1% of tolerated risks surpassing their review date.
- Work to improve health and safety risk sub type categories and assimilation of these risks has been completed. This will act as a benchmark of performance against all other risk type categories. There continues to be a noticeable improvement in the quantity and quality of health and safety risks held on the risk register.
- The importance of prioritising, reviewing and improving the quantity and quality of risks held, increasing awareness of the risk management framework and of compliance with the process regarding the escalation of risks remains a key focus area of activity and has been reaffirmed across all divisions, quality and safety leads, risk handlers and risk leads.

Specialist support, policy and procedure setting, oversight responsibility:

- The Trust has a robust overarching organisational health and safety at work policy and statement of intent outlining the strategic and operational arrangements for the effective management of health and safety across services, how this is to be delivered and how it will be performance managed. This is supported by the Board and Accountable Officer demonstrating organisational commitment in achieving its purpose.
- The development and review of associated health and safety policies and procedures forms part of the duties, responsibilities and standing agenda item of the Health and Safety Committee. The Health and Safety Committee also seeks assurances through regular reporting, thematic review and performance monitoring of identified key health and safety activity areas.

Independent challenge on levels of assurance, risk and control:

- Health and Safety Executive - concerns raised by the principal inspector, following a planned visit of the effective oversight and review of maintenance of the CL3 laboratory facilities and associated safety critical equipment, resulted in the issue of an

	improvement notice in April 2022 whereby actions were later withdrawn, with no further proceedings taking place as the principal inspector was satisfied with the letter of response and supporting evidence. • Care Quality Commission - no inspections or concerns raised by the regulator regarding occupational health, safety or risk management activity. A continued focus remains on RIDDOR reportable slips, trips and falls incidents involving patients. A review of slips, trips and falls forms part of the Trust Wide Quality Strategy and Improvement Priorities Framework. • Lancashire Fire and Rescue Service - concerns raised by the principal inspector, following a planned visit to review compliance of the Trust and its PFI partners with provisions set out within the Regulatory Reform (Fire Safety) Order 2005 regarding cooperation and coordination, resulted in the issue of an improvement notice in May 2022. Weekly fire safety meetings, chaired by the Executive Director of Integrated Care, Partnerships and Resilience are held between stakeholders regarding planned improvement works to the fire safety integrity of buildings and infrastructure so as to ensure compliance with the requirements of the improvement notice before 21 April 2023. • Environmental Agency - no inspections or concerns raised by the regulator regarding energy, waste management and or environmental activity. • Medicines and Healthcare Products Regulatory Agency - no inspections or concerns raised by regulator regarding the effective communication and management of safety alerts and other safety critical information issued through the Central Alerting System or the management of medical devices. • Mersey Internal Audit Agency - work in addressing all actions from the risk management audit is nearing completion, with one action item regarding the planning and delivery of risk management and risk assessment training have an extended implementation date of October 2022 following commencement of the Health, Safety and Risk Manager appointment in September 2022. The action plan continues to be monitored by the Risk Assurance Meeting. • A commissioned audit of compliance with the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 has been undertaken by Specialist Training and Consultancy Services Ltd. All recommendations / actions are reviewed and monitored by the Estates and Facilities Divisional Quality and Safety Board. • Trade Unions - challenges on health and safety assurance, risks and controls etc. forms part of the standing agenda of the Health and Safety Committee.

Gaps in controls and assurance: Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level or to improve evidence that the controls are effective

Mitigating actions: Plans to improve controls/assurance

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 evidence of assurance of SMT awareness of health and safety legal responsibilities and the current landscape to support the effective delivery of the organisational health and safety at work policy and CQC 'safe' and 'well led' criteria.	a) Embed Institute of Directors Guidance INDG417 as an important toolkit and driver to benchmark existing performance.	Executive Director of Integrated Care, Partnerships and Resilience	September 2022	Plan underway to agree actions and timescales This action is complete, the Trust has implemented the monthly ERAG meetings.	B
		b) Improve senior management awareness and overview of health and safety legal responsibilities, current safety landscape and what is driving and influencing change.		December 2022	Plan underway to agree actions and timescales	G
		c) Develop strong senior management health and safety leadership competencies through completion of externally accredited ½ day IOSH 'leading safely' qualification.		December 2022	Plan underway to identify external training course provider	G
2	There is no overarching framework or strategy in place for the effective management of health and safety.	a) Adopt a more robust, integrated framework and service delivery model that creates a more unified organisational approach to managing health, safety and risk. b) Develop a health and safety strategy that is aligned to the quality strategy, new patient safety strategy, organisational strategic aims and objectives, values, quality improvement programmes and the human resources behavioural framework.	Executive Director of Integrated Care, Partnerships and Resilience	December 2022	Framework agreed and development of strategy underway	G

BAF 2b

3	A review of the function of the Health and Safety Committee has highlighted a gap in the governance process regarding health and safety related policies and procedures bypassing the Committee for review and approval prior to ratification.	a) Review and amend the Health and Safety Committee Terms of Reference to include review and approval of all health and safety policies and or procedures.	Executive Director of Integrated Care, Partnerships and Resilience	September 2022	a) Review and approval of Health and Safety Committee Terms of Reference has been completed.	B~~G~~
		b) Work collaboratively with the Incidents and Policy Manager in developing and reviewing a policy schedule that captures all health and safety policies and procedures to be used as part of the policy ratification process of the Policy Council.		March 2023	b) Plan underway to agree actions and timescales to strengthen governance arrangements. New Health, Safety and Risk Manager commenced in post who will oversee the completion of this work.	G
4	Further assurances required that all key identified health and safety risks have been fully assessed and that mitigation plans are optimised consistently across the organisation.	Prioritisation of key areas of health and safety risk is being reviewed and monitored by the Health and Safety Committee.	Executive Director of Integrated Care, Partnerships and Resilience	March 2023	Key areas of health and safety risk identified, with ongoing discussions on recourse and supporting delivery of priority risks.	A
5	Lancashire Fire and Rescue Service have issued enforcement action i.e. improvement notice regarding improvement works required to the fire safety integrity of buildings and infrastructure.	Implementation of required improvement works in partnership with Consort and Albany for: a) Burnley General Hospital – Renal Suite b) Burnley General Hospital – Phase 5 c) Royal Blackburn Hospital – Phase 5	Executive Director of Integrated Care, Partnerships and Resilience	September 2022	a) Incident Management Team established between Trust and Consort meeting weekly to co-ordinate action plans to complete required improvements with work to retail and renal units at Burnley General Hospital underway. This action is complete and is meeting on a 2 weekly cycle rather than weekly.	B
				May 2024	b) Identified need for increased resource to support implementation being considered.	A
				April 2023	c) Commencement of passive fire protection work programme at Royal Blackburn Hospital in July 2022 including improvements to fire doors, ceiling voids, plant rooms, fire alarm system, emergency lighting and fire walls.	A

BAF Risk 3

Risk Description: The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.	**Executive Director Lead:** Chief Operating Officer, Executive Director of Integrated Care, Partnerships and Resilience
Strategy: Clinical Strategy	**Date of last review:** Executive Director: 6 October 2022 ERAG: 27 October 2022
Links to Key Delivery Programmes: Tackling Health and Care Inequalities	**Lead Committee:** Finance and Performance Committee and Quality Committee

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

Current Risk Rating: C4 x L3 = 12

Initial Risk Rating: 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)

At Trust and System level there is a sign up to reducing health inequalities which has been endorsed by the Trust Board and Provider Collaborative Board. At present, reliance is placed upon existing systems and processes which have not been designed to intentionally introduce health inequalities, but which can be further developed.

To further strengthen our position, the following controls, systems and processes are being established:

- Development of a Trust-wide Health Equity strategy, which will focus on reducing health inequalities affecting patients and/or care pathways.
- Establishment of a Health Equity Alliance 'Delivery Group', which will oversee specific workstreams that are prioritised through the strategy - establishing systems and processes, including terms of references, delivery plans and control processes.
- Development of a communications sub-strategy to raise the appropriate awareness amongst staff, patients and relevant stakeholders.
- Creation of systems and processes for screening waiting lists for health inequalities
- Integration of 'personalised care' into the outpatients' improvement programme in key areas such as 'patient-initiated follow-up' (PIFU) and virtual consultations (VC).
- Creation of operational delivery processes and controls to support five clinical areas identified in the national 'Core20PLUS5' approach to reducing health inequalities. These are:
  a. Maternity
  b. Severe mental illness
  c. Chronic respiratory disease
  d. Early cancer diagnosis
  e. Hypertension case finding
- Integration of continuous improvement methodology processes into each specific area to support deliver of key priorities
- Monitoring and controlling key deliverables through established reporting mechanisms for operational performance
- Creation of mechanisms to ensure patient and staff feedback is gained and reacted upon where applicable.
- Inter-Divisional working groups such as Weekly Operations, Outpatients Steering Group, Elective Recovery Board amongst others.

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

- By targeting specific population groups, the Trust will monitor, and support actions intended to overcome inappropriate variations in service delivery
- Appropriate screening of patient waiting and holding lists for health inequalities in relation to the Trust's elective recovery and outpatients' improvement programmes

Specialist support, policy and procedure setting, oversight responsibility:

- Formation of a Pennine-Lancashire, Health Equity Board, which includes key stakeholders across the health and care, council, education, research, voluntary and patient groups.
- Secured a Public Health Registrar (PHR), In partnership with Blackburn with Darwen Unitary Authority (BWDUA), to work with the Trust on tackling wider determinants of health equity
- Funding of a Programme Manager post has been funded to work with the Trust, in partnership with the ICS.

Independent challenge on levels of assurance, rick and control

- Outputs and decisions from the Health Equity Board, will devolve to respective steering groups for actioning and follow-up, then fed back to the Board for ongoing monitoring and peer-led review
- Progress in the form of policy reviews, pathway (re)development and research will be shared for system-wide learning and peer-led review.

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.

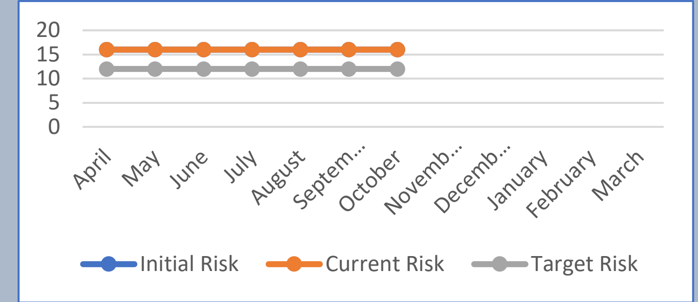
Mitigating actions: actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk.

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	Health Equity strategy is not yet developed	Draft a Health Equity Strategy for Board/Integrated Care Partnership (ICP)/ICS approval	Executive Director of Integrated Care	January 2023	Strategy is currently in its development stage. An outline of the proposed strategy was presented at the Health Equity Alliance meeting in September, with consensus	G

			Partnerships and Resilience		to progress. This now requires finalising along with some outlined workstreams that cover the identified areas of focus.	
2	Pennine-Lancashire, Health Equity Board is not yet established	Set-up the inaugural meeting of Health Equity Board	Executive Director of Integrated Care Partnerships and Resilience	July 2022	Pennine-Lancashire Health Equity Alliance has been established and held the first meeting in June. Regular meetings are now scheduled and core membership established	B
3	Operational Delivery Group is not yet established	Assemble key members for an Operational Delivery Group	Executive Director of Integrated Care Partnerships and Resilience	November 2022	It is envisaged that the Health Equity Alliance will undertake the role of the Operational Delivery Group and regular meetings are taking place between the Executive Director of Integrated Care Partnerships and Resilience and the Population Health Lead for Pennine Lancashire. Operational stakeholder groups have been identified with preliminary meetings undertaken in Respiratory Services and around Mental Health in ED. Further meetings set up for Maternity and Stroke services.	G
4	Operational plans for Core20PLUS5 are not yet formulated	Draft deliverable plans to reduce inequalities based on the five key areas	Executive Director of Integrated Care Partnerships and Resilience / Chief Operating Officer	September 2022	The Health Equity Alliance agreed that Core20PLUS5 would be used as clinical 'domains' from which to develop sub-strategies, dependent on issues pertinent to the region. Two-weekly progress meetings have been scheduled with the ELHT leads and the Pennine-Lancs, Programme Director for Public Health to ensure momentum is upheld.	G
5	Process to screen waiting lists for inequalities is not yet formulated	Work with business intelligence leads and clinical staff to create an inequalities screening tool	Chief Operating Officer	November 2022	Additional information acquired from NHE that will help the Trust identify specific reporting needs. These will be captured in a briefing paper for the Board. Work still underway. A preliminary report has been presented but further work needed before formally presenting to the senior team	A
6	Patient-centred feedback for PIFU has not been gathered	Patient survey to be finalised and sent out to a cohort of patients to explore personalised care element	Chief Operating Officer	November 2022	Survey return was poor (5%), but lack of communication was a general theme. This is being captured as part of the outpatient's improvement workstream. Further learning is being undertaken prior to survey redesign and re-distribution. There is no further update to provide.	R
7	Communications sub-strategy has not yet been developed	Create a communications sub-strategy to promote the Trust's vision for health equity	Executive Director of Integrated Care Partnerships and Resilience	November 2022	Initial discussion undertaken at Health Equity Alliance and agreement made that this would be a shared strategy across all system partners. Outline of Communication strategy scheduled to be presented in October's Health Equity Alliance meeting.	G
8	Public Health Registrar support has not yet been established	Recruitment to this post in partnership with BWDUA	Executive Director of Integrated Care Partnerships and Resilience	August 2022	Contract in place and the Public Health Registrar has commenced working with the Trust	B
9	Programme Management support has not yet been established	Recruitment to this post in partnership with ICS partners	Executive Director of Integrated Care Partnerships and Resilience	November 2022	Recruitment over and successful candidate due to start on 1st November	G

BAF Risk 4a

Risk Description: The volume of activity that the Trust is able to deliver is insufficient to achieve the required targets and eradicate backlogs.	**Executive Director Lead:** Chief Operating Officer	
Strategy: Clinical Strategy	**Date of last review:** Executive Director: 6 October 2022 ERAG: 27 October 2022	
Links to Key Delivery Programmes: Elective Pathway Improvement	**Lead Committee:** Finance and Performance Committee	
Risk Rating (Consequence (C) x Likelihood (L) **Current Risk Rating: C4 x L4 = 16** Initial Risk Rating: C4 x L4 = 16 Target Risk Rating: C4 x L3 = 12 	**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).

Overall planning and delivery processes:
- Robust annual planning processes and ongoing review processes in place to continually assess clinical and operational demand and capacity across all specialities, modalities and points of delivery
- Elective pathway improvement identified as a Key Delivery Programme as part of the Trust Strategic Framework and a supporting Pennine Lancashire wide elective care improvement plan inclusive of theatres, diagnostics, cancer, endoscopy and outpatient improvement plan has been developed
- Trust clinical strategy developed to identify key developments required over 5-year period to support ongoing delivery and development of elective care services.
- Development of systems and processes to support reduction in risk to Health Equity (refer to BAF 3)
- Development of system and processes to assess and reduce risk of clinical harm potential for patients on elective waiting lists and support delivery of safe, personal and effective care (refer to BAF 2a)
- Collaborative working across Lancashire and South Cumbria on delivery and development of all elective care services via Elective Care Recovery Group with system-level plans in place and programmes of work identified.
- Additional capacity provided through insourcing, Independent Sector contracts and Mutual Aid arrangements within Lancashire and South Cumbria Integrated Care System (ICS).
- Revised the H2 plan to take into account the impact of TIF, anticipated efficiency gains and the delay in the implementation of Cerner.

Operational Management processes:
- Robust daily operational management processes in place to support ongoing monitoring of activity, demand and performance.
- Weekly monitoring of activity delivery to plan and effectiveness of remedial actions at divisional and specialty level by point of delivery (PoD)
- Weekly Patient Tracking List (PTL) meetings with specialty leads including for cancer to ensure tracking at individual patient level
- Ongoing implementation and monitoring of elective improvement plans including theatre productivity, diagnostic clearance plans etc. to ensure effective support to delivery of overall activity level.
- Implementation of chatbot for an accurate waiting list status for prioritised treatment based on clinical need and chronological wait
- Additional support secured for waiting list validation to ensure reporting of accurate waiting list position.

Oversight arrangements:
- Pennine Lancashire Elective and Outpatient improvement board co-chaired by Chief Operating Officer (COO) and Interim Director of Service Development and Improvement overseeing delivery of performance and improvement plan
- Monthly elective care steering group chaired by Deputy COO overseeing elective/diagnostic/cancer plan
- Monthly outpatient steering group chair by Deputy COO overseeing outpatient improvement plan
- Weekly Operational performance meetings focusing on high-risk areas and delivery of agreed improvement trajectories
- Weekly monitoring of Referral to Treatment (RTT) and cancer wait time position using performance dashboard at specialty/tumour site level

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:

- Achievement of zero 104 week waits by July 2022 in line with submitted plans.
- The Trust is on trajectory to achieve the target in relation to 78-week waiters by 31 March 2023.
- Clear trajectories for other key targets for Referral to treatment Times, Cancer, Diagnostics and Activity levels in place and monitored via reporting to weekly operational team meeting, executive team meeting, senior leadership group.
- The Trust is achieving the cancer backlog recovery trajectory.

Specialist support, policy and procedure setting, oversight responsibility:

- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital
- Cancer Alliance support on focussed areas requiring improvement
- Integrated Performance Report and remedial and improvement plans reviewed at Senior Leadership group, Quality Committee, Finance and Performance Committee and Trust Board
- 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.
- Re 104% delivery requirements - The Trust has submitted and implemented specialty level plans for demand and capacity which focus on 5 high-risk RTT specialties. Performance against the plans is being monitored and some areas are achieving in excess of 104%, whilst others remain under the requirement.
- In relation to the requirement for 6-week diagnostic performance to be at 95%, plans were implemented at modality level in July 2022, when performance was at 83.13%. See action 2 (below) for further update on work being undertaken.

Independent challenge on levels of assurance, risk and control:

- Elective recovery and annual plans signed off by Lancashire and South Cumbria Integrated Care Board (ICB), regional and national teams.
- Elective recovery plans reviewed by KPMG (Audit Company) as part of 2022-23 annual planning process
- High Volume Low Complexity (HVLC) procedures review currently underway to identify opportunities for improvement.

BAF Risk 4a

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 at 104% of 2019-20 levels not achieved consistently	The controls and weekly monitoring taking place to work towards the achievement of the 104% trajectory.	Chief Operating Officer	March 2023	Weekly monitoring meetings with COO/ deputy. Progress remains the same (06.10.2022)	G
2	Diagnostic clearance to 95% <6 weeks at 95% by March 2025	Implementation of Modality level delivery plans	Chief Operating Officer	March 2024	ICS wide modelling taking place and discussion are ongoing around mutual aid to give patients across the LSC area equal access.	G
3	Increased >62-day backlog	Joint work with the Cancer Alliance on improvement	Chief Operating Officer	End June 2022	Although a Tier 1 Trust, the Trust remains ahead of trajectory for backlog clearance. This will be moved into sources of assurance at the next review.	B
4	Pennine Lancashire Elective and Outpatient Improvement Board has been reformed but needs to mature and further develop processes in order to be able to provide full assurance on delivery of plans.	Programme management and reporting processes fully established.	Chief Operating Officer/ Interim Director of Service Development and Improvement	End October 2022	Initial board meeting held to review plans. Meeting in June will have a focus on work required to improvement assurance. A series of improvement workshops have been held over September 2022 which will inform a refreshed action plan. This will be moved into sources of assurance at the next review.	G
5	Improvement Hub team support identified for key projects but detailed delivery plans still in development	Completion of scoping and agreement of detailed timescales and plans for agreed areas of focus.	Interim Director of Service Development and Improvement	End July 2022	Scoping underway and on course for delivery to agreed timescales. Scoping complete and the Trust is now in the delivery phase, including reporting through FPC on progress. This will be moved into sources of assurance at the next review.	B
6	Clinical Strategy ambitions need translating into multi-year delivery plans and aligning to Lancashire and South Cumbria Provider Collaboration Board (PCB)/ICS plans.	Finalisation of Clinical Strategy and detailed delivery plans. Ongoing work to align to wider Lancashire and South Cumbria plans	Executive Team	End September 2022	Clinical strategy currently being consulted upon. Draft delivery plans in place and year 1 priorities agreed. Complete Clinical strategy is complete and signed off, work continues to take place to align it to the LSC plans and the detail of delivery plans in line with the annual planning processes. This will be moved into sources of assurance at the next review.	B
7	Increased risk around the willingness of medical staff to undertake additional activity for the current rate of pay.	Discussions ongoing across the ICS to review pay rates.	Executive Medical Directors (ICS wide)	November 2022	Discussions ongoing across the ICS to review pay rates.	G

BAF Risk 4b

Risk Description: The Trust is unable to see, treat and discharge/admit/transfer patients within the prescribed timeframes due to:

- the volume and complexity of their needs
- the unavailability of alternative consistent services in the community
- lack of workforce (links to BAF 5b)
- lack of flow within the organisation

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

Strategy: Clinical Strategy

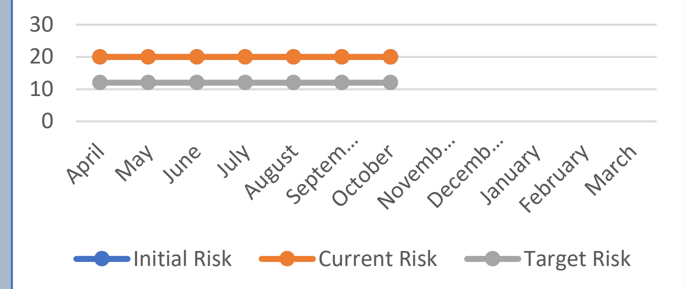
Date of last review: Executive Director: 13 October 2022
ERAG: 27 October 2022

Links to Key Delivery Programmes: Urgent and Emergency Care Improvement

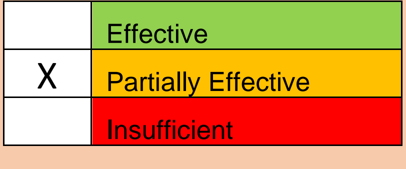
Lead Committee: Finance and Performance Committee

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

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



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)

Overall planning and delivery processes:
- Annual planning processes and ongoing review processes in place to assess demand and capacity and anticipated performance trajectories for Urgent and Emergency Care including out of hospital, front door services, same day emergency care and in-patient care with in-house bed modelling system in development.
- Urgent and Emergency Care Improvement identified as a Key Delivery Programme as part of the Trust Strategic Framework and key priority for wider Pennine Lancashire Integrated Care Partnership (ICP). A joint delivery and improvement plan (Accident and Emergency Delivery Board (AEDB) plan on a page) developed as a system to address demand management for urgent and emergency care (UEC) including primary care access and ELHT specific plan agreed as part of wider system plan.
- Links made to other Key Delivery Programmes e.g. Care Closer to Home/place-based partnership and Pennine Lancashire Delivery Groups to ensure consistency of plans.
- Robust planning arrangements in place for winter and Bank Holidays to ensure appropriate capacity planning for demand forecasts.

Operational Management processes:
- 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
- Ongoing implementation of ambulance handover improvement plans to sustain ambulance handover performance and improve on the current baseline including direct admission to Same Day Emergency Care (SDEC) areas.
- Ongoing collection of key data e.g. not meeting criteria to reside and production/use of Inpatient Patient Tracking List to support high quality daily operational management processes e.g. Every Day matters meetings
- 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).
- Operational and Improvement plan to continue to strengthen internal ED processes to manage maximum time in department to 12-hours from arrival to discharge
- Implementation of plans to further develop the Same Day Emergency Care (SDEC) model to include the acute frailty pathway via Older Peoples Response Area (OPRA)
- Manage length of stay (LoS) over 3 days on the Acute Medical Unit (AMU) and Emergency Surgical Unit (ESU)
- Improve ward discharge process based on the best practice discharge bundle and monitoring board round effectiveness
- Clinical engagement with the required change ensuring ownership for discharge planning on admission

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:
- Close monitoring of total time in department within 12-hours from arrival to discharge/transfer/admit
- Site meetings 7 days a week ensuring timely escalation of delays (potential and actual) with corrective actions
- Clear roles and responsibilities within Emergency Department (ED) ensuring grip and control with identified doctor and nurse in charge accountable for the department flow
- Monitoring of ambulance handover times, time to triage, first assessment time and time to bed from decision to admit ensuring preventative measures in place to reduce any delays
- The daily flows into SDEC areas by 07:30 am (including OPRA) have been reviewed and compliance strengthened to help decongest ED and ensure timely, safe and effective pathways for patients requiring Emergency Care.

Specialist support, policy and procedure setting, oversight responsibility:
- Integrated Performance Report and remedial and improvement plans reviewed at Senior Leadership group, Quality Committee, Finance and Performance Committee and Trust Board
- System level plan monitoring at Pennine Lancashire via AEDB and Integrated Care Board (ICB) level via relevant system forums

Independent challenge on levels of assurance, risk and control:
- Annual plans signed off by Lancashire and South Cumbria Integrated Care Board, regional and national teams.
- CQC Transitional Monitoring Approach (TMA) review of urgent and emergency care at ELHT to give assurance on areas of best practice and opportunities for improvement
- CQC UEC system-level review will independently identify areas of best practice and opportunities for improvement

BAF Risk 4b

- Continued development of 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 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.
- Developed direct pathways to OPRA with NWAS which will provide a better patient experience and reduce congestion.
- Agreed a SOP with ED and acute medicine to utilise the ambulatory care unit for appointed patients out of hours which will increase cubicle capacity in the ED.

Oversight arrangements:

- Daily, weekly and monthly performance reports for UEC in place to focus on performance improvement.
- Daily 'Pressure of Emergency Pathways' meeting with Executive Team and key leads from Emergency Pathway to provide oversight and support
- ELHT Emergency Care Improvement Steering Group meets every 2 weeks to monitor the implementation of the UEC improvement plan across ELHT covering inflow, flow and outflow
- AEDB meets every 2 weeks to oversee the implementation of the system UEC improvement plan across the system

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	System plan on demand management in the community for preventing UEC attendances	Agreed system plan for demand management schemes in the community with increased primary care access.	Executive Director of Integrated Care Partnerships and Resilience	End September 2022	Plan in development across partners. There is no further update to provide at this time	A
2	Mental Health pathways further developed with LSCFT to minimise time in ED	Agreed system plan with LSCFT to manage patients with MH needs outside of ED for patients who are assessed as medically fit.	Executive Director of Integrated Care Partnerships and Resilience	End October 2022	Pathways agreed but capacity not yet available. Refer to BAF 2a actions 5a/b.	R
3	Improved ED processes for managing to a maximum of 12-hours total time from arrival	Review and improve internal ED processes to ensure alternative pathways and a stronger focus on reducing delays for patients on non-admitted pathways.	Executive Director of Integrated Care Partnerships and Resilience / Chief Operating Officer	End September 2022	Progress being made including reconfiguration of ED/UCC flows. This work is ongoing.	A
4	Strengthen ward discharge bundle and clinical ownership for timely discharges	Embed the discharge bundle across all wards with clinical champions to promote best practice.	Executive Medical Director/ Executive Director of Nursing	End August 2022	Re-enforcing agreed discharge care bundle. This work is ongoing.	A
5	Total understanding of bed requirements required.	Completion of bed modelling to consider required capacity.	Chief Operating Officer	November 2022	Commissioned the bed modelling and work is progressing	A
6	The need to reduce hospital occupancy, reduce overcrowding in ED and support people at home (addresses issues raised in NHSE letter on Core objectives and key actions for operational resilience dated 12 August 2022)	Development of the IHSS model and the development of a PL IHSS service, collocated in a community hub with the intermediate care allocation team (ICAT) and as part of these developments to ensure an IHSS front door team operating 7 days per week within the ED.	Executive Director of Integrated Care Partnerships and Resilience	November 2022	Mobilisation of 24/7 IHSS service complementing the 24/7 ICAT service and 8 am – 10pm IHSS front door service 7 days er week.	A
7	Bed capacity during winter (addresses issues raised in NHSE letter on Core objectives and key actions for operational resilience dated 12 August 2022)	Maintain Ward 22 for winter escalation	Executive Director of Integrated Care Partnerships and Resilience	November 2022	Funding secured for ward 22 from the ICB	B
8	Winter planning	Development of a winter plan	Executive Director of Integrated Care Partnerships and Resilience	November 2022	Winter plan in place however limited funding available to support schemes. Some schemes will need to be delivered on an 'at risk' basis	G

BAF Risk 5a

Risk Description: Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce.	**Executive Director Lead:** Executive Director of HR and OD, Operational Director of HR and OD
Strategy: People/Workforce Strategy	**Date of last review:** Executive Director: 13 October 2022 ERAG: 27 October 2022
Links to Key Delivery Programmes: People Plan Priorities	**Lead Committee:** Quality Committee

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

Current Risk Rating: C4 x L2 = 8

Initial Risk Rating: C5 x L4 = 20

Target Risk Rating: C3 x L2 = 6

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)

- Employee Engagement Sponsor Group – Chaired by Chief Executive with representation from across Divisions/Trust to oversee and hold Divisions to account on employee engagement and experience (eg staff survey).
- Black, Asian and Minority Ethnic (BAME) Strategic Oversight Group – formulated from Executives, Non-Executive Directors (NEDs) and BAME Network Chairs in order to hold the Trust to account for progress on its anti-racist ambition, Workforce Race Equality Standards (WRES) progress and wider race inclusion agenda.
- Inclusion Group – brings together Chairs from staff networks along with Executive and NED sponsors to support the delivery of the Trust's inclusion agenda.
- Leadership Strategy Group – exists to develop a leadership and talent management approach to meet the needs of the organisation. Chaired by the Director of HR and OD and reports to the Quality Committee and Trust Board. The leadership strategy was approved at Executive Team and Senior Leadership Group in May 2022 for presentation at the Quality Committee and Board in September 2022.
- Joint Local Negotiating Committee (JLNC) and Joint Negotiating Consultative Committee (JNCC) to support partnership working with our Trade Union colleagues.
- Staff Safety Group – Chaired by the Executive Director of Integrated Care, Partnerships and Resilience. The purpose of the group is to enable staff to address issues of concern in relation to staff safety in the workplace.
- Freedom to Speak Up (FTSU) Guardian and Champions – in line with the national FTSU agenda. They report to the Staff Safety Group, Quality Committee and Trust Board.
- Establishment of the Workforce Assurance Group, which commences from October 2022.

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's Staff Safety Group oversees the day to day operational risks and interventions to ensure staff safety matters are addressed.
- Five Staff Networks, each are supported by an Executive Lead and reporting through the Inclusion Group:
  - BAME,
  - Women's,
  - Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+),
  - Disability and Wellness,
  - Mental Health
- Agreement that the Chief Executive will act as the Executive Sponsor for the BAME Network. Following the festival of inclusion there is agreement that each staff network will have a different Executive sponsor.
- Freedom to Speak-Up (FTSU) – the Trust has FTSU Champions embedded across the organisation to support the FTSU Guardian in enabling staff to raise concerns. The Trust is currently recruiting new champions to increase access and fill gaps caused by turnover.
- Implementation of the Team Engagement and Development (TED) Tool across the organisation will enable teams to manage team culture.
- The Trust's Behaviour Framework will be embedded across the organisation and integrated into the recruitment and appraisal processes.
- The Trust's Big Conversation programme, following publication of the Staff Survey results enables the Trust to respond and improve staff experience.
- Flexible working manifesto in place to assist staff and managers in exploring opportunities to work flexibly.
- Human Library sessions have taken place during the Festival of Inclusion and the Trust is now seeking to establish its own human library.
- There are now a number of instillations in place across the Trust sites to promote the Trust's inclusivity networks and its commitment to an inclusive workforce

Specialist support, policy and procedure setting, oversight responsibility:

- Director of HR and OD 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.
- NED EDI lead is a member of the regional BAME Assembly.
- We are participating in a new national rainbow badge programme which will enable us to develop a robust action plan and achieve accreditation as a Trust.
- The Trust has a Partnership Officer (link between the Unions and Trust) who works with the Director of HR and OD to ensure that employee relations between the Trust and Trade Unions colleagues is effective.

BAF Risk 5a

	Independent challenge on levels of assurance, risk and control: • WRES and Workforce Disability Equality Standard (WDES) standards are monitored nationally and reported to the Trust Board on an annual basis. • National Staff Survey reports and benchmarks the Trust's performance against other organisations at a national and regional level. • Required to work within the national FTSU framework and are accountable to the National Guardian for delivery.

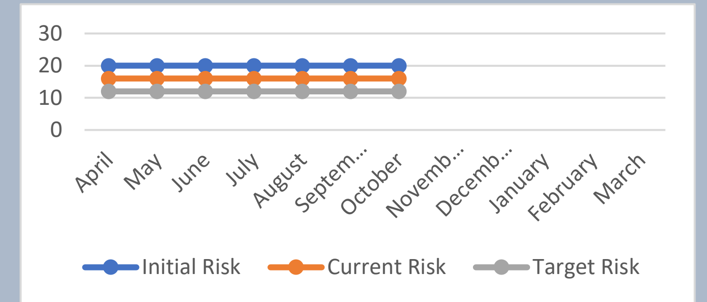
Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as gaps in controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing.

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	The need for a refreshed Leadership Strategy	The Leadership Strategy will be presented to the Quality Committee and Board in January 2023.	Director of HR and OD	December 2022	The Strategy has been to Executive Team and Senior Leadership Group. Leadership Forum is being established by way of engagement across the Trust and planned to be in place by the end of September 2022. Progress is being made on the strategy but a combination of team capacity and organisational pressures have delayed the progress. The OD team are working with a number of teams across the Trust to develop bespoke leadership development interventions.	A~~G~~
2	Workforce Committee to be established	Membership and Terms of Reference (ToR) to be agreed and a meeting cycle established.	Director of HR and OD	October 2022	Draft ToRs have been prepared and reviewed. The first meeting will take place at the end of October 2022 at which point this action will be complete.	G
3	Full roll out of the behaviour framework	Additional communications and OD support with individual teams.	Director of HR and OD	March 2023	The Workforce Innovation Team are working with individual teams around implementation of the Behaviour Framework. The Behaviour Framework is reflected in appraisal documentation and is starting to formally be included in the recruitment processes. An update to the Quality Committee will be provided in March 2023.	G
4	Capacity of staff network members to support the delivery of the inclusion agenda	Explore the option for some protected time.	Director of HR and OD	November 2022	Business case is currently in development. An initial review has been undertaken with Executive colleagues.	A
5	Further alignment of leadership and Organisational Development (OD) activities to the Safe, Personal, Effective Plus (SPE+) Improvement Practice as part of Trust Improvement Continuum required	Cross-correlation of plans and training/development offers to maximise benefits and consistency of message	Director of HR and OD/ Interim Director of Service Development and Improvement	November 2022	Scoping discussions underway. Organisational Development and Culture being built into Improvement Practice Development Plan. This will form part of the leadership offer but there is no further update to provide at this point.	A

BAF Risk 5b

Risk Description: Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy)	**Executive Director Lead:** Executive Director of Human Resources and Organisational Development	
Strategy: Workforce / People Strategy	**Date of last review:** Executive Director: 13 October 2022 ERAG: 27 October 2022	
Links to Key Delivery Programmes: People Plan Priorities / R&D, Education and Innovation	**Lead Committee:** Finance and Performance Committee	
Risk Rating (Consequence (C) x Likelihood (L)): **Current Risk Rating: C4 x L4 = 16** Initial Risk Rating: C4 x L5 = 20 Target Risk Rating: C3 x L4 = 12  	**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)

- Agreed Integrated Care System (ICS), place-based workforce plans and Trust People Plan 2022-23 – The ICS plan stratifies actions to be delivered at organisation, place and system level. The plan is monitored through the Provider Collaboration Board (PCB) Workforce Steering Group and the ICS 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. The place-based workforce plan will be managed through the Pennine Lancashire People Board and accountable through Chairs and Chief Executives. This will be reported through Executives and the quarterly workforce report. The Trust People plan is operationally delivered through the Senior Leadership Group (SLG) and Divisional Management Boards (DMBs) and delivery is accountable through Finance and Performance Committee (FPC) as part of the quarterly workforce report. This also forms part of the workforce section of the Integrated Performance Report (IPR).
- International Nurse Recruitment Plan 2022-23 – aiming to have zero nursing vacancies by March 2023 (initial plan was October 2022 but due to international developments affecting visas this was revised). The plan is being monitored through the Recruitment and Retention Group – reported through quarterly workforce report to FPC. Also monitored through the IPR which is presented to the Board at each meeting.
- Health and Wellbeing – have comprehensive health and wellbeing offer and are leading the ICS Enhanced Health and Wellbeing and occupational health workstream. This is monitored through the PCB workforce steering group; regular updates are provided to the Board on wellbeing and a NED wellbeing guardian is in post. A Health and Wellbeing Strategy is also in place – this was approved by the Board in January 2022.
- Department of Education, Research and Innovation (DERI) Strategy – newly developed and discussed by the Board – clearly articulates the ambition of the Trust to support workforce, research and innovation to make the Trust a more attractive place to work. Have just agreed that DERI will produce a bi-annual report for FPC Committee.

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:

- Recruitment and Retention Group have oversight of the vacancies and risks associated with nurse staffing – overseen by Senior Nurse Leadership of the Trust.
- 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. Also inform delivery against the clinical strategy.
- Medical Recruitment and Retention Steering Group
- Workforce Innovation team – looking at how we can improve what we offer as an employer at a Trust level to enable us to retain people (flexible working, redesign).
- Trust Well Team – lead on engaging with the workforce and developing the Trust response to emerging wellbeing needs.
- Operationally this is delivered through the DERI and Educational Delivery Board.
- Establishment of a Workforce Assurance Group will provide Divisional and organisational focus on workforce priorities and enable co-ordination of activity across multiple teams. The Group will report to the Trust's Quality Committee.

Specialist support, policy and procedure setting, oversight responsibility:

- Recruitment, retention and staff in post data is monitored through IPR and Quarterly Workforce Report to FPC.
- Policies and procedures at a workforce level are done through engagement at divisional level and with staff networks, work with staff side colleagues and through agreement via the policy group and ratification at a Trust Board and Sub-Committee level.
- 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.

Independent challenge on levels of assurance, risk and control:

- 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).
- Workforce Race Equality Standard (WRES) and Workforce Diversity Equality Standard (WDES) action plans with timelines in place. Regular reporting to the 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 5b

	• Monitored by NHS England and the ICB on our bank and agency spend – have been identified as good practice – drives recruitment strategies for the Trust. • Workforce Audit Plan – translates to Annual Internal Audit Plan – escalated to Sub-Committees.

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	Develop recruitment plan to support delivery of the 2022-23 workforce plan	Director of HR and OD	October 2022	Plan has been agreed but required refinement based on current workforce transformation activity. The plan remains under constant review.	G
2	Achieve zero nurse vacancy position	Delivery of plan focused on nurse recruitment and retention	Director of HR and OD	March 2023	Workforce Innovation Team are undertaking a focused piece of work specifically on retention.	G
		Delivery of international recruitment campaign – further new starters	Director of HR and OD	October 2022	International Nurse pipeline is continuing to deliver against this trajectory with some minor delays due to visa processing. A further cohort of international nurses has recently been agreed via Executive Team. The Trust has been successful in securing circa £110,000 against three recent HEE bids, for upskilling funding.	G
3	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. The first milestone is to agree the strategy.	Director of HR and OD	October 2022	Delivered flexible working manifesto and are working with teams to deliver flexible working pilots. Trust retention strategy to be developed – strategy to go through Executive Team and then be presented to Quality Committee at the end of October 2022. A new approach to exit interviews called 'Moving On Conversations' has been rolled out and this will inform the retention strategy. The Workforce Innovation Team have been undertaking engagement with newly qualified nurses and those nurses nearing retirement age to gain insight into what would help to retain them. There is no further update to provide on this action.	G
4	Regional/national shortage of roles	Explore opportunities for collaborative working/system-wide roles through Lancashire and South Cumbria ICS e.g. Diagnostic Network	Director of HR and OD	April 2023	ICS Clinical Strategy and Trust Clinical Strategy will start to identify where wider system opportunities exist. Work is ongoing with PCB colleagues to identify wider system opportunities as the clinical strategy emerges. The timeline for this work is largely of the hands of the Trust.	A
5	Risk of staff leaving the NHS due to burnout.	Delivery of the Enhanced Health & Wellbeing offer to the ICS. Next steps are to revised the model and proposition.	Director of HR and OD	December 2022	Exploration phase is complete with a model expected by December 2022. A wellbeing website has been delivered providing consistency across the ICS. Following the exploration phase proposals to spend the £1.5m awarded to the ICS are being developed, date to be confirmed. The winter wellbeing offer is being promoted across the Trust. The costs of living working group has been established and is working up a number of support offers to help staff in the current financial climate. A number of initiatives have been implemented to support staff.	G

					The OD and Well team are continuing to explore how staff can be further supported during this period of unprecedented demand.	

BAF Risk 6

Risk Description: 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.	**Executive Director Lead:** Executive Director of Finance
Strategy: Finance Strategy	**Date of last review:** Executive Director: 5 October 2022 ERAG: 27 October 2022
Links to Key Delivery Programmes: Waste Reduction Programme	**Lead Committee:** Finance and Performance Committee

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

Current Risk Rating: C5 x L4 = 20

Initial Risk Rating: C5 x L4 = 20

Target Risk Rating: C4 x L3 = 12

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 plans for 2022-23 developed via annual planning process and signed off by the Trust 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 2022, further update to go to Audit Committee in October 2022.
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Waste reduction programme 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.

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 Corporate Collaboration group oversees potential savings and other benefits of corporate collaboration opportunities including strengthening fragile services.
- System Financial Recovery Board has been established with the aim of ensuring financial sustainability across all Integrated Care System partners.
- 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.

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:

- 2021-22 financial targets achieved in accordance with agreed plan.
- Financial plan submitted to System and Regional team in line with all national planning deadlines/timetable and opening plans have been issued to budget holders
- 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 Waste reduction programmes continuing to be developed
- Deficit to month 5 reported due to system planning gap. 2/3 of the system planning gap now has potentially identified schemes. The Trusts and ICB continue to work as a system to address this gap.
- Additional financial controls are in place to reduce spend.
- The Financial Plans for 2022-23 were presented to the Board at their meeting in May 2022 and approved.
- Benefits Realisation team established, recruited to and some staff have commenced in post.
- There have been additional financial controls and systems implemented to improve control of spend.

Specialist support, policy and procedure setting, oversight responsibility:

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

Independent challenge on levels of assurance, risk and control:

- Internal and external audit – agreed internal audit plan for 2022-23, clean Head of Internal audit opinion received, clean external audit of annual accounts for 2021-22 received, counter fraud workplan for 2022-23 agreed.
- Mersey Internal Audit Agency (MIAA) audit of Care Quality Commission (CQC) Well-led evidence underway.
- Re-accreditation at Finance Staff Development (FSD) level 3 (the highest level) for financial management within the finance team and supporting the wider organisation. 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.

BAF Risk 6

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Medium term financial strategy to be developed (financial recovery)	Finalise and sign-off through Finance and Performance Committee	Executive Director of Finance	Q3 2022-23	Draft strategy currently in development This will move to Q2 due to delays in the national planning cycle.	RA
2	Fully identified Waste Reduction Programme 2022-23	Continue work with Divisions and central to develop plan for 2022-23	Executive Director of Finance	To be confirmed	Partially completed and reviewed at FAB. Current gap is around 25% of total. To be reviewed monthly. May 2022 not met due to operational pressures and the level of savings requirement.	A
3	ICS system finance governance to be determined/clarified.	Directors of Finance (DoFs)/ Chief Finance Officers (CFOs) to work with ICB leads to ensure robust governance.	System leads	No date set yet but reviewed in September 2022 and further review in November 2022.	Work continues through the System Finance groups. ICB formalised structure from July 2022, governance decision still to be finalised but the majority of financial decisions are going through the System Finance Group for review. Executive ensuring that decisions also go through Trust Boards.	A
4	Accountability Framework to be ratified.	Redevelopment of Trust Accountability Framework to reflect principles of Improvement Practice and management system developments.	Executive Director of Finance	November 2022	To go through Executive Team and Senior Leadership Group in July 2022. This remains under review by the Executive Team and will be presented to SLG in November 2022.	A
5	Full system planning gap not identified.	The Trust is working with other Trusts and ICB to address the gap.	Executive Director of Finance	November 2022	Programme of works identified and DoF is close to all work on the system gap, current position is 2/3 looks achievable but further work to do as this is at risk.	A
6	Additional financial pressures identified in year related to EPR, pay award funding, non-pay inflation, impact on staff of cost of living, winter pressures, and elective recovery.	In-depth review to determine mitigations and report through Finance and Performance Committee.	Executive Director of Finance	November 2022	Currently underway	A

Risk Description: The Trust fails to deliver the strategic objectives set out in its NHS Green Plan	**Executive Director Lead:** Executive Director of Finance
Strategy: Wider sustainability (NHS Green Plan)	**Date of last review:** Executive Director: 5 October 2022 ERAG: 27 October 2022
Links to Key Delivery Programmes: Waste Reduction Programme / Sustainability	**Lead Committee:** Audit Committee

Risk Rating (Consequence x likelihood):

Current Risk Rating: C5 x L3 = 15

Initial Risk Rating: C5 x L4 = 20

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)

Strategy Development:

- ELHT's Green plan 2022-2025, which sets out the road map to achieve the Net Zero goals of the NHS and other sustainability requirements outlined in the NHS Long Term Plan and NHS Standard Contract, has been developed and signed off by the Trust Board in March 2022 to ensure the Trust is able to meet its required obligations.
- NHS Green plan published on Trust website to facilitate public access to commitments made and the monitoring of the achievement of the objectives.

Strategy Delivery:

- A 3-year measurement contract has been agreed and is in place with an external provider to support monitoring of anticipated benefits as outlined in the agreed Green Plan. Annual assessment will take place once a year in November to undertake measurement and document progress against key plan objectives.
- There is Lancashire and South Cumbria Integrated Care System (ICS) oversight arrangements in place via ICS Estates and Facilities team and Estates Infrastructure Group to monitor delivery against the agreed plan. The Trust Green plan also forms part of wider ICS plan.

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:

- Green Plan target setting achieved in accordance with agreed timescales
- Green Plan submission to ICS achieved in accordance with agreed timescales
- Divisional Waste reduction programmes in development
- National feedback received on NHS Green plan – positive with some recommendations (already covered in local action plan)

Specialist support, policy and procedure setting, oversight responsibility:

- Benefits realisation team recruited to who will assist in monitoring of plan
- Corporate collaboration – full participation in all areas to maximise benefits for collaborative working and sustainability (refer to BAF 1)
- Clinical pathways ICS – full participation in all current identified work programmes (refer to BAF 1)

Independent challenge on levels of assurance, risk and control:

- Independent oversight arrangements in place with annual review over 3 years

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: 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	Green Plan governance arrangements to be established	Governance to be agreed through Executive Team and Senior Leadership Group	Executive Director of Finance	November 2022	In development – to go to Executive Team Meeting/Senior Leadership Group in August 2022 Delayed to November 2022 due to operational pressures	A

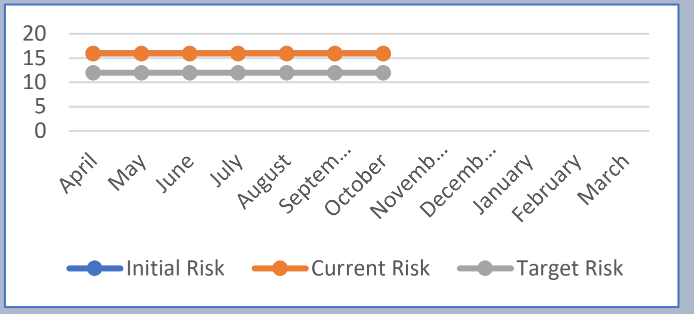
2	Benefits Realisation team establishment	Lead post to be recruited to	Executive Director of Finance/ Interim Director of Service Development and Improvement	July 2022	Project team staff in post; lead post recruited and commenced in post Complete	BA
3	Fully identified Waste Reduction Programme 2022-23	Continue work with Divisions and central to develop plan for 2022-23	Executive Director of Finance	To be confirmed	Partially completed and reviewed at Finance Assurance Board (FAB). Current gap is around 25% of total. To be reviewed monthly May 2022 not met due to operational pressures and the level of savings requirement.	A
4	Fully identified programme to meet annual targets for NHS Green plan	Underway – linked to governance in point 1	Executive Director of Finance	November 2022	In process of being pulled together. Will be included in presentation to Execs/SLG Delayed to November 2022 due to operational pressures	A
5	Trust wide sustainability group paused through covid	To be re-established	Executive Director of Finance	November 2022	Revised TORs in development – Inaugural meeting September/early October Delayed to November 2022 due to operational pressures	A

BAF Risk 8

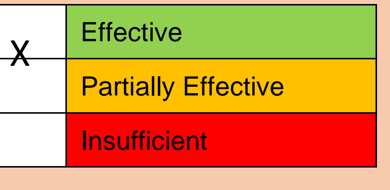
Risk Description: The Trust's transition towards increased digitisation of records and communication disrupts the current clinical and operational service delivery to such a degree that it increases the risk of harm to patients, The reliance on digital systems also increases the impact upon the services should the Trust be subject to a Cyber-attack or significant infrastructure failure.	**Executive Director Lead:** Executive Director of Finance
Strategy: Digital Strategy	**Date of last review:** Executive Director: 4 October 2022 ERAG: 27 October 2022
Links to Key Delivery Programmes: eLancs Programme / EPR	**Lead Committee:** Finance and Performance Committee

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

Current Risk Rating: C4 x L4 = 16
Initial 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: 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)

eLancs/ePR programme

- Detailed eLancs and ePR programme plans in place which are constantly monitored and evaluated by the Informatics ePR Team with supporting delivery team structure in place to ensure appropriate mobilisation of resources.
- Daily meetings with senior team leaders to discuss progress and address upcoming work programmes and issues.
- Detailed risk and Issues logs, constantly monitored and updated and reported via ePR governance structure.
- Regular updates provided to Senior Leadership Group and Monthly meetings with the Executive.
- Stop / Start / Continue workshops to explore transformation changes in the clinical and operational field to ensure operational readiness and deliver safe and effective transition to the new ways of working and overseen by Interim Director of Service Development and Improvement.
- Operational readiness phase preparations underway and overseen by the Chief Operating Officer. Organisational readiness group set up in line with ePR Governance structure.
- ePR Go live date being reprofiled due to extension of system interface work, detailed project plans for all systems in place. Executive and Board fully briefed. The Trust will confirm new go live date mid October 2022.

ICS strategic ePR developments:

- ELHT presents to and is fully engaged in single ePR convergence programme for Lancashire and South Cumbria. The Integrated Care System (ICS) is building upon the work ELHT is doing to implement ePR.
- Working with the ICS the digital teams recently completed a population health management solution appraisal and plans are in place to undertake a full business case for such a solution before the end of the financial year.

Core infrastructure and Cyber defences

- ELHT has significantly upgraded its networks, core infrastructure and cyber defences utilising the latest technology and tools in accordance with best practice and in coordination with ICS colleagues.
- ELHT has been joint authors and contributors to the development of the 'Northern Star' digital strategy which set out the strategic goals for key digital services (infrastructure / personnel / systems and corporate services). The strategy sets out a common set of principles for future digital services.

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

- Regular formalised ePR Gateway reviews undertaken to ensure programme is meeting all quality indicators and deliverables, also ensuring resources are lined up for the next phase of the programme.
- ELHT has representation on all key strategic digital governance groups including Core ePR Group, Digital Design Authority and Digital Portfolio Board.
- ELHT continue to attend all supplier pre-engagement events, supports the formulation of all business cases and output-based specifications for a consolidated ePR system across the region.
- ELHT are signatories to the Common Systems Roadmap whose main themes are to support the development of shared core hospital ePR, shared specialty systems and the development of a data orchestration ecosystem.

Specialist support, policy and procedure setting, oversight responsibility

- ICS wide, Information Governance and Information Security Boards set up ensuring best practice is maintained and lessons learnt identified and disseminated.
- 5 Core Infrastructure teams set up to explore key corporate digital areas: Printers, End User Devices, Unified Communications, Service Desk, Managing patient records.
- Digital Northern Star paper has been produced, presented to the ICB and signed off by the Provider Collaborative Board which extends the previous Memorandum of Understanding between providers into a formal arrangement to collaborate and develop.
- £5m has been secured at ICS level to support the development of a shared data warehouse and Trusted research environment, ELHT has been instrumental in supporting this bid and has already built the infrastructure necessary to take the solution forward.
- Finance and Performance committee receive regular reports on progress of eLancs and ePR programme and will oversee benefits realisation.
- Weekly updates provided to Senior Leadership Group.
- Monthly face / face with Trust Executive including St Vincent's (external oversight group).

Independent challenge on levels of assurance risk and control

• ELHT is a core contributor to ICS wide strategic groups, focussing particularly on Cyber defences and Information Governance. Congruence in procurement and deployment of systems has been attained for key defence and support tools.	• Employment of an external outside expert group to monitor progress and advise on corrective actions if required. • ELHT attends bi-weekly meetings with all Chief Information Officer's (CIO) and senior digital leaders in the ICS to monitor progress and set activities to support the digital northern star. • MIAA Data Security Protection Toolkit (DSPT) assessments prior to submission. • External Penetration Testing of Systems. • External Audit of programme and spend (Mazars).

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/Impact	BRAG
1	Resource constraints in Cyber teams across the region	Address local vacancies and skill set deficits and coordinate with regional leads to centralise functions where possible	Executive Director of Finance	October 2022	Applications received, shortlisting commenced.	G
2	Capacity of digital senior leaders at ELHT to fully contribute to ICS strategic initiatives due to pressure of ePR workload	Ensure senior leaders co-ordinate activity and share pressure, triage meetings to remove less significant meetings and duplication.	Chief Information Officer	April 2023	Meetings shared and most important have ELHT representation, offline contributions to others maintained. Meeting other CIO's out of core hours bi-weekly to update and manage ICS challenges. New ICB Digital Lead employed, reviewing co-ordination and corporate collaboration between provider organisations.	G
3	Requirement to have independent readiness assessment nearer to Full Dress Rehearsal	Engage third party to undertake organisational readiness assessment	Chief Information Officer	February 2023	Discussed with previous Cerner sites and NHS England – a number of suppliers have been highlighted. FDR date moved (awaiting new go live date) bi-weekly meetings with NHS Digital	G
4	Policies / procedures / SOP's and Locsips not yet updated to reflect change in systems.	Coordinate prioritisation, updates and ongoing revision of all documents.	Associate Director of Quality and Safety	November 2022	Paper re process being developed and working groups being set up.	G
5	Updated Digital Strategy to reflect current changes	Update ELHT Digital Strategy to reflect Integrated Care Board changes, ePR delivery, NHS England focus and emerging national strategies	Chief Information Officer	January 2022	Document in development, regularly updated, final version to be published on completion of ePR go live.	G
6	Business Case completion for consolidated ePR across Lancashire and South Cumbria	Blackpool Teaching Hospitals need to complete and gain approval for their business case for ePR which will facilitate procurement across the ICS for which ELHT will be a part.	Chief Information Officer, Blackpool Hospitals NHS Foundation Trust	September 2023	Business case in preparation.	A

BAF Risk 9

Risk Description: The Trust's Improvement Practice and key delivery programmes do not sufficiently build improvement capability and support delivery on agreed outcomes.	**Executive Director Lead:** Interim Executive Director of Service Development and Improvement
Strategy: ELHT Strategic framework (SPE+ Improvement Practice and Key Delivery Programmes)	**Date of last review:** Executive Director: 10 October 2022 ERAG: 27 October 2022
Links to Key Delivery Programmes: Overarching all Key Delivery Programmes	**Lead Committee:** Finance and Performance Committee

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

Current Risk Rating: C4 x L3 = 12

Initial Risk Rating: C4 x L4 = 16

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)

Improvement Practice:

- Established and evidence-based Improvement Methodology and Practice (Improving Safe, Personal and Effective Care (SPE+)), led by Interim Director of Service Development and Improvement to ensure delivery of more reliable improvements and outcomes.
- Development of Lancashire and South Cumbria (LSC) system-level method of improvement and agreed testing on one system priority during 2022-23 to support single approach to system improvement work.
- Established Improvement Hub team to support delivery of Improvement priorities within Key Delivery Programmes
- SPE+ Improvement Practice Development Objectives 2022-25 agreed as part of Trust Strategy refreshes (to be built into all strategies but currently signed off as part of Quality Strategy and Clinical Strategy via Trust Board) to ensure organisational sign up to Improvement and development of improvement capacity and capability across the organisation
- Detailed Improvement Practice Development Plan 2022-25 and 1-year delivery plan to support embedding of improvement across the organisation.
- Alignment of Improvement Hub team resources to support improvement priorities within key delivery programmes
- Level 2 and 3 training complete and available. Level 1 and 4 training in development. Training delivery plan development complete.

Strategy Deployment:

- Strategy deployment framework designed to ensure clear alignment of Trust vision, values, goals to key delivery programmes and business plans that meet national and local planning requirements
- Key delivery programmes being reviewed/established internally and across Place Based Partnerships (PBP) / Provider Collaboration Board (PCB) / Integrated Care System (ICS) as appropriate with clear programme/project plans and benefits realisation framework aligned to SPE+
- Successful completion of 2022-23 planning to sign off key strategies, agree operational plans and identify Key Delivery and Improvement Programmes

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:

- ELHT Key Delivery Programme Boards, Pennine Lancashire Place-Based Partnerships Boards and PCB/ICS Programme Boards established or in process of being established to monitor delivery of programme and improvement plans
- Trust Improvement Register has 400+ improvement projects registered (March 2022) and status monitored at Divisional Transformation Boards and Clinical Effectiveness Committees.

Specialist support, policy and procedure setting, oversight responsibility:

- Key Delivery and Improvement Programmes monitored at Senior Leadership Group and relevant Trust Board sub-committees
- Pennine Lancashire Delivery Boards and PCB/Integrated Care Board (ICB) Programme Boards report through relevant Pennine Lancashire, PCB/ICB governance structures
- External Executive Sensei support on development of Improvement Practice in place

Independent challenge on levels of assurance, risk and control:

- Mersey Internal Audit Agency (MIAA) audit of financial sustainability and improvement practice complete with action plan agreed and sign off off at Audit Committee with substantial assurance
- MIAA audit of CQC Well-led evidence complete
- Peer to peer challenge and reviews by LSC Improvement Leads

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.

BAF Risk 9

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/Impact**	**BRAG**
1	Final SPE+ Improvement Practice Development Plan	Finalise and sign off final detailed plan 2022-23 including key performance indicators and monitoring plan	Interim Director of Service Development and Improvement	December 2022	Plan developed and shared with Executive. Trust Board development session being planned for December 2022 to ratify.	G
2	Resource alignment to Improvement Priorities	Complete Improvement Hub alignment to improvement priorities in key delivery programmes	Interim Director of Service Development and Improvement	September 2022	Complete	B
3	SPE+ capacity and capability development plan	Finalise training delivery plan and associated communication plan to ensure uptake of training in line with agreed training numbers	Interim Director of Service Development and Improvement	March 2023	Increase attendance to Level 2 and 3 training in 2022-23 and launch Level 4 from April 2023.	G
4	System Improvement Model developed and in early stages of testing (refer to BAF1).	Active participation in development of Model for Improvement. Testing of Improvement Model on Frailty/Respiratory.	Interim Director of Service Development and Improvement	March 2023	Engineering Better Care for L&SC underway for Frailty. Pennine Lancashire team in place and workshop 1 complete	B
				Autumn 2023	Ongoing participation in Engineering Better Care for L&SC Programme and further refine of system improvement model.	G
5	Ongoing Strategy deployment framework development required to mature approach	Further development of strategy deployment approach to create a golden thread from Trust Strategy and team and individual objectives.	Interim Director of Service Development and Improvement	End December 2022	Completion of outstanding in accordance with agreed timeline. Review and develop plans for 2023-24 operational planning at organisational level and work with system partners to align planning for 2023-24.	G
6	Key Delivery programmes to be fully established and provide assurance of delivery through agreed reporting arrangements	Full mapping of all key delivery programmes (ELHT/PBP/PCB) and finalisation of clear delivery plans and associated measurement plan	Exec per programme	March 2023	Complete but ongoing review required to update as PCB/ICB priority workstreams are reviewed and established as the ICB develops over coming months. Work ongoing to mature measurement plans and ongoing evidence of impact.	G
7	Executive Wall and Visual Management	Development of executive leadership wall to enable oversight of all key delivery programmes	Interim Director of Service Development and Improvement	End October 2022	Pilot and establish regular Executive Wall meetings to review and oversee Key Delivery programmes and delivery of Trust Goals - commences 1 November	G

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

9 November 2022

Item	**144**
Purpose	Information Assurance

Title	Patient Safety Incident Response Assurance Report
Executive sponsor	Mr J Husain, Deputy 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 management of serious incidents reported to CCG under the Serious Incident Framework (SIF) up to 30th November 2021. This report includes information on maternity specific serious incidents reporting as required by Ockenden recommendations.

Recommendation: The Board is asked to receive the included update on the implementation of the PSIRF.

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

Related to key risks identified on assurance framework

1. The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter.
2. The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive.
3. The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.
4. The Trust is unable to see, treat and discharge/admit/transfer patients within the prescribed timeframes due to:
    - the volume and complexity of their needs
    - the unavailability of alternative consistent services in the community
    - lack of workforce (links to BAF 5b)
    - lack of flow within the organisation
5. The Trust's Improvement Practice and Management System (including strategy deployment framework and associated key

delivery and improvement programmes) do not sufficiently build improvement capability and support delivery on agreed outcomes.

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

1. Incidents reported under the Patient Safety Incident Response Framework (PSIRF) from 1st December to 12th October 2022

1.1 Patient Safety Incident Investigations (PSII)

1.1.1 As part of the Trust being an early adopter of the PSIRF, certain incidents that meet a national or local priority are selected for investigation by the (PSII) Team, as of 12th October 2022 the Trust has reported a total of 32 PSIIs:

- Of the 32 reported PSIIs:
  - 14 are currently being investigated by the PSII Team, these have been allocated to lead who work with patients and families to develop Terms of Reference and agree timescales.
  - A further 8 Incidents are currently being investigated by the Healthcare Investigation Branch (HSIB) on average these take 6 months before the Trust receive the final report
  - 4 investigations have been completed and the reports are awaiting Trust approval at PSIRI Panel
  - 6 investigation reports and safety improvement actions have been approved for closure by the PSIRI panel, actions plans are monitored and completion and improvement at the bi-monthly Lessons Learnt Group
- The PSII Team are currently reviewing 12 incidents that meet the criteria under a local priority for investigation.
- A thematic review of all completed investigations is planned for December 2022
- Appendix 1 provides a breakdown on the number of PSII being completed under each category

1.2 Patient Safety Responses (PSR)

1.2.1 All incidents that are of moderate or above harm, that do not meet the national or local reporting priorites for a PSII are required to have a Patient Safety Response (PSR) completed and managed within division. Appendix 2 provides a breakdown of the types of PSR investigations and numbers undertaken as of 12th October 2022.

1.2.2 Over the last 3 months the Divisions have made several improvements to their Divisional Patients Safety Investigation Groups (DPSIG) to enable oversight, assurance and closure of their Patient Safety

Responses (PSR). This has resulted in a significant improvement in the timely allocation, completion and approval of the PSR.

1.2.3 Significant work has been undertaken in MEC division to review the high number of previously outstanding Pressure Ulcer Checklist investigations this has been achieved through a cluster review approach and has led to more timely learning. Once the division has completed these outstanding reviews they will revert back to completing individual PU checklists.

2. Incidents Reported Under the Serious Incident Framework (SIF) to ICB

2.1 Prior to 1st December 2021 the Trust reported Serious Incidents to the Strategic Executive Information System (StEIS) and these required submission to the ICB for closure. As of 12th October 2022, there are 13 open investigations:

- 7 are awaiting feedback from division following queries from the ICB
- 1 is awaiting completion of SIRI feedback
- 1 is awaiting a response from the ICB
- 4 are being investigated by HSIB

2.2 The Trust has 13 reports open under old serious incident framework. Of these 9 investigations and reports have been completed, approved internally and submitted to the ICB for closure, of which 6 have been sent back for further information. 4 are HSIB investigations which can take up to 12 months to close from the date of reporting and are outside the control of the Trust

2.3 There have been a lot of changes of staff within the ICB and this seems to be having an impact on the Trust being able to agree closure with the ICB.

3 Never Events

3.1 The Trust has reported 2 Never Events this year (2022) and completed the investigations, both have now been reviewed and safety recommendations agreed at PSIRI panel. Action plans are being monitored at the bi-monthly Lessons Learnt Group.

4 Patient Safety Incident Requiring Investigation (PSIRI) Panel Overview

4.1 To date the panel has reviewed 10 completed PSII reports:

- 4 reports were approved however require minor amendments

- 6 investigations have had minor amendments completed following PSIRI and are now closed
    - Final reports and safety actions have been shared with patient and/or family.

5 Lessons Learnt and Patient Safety Group

5.1 At the Lessons Learnt group in August a theme was highlighted around clinical handover communication. It was agreed that a new ELHT Patient Safety Alert would be developed to focus on the use of the SBAR tool to enhance communication in clinical handovers. After consideration it was agreed it would be best to develop this in a task and finish group with representation from each Division and supported by DERI. The alert is currently under develop and due to be published this month.

5.2 The falls steering group have focused attention on enhanced care provision over the past quarter as themes from falls with harm indicate challenges around increased observation of care for patients at risk of falls. A focus on embedding of a Cohort Bay sign, this is a capital **C** laminated and placed on the entry door to the cohort bay which indicates that the patients in the bay are at an increased risk of falls and always require a level of enhanced observation. Over the last 3 months there has been a drop in the number of falls which has caused harm to the patient being due to lapses in care.

5.3 Family care are currently reviewing their PMRT process to improve early involvement of clinicians involved in incidents to gain a better understanding of care and to ensure that any concerns or questions from family are captures and addressed as part of the investigation. The division has also developed guidance for supporting staff following a patient safety incident

6 Patient Safety Group

6.1 Work continues to update the Trusts Patient Safety Incident Response Plan and Policy in line with the final draft of the National Patient Safety Incident Response framework was published Nationally on 16th August.

6.2 As part of enhancing and supporting the way lessons learnt are shared across the Trust, the first ELHT Patient Safety Bulletin has been published by the PSII team

and sent out to all Divisions. The bulletin will be published quarterly going forward. The first bulletin contains information on:

- The PSII Team, their roles and background
- Learning from the Never event involving an invasive procedure in April 2022
- Learning from a patients fall with regards to post-falls checklist
- Information on training the team provide and how to book

6.3 A PSIRF review workshop has been arranged on 11th November to review what the trust has achieved with the implementation of PSIRF, what is working well and what areas of the process requires further improvement. All divisions have been invited and are attending.

6.4 A Northwest regional PSIRF Implementation collaborative has been set up to support trusts within the northwest to share ideas, experience and best practice on implementation of PSIRF. There are 4 events planned over the next 6 months with the first on 4th November, the trust will be presenting at the first event providing an overview of its implementation journey of PSIRF, the positive and challenges. These events will also support building key relationships across our ICB, and hopefully enable better joint investigations and sharing learning across the northwest.

7 Maternity specific serious incident reporting in line with Ockenden recommendations

7.1 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 32 maternity related incidents have been reported on StEIS of which:

- 15 have been closed by the ICB with learning
- 12 have been agreed for de-escalation from StEIS by the ICB as no lapses in care identified.
- 3 are currently being investigated by HSIB
- 2 are awaiting feedback from division following queries from the ICB

7.2 Under Ockenden recommendations the Trust is required to provide the Board with the details of all deaths reviewed and consequent action plans using the Perinatal Mortality Review Tool on a quarterly basis, this is included in Appendix 3.

Appendix 1: Priority and category of incidetns accepted for Patient Safety Incident Investigations as of 31st October 2022

PSIIs (National or Local Priority)	Categories (report since 1st Dec 2021 to 12th October 2022)	No: reported	No: under investigation	No: awaiting approval	No: closed
National	Never Events	2	0	2	0
	Learning from Deaths (due to problems in care)	13	8	2	3
	Death or long-term severe injury of a person in state care or detailed under the MHA	0	0	0	0
National priorities to be referred to another team	Maternal Death (HSIB)	2	2	0	0
	Neonatal Death (HSIB)	3	2	0	0
	Unexpected term admission to NICU (HSIB)	3	3	0	0
	Incidents in screening programmes	1	1	0	0
Local	Fall leading to #NOF	2	2	0	0
	DNACPR communication with patient/family	1	0	0	1
	Nil by mouth in venerable adult (6 days)	1	0	0	1
	ED internal transfer / problems / issues	3	0	0	1
	104 Cancer Breach causing moderate or above harm	1	1 ★	0	0
Total		**32**	**22**	**4**	**6**

★ (The 1 investigationt for 104 cancer breach is a cluster review of 6 individual cases)

Appendix 2: Patient Safety Response tools used as of 31st October 2022

No. of PSRs	
Investigation tool	**No.**
Immediate actions	2
Open discussion	5
Rapid review	140
Risk assessment	1
Falls checklist	18
Pressure checklist	520
Clinical/Peer review	45
Cluster review	5
Concise report	53
Specialised reviews	65
Timeline mapping	10
Round table	11
Awaiting to be assigned	34
Total	**909**

Appendix 3 PMRT Board report October 2022

October 2022

Purpose	Information√
	Action√
	Monitoring√

Title	Family Care Divisional Quarterly PMRT Report July 22 – Sept 22
Author	Kathryn Sansby, Bereavement specialist Midwife
Executive sponsor	Tracy Thompson, Head of Midwifery/ Divisional Director of Nursing

Summary: This report aims to enable the division to demonstrate actions taken in response to mortality within the division and to share learning from mortality reviews. This report is a mechanism for sharing improvements and changes in practice made as a result of investigations into mortality. The report enables the sharing of good practice across directorates and wider within the organisation where appropriate.

Recommendation:

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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 the clinical strategy, benefits, and improvements (safe, efficient, and sustainable care and services) and the organisation's corporate objectives Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not

	sufficient to support the delivery of sustainable, safe, and effective care through clinical pathways The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact (delete yes or no as appropriate and give reasons if yes)

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

Previously considered by:

Introduction

During recent years, there have been several investigations into substandard care at various NHS Trusts around in England that has contributed to stillbirths and neonatal deaths. Reports such as the Kirkup report, and drivers such as SANDS have called for a robust system of review for all baby deaths from 22 weeks of gestation up until 28 days of life.

ELHT has had a system in place for a multi-disciplinary review of all perinatal cases for the last few years, however, in response to the National requirement for a robust, standardised review system, the Perinatal Mortality Review Toolkit (PMRT) has been in use since December 2018.

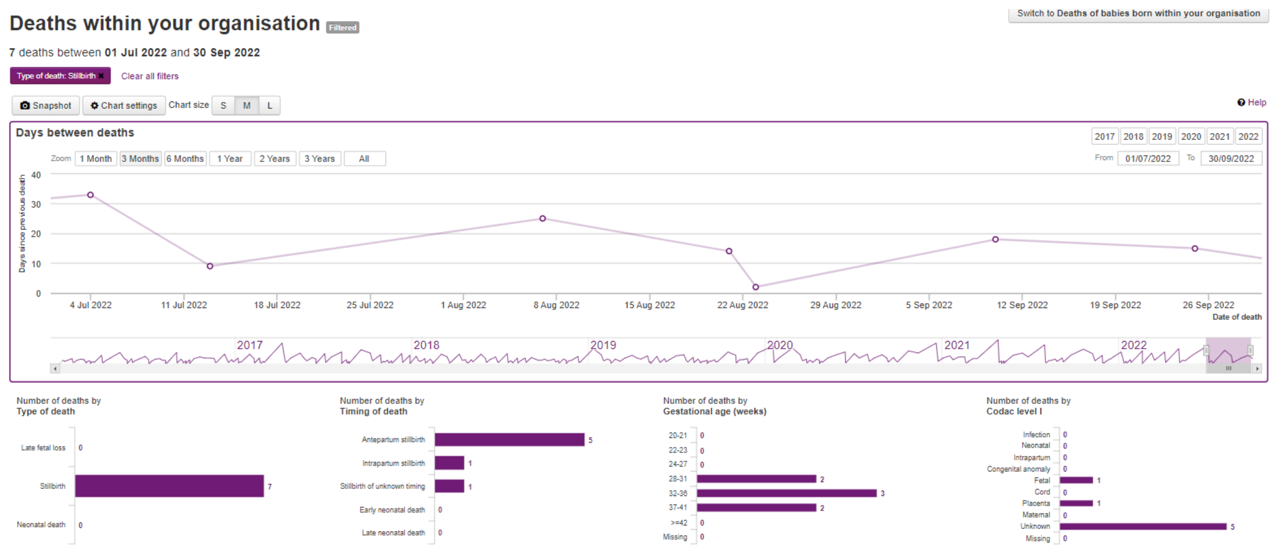
The Healthcare Quality Improvement Partnership appointed a collaboration led by MBRRACE to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'. The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

The aim of the PMRT process, is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. This will support:

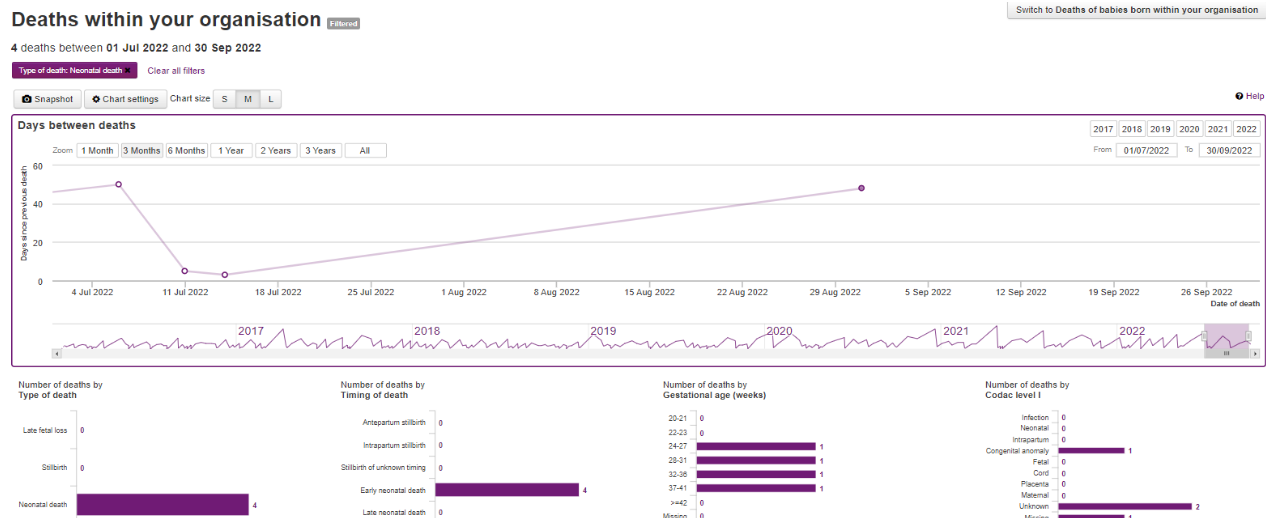
- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

A report should be presented to the Trust Board each quarter detailing the deaths that have occurred and cases that have been reviewed and any learning or issues identified.

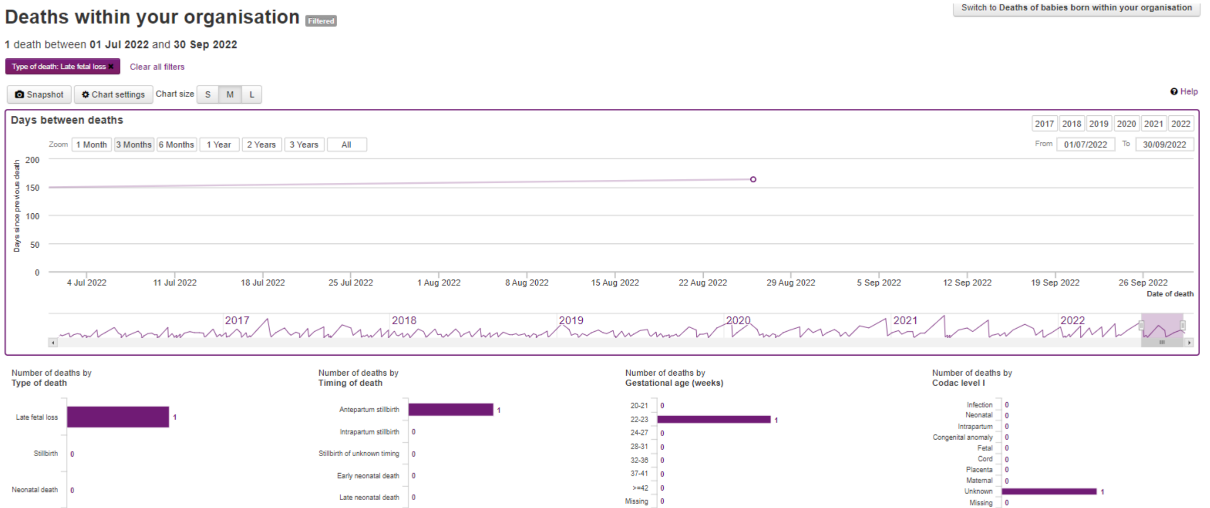
Stillbirths July- September



Neonatal deaths July- September



Late miscarriages (after 22 weeks gestation) July – September



Perinatal mortality review process

Each of these cases will be reviewed in line with the Perinatal Mortality Review Process including the use of the Perinatal Mortality Review Toolkit.

Each case will be reported to MBRRACE within 7 days of the death, and the PMRT process will commence within 2 months of the death.

The review panel meeting should take place 12-16 weeks following the death; this is to allow time to review the case, speak to parents and families and due to the time required for pathology and histology investigations to be completed.

A report should be published within 6 months of the death, although other investigations can delay this.

In addition, 1 of the cases has been referred to HSIB and another to the Coroner. The HSIB investigation must be completed before the PMRT review meeting can take place.

This process has CNST safety actions associated to it, which sets the timeframe for the cases to be reported and completed.

CNST criteria Year 4;

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

<u>Required standard a)</u>

i. All perinatal deaths eligible to be notified to MBRRACEUK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust.

If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

d) Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

Compliance with Safety Action 1; July – September 2022 – new cases

Month	a)i 1	a)i 2	a)ii	b	c	d
July; 5 new cases	100%	60%	100 %	N/A	100%	100%
August; 6 new cases	100%	84%	100%	N/A	100%	100%
September; 2 new cases	100%	50%	100%	N/A	100%	100%

Standard a) i2 pertains to closing MBRRACE cases within 1 month of the death; this standard has not been met due to human error (the cased was closed in 3 cases 1 month following the date the case was reported rather than the date of death)

July- August 2022 – Completed cases (Not eligible for CNST reporting period)

Month case reviewed	a)i 1	a)i 2	a)ii	b	c	d
July - 3	100%	N/A	N/A	N/A	100%	100%

August - 0	**100%**	**N/A**	**N/A**	**N/A**	**100%**	**100%**
September - 7	**100%**	**N/A**	**N/A**	**N/A**	**100%**	**100%**

Lessons learned from PMRT review meeting

- 7 cases had no learning identified from review process.

Case #	Issue	Action	Progress
81649	Carbon monoxide (CO)monitoring not performed as per guideline.	1. CO monitoring guideline to be updated to reflect challenges in practice and amendments included; CO monitoring to be undertaken at Booking appointment and 36 week appointment as mandatory 2. Teaching package to be devised and rolled out to all midwifery and medical staff as mandatory	Completed 30/09/22
80357	VTE not scored accurately until 28 weeks gestation – history of DVT required heparin.	1.Individual feedback to staff concerned 2.All staff reminded to score VTE correctly via Share to Care	Completed 30/09/22
78656	Planned homebirth - baby stillborn following difficulty in auscultation of fetal heartbeat during labour. Woman declined transfer to birth suite. Baby born at home with no signs of life, CPR stopped at home, and mum and bay transferred later to hospital	Guideline updated and strengthened to guide midwives when women are opting for care outside of guidance or declining care in community setting. Guideline updated to provide clear actions to be taken when a baby requires any resuscitation to include presence of paramedics and need for immediate transfer to hospital continuing CPR until care taken over by neonatal team	Guideline awaiting ratification PROMPT training updated to include neonatal resuscitation outside of Hospital setting.

Lewis Wilkinson, Incident and Policy Manager

Jacquetta Hardacre, Assistant Director of Patient Safety and Effectiveness

TRUST BOARD REPORT

Item 145

9 November 2022

Purpose Information

Assurance

Title	Safeguarding of Patients at ELHT Post Edenfield Documentary
Executive sponsor	Mrs J Molyneaux, Interim Chief Nurse

Summary: On the 28 September 2022 the BBC aired a Panorama programme showing patients being abused whilst in the care of a Greater Manchester NHS Trust. This paper demonstrates ELHTs responsiveness in reviewing safeguarding of care and the culture of its services.

Recommendation: The Board is asked to note the actions taken by the Trust in response to the letter sent by the NHS England Mental Health Director and the measures and safeguards in place to ensure the safety of its patients.

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

Related to key risks identified on assurance framework

1. The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter.
2. The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive.
3. The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by: Executive Team meeting, Quality Committee.

Introduction

The BBC Panorama program 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.

A formal request that NHS organisations urgently review their services to consider - 'could this happen here'?

There were 3 key themes urgently requested to be reviewed:

1) Boards to review the safeguarding of care in their organization and identify any immediate issues requiring action now; including but not limited to
    a. freedom to speak up arrangements
    b. advocacy provision
    c. complaints
    d. CERTs and ICETRs (**Not applicable to ELHT)**
    e. other feedback on services
2) Ask how we are not only hearing the patients voice but how we are acting on it? Give consideration to independent peer led support to people being cared for in ELHTs most restrictive settings and peer-led feedback mechanisms.
3) Review use of restrictive interventions, seclusion and segregation, and plans to support people out of these restrictions.

Boards to review the safeguarding of care in their organization and identify any immediate issues requiring action now; including but not limited to

- freedom to speak up arrangements
- advocacy provision
- complaints
- CERTs and ICETRs (**Not applicable to ELHT)**

- Freedom to speak up arrangements

ELHT has a 'Freedom to Speak Up Guardian' (FTSUG) and a deputy role to support this work. The process for raising a concern is fully embedded into the

Corporate Induction and training Programme and is taken from the National Guardian Office (NGO), on ‘speak up', and is now available to all staff with 800 learners completing this module. The ‘listen up’ and ‘follow up’ modules have recently been launched and aimed at senior managers and executives. The appraisal process now incorporates confirmation of awareness of the FTSUG and the service, ELHTs current appraisal compliance is 70% as a consequence of the pressures of the pandemic and all areas are being supported to improve compliance. In addition, the Trust has identified Staff Guardian Champions, these colleagues are all trained in accordance with the NGO guidance, and they meet monthly.

Over the last 6 years 1099 concerns have been raised through the ELHT FTSU processes, 262 of these between April 2021 and March 2022 with 70 of these concerns related to patient care. Over the last 12 months ELHT FTSUG has received 5 concerns identified as whistle blows. Whilst these figures are higher than previous years it is perceived that this demonstrates that staff feel able to raise concerns. The reporting of concerns is escalated to appropriate managers and senior management, with visible action plans and lessons learnt. Policies to support the freedom to speak up and whistleblowing are available to all staff. Formal reports are written and provided up to board level.

- Advocacy provision

ELHT does not detain people under the Mental Health Act and therefore has no formal advocacy arrangements in place, but this would be addressed and commissioned if Mental Health Registration went ahead. In clinical areas general advocacy services are promoted for patients that may require this.

The Trust has a standard operating procedure (SOP) for enhanced care. The purpose of this SOP is to ensure that patients requiring enhanced care, also known as 1:1 care have the appropriate level of supervision and observation available to them. The level of enhanced care is an integral part of a therapeutic care plan, to ensure the sensitive monitoring of the patient’s behavior and mental state and identify factors that may exacerbate or inhibit challenging behaviors; whilst at the same time, fostering a positive therapeutic relationship and using the least restrictive means to maintain safety.

The decision to implement a type of enhanced care is made following a holistic risk and multidisciplinary assessment of the patient's physical and psychological state as well as social and environmental factors at that moment in time. This needs to be clearly documented with the rationale for the level of observations clearly stated and an appropriate observer identified. Examples of instigating enhanced care would be for patients at risk of falls, patients with delirium or confusion who may be wandersome or patients who are extremely vulnerable.

- <u>Complaints</u>

There are Trust policies and procedures to support complaints processes, including reviewing of themes, lessons learnt and actions.
The following information sets out the current concerns and complaints activity within the Trust:

a. Currently the Trust is responding to 71 formal complaints
b. Average number of days to close a complaint is 48 days (August 2022)
c. The top five current complaint themes are as follows:
    i. Patient care
    ii. Clinical treatment in emergency care
    iii. Clinical treatment in surgical services
    iv. Values and behaviors of staff
    v. Communication

d. The Trust currently has 9 complaints being considered by the PHSO; the themes of the complaints are:
    i. Nurse home visiting
    ii. Fall in hospital
    iii. End of life care
    iv. Treatment provided
    v. Visiting restrictions

e. The Trust refers to low level concerns such as queries about appointments as 'level 2' complaints. At the time of the report there were 312 open cases, the top themes from those cases are:
    i. Aspects of Care and Treatment
    ii. Appointment issues

iii. Waiting times for treatment
iv. Delay/Failure to diagnose
v. Medication problems

Over the past twelve months the above data has contributed to services improvements in the following areas:

1. Emergency care in respect of pain management, patient champions to take care of patients and their family's additional needs. Training staff on effective early resolution to concerns and complaints.
2. Strengthening staff approaches to DNACPR discussion with patients and relatives.
3. Improvements to overall aspects to end of life care for patients and their relatives/carers.

- Feedback on other services

Patients across the organisation are encouraged to participate in the Friends and Family Test. Here themes are reviewed and reported. Inpatient areas publicly display themes; 'You said, we did'. Detailing any themes in individual and actions taken. Regular reports on FFT, complaints, numbers, level, themes and responsiveness are all reported in divisions and through the Board Assurance Framework.

There are regular external patient representative groups who ELHT regularly liaise with to receive services user feedback to act upon.

In September 2022 the Trust had an overall FFT positive rating of 92%, with a 4% negative rating. Each Division, Directorate, ward and outpatient area has access to more granular FFT data and are expected to review and where required act upon positive and negative feedback.

Staff actively capture patient, care providers and staff stories from complaints and other sources, which are shared at ward handovers, various forums, and Trust Board meetings.

- Safeguarding

Safeguarding training is mandated for all staff in regard of Safeguarding Adults and Children, in line with intercollegiate guidance. Safeguarding level 3, recently launched, provides an element specific to learning disability patients. Due to difficulties releasing staff to attend the safeguarding team are currently adapting this training to enable attendance over Microsoft Teams.

The Trust has a well-established Safeguarding team, who not only provide training, but are visible across the Trust supporting staff, observing care and advising on complex cases. There is a Trust wide Safeguarding board, that review's themes and discusses any developments that are required.

Ask how we are not only hearing the patients voice but how we are acting on it? Give consideration to independent peer led support to people being cared for in ELHTs most restrictive settings and peer-led feedback mechanisms.

The patients' voice is of great importance at ELHT with a variety of ways for patient to do this, be heard and acted upon. Patient stories are encouraged and supported by the Patient Experience staff, these are shared and articulated at numerous meetings from floor to Board. The Customer Relations Team are required to escalate any safeguarding concerns or concerns in relation to dementia or learning disabilities to their line manager and Safeguarding Team.

b). Learning Disability Liaison Team and Dementia Lead Nurse.

Vulnerable patient groups such as people living with dementia, learning disabilities or complex mental health conditions often require additional support to ensure their voice is heard during their engagement with health care services. Healthcare professional advocate for our patients in numerous ways across ELHT. Firstly, encouraging a culture of person-centred care by using tools like hospital passports, 'This is Me' and 'Reach Out to Me' documents assist staff to understand the unique perspective of the individual in receipt of care and get to know them better, empowering patients to maintain their identity in clinical settings. Involving patients in their care decisions is made more practical using these tools and is essential in advocating autonomy.

ELHT also recognises the vital role that carers play in ensuring quality care is provided to our vulnerable patient groups. John's Campaign is advocated in all clinical areas across ELHT and allows for vulnerable patients to be supported by their family or carers. In addition, the 1:1 Partnership in Care guidelines set out by the trust highlight the further opportunities for relatives and carers to support the patient during their stay in a clinical setting, including: assisting with personal care, assisting with mealtimes, sharing memories or simply making someone feel safe with a familiar presence. All patients who are admitted to hospital across ELHT are also assessed using an enhanced care scoring system to identify those who may require a higher level of observation to maintain their safety. The partnership in care guidance allows for relatives and carers to provide this level of observation where appropriate.

People with learning disability and autism, their supporters/carers and ELHT staff have access to the support and advice of the learning disability nursing team. The aim of the team is to ensure that this at-risk group have safe equitable access to services in the Trust throughout their treatment journey.

A standard escalation pathway is used to enable clinicians to contact the LD liaison team for support and advice, to ensure the individual needs of this patient group are identified and coordinated. Having attended and reviewed a patient the team record their specialist advice in the patients clinical file and to attach an identifying sticker in the record to ensure this does not get overlooked as the clinical record develops during the patient's stay.

NHS England have developed standards to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism or both. ELHT contribute to this data collection each year. The findings from this are collated into the LD Improvement Plan. In order to increase the oversight and visibility of this agenda, an LD focus group is being established as a sub-group of the Safeguarding Assurance and Governance Committee, which reports to the Quality Committee as a sub-group of the Board.

Recommendations from the results of national audit and other service improvement drivers for service delivery including Learning from lives and deaths

– People with a learning disability and autistic people (LeDeR) policy 2021; the STOMP agenda and NICE impact report 2021 inform the current 3-year plan for the care and treatment of people with learning disability and autism accessing our acute hospital services.

In line with the national LeDeR requirements the team review all the deaths in trust of people who have a learning disability. From April 2022 we have included the deaths of people with autism. A standard process has been integrated into Datix which enables the escalation of all patients who have died in our care (who have an associated Learning Disability) for review by the LD team.

This is in addition to the routine Structured Judgement Review (SJR) process. The outcome of the SJR is forwarded to the NHS England LeDeR platform to inform their data collection. The key findings and recommendations are reflected in actions identified from ELHT reviews are listed below and have been incorporated into the LD Improvement Plan:

- Strengthening the understanding of the Mental Capacity Act and how to coordinate and document Best Interest Decisions (this is coordinated through the MIAA improvement plan following audit in 2022)
- Ensuring coordinated End of Life Care Planning to better engage patients and families and enable preferred place of death
- Improving Co-ordination and Communication for people with a Learning Disability who often have complex needs through increased use of the Hospital Passport (including to support DNACPR decisions)
- Improving the awareness of Learning Disabilities and the potential impact on health as opposed to being the defining condition.

<u>The ELHT Dementia Lead Nurse</u>

This role supports vulnerable patient groups by providing practical advice to staffing groups, being available as a signposting service for referrals, acting as an advocate for patients in best interest meetings and ensuring the trust is moving dementia services forward in line with national guidance through the ELHT Dementia Strategy Group Meeting. Royal Blackburn Teaching Hospital

also has a dementia friendly ward C5, designed in accordance with the King's Fund Dementia Friendly Environment Project, where the ELHT Dementia Lead Nurse is based, and patients identified as requiring additional support to meet their needs can be admitted to.

A variety of training is available to healthcare professionals across to ensure patients receive a high quality of care. Both Dementia Tier One and Two e-learning packages have been designed in accordance with the Dementia Standards Training Framework are available to staff.

The Dementia Tier 1 e-learning package has been made mandatory for all patient facing staff and compliance currently sits at 85% as of the 10th of October 2022.To supplement this online training, ELHT Dementia Lead Nurse has created a short, clinically based training session to support health care professionals to understand patient behaviors and consider the unmet needs of people living with dementia. This training has been designed to take less than 10 minutes to complete and has a handout for staff to keep. On a wider scale, staff can attend de-escalation training sessions and enhanced care support training to ensure vulnerable patients receive care that aligns with trust policies and values.

Review use of restrictive interventions, seclusion and segregation, and plans to support people out of these restrictions.

At ELHT we do not detain patients under the Mental Health Act, therefore we do not routinely practice seclusion or segregation. Any deprivation of liberties (DoLS) must be applied following policies and procedures. Staff receive training on their mandated safeguarding and the quality is monitored as part of the Nursing, Accreditation Performance Framework (N.A.P.F.) The number of DoLS patients are reviewed twice a day on staffing calls to ensure safe staffing numbers to care for these patients.

Patients can be brought to the Emergency department by the police under a Section 136 as a place of safety. The ED have a specific and recently updated procedure to ensure the safe management of these patients, in line with the regional guidance.

ELHT's Emergency Department houses the Mental Health 136 patients until Mental Health Provider beds are available. These patients are cared for in a purpose-built area of ED to provide a more calming and safer environment. Joint assessments ELHT and LSCFT on physical and mental health needs are performed. Any deprivation of liberty is recommended by LSCFT Mental Health staff only. ELHT ED staff complete a Mental Health Assurance Tool every shift for adults (soon to be introduce for patients under the age of 18). The tool captures and prompts relevant and appropriate care for patients in ED.

There are patients who may need temporarily restraining for a short time if they become an immediate risk to themselves or others. This is escalated to appropriately trained staff to do so and reported via Datix. ED are currently rolling out a training Programme for staff caring for mental health patients. This encompasses compassionate care and is in line with the Treat as One document (NCEPOD, 2017).

Risks previously identified, in relation to our external security providers use of restricted practices, is being managed through the ongoing transfer of this team to our internal estates division. Incidents in relation to this are escalated to the staff and patient safety group.

The current ELHT policy for restraint is under review to enhance the information in relation to the types of restraint, training and education available and the monitoring of such. The new policy focuses on enabling staff to de-escalate challenging behaviors to reduce the likelihood of escalation and the need for restraint. This is due to be ratified at the next Patient Safety Group in November.

Additional assurance processes.

A). Nursing Assessment Performance Framework (N.A.P.F) team.

ELHT has invested in a corporate clinical team who perform regular Nursing Assessment Performance Framework (N.A.P.F). Visits have taken place in 63 clinical areas (e.g., in-patients, Community Nursing, theatres and ED). The team provide a peer review / accreditation which is based upon the CQC key lines of enquiry (KLOE). The service was established in 2015 and the process has been reviewed externally by the Mersey Internal Audit Agency (MIAA). The latest review in 2020 assessing the robustness and reliability of the N.A.P.F. processes stated them to be 'one of the most comprehensive systems' the MIAA have examined commending the internal accreditation system as providing 'high assurances. Whilst the title of the Team alludes to nursing, the assessment is a holistic review of the clinical area where the nurse or midwifery manager takes accountability for the areas action plans.

In 2022 the Team have performed 73 assessments across 63 areas. The assessments involve speaking with staff and patients separately and triangulate the findings. The assessment questions relating to the Panorama key themes have been added as appendices to provide evidence and assurances relevant to the inquiry. The overall score is the percentage of all the areas assessed to date in 2022.

The N.A.P.F. assessment process observes care delivery and involves asking patients and relatives about their care.

- Appendix 6 shows that ELHT staff are respectful, caring and compassionate.

- The questions and overall % on the N.A.P.F assessments relating to Freedom to Speak Up, the results evidence staff are aware of their responsibilities in raising concerns (appendix 5).

- Appendix 4 demonstrates the questions relating to advocacy and advocacy services and overall % on the N.A.P.F assessments. It is evident throughout the N.A.P.F. process in the 63 areas assessed that staff can articulate their responsibilities to safeguard vulnerable patients.

- Additionally, the N.A.P.F. data relating to complaints (appendix 5) shows that staff are aware of complaints processes and use the information to improve

care, however the overall monitoring and sharing of local action plans requires improvement.

- The N.A.P.F. Team observe care of the most vulnerable patients, interview the staff and scrutinise the documentation relating to mental capacity, care delivery rationale and decisions to deprive a patient's liberty. Appendix 7 demonstrates that staff have a good understanding of this.

B) Executive 'walk abouts'.

There is a rolling program or executive and nonexecutive 'walk abouts' across the organisation. These have continued to be held virtually during the pandemic.

C). Senior Nurses/Matrons

The Trust has senior Nurse presence 24/7. This is senior Nurse leaders and Matrons being visible out in the clinical settings, talking to staff, patients and observing care during working hours and an out of hours team comprising of clinical site manager, Matron, Band 7 support of the matron and Deputy Clinical site managers.

D). ELHT Behavioral Framework

A Behavioral Framework was launched at ELHT during the annual Festival of Inclusion in 2021. This is linked to the NHS People Plan action to create a civil and respectful workplace culture. We have 34 Behavioral Framework Champions across all Divisions of the Trust and including staff side colleagues.

A series of five podcasts have been recorded with colleagues from different divisions and teams across the Trust talking about why they think setting behaviour expectations is important. Each podcast relates to an element of the Framework – **Excellence, Keeping it Simple, Building Trust and Respect, Working Together and Taking Responsibility** and the series is still live on our audio portal.

The Behavioral Framework is now part of the Trust induction to ensure that all staff know what is expected of them from day one, as well as it being integral to

the Trust appraisal process, which includes a conversation and opportunity to reflect about behaviors and how staff all work as a team. ELHT is also working to further embed values, attitude and behavior further into the recruitment and selection processes.

A wealth of information is available via a Trust SharePoint page to support staff and managers in having discussions around behaviors, including:

- A Behavioral Framework self-assessment tool and self-reflection exercises
- E-learning around holding courageous conversations and coaching
- Presentations to enable team conversations around behavior
- How to challenge poor behaviors in the right way

Internal audit processes.

The Trust has integrated reports on complaints and freedom to speak up processes alongside incident reporting, into its annual internal audit program.

NHS England have approached the Quality and Safety team, to participate in a piloting the Health Equity Assessment Tool (HEAT), From January 2023. This is being coordinated via the Patient experience team. This demonstrates the Trusts commitment to equity of access and treatment to all patient groups.

Conclusion

The shocking and reprehensible bullying and abuse behaviors the BBC Panorama programme showed in an NHS Trust has initiated a rapid response for organisations to review their processes and assurances in relation to safeguarding and raising concerns.

At ELHT it is evident that there are embedded processes to enable staff, patients and families to raise concerns and be heard. There is also evidence that data that monitor's this is triangulated and visible at various levels across the organisation, e.g. staff safety group, patient experience group and quality committee.

To ensure robust challenge we have representatives from Health watch and the ICB across all of our Governance meetings. We are looking to introduce patient safety partners in line with the national patient strategy, as a quality strategy priority.

In relation to restricted practices, these are implemented only in the context of DoLS requirements. Which have been reviewed and has clear oversight via an improvement plan. There is evidence that the Trust is aware of potential risks associated with the mental health act and the mental capacity act. Specific risks relating to these are on the corporate risk register and monitored monthly by the Chief executive at the execs risk assurance group (ERAG).

Recommendations

Area of improvement	Recommendation	Timeframe
Develop staff knowledge and education of restraint	Implementation of the De-escalation Policy once ratified	Jan 2023
Increase further the Visibility and monitoring of potential harm to at risk patient groups	Introduction of subgroups to the Trust wide Safeguarding committee, to include MH and LD groups to monitor, report and escalate any concerns in incident/risk/complaints to the Quality Committee as appropriate	Jan 2023

Appendix 1

NAPF 2022 data – Freedom to Speak Up Questions

S5-6	Staff are aware of the Raising Concerns at Work policy?	100 %
W2-4	Staff are aware of their responsibilities in relation to incident reporting and risk management (safety incidents, near misses, raising concerns)?	100%

Appendix 2

ELHT Staff Survey 2021- Culture and bullying - National Staff Survey 2021 also show that ELHT is higher than the national average with regards to organisational culture in relation to bullying and abuse (appendix 2).

Q		2017	2018	2019	2020	2021		National Ave	ELHT
14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	74%	75%	76%	77%	76%		74%	76%
14b	Not experienced harassment, bullying or abuse from managers	90%	89%	89%	90%	91%		89%	91%
14c	Not experienced harassment, bullying or abuse from other colleagues	84%	83%	84%	84%	86%		82%	86%
14d	Last experience of harassment/bullying/abuse reported	52%	49%	50%	51%	48%		48%	48%

17a	Would feel secure raising concerns about unsafe clinical practice	71%	74%	74%	75%	75%		73%	75%
17b	Would feel confident that organisation would address concerns about unsafe clinical practice	62%	66%	67%	64%	63%		59%	63%

Appendix 3

NAPF 2022 data – Safeguarding related questions

S1-10	Staff are aware of their role as being the person to raise the alert for both children and adult safeguarding 'Safeguarding is Everybody's Business'	100
S1-15	Can staff articulate requirement of DSSA requirements (delivering same sex accommodation)	98
S1-4	Staff are aware of how to access specialist mental health advice and support. i.e. Mental Health Liaison Team, Crisis Team, ELCAS	100
S1-5	Staff are aware of all policies relating to Safeguarding Adults and Children, including Recognising and Dealing with Abuse of Vulnerable Adults, Safeguarding Children, Learning Disabilities and Domestic Abuse	100
S1-63	Is there a dedicated children's recovery area that is separate from adult areas?	100
S1-64	Is there a dedicated waiting area in ED/UCC for children?	100
S1-7	Staff are aware of how to recognise domestic abuse and know how to make appropriate referrals and/or signpost for support e.g. Safeguarding Team or Independent Domestic Violence Advisors / Advocates (IDVA)	100
S1-8	Staff are able to identify the referral process to the Safeguarding Adult/Childrens Team for vulnerable patients/children	100

S1-9	Staff are able to identify the process for raising a Safeguarding Alert for alleged abuse of a vulnerable adult/child	100

Appendix 4

NAPF data 2022 – Advocacy related questions

C2-6	Patients receive information they can understand to make informed choices regarding their care and treatment	100
C2-7	Staff are aware of, and support patients to have access to advocacy services that are able to speak on their behalf	99
C2-4	People receive the care and support they need in accordance with their valid consent (including the MCA 2005 and Children's Acts 1989 and 2004)	92
Safe 5- Q6	Staff are aware of the Raising Concerns at Work policy?	100

Appendix 5

NAPF data 2022 – Complaints related question

S5-10	Peoples concerns and complaints are encouraged, explored and responded to in good time.	100
S5-11	Do staff know what to do if a patient or relative voices concerns/complaints	100
S5-12	Staff are aware of the Trusts complaints procedures	100
S5-14	Incidents, concerns and complaints are used as an opportunity for learning and/or improvements? (How is this information shared?)	92
S5-15	There are action plans following incidents/complaints which are monitored and shared to ensure delivery?	77

S5-8	Information on how to contact Customer Relations Team is prominently displayed	99
C2-11	People and those that matter to them are encouraged to make their views and concerns known and that these are addressed and respected	100
C1-6	Staff actively, seek, listen to and act on people's concerns, views and decisions^	100

Appendix 6

NAPF data 2022 – Caring questions

C1-1	Peoples needs in respect of age, disability, gender, race, religion or belief, sexual orientation and gender reassignment are understood by the staff that support them and are met in a caring way	100
C1-10	Patients relatives and friends are able to visit without undue restrictions'	100
C1-12	Staff are motivated, caring and supportive	100
C1-14	Patients relatives and friends are encouraged to participate in care and support as required	100
C1-2	Introductions-Staff introduce themselves to patients and their relatives ^^Patients are aware of the nurse who is caring for them today?	100
C1-4	People say they are treated with kindness and compassion in their day to day care.^	100
C1-8	Staff treat, patients and visitors courteously	99
C1-9	Staff understand and promote respectful and compassionate behaviour	99
C2-1	Staff are able to demonstrate an understanding of 'Best Interest' decision-making for those patients who lack the mental capacity to make a specific decision, in line with the Trust's Mental Capacity Act Policy	95

C2-10	Staff include patients/parents in conversations and plan of care (delivered in a way that patients and relatives can understand)	100
C2-11	People and those that matter to them are encouraged to make their views and concerns known and that these are addressed and respected	100
C2-12	People are given the information and explanations they need in a timely manner and in a way they can understand to enable them to make informed choices in relation to care and treatment	99
C2-13	People are involved as partners in their own care as much as they are able and wish	100
C2-17	Patient privacy, dignity and modesty is maintained at all times by the use of curtains, screens and appropriate clothing and bedding. ^	100
C2-18	People are treated with dignity and respect at all times^	100
C2-19	Permission is obtained before entering any private areas. i.e. curtains, bathrooms, cubicles	100
C2-21	Do patients feel able to discuss concerns/issues they may have with staff	100
C2-6	Patients receive information they can understand to make informed choices regarding their care and treatment	100

Appendix 7

NAPF data 2022 – Mental Capacity and restraint

C2-3	Staff are able to demonstrate an understanding of least restrictive practice (Mental Capacity Act) and discuss how appropriate decisions are made about restraint as a last resort	95

C2-4	People receive the care and support they need in accordance with their valid consent (including the MCA 2005 and Children's Acts 1989 and 2004)	92

Jane Pemberton, Interim Deputy Director of Nursing

Heather Coleman, Corporate Head of Nursing

Alison Brown, Associate Director of Quality and Safety

Matthew Ireland, Acting Deputy Director of HR

TRUST BOARD REPORT

9 November 2022

Item	**146**
Purpose	Information Assurance

Title	Integrated Performance Report
Executive sponsor	Mrs S Gilligan, Chief Operating Officer

Summary: This paper presents the corporate performance data at September 2022

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 assurance framework

1. The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
2. The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter.
3. The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive.
4. The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.
5. The volume of activity that the Trust is able to deliver is insufficient to achieve the required targets and eradicate backlogs.
6. The Trust is unable to see, treat and discharge/admit/transfer patients within the prescribed timeframes due to:
   - the volume and complexity of their needs
   - the unavailability of alternative consistent services in the community

- lack of workforce (links to BAF 5b)
- lack of flow within the organisation

7. Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce.
8. Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy).
9. 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.
10. The Trust fails to deliver the strategic objectives set out in its NHS Green Plan.
11. The Trust's transition towards increased digitisation of records and communication disrupts the current clinical and operational service delivery to such a degree that it increases the risk of harm to patients. The reliance on digital systems also increases the impact upon the services should the Trust be subject to a Cyber-attack or significant infrastructure failure.
12. The Trust's Improvement Practice and Management System (including strategy deployment framework and associated key delivery and improvement programmes) do not sufficiently build improvement capability and support delivery on agreed outcomes.

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

Lancashire and
South Cumbria
Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Board of Directors, Update
Corporate Report

Executive Overview Summary

Positive News

- Average fill rates for registered nurses/midwives and care staff remain above threshold, although continue to be extremely challenging.
- Friends & family scores remain above threshold for inpatients, outpatients and community although have deteriorated from previous levels. Maternity scores have risen above threshold this month and are similar to pre covid levels.
- The complaints rate remains below threshold, and is showing no significant variation.

Areas of Challenge

- There was one incident reported in month which met local or national priorities and was reported onto steis.
- There were 5 healthcare associated clostridium difficile infections, 8 post 2 day E.coli bacteraemia, 4 P.aeruginosa, and 3 Klebsiellas detected in month.
- Friends & family scores in A&E are below threshold.
- The Hospital Standardised Mortality Ratio (HSMR) has increased this month and is 'above expected levels'.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) was not achieved in September at 75.2%.
- There were 627 breaches of the 12 hour trolley wait standard (35 mental health and 592 physical health), which is a significant deterioration.
- There were 466 ambulance handovers > 30 minutes and 18 > 60 minutes. Following validation, 3 of the 18 were actual ELHT breaches and 15 were due to non-compliance with the handover screen. The trend is showing significant improvement.
- Performance against the cancer 31 and 62 day standards has deteriorated and the standards were not met in August at 90.6% and 44.9%.
- The 28 day faster diagnosis standard was not met in August at 74.3% and is still showing significant deterioration from normal variation.

- There were 19 breaches of the 104 day cancer wait standard.
- The 6wk diagnostic target was not met at 15.5% in September.
- In September, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 48,526, and the number over 40 weeks has increased to 2,707.
- In September, there were 646 breaches of the RTT >52 weeks standard.
- In September, there were 3 breaches of the 28 day standard for operations cancelled on the day.
- Length of stay - elective and non-elective are showing deteriorating performance this month.
- Sickness rates are above threshold at 6.3% (August).
- Trust turnover rate continues to be higher than normal, but remains below threshold.
- The Trust vacancy rate is above threshold at 5.9%, and based on current variation is not capable of hitting the target routinely.
- Compliance against the Appraisal (AFC staff) remains below threshold. Appraisals were on hold until March 21.
- Compliance against the Information Governance Toolkit remains below the 95% target at 93%.
- Temporary costs as % of total pay bill remains above threshold at 12%.
- Most areas of core skills training are above threshold, with the exception of information governance and fire safety.
- The Trust is reporting a year-to-date adjusted deficit of £2.5m in month 5, this is £2.8m behind plan which relates to the unmitigated element of the system planning gap held by the Trust. Work will continue through the year across the Trust and system to mitigate this gap by the 31st March 2023.

No Change

- The emergency readmission rate is within the normal range.
- The Summary Hospital-level Mortality Indicator (SHMI) has remained as expected at 1.05.
- Venous Thromboembolism (VTE) risk assessment performance remains above threshold.
- There were 57 operations cancelled on the day (non-clinical). This has returned to pre-covid levels.
- CQUIN schemes have been reintroduced for 2022/23, though for CCGs the CQUIN value will be included in block payments with no adjustment based on achievement levels.

This report presents an update on the performance for September 2022 and follows the NHS Oversight Framework. The narrative provides details on specific indicators under the five areas; Safe, Caring, Effective, Responsive, Well Led

Safe

	Indicator	Target	Actual	Variation	Assurance
M64	Clostriduim difficile (C.diff) - 'Hospital onset healthcare associated (HOHA)'	n/a	5		No target set to provide assurance against
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	0		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	67	30		
M65	MRSA	0	0		
M124	E-Coli (HOHA)	n/a	4		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	2		
M157	Klebsiella species bacteraemia (HOHA)	n/a	3		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	17.8		
M69	Serious Incidents (Steis)	No Threshold Set	1		
M70	Central Alerting System (CAS) Alerts - non compliance	0	0		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	99%		P

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	94%		
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	40%		
C40	Maternity Friends and Family - % who would recommend	90%	96%		
C42	A&E Friends and Family - % who would recommend	90%	75%		
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	8%		
C44	Community Friends and Family - % who would recommend	90%	94%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	94%		
C15	Complaints – rate per 1000 contacts	0.40	0.16		
M52	Mixed Sex Breaches	0			

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.05		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at Jun-22)	Within Expected Levels	113.6		
M74	Hospital Standardised Mortality Ratio - Weekday (as at Jun-22)	Within Expected Levels	111.5		
M75	Hospital Standardised Mortality Ratio - Weekend (as at Jun-22)	Within Expected Levels	119.7		
M73	Deaths in Low Risk Conditions (as at Jun-22)	Within Expected Levels	N/A		
M159	Stillbirths	<5	2		
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

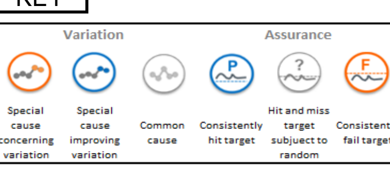
	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95.0%	73.8%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95.0%	75.2%		
M62	12 hour trolley waits in A&E	0	627		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	466		
M84	Handovers > 60 mins (Arrival to handover)	0	18		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	44.0%		
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set	69.0%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	41698	48,526		
C4.2	Referral to Treatment (RTT) waiting times Incomplete pathways -over 40 wks	No Threshold Set	2707		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	474	646		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1.0%	15.5%		?
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	44.9%		?
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	73.3%		?
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	90.6%		?
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	100.0%		P
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	82.1%		?
C36	Cancer 62 Day Consultant Upgrade	85.0%	75.7%		?
C25.1	Cancer - Patients treated > day 104	0	19.0		?
C47	Cancer - % Waiting over 62 day (Urgent GP Referral)	N/A	17.20%		
C46	Cancer - 28 Day faster diagnosis standard	75.0%	74.3%		?
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	3		?
M138	No.Cancelled operations on day	No Threshold Set	57		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re-admissions within 30 days	No Threshold Set	12.2%		
M90	Average length of stay elective (excl daycase)	No Threshold Set	3.6		
M91	Average length of stay non-elective	No Threshold Set	5.4		

Well Led

	Indicator	Target	Actual	Variation	Assurance
M77	Trust turnover rate	12.0%	7.5%		
M78	Trust level total sickness rate	4.5%	6.3%		
M79	Total Trust vacancy rate	5.0%	5.9%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	70.0%		
M80.35	Appraisal (Consultant)	90.0%	93.0%		
M80.4	Appraisal (Other Medical)	90.0%	96.0%		
M80.2	Safeguarding Children	90.0%	94.0%		
M80.21	Information Governance Toolkit Compliance	95.0%	93.0%		
F8	Temporary costs as % of total paybill	4%	12.0%		
F9	Overtime as % of total paybill	0%	0%		
F1	Variance to H1 financial performance surplus / (deficit) (£m)	£0.0	-£3.4		
F2	Variance to H1 Waste Reduction Programme (WRP) achieved (£m)	£0.0	£0.0		
F3	Liquidity days	-12.4	(£12.3)		
F4	Capital spend v plan	85.0%	84.0%		
F18a	Capital service capacity	1.4	1.2		
F19a	H1 Income & Expenditure margin	0.0%	-1.0%		
F21b	Variance to agency ceiling (in millions) *	£0.0	-£2.5		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	93.6%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	97.4%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	96.9%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	98.7%		

NB: Finance Metrics are reported year to date.

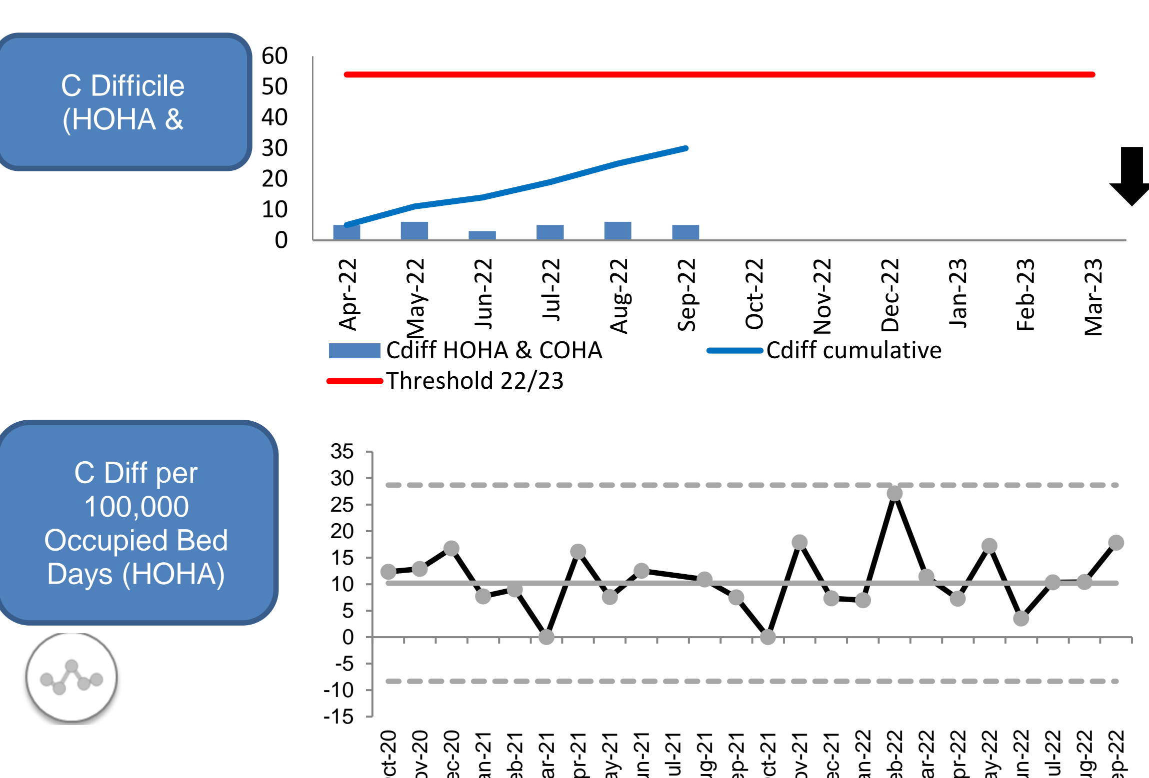
KEY



SPC Control Limits

The data period used to calculate the SPC control limits is Apr 18 - Mar 20.

SAFE



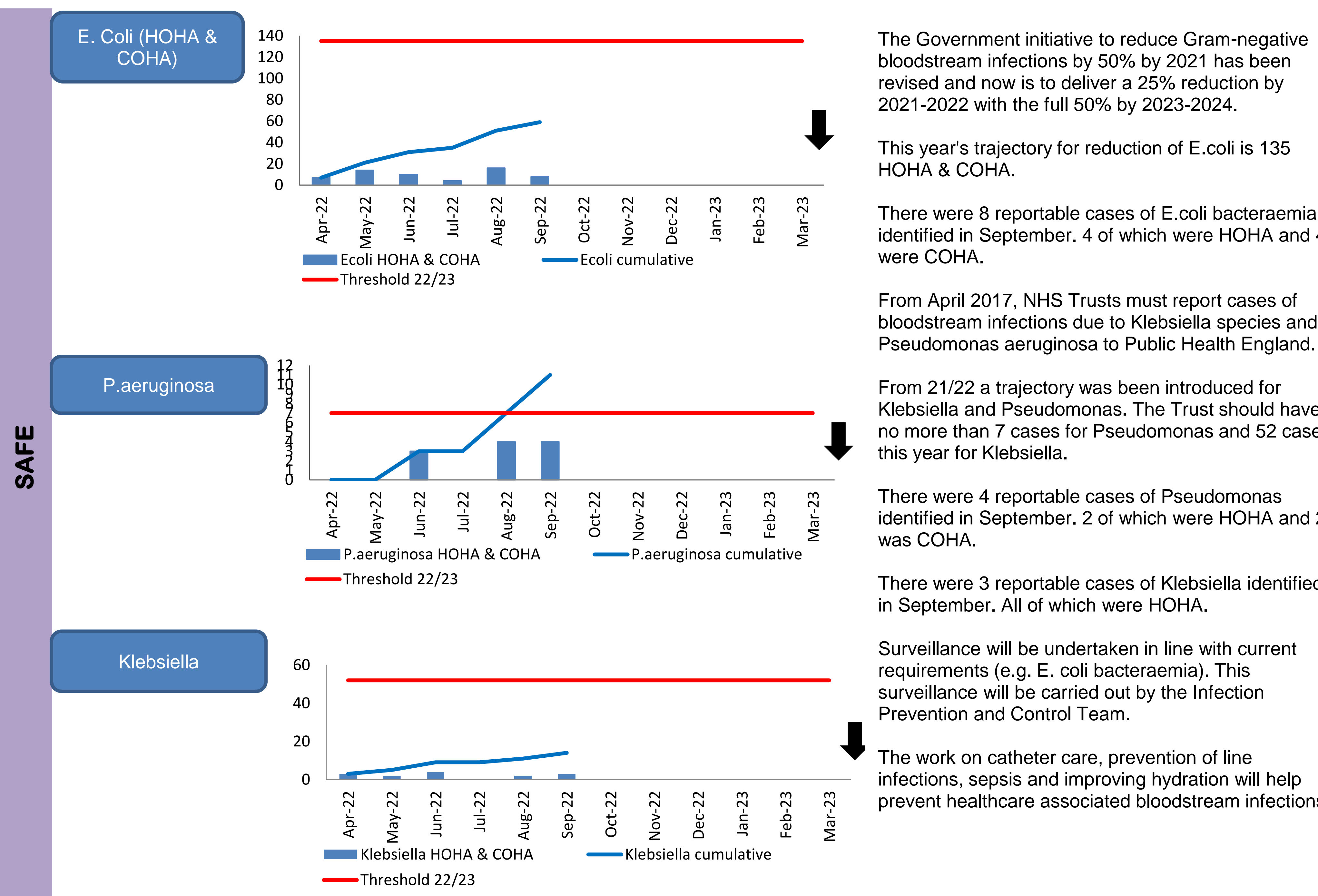
There were no post 2 day MRSA infection reported in September. So far this year there has been 1 case attributed to the Trust.

The objective for 2022/23 is to have no more than 54 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)'. The final figure for cases reported in 2021/22 was 57.

There were 5 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in September. All 5 were HOHA and 0 were COHA.

The year to date cumulative figure is 30 (HOHA & COHA). The detailed infection control report will be reviewed through the Quality Committee.

The rate of HOHA infection per 100,000 bed days is still within the normal range in September.



The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

This year's trajectory for reduction of E.coli is 135 HOHA & COHA.

There were 8 reportable cases of E.coli bacteraemia identified in September. 4 of which were HOHA and 4 were COHA.

From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England.

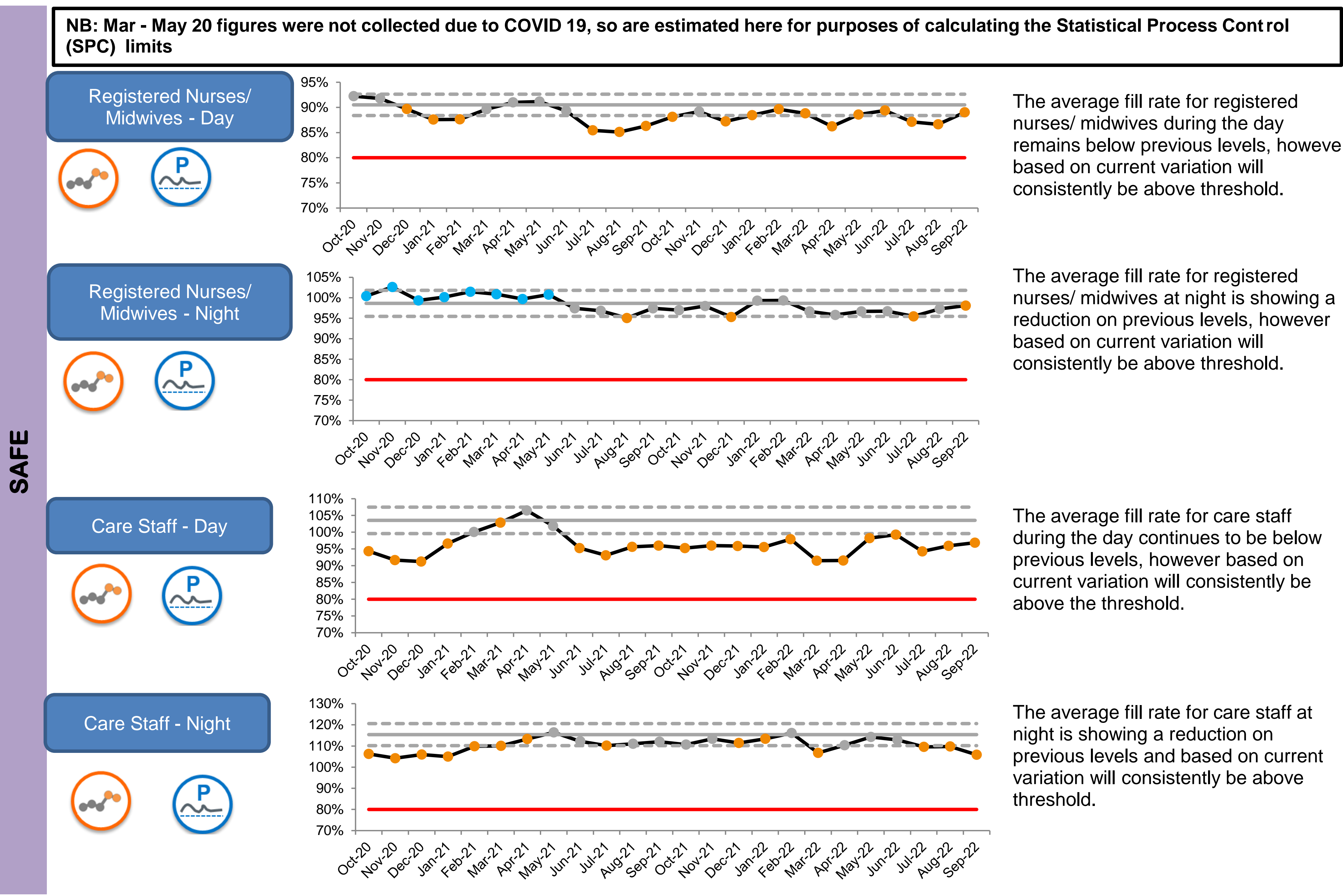
From 21/22 a trajectory was been introduced for Klebsiella and Pseudomonas. The Trust should have no more than 7 cases for Pseudomonas and 52 cases this year for Klebsiella.

There were 4 reportable cases of Pseudomonas identified in September. 2 of which were HOHA and 2 was COHA.

There were 3 reportable cases of Klebsiella identified in September. All of which were HOHA.

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.


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
SAFE
Registered Nurses/ Midwives - Day
The average fill rate for registered nurses/ midwives during the day remains below previous levels, however based on current variation will consistently be above threshold.
Registered Nurses/ Midwives - Night
The average fill rate for registered nurses/ midwives at night is showing a reduction on previous levels, however based on current variation will consistently be above threshold.
Care Staff - Day
The average fill rate for care staff during the day continues to be below previous levels, however based on current variation will consistently be above the threshold.
Care Staff - Night
The average fill rate for care staff at night is showing a reduction on previous levels and based on current variation will consistently be above threshold.
Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22

SAFE

Staffing in September 2022 remains extremely challenging, Covid is still impacting on staff sickness and pressures due to last minute sickness.

The already established vacancies, maternity leave, and effect of acuity is also impacting on staffing. Lots of cross cover between wards, the movement of staff to support crowding in the Emergency Department and the high use of bank and agency staffing continues. The constant movement of staff to cover other areas continues to have an effect on staff morale.

In September 2022, 1 ward fell below the 80% for Registered Nurses/Midwives for the day shifts. This has reduced from 7 wards last month. However, there is still the on-going consequence of Covid, maternity leave, sickness and vacancies. Bank and agency fill is challenging, with high numbers of last-minute cancellations or no shows.

MEC
Ward C11- The shortfall was due to a lack of coordinators on most shifts.

It should be noted that actual and planned staffing does not denote acuity, dependency, the number of women in labour or bed occupancy. The divisions consistently risk assess and flex staffing resources to support staffing. Every option is explored throughout the day and night to support staffing.

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
Sep-22	89.0%	96.9%	98.1%	105.8%	28,059	8.67	1	0	0	1

SAFE

Monthly Trend

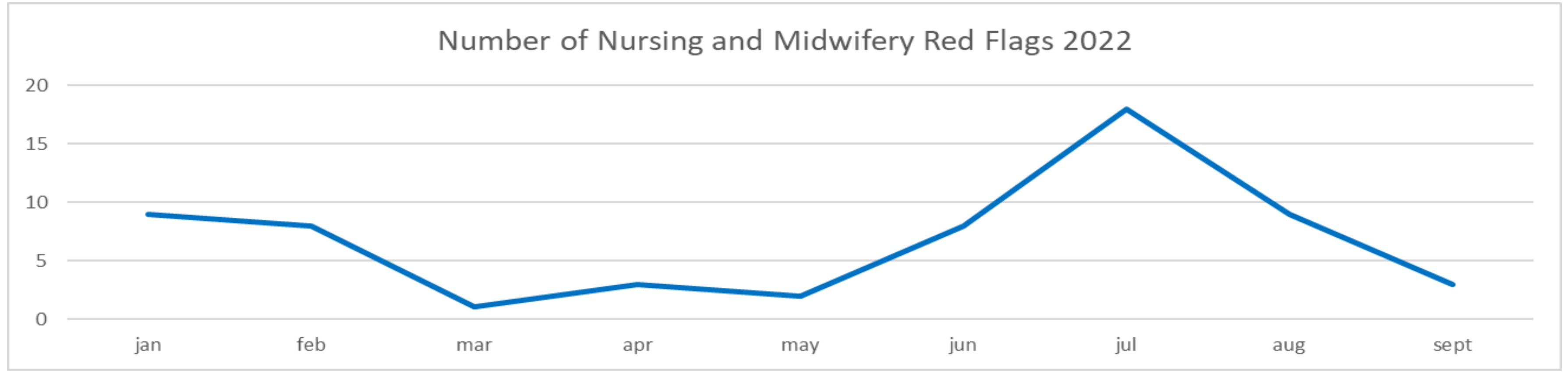
	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Oct-21	88.1%	95.3%	97.0%	110.6%	28,426	8.61	6	3	0	2
Nov-21	89.2%	96.0%	98.0%	113.4%	27,594	8.77	4	4	0	2
Dec-21	87.2%	95.9%	95.3%	111.4%	27,266	9.06	3	3	1	2
Jan-22	88.4%	95.6%	99.3%	113.4%	28,602	8.88	3	5	2	2
Feb-22	89.6%	97.9%	99.4%	116.1%	25,833	8.93	2	1	0	1
Mar-22	88.8%	91.5%	96.7%	106.7%	26,267	9.18	3	3	0	1
Apr-22	86.2%	91.5%	95.8%	110.3%	27,446	8.48	8	5	1	0
May-22	88.5%	98.2%	96.7%	114.3%	29,023	8.57	2	0	1	1
Jun-22	89.4%	99.3%	96.7%	112.9%	29,023	8.57	1	1	2	0
Jul-22	87.1%	94.3%	95.5%	109.5%	29,057	8.26	3	1	2	1
Aug-22	86.6%	95.9%	97.3%	109.7%	28,829	8.54	7	1	0	0
Sep-22	89.0%	96.9%	98.1%	105.8%	28,059	8.67	1	0	0	1

SAFE

National Nursing Red Flags
On reviewing Datix in September 2022 there were 3 incidents in total reported as Nursing Red Flags. This is 6 less than last month.

MEC
- **AMUA** - Delays or omissions with regular checks on patients to ensure their fundamental care. This was due to high acuity on the ward and staff HCA shortage. No Harm to patients as a result of delays. Appropriate escalation channels followed.
- **AMUA** - Delays or omissions with regular checks on patients to ensure their fundamental care. This was due to high acuity on the ward and staff HCA shortage. No Harm to patients as a result of delays. Appropriate escalation channels followed
- **AMUA** - Delays or omissions with regular checks on patients to ensure their fundamental care. This was due to high acuity on the ward and staff HCA shortage. No Harm to patients as a result of delays. Appropriate escalation channels followed.

The graph below demonstrates the total number of reported Nursing and Midwifery Red Flags per month.



Anecdotally staff resilience is low, they are tired, and some remain affected by the pandemic against a backdrop of high acuity, usage of a high proportion of agency staff, junior skill mix, and the constant moving of staff to support other areas. Staff are working extremely hard and are doing a remarkable job. Staffing the wards safely and supporting staff remains the highest of priority. Through the senior nursing teams, discussion has taken place particularly in relation to ensuring rest breaks are provided and supported with encouragement to the staff to report inability to take breaks to the matron and or clinical site manager.

SAFE

Actions taken to mitigate risk

- Safe staffing conference at 10:00 am followed up with meetings throughout the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours, utilising the acuity and dependency tool (Safe Care)

- Extra health care assistant shifts are used to support registered nurse gaps if available

- Recruitment Strategy, this continues as an internal QI project, with regular monthly meetings monitoring progress. A short task and finish group has been set up looking at making improvements to the recruitment website.

- Nurse recruitment lead continues to work closely with divisions demonstrating recruitment data dashboard to enable and empower divisions to proactively manage recruitment

-International midwifery recruitment in progress with plan to employ a minimum of 2 overseas midwives in early 2023

- Between January 2021 and March 2022, we will have recruited 122 international nurses.

For Apr 2022 - Dec 2022 our target is 71 nurses recruited by 31st Dec 2022. So far, we have brought over;

4 in April 2022 with 1 extra to complete the previous year's target.
11 in May 2022
12 in June 2022
10 in July 2022
11 August 2022
11 September 2022

We are expected to bring over:
9 October 2022
3 November 2022

A business case to recruit a further 30 International Nurses in 2023 has been approved and submitted to NHSE with an agreement to recruit;
10 Jan 2023
10 Feb 2023
10 March 2023

The Recruitment Lead Nurse is working closely with ward managers and recruitment to place the international nurses appropriately, aligned with vacancy gaps.

SAFE

International recruitment 2022												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
MEC	4	4	12	5	6	9	8	7	5			
SAS	5	2	2	1	0	2	0	0	1			
FC	0	1	2	1	0	0	0	0	2			
CIC	3	1	4	0	5	1	2	4	1			
Total	12	7	18	7	11	12	10	11	9			

Family Care Staffing Summary – September 2022

On reviewing Datix in September 2022 there were no national Midwifery or Nursing Red Flags reported.

Maternity (Midwife to Birth Ratio)

Month	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Staffed to full Establishment	01:27	01:27	01:26	01:27	01:27	01:28	01:27	01:27	01:27	01:28	01:27
Excluding mat leave	01:28	01:29	01:27	01:27	01:27	01:29	01:29	01:28	01:27	01:28	01:27
With gaps filled through ELHT Midwife staff bank Per week	Bank Usage 23.40 wte	Bank Usage 17.43	Bank Usage 42.28	Bank Usage 17.33	Bank Usage 18.76	Bank Usage 14.79	Bank Usage 15.80	Bank Usage 14.87	Bank Usage 23.90	Bank Usage 16.10	Bank Usage 20.75

SAFE

Maternity- September bank filled hours were covering vacancies/ pregnancy shielding, extensive short, long-term sickness. There was an increase in bank hours filled for compared to August.

Safe midwifery staffing levels continued to be reviewed with the appropriate risk assessments throughout the day at each safety huddle (plus additional staffing/ leadership huddles most days) during periods of extreme staffing pressures to mitigate throughout the whole of maternity services; midwives were redeployed to other areas to support acuity and activity as and when required.

Daily and weekend staffing plans are summarised with a further review of skill set and experience for each midwife/ maternity support worker prior to be redeployed. All plans are available on Sharepoint.

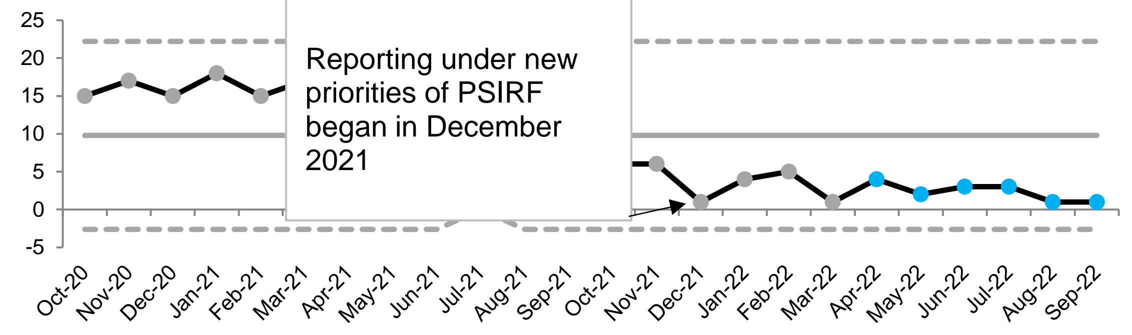
Neonatology – All nursing duties were covered to maintain safe staffing aligned with acuity and activity. Enhanced pay continued to support safe staffing.

Paediatrics – No exceptions

Gynaecology – No exceptions

SAFE

Serious Incidents



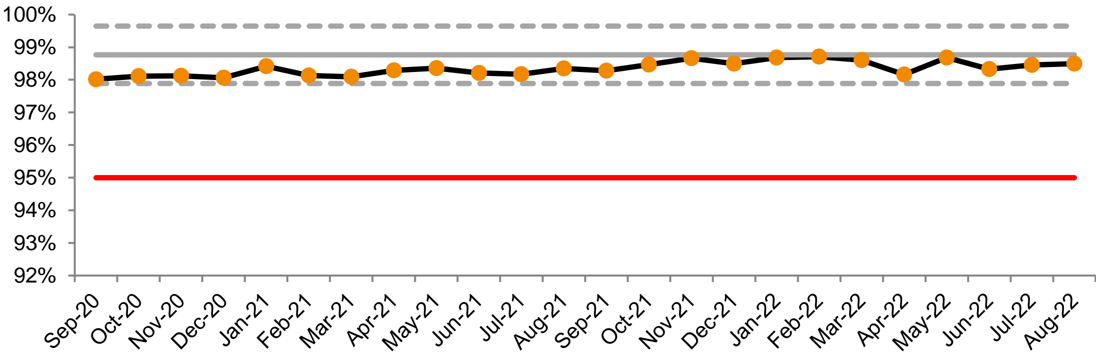
There were no never events reported in September.

One incident meeting a national or local priority and whereby a patient safety incident investigation (PSII) is underway, has been reported onto STEIS.The Trust started reporting under these priorities on 1st December 2021.

PSIRF Category	No. Incidents
National priority - incident resulting in death	1

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.

VTE assessment

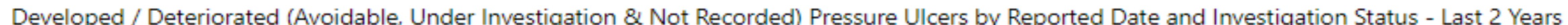


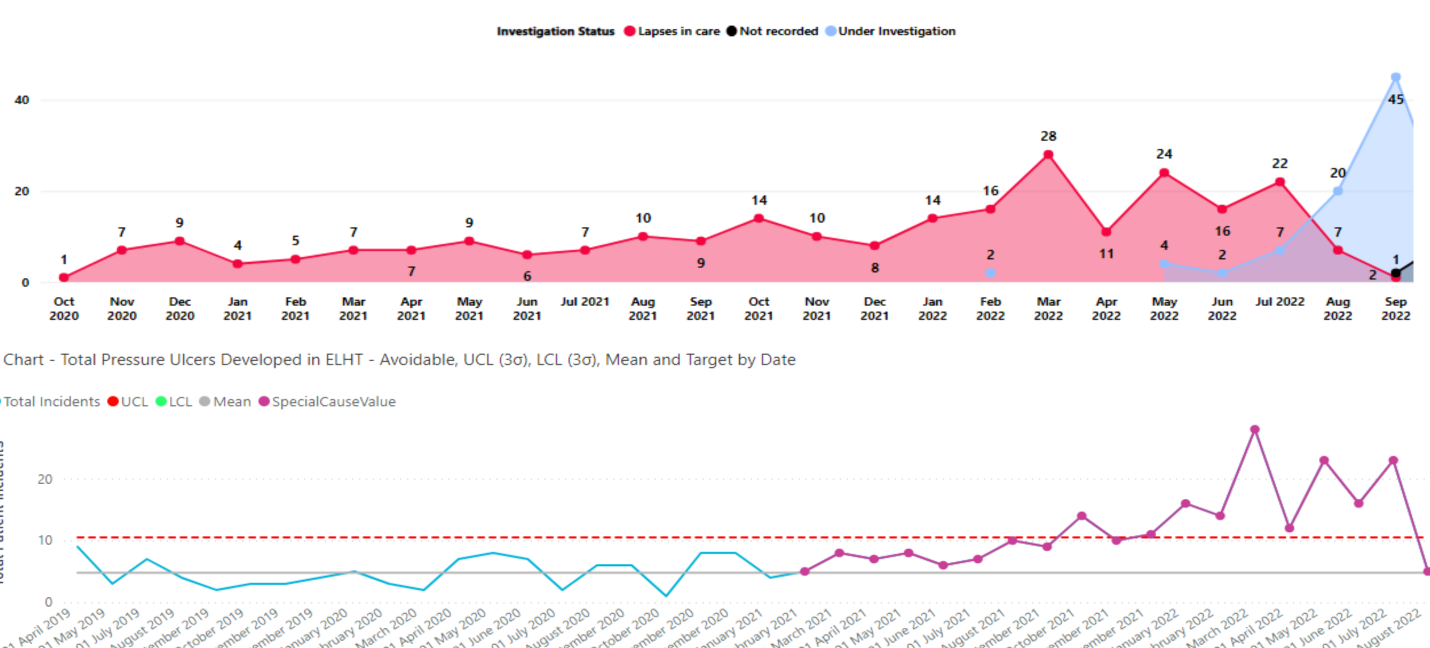
The Venous Thromboembolism (VTE) assessment trend continues to be below previous levels, however is still above the threshold.

SAFE

Pressure Ulcers

For September we are reporting the current unvalidated pressure ulcer position, pending investigation, as follows:





The data shows the current position of pressure damage by incident date. Months of Feb 22-Sep 22 are currently pending investigation. The majority of these sit within the MEC division, most of these have now been cleared with a small number outstanding this should be reflected in the next months data refresh. A robust action plan is in place and will be presented at the trust wide pressure ulcer steering group. The number of lapses in care within each month period can fluctuate when the incident is approved via the PURLP process.

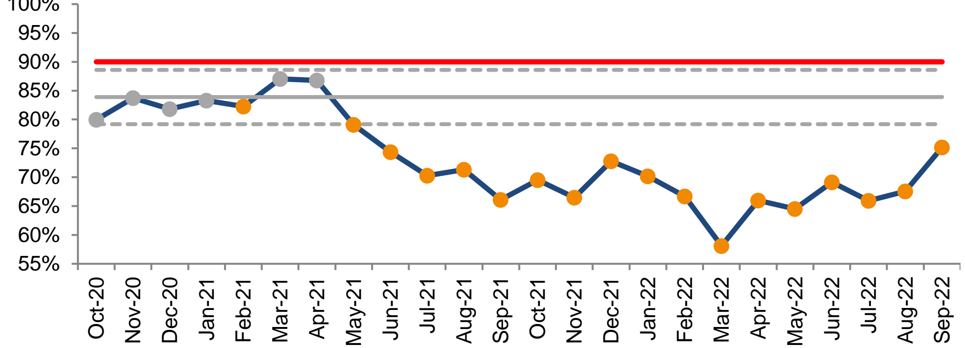
We remain consistently above the mean and upper control limit. From Jan - Sep 2022 there have been an average of 16 lapses in care per month. The areas where we are seeing an increased number currently is ED and AMU. The trust pressure ulcer steering group continues to review practice using QI methodology, due to the increase in pressure ulcer lapses in care an update will sent to quality board. From September, we have recommenced the learning and reflection panels for all lapses in care.

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.

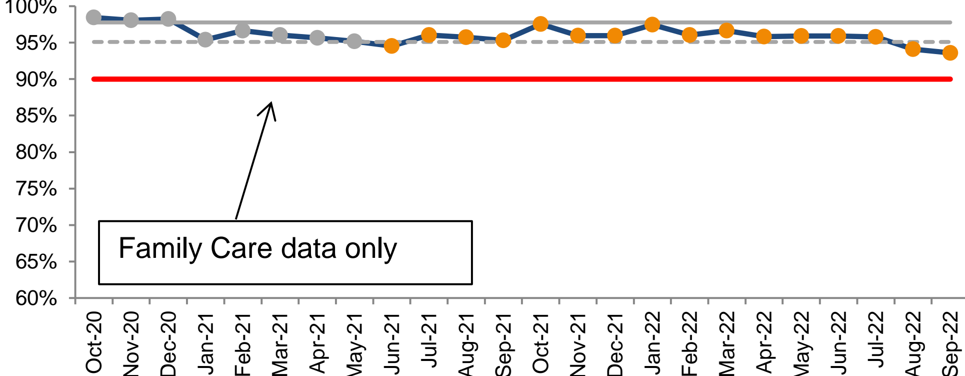
Inpatient data collection was suspended April 20 - Sep 20 due to COVID

Friends & Family A&E



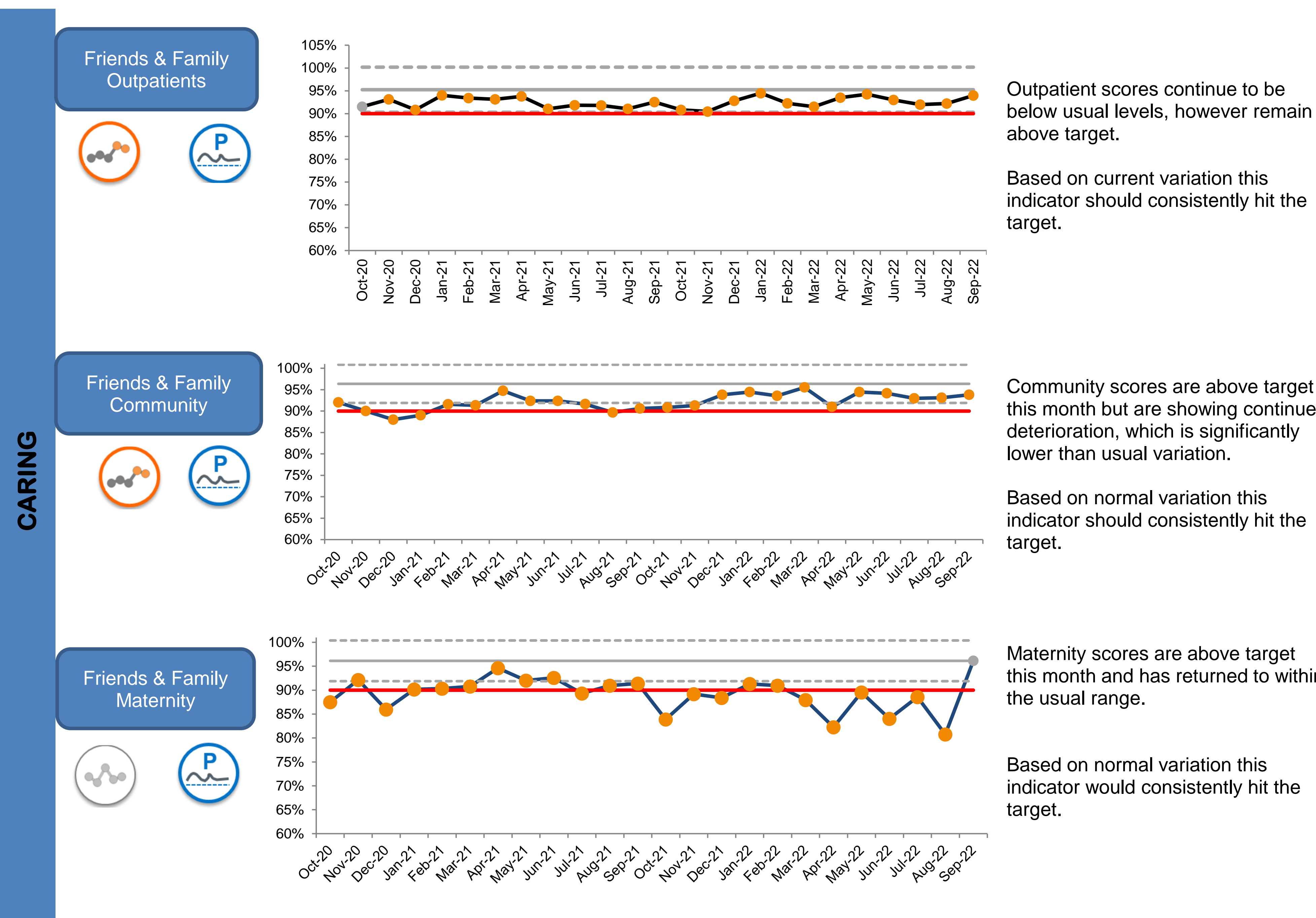
A&E scores are showing a significant deterioration in the last 17 months. Based on current variation this indicator is not capable of hitting the target routinely.

Friends & Family Inpatient



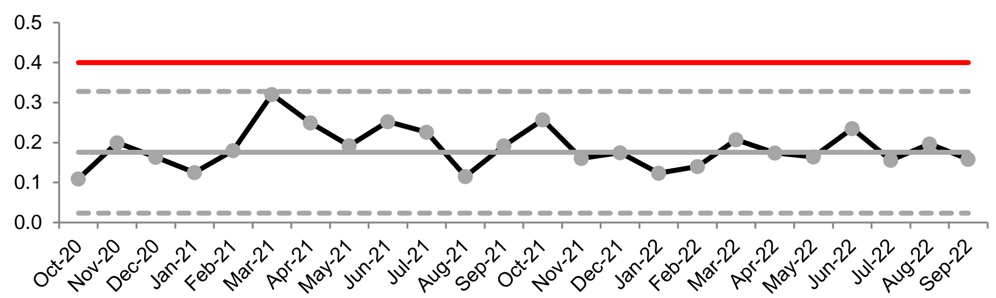
Inpatient data was suspended April - September 20 due to the COVID pandemic. Paper surverys were resumed in Family Care from 1st August 20 and across all areas from 1st September 20.

The trend is showing significant deterioration, however based on recent performance will consistently be above threshold.


CARING
Friends & Family Outpatients
105%
100%
95%
90%
85%
80%
75%
70%
65%
60%
Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Outpatient scores continue to be below usual levels, however remain above target.
Based on current variation this indicator should consistently hit the target.
Friends & Family Community
100%
95%
90%
85%
80%
75%
70%
65%
60%
Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Community scores are above target this month but are showing continued deterioration, which is significantly lower than usual variation.
Based on normal variation this indicator should consistently hit the target.
Friends & Family Maternity
100%
95%
90%
85%
80%
75%
70%
65%
60%
Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Maternity scores are above target this month and has returned to within the usual range.
Based on normal variation this indicator would consistently hit the target.
P
P
P

CARING

Complaints per 1000 contacts



The Trust opened 20 new formal complaints in September.

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 September the number of complaints received was 0.16 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
Antenatal	Family Care	92.86	100	100	100	97.92
Community	Community and Intermediate Care Services	93.46	91.72	92.34	95.11	93.07
Community	Diagnostic and Clinical Support	100	90.32	98.39	-	93.28
Community	Family Care	100	100	-	92.5	94.64
Community	Surgery	100	96.67	-	-	97.56
Delivery	Family Care	100	-	100	100	100
Inpatients	Community and Intermediate Care Services	93.02	92.11	91.57	92.93	92.29
Inpatients	Diagnostic and Clinical Support	100	72.12	94.35	95.63	91.88
Inpatients	Family Care	95.83	92.07	94.44	94.29	94.31
Inpatients	Medicine and Emergency Care	87.75	81.58	84.96	86.57	85.13
Inpatients	Surgery	92.59	85.06	91.79	91.18	90.28
OPD	Diagnostic and Clinical Support	98.34	98.93	97.61	94.74	98.36
OPD	Family Care	100	100	100	100	100
OPD	Medicine and Emergency Care	100	90.98	97.5	93.64	94.65
OPD	Surgery	100	92.06	95.96	98.7	96.54
Other	Diagnostic and Clinical Support	100	100	100	-	100
Paediatric	Family Care	98.33	100	61.36	100	92.34
Postnatal	Family Care	100	100	100	100	100
SDCU	Family Care	98.28	91	96.79	95.59	95.68
	Total	**95.69**	**91.51**	**93.21**	**94.66**	**93.61**

From 1st May 2020 the Trust moved to a new system, CIVICA to manage the Friends & Family Test (FFT) and patient experience surveys.

The new reports have now been configured and the table demonstrates divisional performance from the range of patient experience surveys in September 2022.

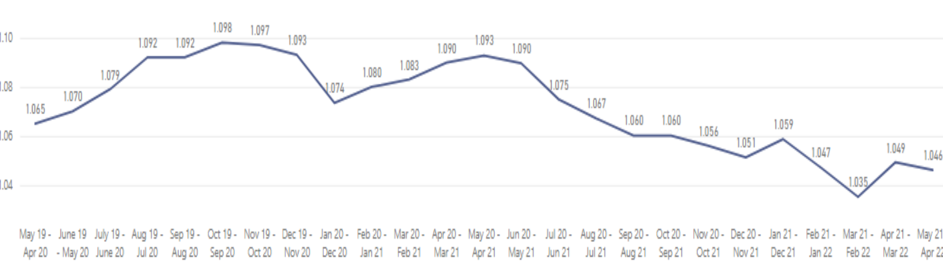
The threshold is a positive score of 90% or above for each of the 4 competencies.

The overall Trust performance from the range of patient experience surveys was above the threshold of 90% for all of the 4 competencies in September 2022.

Divisions are encouraged to review survey feedback to identify areas for improvement.

EFFECTIVE

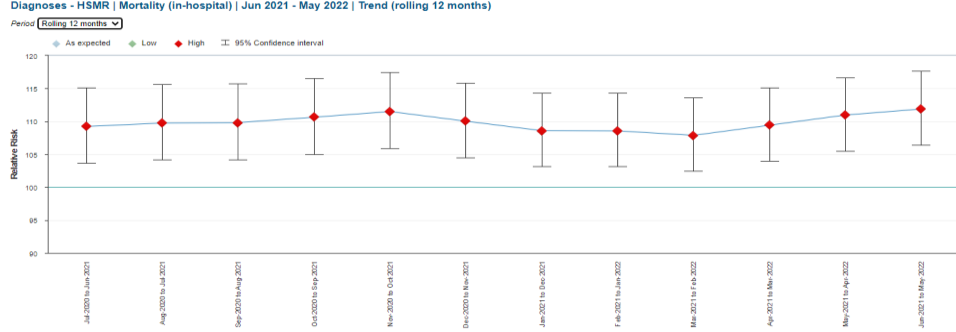
SHMI Published Trend



Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month Jul 21 – Jun 22
	ALL
TOTAL	113.6
Weekday	111.5
Weekend	119.7
Deaths in Low Risk Diagnosis Groups	Not Available

Dr. Foster HSMR monthly trend



The latest Trust Summary Hospital-level Mortality Indicator (SHMI) value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period May 21 to Apr 22 has remained within expected levels at 1.05, as published in September 22.

The latest indicative 12 month rolling Hospital Standardised Mortality Ratio (HSMR), (Jul 21 – Jun 22) has increased from last month and is 'above expected levels' at 113.6 against the monthly rebased risk model.

The benchmark model has been adjusted this month to account for data up to March 21, meaning risk scores are increasingly adjusted for changes seen during the pandemic.

There are currently three HSMR diagnostic groups with a significantly high relative risk score: Acute cerebrovascular disease, Septicemia (except in labour), and Congestive heart failure nonhypertensive.

Septicemia (except in labour) is also currently also alerting on the nationally monitored SHMI groups.

These are being investigated through the mortality steering group and each have a nominated clinical lead and associated action plan.

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.

Learning Disability Mortality Reviews

No update provided

EFFECTIVE

Structured Judgement Review Summary

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 below 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.

	Month of Death												
Stage 1	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar 20	Apr 20 - Mar 21	Apr 21 - Mar 22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	TOTAL
Deaths requiring SJR (Stage 1)	46	212	250	262	214	161	14	10	12	14	18	11	79
Allocated for review	46	212	250	262	214	161	14	10	12	14	18	11	79
SJR Complete	46	212	250	262	214	158	14	9	9	9	12	1	54
1 - Very Poor Care	1	1	0	0	1	1	0	0	0	0	0	0	0
2 - Poor Care	8	19	22	34	35	22	4	1	0	3	1	0	9
3 - Adequate Care	14	68	70	70	65	45	3	3	2	3	6	1	18
4 - Good Care	20	106	133	129	103	78	6	5	6	3	5	0	25
5 - Excellent Care	3	18	25	29	10	12	1	0	1	0	0	0	2
Stage 2													
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	4	1	0	3	1	0	9
Deaths not requiring Stage 2 due to undergoing SIRI or	3	2	1	4	1	2	0	0	0	0	0	0	0
Allocated for review	6	18	21	30	35	21	4	1	0	3	1	0	9
SJR-2 Complete	6	18	21	30	35	21	4	1	0	1	1	0	7
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0	0	0	1
2 - Poor Care	3	6	7	13	13	9	2	1	0	1	0	0	4
3 - Adequate Care	2	10	13	13	21	10	1	0	0	0	1	0	2
4 - Good Care	0	1	0	2	1	1	0	0	0	0	0	0	0
5 - Excellent Care	0	0	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 20	Apr 20 - Mar 21	Apr 21 - Mar 22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Total
stage 1 requiring allocation	0	0	0	0	0	0	0	0	0	0	0	0	0
stage 1 requiring completion	0	0	0	0	0	3	0	1	3	5	6	10	25
Stage 1 Backlog	0	0	0	0	0	3	0	1	3	5	6	10	25
stage 2 requiring allocation	0	0	0	0	0	0	0	0	0	0	0	0	0
stage 2 requiring completion	0	0	0	0	0	0	0	0	0	2	0	0	2
Stage 2 Backlog	0	0	0	0	0	0	0	0	0	2	0	0	2

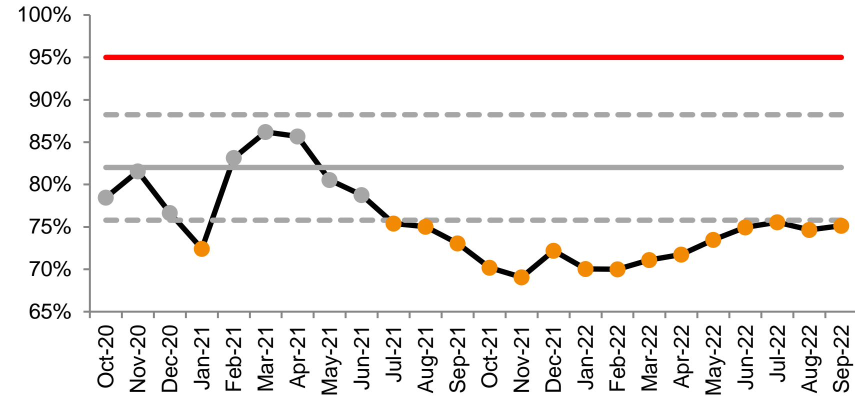
EFFECTIVE

Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes have been reintroduced for 2022/23, though for CCGs the CQUIN value will be included in block payments with the intention that no adjustment will be made based on achievement levels. For Specialised Commissioning the CQUIN value is also included in block payments, though Specialised Commissioners have indicated that financial adjustment will be made based on achievement levels. Both positions are subject to change until contracts are finalised, with discussions ongoing at an ICS level.

RESPONSIVE

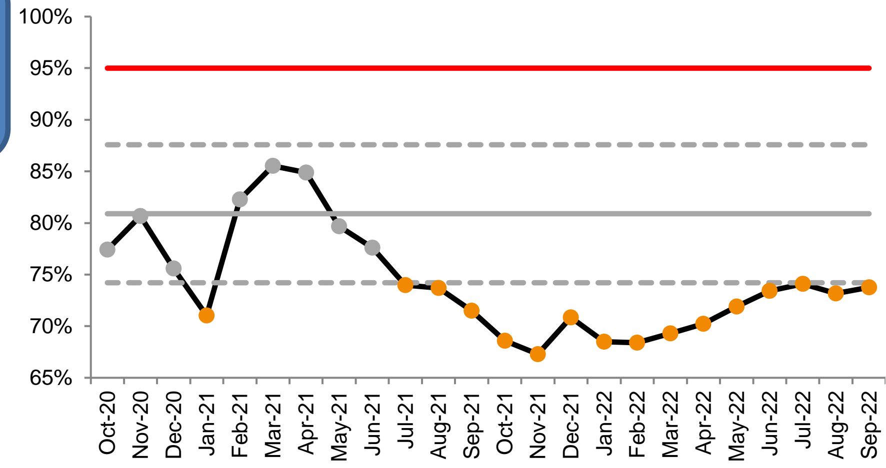
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 75.16% in September, which is below the 95% threshold and the Trust trajectory (87%).

The trend continues to show a deterioration on previous performance and based on current variation is not capable of hitting the target routinely.

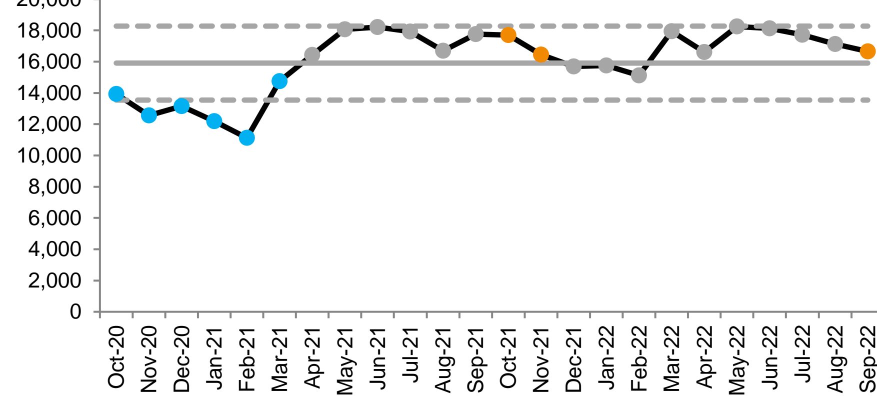
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 73.75% in September.

The national performance was 71.0% in September (All types) with none of the 110 reporting trusts with type 1 departments achieving the 95% standard.

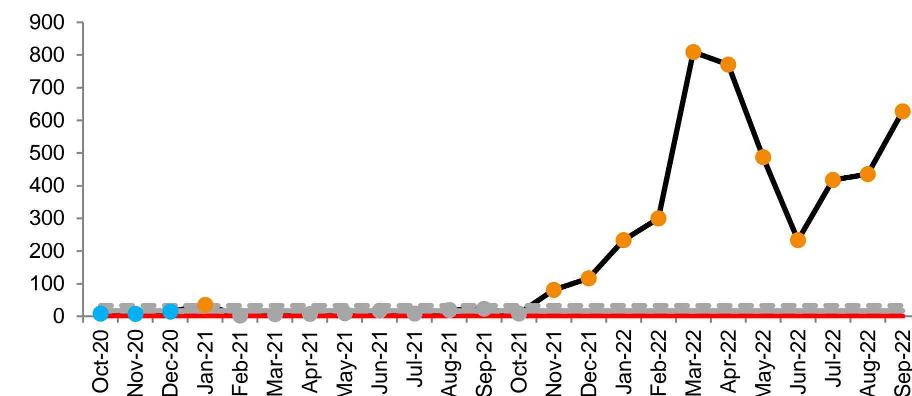
A&E Attendances - Trust



The number of attendances during September was 16,663, which is now showing a significant increase on previous levels.

RESPONSIVE

12 Hr Trolley Waits

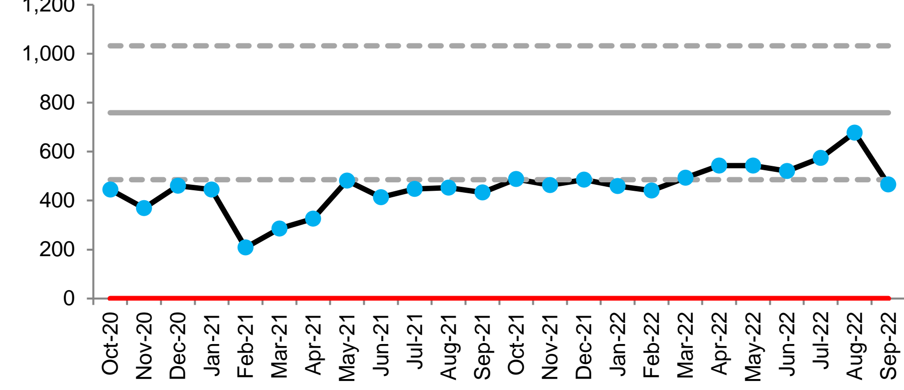


There were 627 reported breaches of the 12 hour trolley wait standard from decision to admit during September, which is higher than the normal range. 35 were mental health breaches and 592 were physical health.

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	35	592
Average Wait from Decision to Admit	33hr 39 min	17hr 19 min
Longest Wait from Decision to Admit	80hr 54 min	41hr 31 min

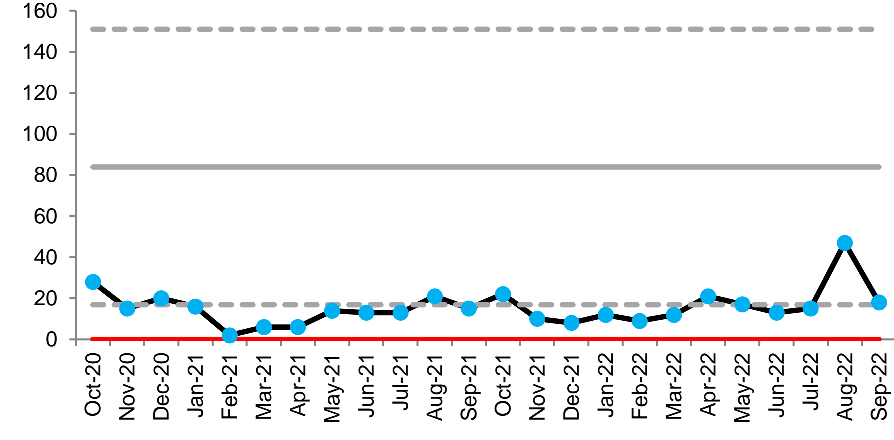
Ambulance Handovers - >30Minutes



Following a review of North West Ambulance Service data and reporting, the ambulance handover metrics have been amended and now show the arrival to handover time, having previously shown the notification to handover.

There were 466 ambulance handovers > 30 minutes in September. The trend is still showing significant improvement from previous levels, but based on current variation is not capable of hitting the target routinely.

Ambulance Handovers - >60 Minutes



There were 18 ambulance handovers > 60 minutes in September, which continues to demonstrate a signifcant improvement. Following validation, 3 of the 18 were actual ELHT breaches and 15 were due to non-compliance with the handover screen.

The average handover time was 22 minutes in September and the longest handover was 1hr 40 minutes.

RESPONSIVE

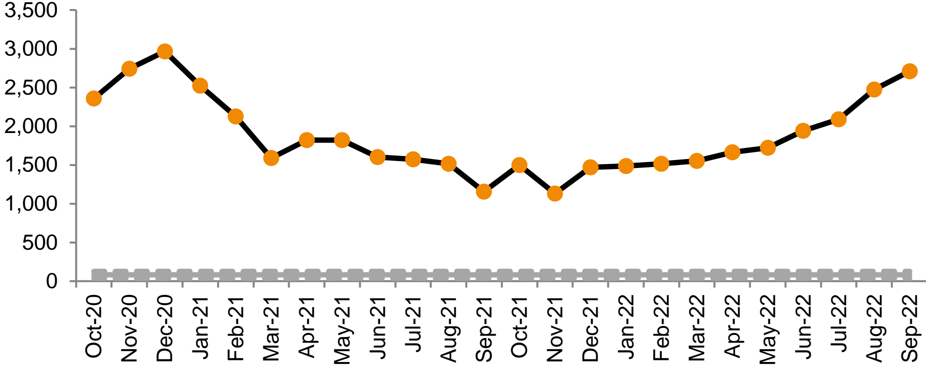
Referral to Treatment (RTT) Total Ongoing

50,000
45,000
40,000
35,000
30,000
25,000
20,000

Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22

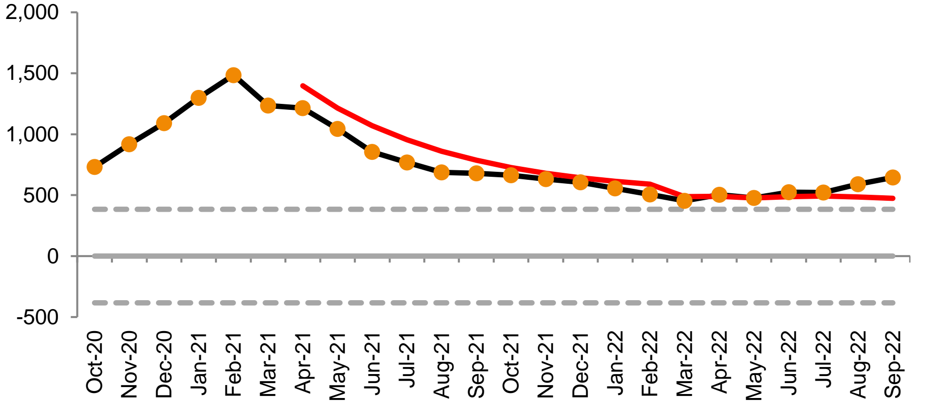
At the end of September, there were 48,526 ongoing pathways, which has increased on last month and is above pre-COVID levels.

RTT Total Over 40 wks



The number of pathways over 40wks increased in September with 2707 patients waiting over 40 wks at month end.

RTT Total Over 52 wks

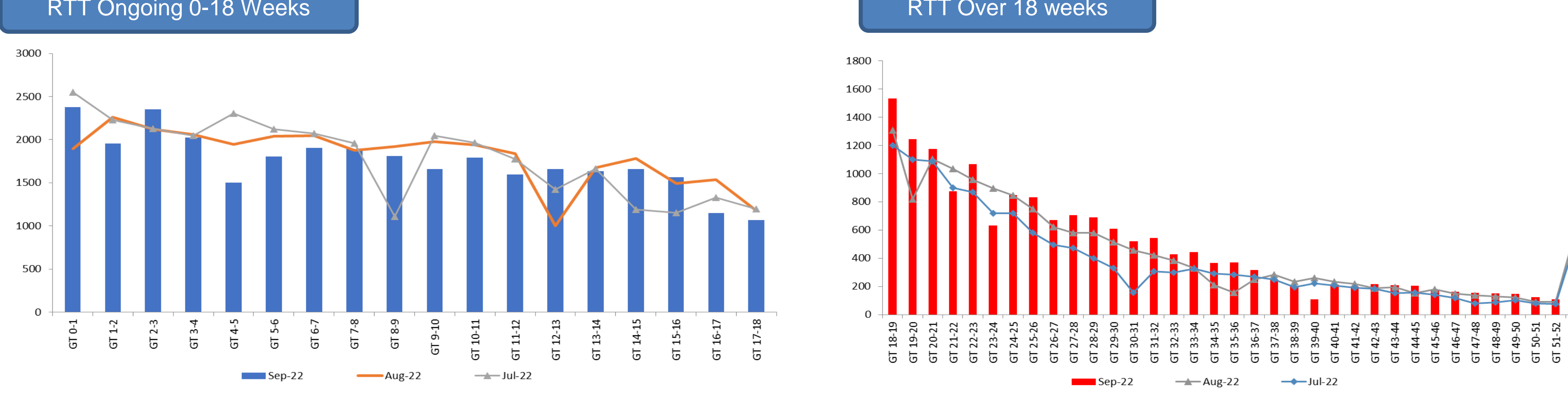


There were 646 patients waiting over 52 weeks at the end of September.

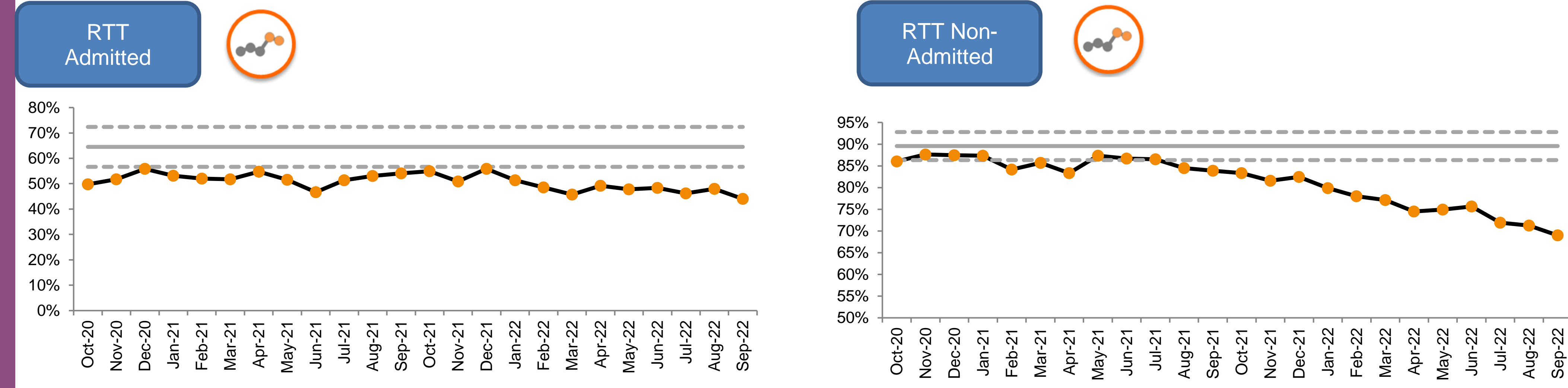
There were no patients waiting over 104 weeks.

RESPONSIVE

The bar charts show the numbers of RTT ongoing pathways by weekband, compared with previous 2 months.

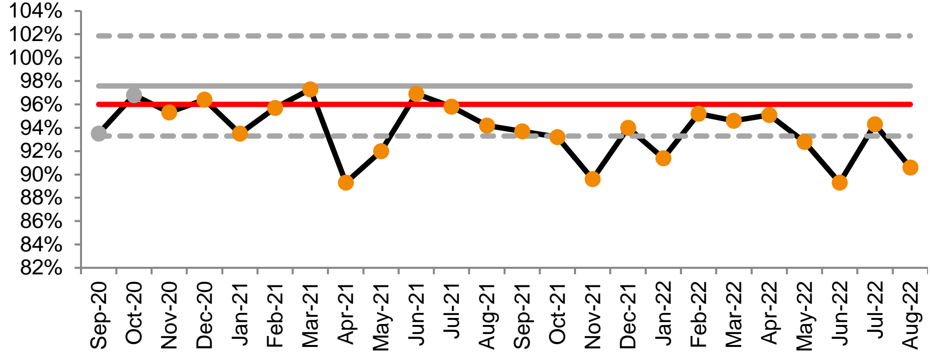


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.



RESPONSIVE

Cancer 31 day

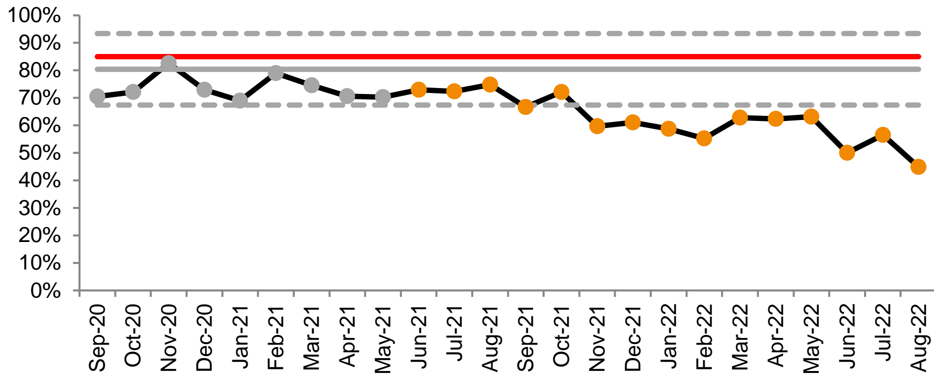


The 31 day standard was not achieved in August at 90.6%, below the 96% threshold.

Q1 was not achieved at 92.4%

The trend is showing deteriorating performance and based on current variation, the indicator is at risk of not meeting the standard.

Cancer 62 Day

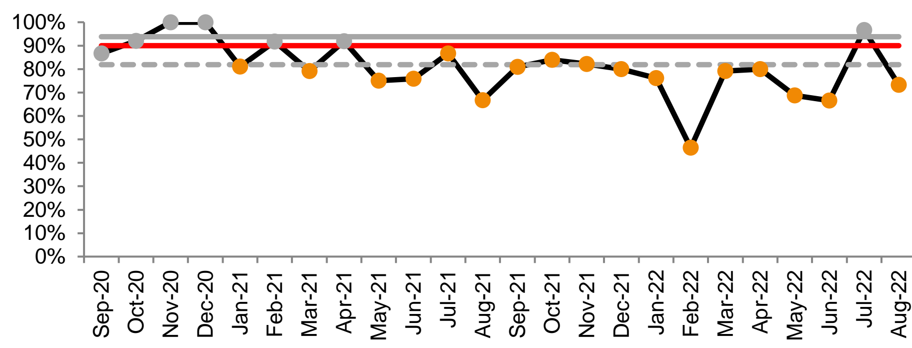


The 62 day cancer standard was not achieved in August at 44.9% below the 85% threshold.

Q1 was not achieved at 61.4%

The trend is showing deteriorating performance and based on the current variation, the indicator remains at risk of not meeting the standard.

Cancer 62 Day Screening



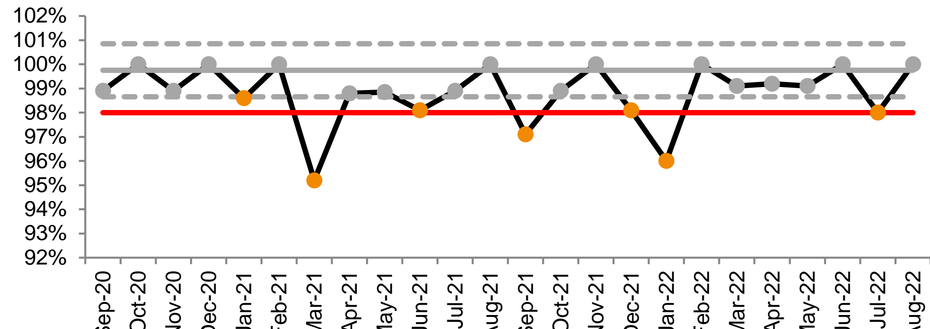
The 62 day screening standard was achieved in August at 73.3%, below the 90% threshold.

Q1 was not achieved at 71.0%

The trend is showing deteriorating performance and based on the current variation, the indicator remains at risk of not meeting the standard.

RESPONSIVE

Cancer - Subsequent treatment within 31 days (Drug)



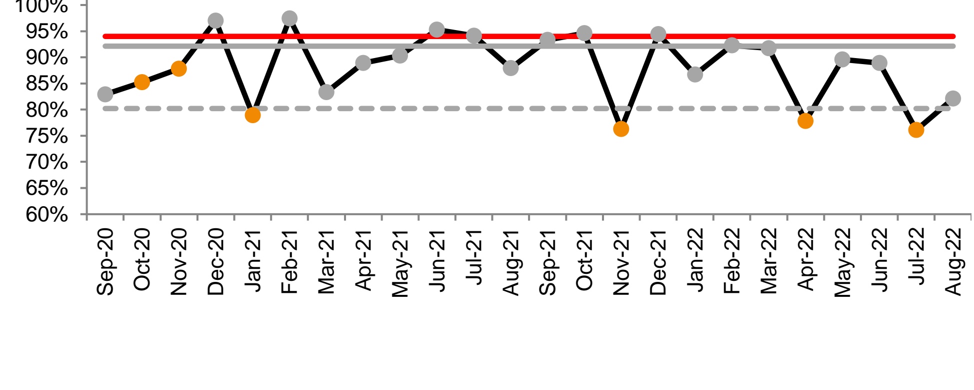
The subsequent treatment - drug standard was met in August at 100%, above the 98% threshold.

Q1 was achieved at 99.4%*

* Following further validation, June 21 performance has been revised up to 98.1% from the nationally submitted position of 95.6%. This was resubmitted in November 21.

The trend is showing normal variation and based on the current variation, the indicator should consistently achieve the standard.

Cancer - Subsequent treatment within 31 days (Surgery)

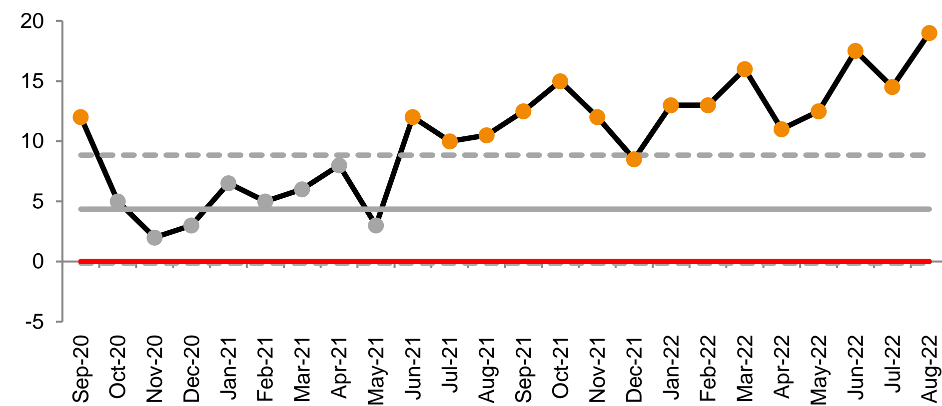


The subsequent treatment - surgery standard was not met in August at 82.1%, below the 94% standard.

Q1 was not achieved at 86.0%

The trend is showing normal variation and based on the current variation, the indicator remains at risk of not meeting the standard.

Cancer Patients Treated > Day 104

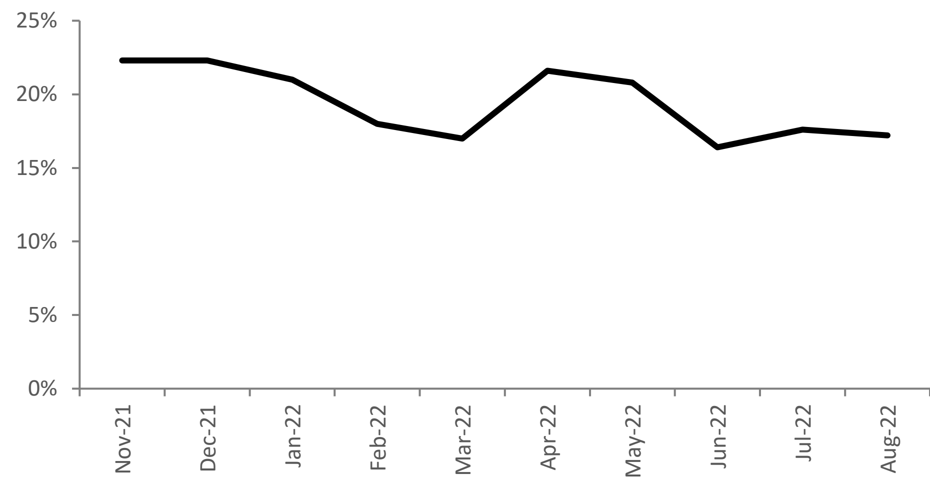


There were 19 breaches allocated to the Trust, treated after day 104 in August and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the consultants involved in the pathway as required.

The trend is showing a significant increase this month.

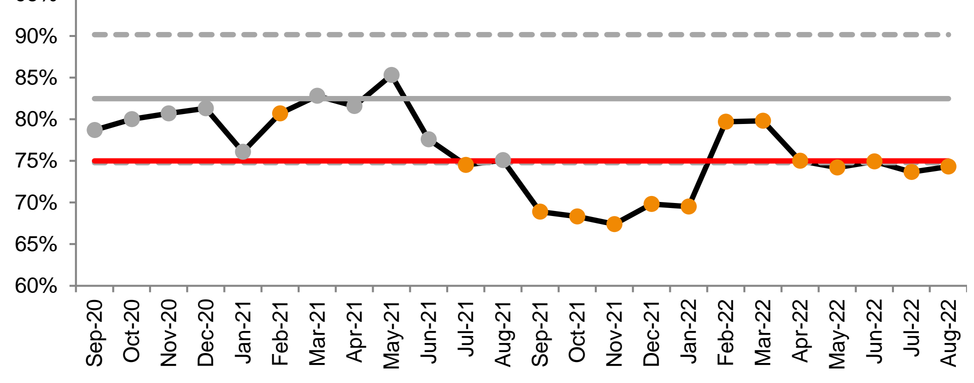
RESPONSIVE

Cancer % Waiting >62days (Urgent GP Referral)



At the end of August there was 17.2% of patients over 62 days still waiting to start treatment.

Cancer 28 Day faster diagnosis



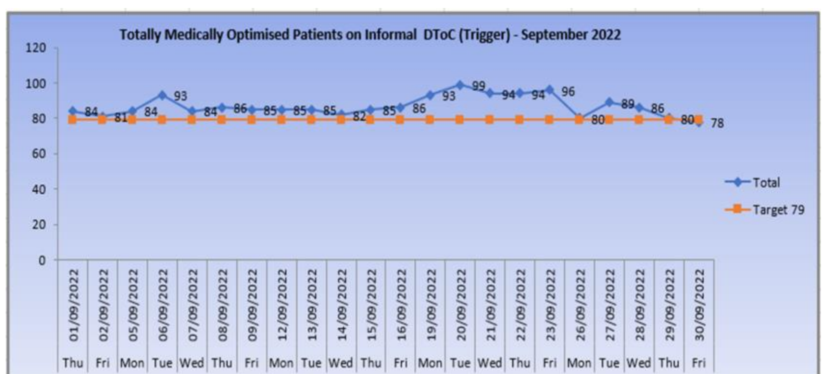
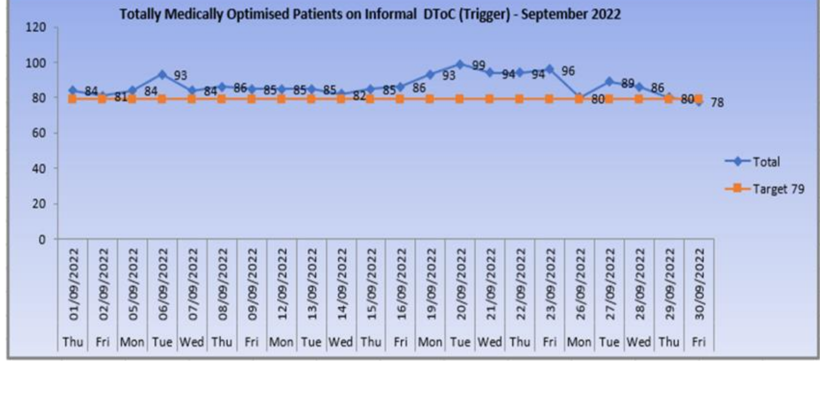
The 28 day faster diagnosis standard did not acheive the target in August at 74.32%

Q1 was achieved at 74.9%

The trend is showing significant deterioration over the last 12 months.

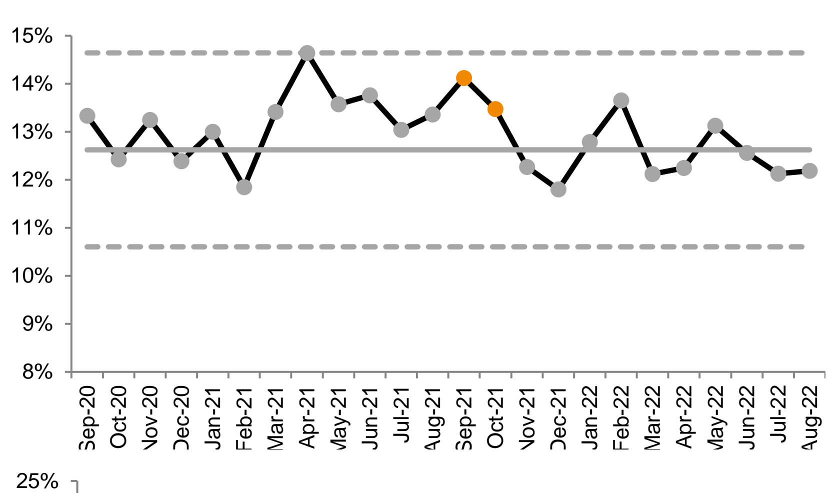
RESPONSIVE

Delayed Discharges

The formal reporting has now stopped as performance around discharge is being monitored regionally and nationally by the Discharge Patient Tracking List. The aim is to have fewer than 79 patients delayed in hospital and this is monitored daily. The delayed transfer of care work is now monitored locally and on a daily basis with a case management focus of the MFFD list. (Medically fit for discharge).

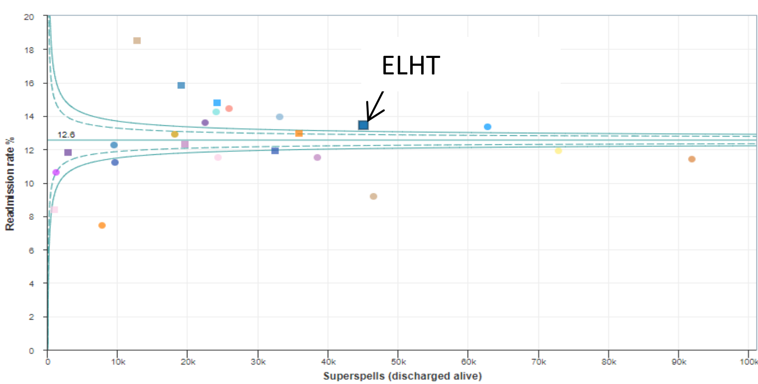
Emergency Readmissions



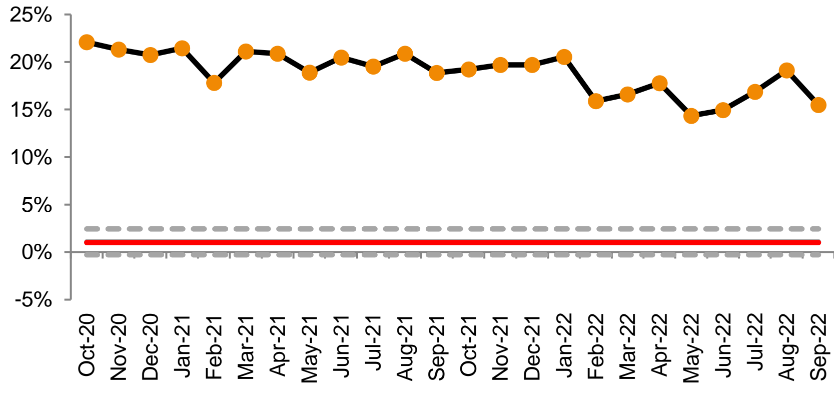
The emergency readmission rate trend is within the normal range.

Dr Foster benchmarking shows the ELHT readmission rate is higher than the North West average.

Readmissions within 30 days vs North West - Dr Foster
January 2021 - December 2021



Diagnostic Waits



In September, 15.47% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is above the 1% threshold.

The trend remains significantly higher than normal and based on current variation this indicator is at risk of failing the target.

Nationally, the performance is failing the 1% target at 30.5% in August (reported 1 month behind).

RESPONSIVE

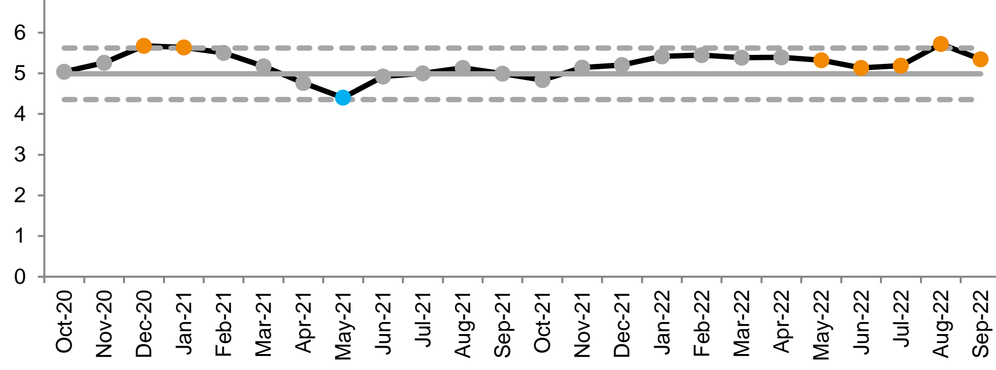
Average length of stay benchmarking

Dr Foster Benchmarking Jun 21 - May 22

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	60,543	10,060	50,483	3.3	2.5	-0.8
Emergency	63,530	63,530	0	4.0	4.2	0.2
Maternity/ Birth	13,198	13,198	0	2.2	2.2	0.0
Transfer	212	212	0	8.7	23.0	14.3

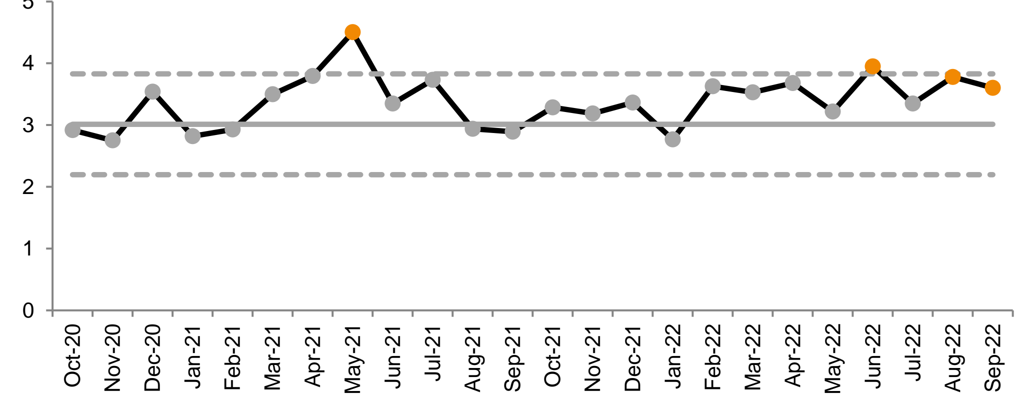
Dr Foster benchmarking shows the Trust length of stay to be above expected for emergency and below expected for elective, when compared to national case mix adjusted, for the period June 21 - May 22.

Average length of stay - non elective



The Trust non-elective average length of stay is showing deteriorating performance this month.

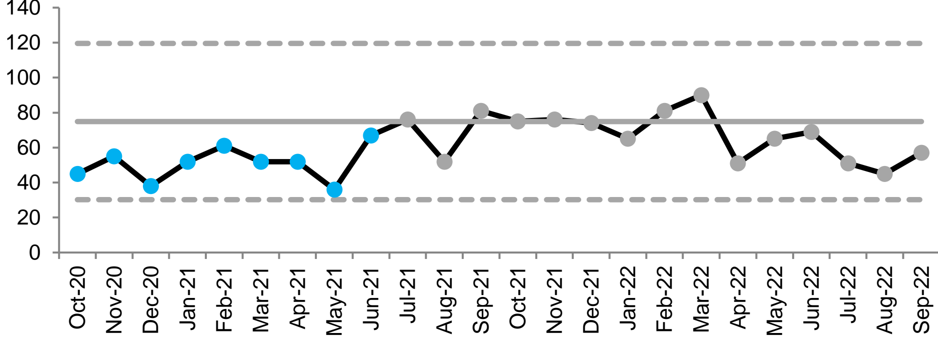
Average length of stay - elective



The Trust elective average length of stay is showing deteriorating performance this month.

RESPONSIVE

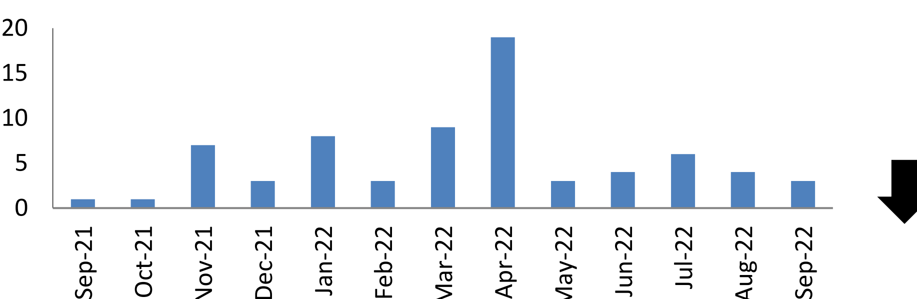
Operations cancelled on day



There were 57 operations cancelled on the day of operation - non clinical reasons, in September.

The trend is showing a return to normal variation.

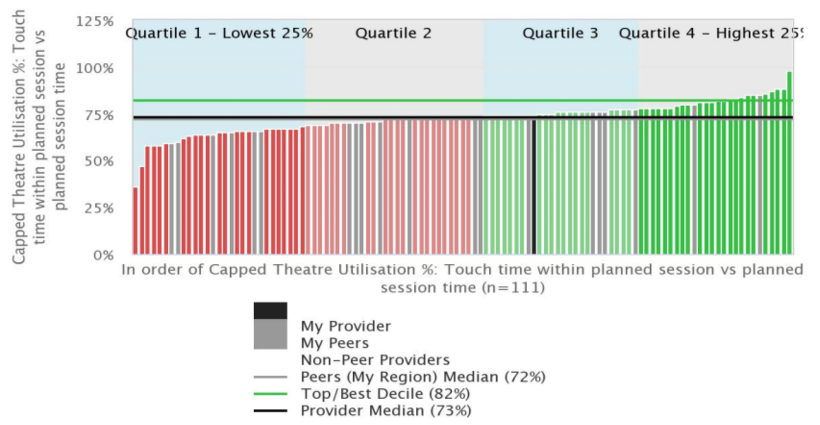
Operations cancelled on day - breaches of 28 day



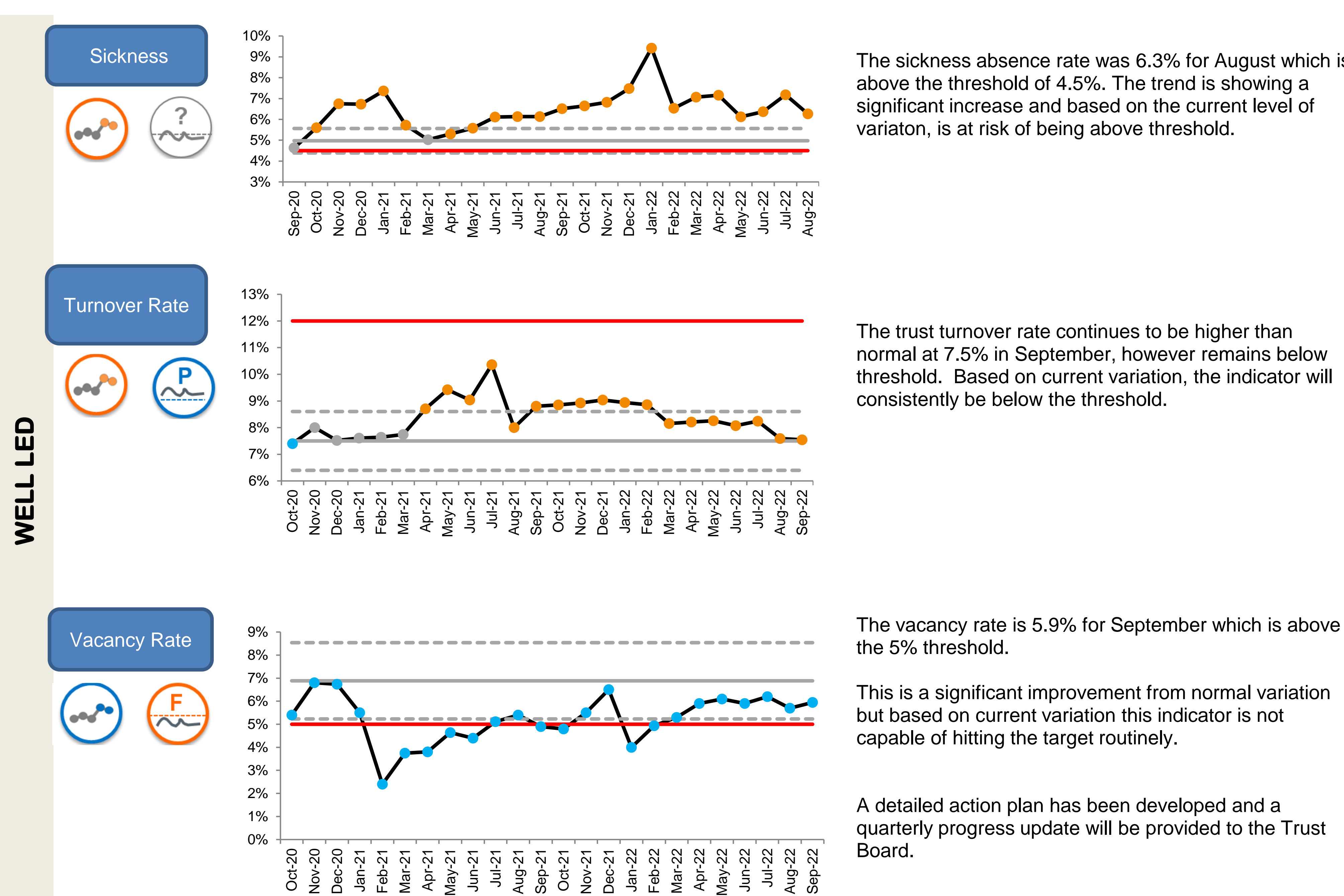
There were 3 'on the day' cancelled operations not rebooked within 28 days in September.
These will be provided to the Finance & Performance Committee.

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 74% for the latest period to 11th September 22. This is in the third quartile nationally, with 4 being the highest and 1 the lowest.



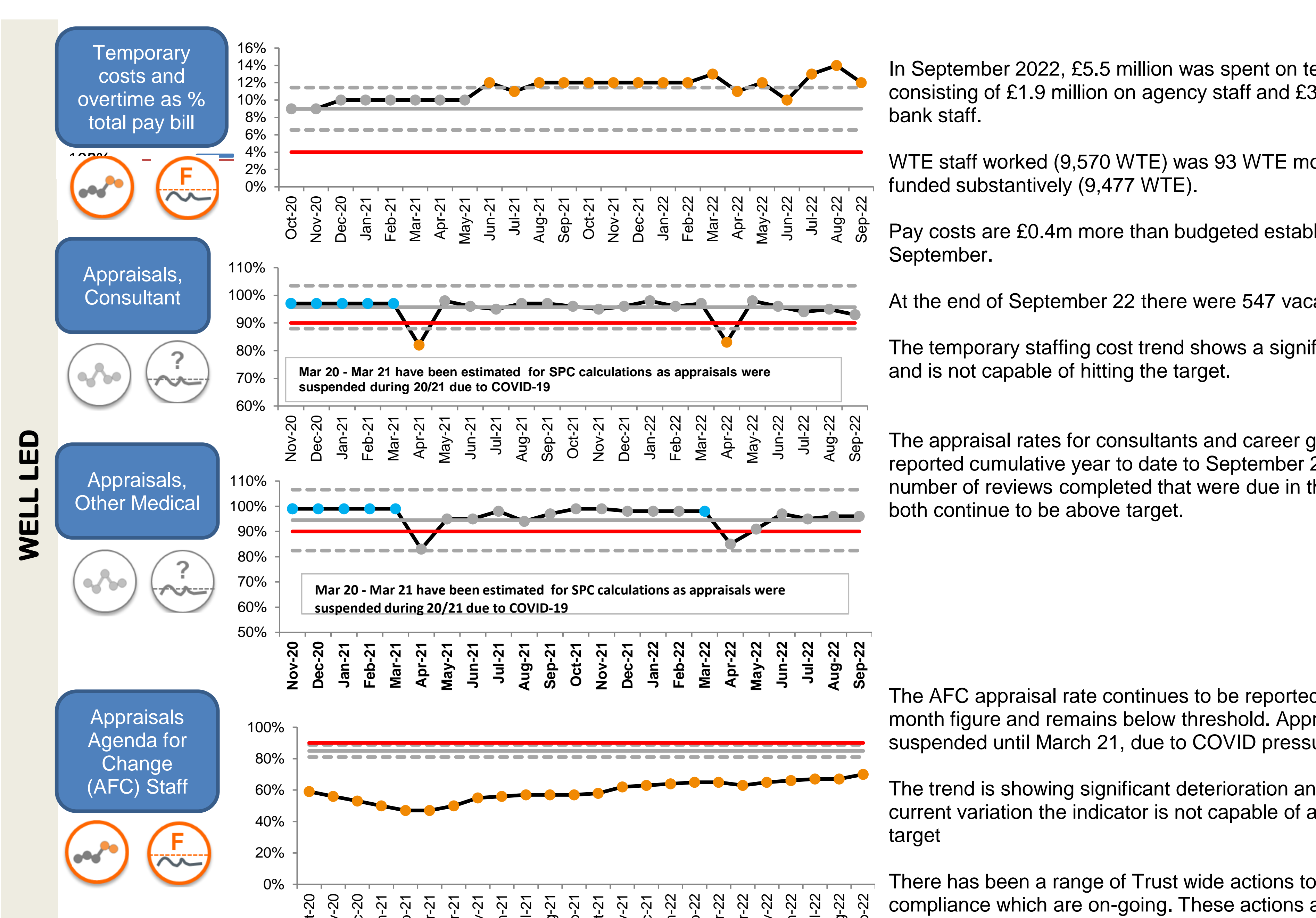
The sickness absence rate was 6.3% for August which is above the threshold of 4.5%. The trend is showing a significant increase and based on the current level of variaton, is at risk of being above threshold.

The trust turnover rate continues to be higher than normal at 7.5% in September, however remains below threshold. Based on current variation, the indicator will consistently be below the threshold.

The vacancy rate is 5.9% for September which is above the 5% threshold.

This is a significant improvement from normal variation 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.



In September 2022, £5.5 million was spent on temporary staff, consisting of £1.9 million on agency staff and £3.6 million on bank staff.

WTE staff worked (9,570 WTE) was 93 WTE more than is funded substantively (9,477 WTE).

Pay costs are £0.4m more than budgeted establishment in September.

At the end of September 22 there were 547 vacancies

The temporary staffing cost trend shows a significant increase and is not capable of hitting the target.

The appraisal rates for consultants and career grade doctors are reported cumulative year to date to September 22 and reflect the number of reviews completed that were due in this period. They both continue to be above target.

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 showing significant deterioration 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.

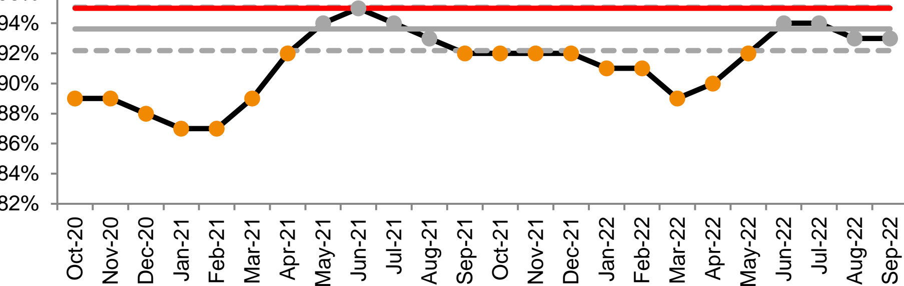
WELL LED

Job Plans

Stage	Consultant	SAS Doctor
Not Published	0	0
Draft	8	5
In discussion with 1st stage manager	135	22
Mediation	0	0
Appeal	0	0
1st stage sign off by consultant	43	4
1st stage sign off by manager	44	6
2nd stage sign off	23	3
3rd stage sign off	54	6
Signed off	48	33
Locked Down	1	0

As at September 2022, there were 356 Consultants and 79 Specialty Doctor/ Associate Specialist (SAS) doctors registered with a job plan on Allocate. The table shows the numbers in each stage of the job planning process.

Information Governance Toolkit Compliance



Information governance toolkit compliance is 93% in September which is below the 95% threshold. The trend is showing normal variation this month and is at risk of not meeting the target.

Core Skills Training % Compliance

	Target	Compliance at end September
Basic Life Support	90%	90%
Conflict Resolution Training Level 1	90%	96%
Equality, Diversity and Human Rights	90%	95%
Fire Safety	95%	94%
Health, Safety and Welfare Level 1	90%	93%
Infection Prevention L1	90%	92%
Infection Prevention L2	90%	90%
Information Governance	95%	93%
Prevent Healthwrap	90%	95%
Safeguarding Adults	90%	92%
Safeguarding Children	90%	94%
Safer Handling Theory	90%	93%

The core skills framework consists of twelve mandatory training subjects. 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 and Fire Safety which have thresholds of 95%

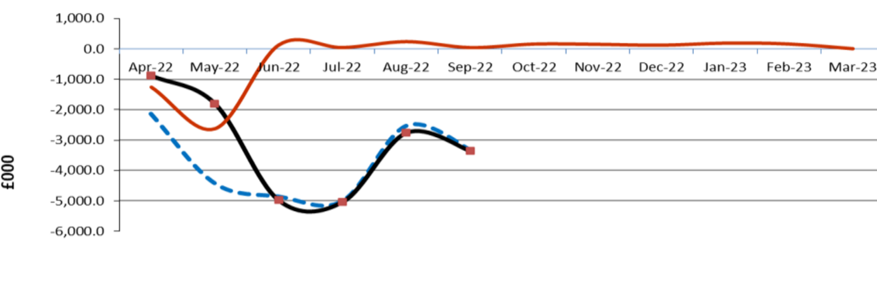
Two core training modules are below threshold: Fire Safety and Information Governance.

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.

WELL LED

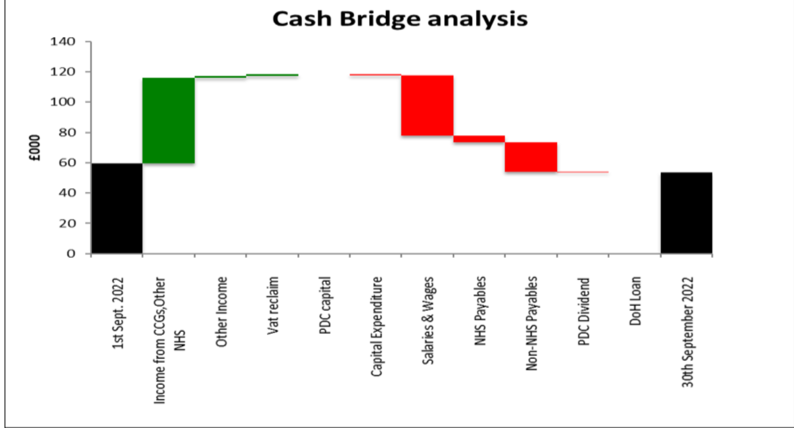
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



The Trust's financial performance is showing a £3.3 million deficit performance year to date against a breakeven financial plan.

Cash



The Trust's cash balance is £53.3 million as at 30th September 2022.

The Trust is reporting a year-to-date adjusted deficit of £3.3m in month 6, which is £3.4m behind plan and relates to the unmitigated element of the system planning gap held by the Trust.

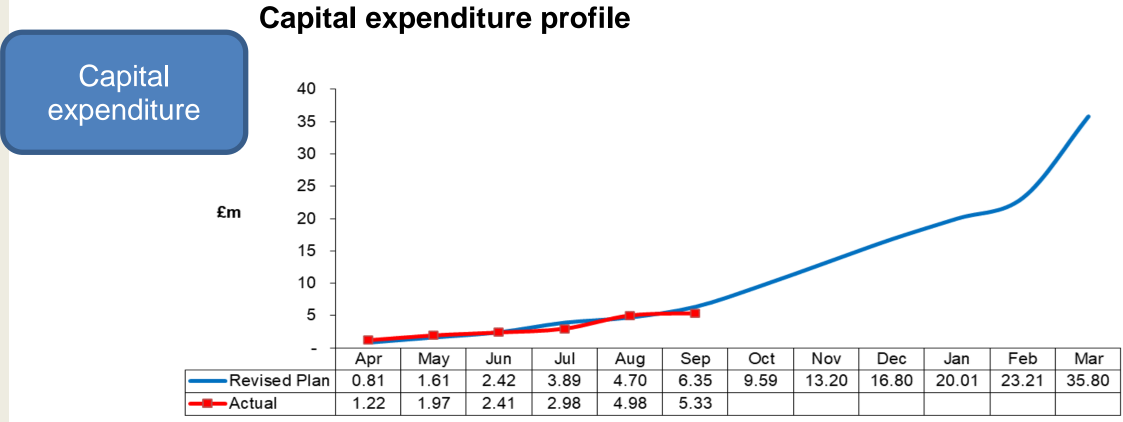
Within the plan, the Trust's system planning gap is £19.9m (£178.7m for the ICS). The ICB have now undertaken a review of potential schemes to mitigate the overall system planning gap of £178.7m. These schemes equate to approximately 2/3rds, £119m, of the system gap. There is risk attached to the achievement of these, however we have some level of assurance to enable us to forecast part closure of the planning gap.

Due to the deferral or unavailability in the current year of £23.1m of planned external funding, a £28.8m capital programme is now forecast. Slippage on the Emergency Village scheme represents the main risk to the full delivery of the capital programme, although mitigations have been identified against the likely, best and worst case underspend scenarios which range from £4.4m - £8.9m and the Trust remains confident that the revised capital programme can be delivered with £5.3m spent to date, £1.0m behind plan.

WELL LED

Capital expenditure

Capital expenditure profile



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	0.81	1.61	2.42	3.89	4.70	6.35	9.59	13.20	16.80	20.01	23.21	35.80
Actual	1.22	1.97	2.41	2.98	4.98	5.33						

The Trust is £1.0m behind its planned capital spend as at 30th September 2022.

The cash balance on 30th September 2022 was £53.3m, a reduction of £6.4m from the previous month. This is largely due to a £4.5m rise in receivables, £3.8m of which is NHS related with ICB related debt the main area of increase.

The WRP target at month 6 was £14.4m. The plan was equally phased to ensure that a disproportionate amount of risk was not pushed into later months of the year. WRP achievement is £14.4m at month 6, in line with plan. It has been necessary to non-recurrently support this position by £10.1m.

Waste reduction programme

WRP schemes analysis

Division	Green £000s	Amber £000s	Red £000s	Non Rec £000s	Rec £000s	Identified Schemes £000s	Annual Target £000s
Medicine & Emergency Care	114	1,005	0	1,047	72	**1,119**	3,290
Community & Intermediate Care	346	45	903	306	988	**1,294**	1,129
Surgical & Anaes Services	2,625	138	10	1,413	1,361	**2,773**	3,677
Family Care	278	215	361	98	756	**854**	1,882
Primary Care	0	0	0	0	0	**0**	75
Diagnostic & Clinical Support	244	407	350	144	857	**1,001**	2,785
Estates & Facilities	946	46	577	556	1,012	**1,568**	1,564
Corporate Services	2,098	226	0	1,871	453	**2,324**	1,050
Education, Research & Innov'N	255	0	0	12	243	**255**	270
Further 2% Non Recurrent Savings	10,063	1,450	2,250	10,063	3,700	**13,763**	13,078
Total	16,969	3,532	4,450	15,510	9,442	**24,952**	28,800

Schemes to the value of £25.0 million have been identified, of which £17.0 million has

TRUST BOARD REPORT

9 November 2022

Item	**147**
Purpose	Information Monitoring

Title	Freedom to Speak Up Annual Report
Executive sponsor	Mr K Moynes, Executive Director of Human Resources and Organisational Development

Summary: This is the sixth annual report on raising concerns since the appointment of the Staff Guardian role in September 2015. It details the background on the guardian role, outlines progress to date, numbers of concerns raised, emerging themes, actioned taken to address themes and information from the National Guardian Office.

Report linkages

Related Trust Goal	Compassionate and inclusive culture Healthy, diverse and highly motivated people
Related to key risks identified on assurance framework	1. Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce. 2. Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy).

Impact

Legal	Yes	Financial	No
Equality	Yes	Confidentiality	Yes

Previously considered by:

(147) Freedom to Speak Up Annual Report

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 now a requirement of the NHS Standard Contract that Trusts appoint a Freedom To Speak up 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 Trust Board of progress made since the last annual report in June 2021, the number of staff who have raised concerns, emerging themes, actions taken and the latest news from the National Guardian Office.

Progress to Date

3. With effect from 1st July 2022, the Joint Office approach has now been disbanded within both ELHT and Blackpool Teaching Hospitals and Jane Butcher has now returned to ELHT in her full capacity and is supported by the newly appointed interim Deputy Freedom to Speak up Guardian, Alison Sugden, who joins us from ELHT Wellbeing Team (covering the maternity leave of Nicola Canty).

   a) Over 1099 concerns have been raised through the FTSUG since April 2016 – March 2022
   b) The figures submitted in this report and all future reports will fall in line with the dates of the yearly figures that are submitted to the National Guardian Office running from April to March and not May to April as in previous reports.
   c) A Staff Guardian section is now fully embedded into the Corporate Induction.
   d) All three levels of training from the National Guardian Office have now been rolled out throughout ELHT, “speak up”, “listen up” and “follow up”. All staff are encouraged to undertake the appropriate training.

e) In addition to the reference to the paragraph that was added to Appraisals to raise awareness of the FTSU service, we have added information regarding the training available for all staff regarding this subject.
f) We continue to work closely with our Champions who joined us over 12 months ago from staff networks (BAME, LGBTQ+ and Disability).
g) Champions are now trained in accordance with the newly published NGO guidance
h) Monthly meetings held with the Champions
i) Electronic feedback forms continued to be trialled to allow for easier accessibility and to increase the numbers completed and returned
j) Walk arounds planned over next few months to promote the service (leaflets, business cards, post it pads etc).
k) Links with Wellbeing team to promote the FTSU service embedded
l) Close working relationships are established with the HRBP's to give feedback on reoccurring themes in relation to HR policies and to address these themes the Early Resolution Policy will provide further support and guidance to staff.
m) HR template letters continue to include the Staff Guardian contact details to ensure that staff have direct access whilst going through HR processes
n) Strong links with the mediation service are embedded and Guardians continue to refer cases directly
o) Since the last report we have undertaken Culture Reviews within the Emergency Department at RBH and Neonatal Intensive Care Unit. (Further details are under whistle-blow)
p) We have been asked to work alongside the Medical Educational Supervisors in Anaesthetics, Critical Care and Theatres to undertake a culture review with the Junior Doctors following on from a comment that has been received in the GMC survey in relation to certain behavioural / culture issues. This review is due to commence shortly.
q) We are being informed that there are potentially issue with our junior doctors feeling unable to raise concerns therefore, we plan to take some proactive measure and hold several speaking up sessions to be aimed at all of our junior doctors within the Trust to ensure that we give them the opportunity to raise any concerns in a confidence. The findings from these sessions will be discussed with Senior Management in a confidential manner so that we can address any concerns appropriately.

Whistle-Blowing

Since October 2021 the Trust has received an unprecedented number of concerns identified as whistle-blows through various routes. 5 have been received since October 2021, in the previous 4 years (since the introduction of the Staff Guardian) there has been a total of 3 concerns raised that have been officially identified as whistle-blows. There has been a separate paper submitted to the Audit Committee in April 2022 that contains further in-depth information

The concerns brought under the whistle-blow relate to:

Emergency Department (Dec 2021), stating a lack of patient safety, lack of support and overall culture. Any immediate patient safety issues where address on receipt of the concerns but the Director of Nursing and Head of Nursing for Emergency and Acute Pathway. A full Staff Guardian Cultural review was undertaken, and the report has been shared with senior management for responses/actions. Sessions have been held with staff to feedback and the actions/recommendation from the review continue to be implemented and monitored. The Staff Guardian and the Head of Nursing have also attended Execs in June to ensure that they are fully aware of the review and how this continues to be addressed and monitored.

Neonatal Intensive Care Unit (Nov 21), stating concerns regarding infection control, education, poor skill mix and lack of support. These concerns were raised directly to the CQC and were responded to by Matron Dawson. Sessions were held with the Director of Nursing and the Staff Guardian giving all staff the opportunity to raise concerns. A Staff Guardian Cultural review was also undertaken including nursing and medical staff. The review has been feedback to the senior management, and they have now given actions/recommendations which is to be feedback to the staff.

Obstetrics and Gynaecology (Oct 21), Anonymous email received regarding the culture and potential racism within the department. An external investigation was commissioned by the Director of HR and the findings are to be feedback to the Senior Team in June 22.

Ophthalmology (Jan 2022), concern stating that there is a culture of bullying and harassment. Work undertaken in the department around the behavioural framework and the expectation of behaviours, discussions around challenges took place to generally problem solve and talk

openly about issue. Further work and actions taking place going forward led by the Triad and the Divisional Director of Nursing.

Pendle Hospital, Hartley Ward (Feb 2022), confidential concern raised through Guardian service regarding potential abuse of patient. Divisional Director of Nursing immediately involved with HR to take the appropriate safeguarding steps. A formal investigation has taken place, the outcome is due shortly.

It is unusual to have so many concerns classed as whistle blows at one time admittedly (5 in 5 months), however, this should be seen as a positive as we are seeing that staff are speaking up and raising concerns. Although one felt the need to raise their concern directly to CQC, the others have used internal routes to speak up. As we have embedded a more open and honest culture within the Trust and introduced the Behavioural Framework, staff are raising concerns about patient safety and cultures more and more.

In relation to the patient safety concerns being raised, the Trust again highly encourages this and is extremely responsive when such concerns are raised, and staff are experiencing this and the positive outcomes of raising concerns.

Staff will have seen that issues raised do get listened to and that the Trust does take them seriously and that lessons are learnt.

As the Staff Guardian for the Trust, I wanted to add that as a Guardian all that I can ask is that staff speak up in a safe environment and that the Trust leaders and Board work alongside me to address these serious concerns and I am confident, as a Guardians, that East Lancashire Teaching Hospital NHS Trust does listen and responds seriously to concerns raised by our staff.

The whistle-blow concerns will continue to be monitored and actioned, and lessons learnt for the organisation out of these concerns will be shared.

The Annual Report – Number of cases, themes and actions taken to address

4. For the period April 21 to March 22 there have been 262 concerns raised which is an increase of 2.68% from the previous year's figure of 254 April 20 to March 21

Year Range	No of Cases	% increase
Apr 16 - Mar 17	38	0%
Apr 17- Mar 18	140	72.90%
Apr 18 - Mar 19	175	20.00%
Apr 19 - Mar 20	231	24.20%
Apr 20 - Mar 21	254	9.06%
Apr 21 - Mar 22	262	3.05%

5. **Emerging Themes April 2021 – March 22**:

Date | Division | Theme

Theme	Count
Patient Care	70
Support through HR Process	60
Perceived lack of support from manager	37
Perceived bullying by manager	16
Covid Related	15
Perceived bullying by colleague	13
Potential inappropriate attitudes or behaviours	13
Safety Risk - Staff	12
Wellbeing	11
Culture	5
Working Environment	3
Alleged racial discrimination	3
Lack of communication	2
Alleged sexuality discrimination	1
Perceived detriment	1

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75

The highest level of concerns raised have been in relation to Patient Safety, 64 of these have been within quarter 4 (Jan 22 – Mar 22). This is an increase against the 14 that were raised last year. However, this is in line with the amount of Staff Guardian Culture reviews that have been undertaken in this period as the concerns will be logged under the initial concern that was raised which led to the review.

The learning outcomes and actions to the concerns raised within the reviews are being rolled out throughout the areas and feedback to staff and continue to be implemented and monitored.

The senior nursing team or senior clinicians are directly involved with all patient safety issues raised. Every staff member raising a concern about patient safety is offered a face-to-face conversation with a relevant senior person should they so wish or Jane is offered the opportunity to speak up on their behalf. Staff are encouraged regularly within their areas to raise concerns to management if they feel able to do so.

Staff requiring support through HR process equates to 60 of the concerns raised, which is a slight increase on the 51 raised in the previous year.

The Staff Guardians work closely with the Senior HR team, Head of Occupational Health and Staff Wellbeing and the Unions to address support for staff who have reported experiencing forms of bullying and harassment. Since the implementation of the Resolution Policy staff have been choosing the option to have the Staff Guardian involved in their resolution and this has impacted on the increase under this theme. Eventually we would envisage a decrease once more lesson learnt from these resolutions are shared and implemented.

Concerns raised under perceived lack of support from managers is 37 which is an increase on last year which was reported at 30. These concerns can be a variety of different issues from a misunderstanding, a communication issue and sometimes the appearance of a lack compassion.

Lessons are learnt throughout each of these concerns and tend to be on an individual basis and there is often agreement with the person raising the concern and the manager on how to move forward together with support and engagement.

The introduction of the Behavioural Framework is also assisting and addressing these concerns. Also, the Engaging Managers course continues to run successfully looking at effective styles of communication and engagement with staff.

6. **National Guardian Office Update:**

Dr Jayne Chidgey-Clark has recently been appointed as the new national guardian after Dr Henriette Hughes OBE stepped down as the National Guardian after 5 years in post.

The national guardian office has introduced new ways of reporting data from April 2022. The changes are in relation to how now record staff groups and professions. There is also a new way of reporting multiple themes from concerns.

The first module of the Freedom to speak up training - Speak Up – is now available for all workers, no matter what their contract terms, and was launched in October and has already been completed by 800 learners. The second model –Listen – has more recently been launched and is aimed at Managers at all levels a final module, Follow Up, for senior leaders – including executive and Non-Executive Directors, lay members and governors – has been launched.

The National office are currently working to produce an updated version of the Guidance for Trust Boards, which includes a reviewed Board Assessment Tool Kit and this should be released in the coming months. The ask will be that existing self-assessments are revamped into the new format, but no timeline has been given currently. In the meantime, any trust without the self-assessment tool should complete the current one available

Recommendation

7. The Board is asked to note and approve the content of the report. Once approved the report will be made available to managers and staff.
8. The Board are asked to support the implementation of Freedom to Speak Up 'Speak Up' training for all staff to aim for a target of 100% compliance.

Lancashire and
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Provider Collaborative

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TRUST BOARD REPORT

Item 148

9 November 2022

Purpose Information

Title	New Hospitals Programme Quarter 2 Board Report
Executive sponsor	Mrs K Atkinson, Interim Executive Director of Improvement and Service Development

Summary: The purpose of this report is to provide an update on the Lancashire and South Cumbria New Hospitals Programme for the Quarter 2 period: July to September 2022.
This quarterly report is presented to the following Boards:

- University Hospitals of Morecambe Bay NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Provider Collaborative

Recommendation: It is recommended the Board:

- Note the progress undertaken in Quarter 2.
- Note the activities planned for the next period.

Report linkages

Related Trust Goal	Deliver safe, high-quality care Improve health and tackle inequalities in our community Drive sustainability
Related to key risks identified on assurance framework	1. The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2. The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities. 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.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

NEW HOSPITALS PROGRAMME Q2 BOARD REPORT

1. Introduction

1.1 This report is the 2022/23 Quarter 2 update from the Lancashire and South Cumbria (L&SC) New Hospitals Programme.

2 Background

2.1 Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) are working with local NHS partners to develop a case for investment in local hospital facilities. The programme is part of Cohort 4 of the Government's commitment to build 40 new hospitals by 2030. Together with eight existing schemes, this will mean 48 hospitals built in England over the next decade, the biggest building programme in a generation. Further information can be found on the 'Improving NHS infrastructure' website.

2.2 The L&SC New Hospitals Programme (NHP) offers a once-in-a-generation opportunity to transform the region's ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare.

2.3 The national New Hospital Programme team will be presenting an updated business case to HMT in late Quarter 3. The outcome of this will determine the capital allocation and phasing for New Hospital Programme Cohorts 3 and 4. In the interim, the national New Hospital Programme team continues to work with schemes to determine the best approach to demand and capacity modelling, sustainable buildings, standard design, digital capabilities, assessing the benefits of new hospital facilities, as well as understanding the most effective commercial frameworks that can be applied.

3 Progress against plan (for the period July to September 2022)

3.1 **Shortlist of options** – the focus at the outset of Quarter 2 was to conclude the analysis below for presentation to the Trust's Boards of Directors and the Strategic Oversight Group (July 2022):

- **Deliverability** – each of the potential new site options have been appraised against a technical assessment criteria to determine sites that are technically deliverable i.e., a new hospital facility could be accommodated on the site. These criteria will continue to be applied to any additional potential new sites that

emerge over the coming period. In addition, the viability of the partial rebuild options on the existing sites was concluded.

- **Clinical viability** – the programme continues to ensure that options and the emerging business case are aligned with the Lancashire and South Cumbria Integrated Care Board clinical strategy, emerging Provider Collaborative Board (PCB) clinical vision and Trust clinical strategies.
- **Baseline travel analysis** – work to identify the current and future issues in relation to travel, transport and access for patients, staff and our population at the current sites for Royal Lancaster Infirmary and Royal Preston Hospital concluded. This provides a baseline for comparison against potential new sites.
- **Affordability and value for money** – updated financial modelling including the return on investment concluded. This is crucial in articulating and quantifying the financial impact of our ageing estate and benefits of new hospital facilities.
- This work has brought the programme to a significant milestone resulting in **recommendations for preferred and alternative options for both Royal Preston Hospital and Royal Lancaster Infirmary** which the Trust Boards of Directors discussed and approved at their meeting in September (UHMB) and October (LTHTr) 2022. Please see section 4 below for further information.

3.2 **Equality impact –** The Programme continues to put equality, diversity and integration at the heart of each option. As part of this commitment, the programme has begun assessing the likely effects of the options on people in respect of protected characteristic groups, health inclusion groups and groups who may be more likely to experience health inequalities.

3.3 **Further travel and transport analysis for new sites –** Detailed analysis is underway and will continue in Quarter 3, considering the impacts of the potential new site options for different people – paying particular attention to protected characteristic groups and health inclusion groups. This important work will sit alongside other equality impact assessment work and will be used to inform decision making at a later date.

3.4 **Early / enabling works** – the programme welcomed the opportunity to bid for funding towards early/enabling works. It should be noted that bids are required to be option agnostic i.e. will need to be completed regardless of the scope, approvals and outcome of schemes. Following extensive work and much consideration with the Trusts a bid was submitted for early works at Furness General Hospital. This would

mark a significant and positive step forwards demonstrating tangible steps to new hospital facilities in Lancashire and South Cumbria.

3.5 **Developing our business case** – the culmination of Quarter 2 was a draft Pre-Consultation Business Case (PCBC). The purpose of PCBC at this stage is to bring together all work undertaken to date and use this to articulate and clearly demonstrate the urgent need for investment in Royal Preston Hospital, Royal Lancaster Infirmary and Furness General Hospital. The PCBC also details how the shortlisted options (section 3.1) could be delivered, the risks and the benefits. Finally, the PCBC really clearly lays out how the programme delivers against the published Case for Change via delivering new hospital facilities for our patients, staff and population of Lancashire and South Cumbria. The PCBC will continue to develop over the coming period.

4 Recommendations for preferred options and alternative options

4.1 As detailed in section 3.1, each shortlisted proposal has been comprehensively assessed for deliverability, affordability, value for money, and viability, considering feedback from patients, local people and staff. To recap, the published shortlist is:

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

4.2 Key elements have been considered to help evaluate each shortlisted option. This includes service configuration; what would be required in terms of rooms, beds and other provisions to be able to meet the operational, space and location requirements; and site location options. This has resulted in recommendations for preferred options and alternative options for both Royal Preston Hospital and Royal Lancaster Infirmary.

4.3 Both the preferred and alternative options and combinations of these are aligned to the published shortlist, and each will be considered in the context of capital affordability and benefits including addressing inequalities, clinical outcomes, productivity and wider socio-economic benefits. They will also be considered alongside “business as

usual" and "do minimum" options, both standard options in all business cases.

4.4 Lancashire and South Cumbria New Hospitals Programme's **preferred option for Royal Lancaster Infirmary** is a new state-of-the-art hospital on a new site, with an ultra-modern Urgent and Emergency Care village, with dedicated areas for same day emergency services, frail patients, patients with mental health needs and those requiring ambulatory care. This option provides an opportunity to significantly improve patient experience, the quality of services provided, and improve the environment for patients, visitors and staff.

4.5 The preferred option of a new build hospital on a new site would bring significant health and care system wide benefits. It would fully address the Case for Change, improve care for patients, improve the work environment for staff, meet environmental commitments, such as Net Zero Carbon, and maximise the wider socio-economic potential. A new build on a new site offers the best clinical, operational and efficiency benefits and meets the requirements set out by the national New Hospital Programme, such as delivering an environmentally friendly and sustainable building, with more single en-suite rooms.

4.6 The Programme's alternative option for RLI is an improved Royal Lancaster Infirmary in the current location to include a new urgent and emergency care village, together with reprovision of critical care, maternity and neonatal, and some inpatient accommodation and diagnostics. An urgent and emergency care village would contain a range of departments focused on delivering urgent healthcare needs – for example, emergency department (A&E), assessment units, diagnostics and radiology, rapid assessment, same day treatment centre, paediatric care, and ambulance facilities.

4.7 The alternative option would bring a range of improvements, particularly for patients needing urgent and emergency care and people accessing maternity services, along with improving clinical adjacencies. However, it only partially addresses the Case for Change and does not address all the required backlog maintenance or the ambitions of the national New Hospital Programme. For example, it would only partially deliver on environmental and sustainability targets because some of the old buildings and existing gas boilers would remain. As much of the new facilities would provide single en-suite rooms for patients as possible, but this would not be at the scale achievable within a new build. It also limits opportunities to make service and quality improvements in the future.

4.8 Lancashire and South Cumbria New Hospitals Programme's **preferred option for Royal Preston Hospital** is a new state-of-the-art hospital on a new site, with an improved and enhanced urgent and emergency service, increased capacity for specialised services and the opportunity to maximise significant quality and productivity gains.

4.9 A new build Royal Preston Hospital on a new site would bring significant health and care system wide benefits. It would fully address the Case for Change, improve care for patients, improve the work environment for staff, meet environmental commitments, such as Net Zero Carbon, and maximise the wider socio-economic potential. A new build on a new site offers the best clinical, operational and efficiency benefits and meets the requirements set out by the national New Hospital Programme, such as delivering an environmentally friendly and sustainable hospital, with more single en-suite rooms.

4.10 The Programme's alternative option for RPH is an improved Royal Preston Hospital on the current site to include a new urgent and emergency care village, together with replacement of some inpatient facilities for non-elective medical and surgical patients, and the replacement of nine theatres and diagnostic facilities. An urgent and emergency care village would contain a range of departments focused on delivering urgent healthcare needs – for example, emergency department (A&E), assessment units, diagnostics and radiology, rapid assessment, same day treatment centre, paediatric care, and ambulance facilities.

4.11 The alternative option would bring a range of improvements, particularly for patients with urgent and emergency needs and would improve clinical adjacencies. However, it only partially addresses the Case for Change and the ambitions of the national New Hospital Programme. For example, it would only partially deliver on environmental and sustainability targets because some of the old buildings and existing gas boilers would remain. As much of the new facilities would provide single en-suite rooms for patients as possible, but this would not be at the scale achievable within a new build. It does not address all of the required backlog maintenance required or tackle issues with the long-term viability of current facilities, such as the much-needed replacement of the ageing ward block, which would therefore still need to be addressed longer term. It also limits opportunities to make service and quality improvements in the future.

5 Public, patient and workforce communications and engagement

5.1 Hearing and reflecting the views of people living and working in Lancashire and South Cumbria is an essential part of shaping plans and proposals for new hospital facilities. Engagement with and involvement of patients, local people, staff and stakeholders is incorporated throughout the New Hospitals Programme's process. Throughout the programme there will be a clear process and regular opportunities for local people and staff to have their say and to influence the business case, helping to shape the future of hospital care in our region.

5.2 The programme team have continued to implement a programme of regular communications and engagement opportunities during the options development period, designed to make sure local people are aware and informed about proposals, know how they can get involved, understand why decisions are made, feel enthusiastic about what is possible, and have trust in the process.

5.3 As of 31 August 2022, 15,579 different individuals have been involved in one or more Lancashire and South Cumbria New Hospitals Programme engagement activities, interacting with us 30,802 times. Public and patients account for 32% of these interactions and NHS staff account for 19%. Health inclusion groups (including those with protected characteristics) and service users (especially those who have difficulty with mobility, stamina, dexterity and mental cognisance) together make up 45% of interactions. The remaining interactions have come from expert patient groups and political stakeholders.

5.4 The key themes of feedback have been as follows:

- There is widespread support in favour of funding for new hospital facilities. Local people, patients and staff all acknowledged the ageing population of the region and health inequalities as a driver for urgent improvements for hospital facilities.
- Travel and accessibility considerations are the biggest talking point.
- People are open to the use of digital tools to enable care closer to home.
- A single new hospital on a new central site is not acceptable to most audiences. The main concerns centred on services being located too far away and potential difficulties travelling to and around the hospital.

- New hospital facilities should be designed with sustainability in mind. Design, layout, and sustainability was the second most popular discussion point after travel and accessibility.
- Hospital sites must be 'future-proofed' to meet the region's long-term needs. Patient-centred care was the most important topic for inclusion groups. People wanted the future of healthcare to be based on holistic care, collaboration, prevention and tackling health inequalities. Inclusion groups hope that there will be more emphasis on training hospital staff to raise their understanding of the needs of under-represented people.

5.5 A public-facing report titled Your Hospitals, Your Say has been produced to provide an overview of activity that has taken place during the options development period and share what the programme has heard from people in Lancashire and South Cumbria to date (as of 31 August 2022). Published in September 2022, the Your Hospitals, Your Say report is available online at https://newhospitals.info/YourHospitalsYourSay. It has been shared with stakeholders and staff and promoted through New Hospitals Programme and NHS partner internal and external communications channels.

5.6 The latest programme milestone update announcing recommendations for preferred options and alternative options for Royal Lancaster Infirmary and Royal Preston Hospital was launched on 26 September 2022, with issue of stakeholder briefings, a media release, internal communications, NHP and partner social media, email newsletter updates, and more. This has resulted in a wide range of local media coverage and positive reaction from local political stakeholders. A new online survey has been launched to capture views on the proposals and on what is most important to people for new hospital facilities.

6 Stakeholder management

6.1 Stakeholder engagement has continued during Quarter 2 with the programme joining discussions at Chorley Council and South Ribble Council.

6.2 The programme team presented an update at the Lancashire Health and Adult Services Scrutiny Committee and Cumbria Health Scrutiny Committee this period.

6.3 Lancashire and South Cumbria and neighbouring area MPs and local authorities, and wider stakeholders have been briefed on the latest programme milestone update and

publication of Your Hospitals, Your Say during September 2022, with a further invitation to meet to discuss the programme further.

7 Programme governance and risk

7.1 During Quarter 2, the Programme has made significant progress on recommendations regarding programme governance and assurance. The Programme continues to review and strengthen the approach to risk as well as continuing to manage dependencies within the integrated care system and national teams.

8 Next period – Q3 2022/23

8.1 Quarter 3 takes us into a period of further detailed analysis on the shortlisted options in preparation for the outcome of the national New Hospital Programme business case. The programme looks forward to working with the national Programme team to understand the outcome of the business case and what this means for new hospital facilities in Lancashire and South Cumbria.

9 Conclusion

9.1 This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 2 2022/23.

10 Recommendations

10.1 The Board is requested to:

- Note the progress undertaken in Quarter 2.
- Note the activities planned for the next period.

Rebecca Malin
Programme Director
October 2022

Jerry Hawker
Programme Senior Responsible Officer

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 149

9 November 2022

Purpose Information

Title	EPRR Annual Assurance Statement and Report 2021/2022
Executive sponsor	Mr T McDonald, Executive Director of Integrated Care, Partnerships and Resilience

Summary: This paper outlines the Trust's assurance statement and annual report regarding emergency preparedness, resilience and response (EPRR) as required by NHS England and NHS Improvement. It has been approved by the EPRR Committee (September 2022) and submitted to Lancashire and South Cumbria Integrated Care Board (as per assurance process for 2022).

Recommendation: To receive the action plan contained within this Report to provide assurance that the Trust is committed to declaring full compliance against the EPRR Core Standards by March 2023.

To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it substantially fulfils its statutory and non-statutory duties and obligations.

Report linkages

Related Trust Goal	Deliver safe, high-quality care Drive sustainability
Related to key risks identified on assurance framework	1. The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive. 2. The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

(149) EPRR Annual Assurance Statement and Report 2021/2022

Lancashire and
South Cumbria
Provider Collaborative

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Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Report for 2021/2022

Executive Summary

2. This report provides an overview of the Trusts emergency preparedness, resilience and response during the past 12 months and provides assurance that East Lancashire Hospitals Trust meets its statutory duties under the Civil Contingencies Act 2004, NHS Act 2006 and the Health and Social Care Act 2012 and its other non-statutory obligations.

3. This report also summarises the current position of the Trust in relation to emergency preparedness and business continuity arrangements based on the completion of the annual EPRR Core Standards Framework and Statement of Assurance submission.

4. Due to the passing of the late Queen Elizabeth II, the Trust Board meeting due to be held in September was stood down. However, it was acknowledged that the provision of delegated authority will again pass to the Executive Director of Integrated Care, Partnerships and Resilience to submit the EPRR Statement of Assurance on behalf of the Trust Board. Due to the timescales within the EPRR Annual Assurance Process, it was agreed that the final Statement of Assurance would be presented to the Trust Board on the 9th November.

2021/22 EPRR Assurance Process

5. The comprehensive EPRR core standards assurance process has been undertaken and ELHT demonstrates a level of **Substantial Compliance**, which this Trust Board is asked to ratify (Appendix A). The completed self-assessment and action plan can be found in Appendix B and C respectively.

6. The Deep Dive area (non-mandatory standards) for 2021-2022 relate to evacuation and shelter. ELHT declared compliance with eleven out of the thirteen standards at the time of the submission and will be fully compliant by December.

Covid-19 Pandemic Response

7. The UK has been responding to the Covid-19 pandemic outbreak since March 2020. In line with the nationally recognised NHS command and control structure for responding to major incidents and emergencies, the Trust established an Incident Co-ordination Centre (ICC) and Divisional and Corporate Operational Co-ordination Centres (OCCs) which remained in place until August 2022.

8. The ICC provided the overarching co-ordination of the Trust's planning, response and resilience from an organisational, local, system, regional and national perspective.

9. The EPRR team continues to act as the single point of contact for the Trust, not only for the Covid-19 response but for other local and national EPRR related responses. It facilitates communication, co-ordination and leadership with respect to response and resilience. It provides robust systems to receive and disseminate information, to co-ordinate and submit situation reports and is formally overseen by the Executive Director of Integrated Care, Partnerships and Resilience as the Trust's Covid-19 Executive Lead and nominated Accountable Emergency Officer (AEO) with responsibility for EPRR.

10. In response to the Covid-19 pandemic, the Trust established a senior level, multi-disciplinary Incident Management Team (IMT) with representatives from each division / specialist area. The Covid-19 IMT originally met twice daily but this was stood down to one meeting a week which was stood down in June, although these meetings continue to be flexible depending on demand.

11. Where needed, ad-hoc, time sensitive cells have been established, chaired by the AOE or Head of EPRR, to ensure that specific programmes and targets have been achieved. This includes Swabbing and Testing (patient and staff), Personal Protective Equipment (PPE) and Clinical Consumables, Vaccinations (flu and covid-19) and Fire Safety.

12. All Covid-19 related organisational risks have been recorded on Datix and where appropriate, escalated to the Quality Committee and Trust Board. This process ensures that all risks and their impact to quality and safety, operational performance, compliance requirements, finance, workforce and stakeholders are recorded and monitored. The Head of EPRR continues to review and update these risks on a regular basis.

13. During winter 2020, a Gold Command structure was established across Lancashire and South Cumbria with senior level representatives from NHS providers, CCGs and mental health, North West Ambulance Service, patient transport, and Critical Care Cell. The Gold

Command meeting is held once or twice a day (Monday to Friday) depending on system capacity and demand. Daily situation reports are submitted to Gold Command and these form the basis of the meeting. The Chair will review current pressures, facilitate mutual aid and escalate issues to the regional NHS E I team as necessary. From 1st November, this reporting and meeting will be facilitated seven days a week in line with regional and national winter planning arrangements.

14. The Head of EPRR continues to represent the Trust on various local, system-wide and regional multi-agency groups throughout the Covid-19 pandemic including supporting mutual aid and the management of local outbreaks.

EPRR Update

15. Over the past 12 months, several EPRR related plans and policies have been reviewed, either in response to Covid-19 or because their review is due. This includes the Major Incident Plan, Heatwave Plan, Cold Weather Plan, Lockdown Policy, Business Continuity Plans and priority services.

16. Business continuity incidents this year include a power cut, phone / bleep failure, and a gas pipe failure. Responses to such incidents have been managed through the timely establishment of effective incident response teams. After each incident, a facilitated debrief is undertaken to identify any lessons to be leaned and good practice that can further improve our response to such incidents in the future and these are shared, monitored and approved formally through the EPRR Committee.

17. The Emergency Department have worked extremely hard over the past six months to get their chemical, biological, radiological and nuclear (CBRN) training and supporting documentation to the required level of compliance.

18. The Trust has a decontamination unit in situ (near ED) which facilitates the decontamination of patients. This unit provides a more reliable, dignified and safer experience for contaminated patients compared to the old inflatable unit. The above points both contribute to ELHT declaring full compliance in relation to the core standards for CBRN.

Recommendations

19. The Trust Board is requested:

a. To receive the action plan contained within this Report to provide assurance that the Trust is committed to declaring full compliance against the EPRR Core Standards by March 2023

b. To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it substantially fulfils its statutory and non-statutory duties and obligations.

Tony McDonald

Executive Director Integrated Care, Partnerships and Resilience

Accountable Emergency Officer

18th October 2022

Appendix A

Lancashire and South Cumbria Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

East Lancashire Hospitals Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, East Lancashire Hospitals Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

30/09/2022

Date signed

09/11/2022	09/11/2022	________TBC_______
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Appendix B – Core Standards Self-Assessment

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully complia...
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	AEO Chief Executive, delegated to Exec Dir of Integrated Care, Partnerships and Resilience	Fully Compliant
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy in place C159, reviewed and last ratified 08/08/2022	Fully Compliant
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	An annual report is submiitted to the Trust Board outlining training and exercises, incidents and compliance in relation to the core standards assurance process	Fully Compliant
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The reporting process is explicitly described within the EPRR policy statement which also covers the workplan	Fully Compliant
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The EPRR Policy requires that sufficient and appropriate resources are allocated to the EPRR function to enable the Trust to fully discharge its EPRR functions	Fully Compliant

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6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The EPRR Policy statement and Business Continuity Plan outline how the Trust will learn from incidents and exercises.	Fully Compliant
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	EPRR risks are an agenda item at the EPRR Committee so risk are considered and recorded. The Head of EPRR attended the Risk Assessment Meeting to escalate risks as necessarry Risk assessment is documented in the MIP and also in the Risk Management Framework (C002) and Procedure (C145).	Fully Compliant
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR risks are monitored through the Emergency Preparedness, Resilience and Response Committee.Where appropriate, risks are recorded on the corporate risk register.in line with the Risk Management Framework and Procedure	Fully Compliant
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Where appropriate, partner organisations are consulted with as part of the planning process / arrangements - this is recorded in the plans / documents and where appropriate, EPRR Committee meeting minutes	Fully Compliant
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a major incident plan (reviewed September 2021) and business continuity plan (reviewed April 2021) of which either could be used to respond to a critical incident depending on the nature of the incident. This type of incident is defined in the Major Incident Plan. The Trust has a major incident plan in place which is reviewed a minimum of every three years.	Fully Compliant
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The Trust has a heatwave plan and cold weather plan which are reviewed every 12 months in line with the national review. These are distributed to all divisions when published and are avaliable on the intranet and sharepoint sites	Fully Compliant

12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3	The Infection Control Team have produced outbreak management guidance in line with current guidance and legilsation and offer support / training to staff in outbreak areas. These have been signed of by the Incident Management Team and IP&C Committee	Fully Compliant
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Due to the covid 19 pandemic, the Trust arrangements in place to respond to future pandemics in line with current guidance and legislation. Lessons learned from the covid 19 pandemic will be reflected upon if there is a new / emerging pandemic in the future	Fully Compliant
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.		Fully Compliant
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	The Trust has a major incident plan and business continuity plan of which either could be used to respond to a mass casualty incident. ELHT have also been involved in the drafting / reviewing of the LRF Mass Casualty Plan. Critical Care are aware of the expectations on them and can expand capacity if required	Fully Compliant
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has arrangements in place to manage the shelter and evacuation of patients should this be necessary. The Evacuation and Shelter Policy C160 i*****.date	Fully Compliant

17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	ELHT can implement effective arrangments to safely manage site access and egress and this has been tested throughout the covid pandemic. The Trust has a Lockdown Policy in place which is reviewed every 2 years and this Policy DATE	Fully Compliant
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has an Official Visitors Access Policy C137 (Reviewed DATE)	Fully Compliant
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust hosts the Resilience Mortunary for Lancashire and South Cumbria and the AEO is fully aware of the excess deaths and mass fatalities arrangements.The Plan is available to on call staff on Sharepoint	Fully Compliant
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	The Trust has a 24 / 7 senior manager and director on-call rota. The Trust also has a 24 / 7 Clinical Site Manager. Both of these on-call systems support the receipt and response of incident notifications. There is an On Call Policy and Pack in place	Fully Compliant
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	The Trust has a 24 / 7 senior manager and director on-call rota. The Trust also has a 24 / 7 Clinical Site Manager. Both of these on-call systems support the receipt and response of incident notifications. There is an On Call Policy and Pack in place On Call Training (EPRR and on call roles) continue to be regularly provided	Fully Compliant

22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	A Training Needs Analysis is underway for all SMOCS and DOCS to ensure that they are competent / current in their role Training records are maintained for all EPRR training The EPRR policy outlines the required training of ICC staff Staff have been requested ot maintain personal training and exercising portfolios. The Head of EPRR has developed a standardised template to support this All training sessions are completed with an attendance certificate to support personal portfolios	Fully Compliant
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	monthly communications test which is reported to the EPRR Committee The command post exericse was last undertaken when the covid pandemic was declared an level 4 incident for the NHS The last live exercise took place Novermber 2019 and a live exercise is scheduled for October 2022. Due to the ICC being in situ to respond to the covid pandemic so a command post exercise has not been done. ED have undertaken a table top exercise this year. Local risks identified by thje EPRR committee form the basis of the test / exercises. Lessons are always learned during the debrief process post exercise / training and post exercise reports are presented to the EPRR Committee and feed through to the Trust Board via the	Fully Compliant
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	Ttraining records and exercise attendance of all staff with key roles for response are recorded Staff have been requested ot maintain personal training and exercising portfolios. The Head of EPRR has developed adn distributed a standardised template to support this All training sessions are completed with an attendance certificate to support personal portfolios	Fully Compliant

25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	EPRR training is part of the Induction training programme (mandatory) Exercises and training is fed through the EPRR Annual Report to the Trust Board EPRR news regularly goes out in Trust comms Divisions are held accountable for business continuity plans through the EPRR Committee and are also accountable for ensuring that their teams / areas of work are aware of where to	Fully Compliant
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The location and establishment of the ICC is clearly documented in the On Call Pack, the Major Incident Plan and in the Incident Co-ordination Centre Handbook	Fully Compliant
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	Planning arrangements are available on Sharepoint and on the network drive for all Senior Managers and Directors On Call. These are version controlled and regularly updated.	Fully Compliant
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	The Trust has a corporate Business Continuity Plan and each ward / department also has a local BCP.	Fully Compliant
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	The Trust has a substantial cohort of trained loggists available to support the decision makers. The on call pack references the need for all decision makers to create and keep their own decisions logs. Logs are available in the oncall pack and online on Sharepoint in the OnCall area	Fully Compliant
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	The Trust responds to sitrep requests as necessary. The Trust continues to do so for covid sitreps. The Trust has a single point of contact e-mail address which is used for co-ordinating sitreps and briefings. The ICC Exec Lead authorises submissions as necessary.	Fully Compliant

31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	ED staff have access to these guidelines both electronically (via email) and hard copies in the Major Incident Store Room.	Fully Compliant
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	ED staff have access to this guidance both electronically (via email) and hard copies in the Major Incident Store Room.	Fully Compliant
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The Comms Team are aware of the Trusts EPRR arrangements and there is an on call rota in place for the comms team (24/7). This enables the Trust to provide support during an incident. All comms are logged centrally for future reference.	Fully Compliant
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	The Comms team have an on call function. Switchboard have a repsonse plan which is tested every 3 months. This tests local communicaiton cascade processes in and out of hours. There is an on-call which details internal and external	Fully Compliant
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	The Trust has arrangements in place to deal with partner agencies during an incident. All Directors have had media training. Information requests are monitored / tracked through the admin hub (EPRR / Coronavirus email accounts) on behalf of the Incident Co-ordination Centre. There are standard holding responses for use in emergency situations.	Fully Compliant
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the	All executives are given media training to enable them to be the nominated Trust spokesperson. The comms team will support with rapid and structured comms with the public	Fully Compliant
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	The AEO attends the LHRP	Fully Compliant
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	The AEO attends the LRF as necessary. The EPRR Team (NHS E I) alos attend and share minutes as appropriate	Fully Compliant

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39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	The Trust is signed up to the mutual aid agreement across Lancashire and South Cumbria. Mutual aid arrangements are also in place across L&SC through the Winter Hub (established winter 2020)	Fully Compliant
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all		
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency		
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas		
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	The Trust is signed up to sharing information and has policies aligned to FOI and GDP guidance.	Fully Compliant
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	The Trusts BCP outlines the Trusts statement of intent in relation to business continuity. This Plan is aligned to ISO 22031. Ward / department BCPs compliance is monitored at the EPRR Committee	Fully Compliant
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers.	The Trusts BCP outlines the scope and objectives of business continuity planning and the risk management process for reviewing risks. This is supported by the Trusts Risk Management Strategy (C002) and Procedure (C145). EPRR / BCM related risks are reviewed and monitored at the EPRR Committee.	Fully Compliant
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the	The Trust undertakes business impact analyses when the Trust BCP is reviewed. All ward / departments undertake	Fully Compliant

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47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations	The Trust has BCPs for all wards / areas which are reviewed annually or post incident as required. These plans include disruptions to: staff, IT and telecoms, premises and suppliers. The Procurment Team request BCPs from suppliers and the IT team have a disaster recovery plan for responding to and recovering from disruption. All BCPs are stored centrally by the EPRR team on the networkk drive.	Fully Compliant
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	BCP compliance is monitored through the EPRR Committee and reported to Trust Board via the core standards assurance process. All BCPs are reviewed via discussion within the division on an annual basis as a minimum. They are also reviewed post incident - this year we have experienced live scenarios including heatwave, telecoms and IT outages so not undertaken formal exercising	Fully Compliant
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The IT team certify that the Trust is compliant with the Data Protection and Security Toolkit on an annual basis	Fully Compliant
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	The Trusts corporate BCP is reviewed as per Policy in line with key performance indicators. Any testing or live activation of the Trust BCP and ward / department BCPs are reviewed through a formal debrief proceedure as per the Trust BCP. BCPs are monitored through the EPRR Committee, which feeds into the Quality and Safety Committee, a sub group of the Trust Board. The annual assurance process is also presented to the Trust Board	Fully Compliant

51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	All BCPs are reviewed on an annual basis as a minimum and submitted to the EPRR team and monitored at the EPRR Committee. All BCPs have been audited for consistency / quality by the EPPR Team during the last 12 months. However, there is no formal internel audit process in place. An external audit has not been undertaken.	Partially Compliant	BC audit to be programmed into the annual internal audit process Schedule an external audit once the internal audit has been completed	Associate Director of Quality and Safety
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	There is a formal debrief process in place (documented within the BCP) to ensure learning from business continuity incident. These are reviewed / monitored at the EPRR Committee to ensure actions are completed and lessons learned. All divisions attend the EPRR Committee meeting to share lessons learned across the Trust and take corrective action as necessary.. A summary of incidents / actions plans are referenced in the Annual Report for EPRR	Fully Compliant		
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value	Business continuity arrangements for suppliers / commissioned services are monitored through contract arrangements	Fully Compliant		
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted		• Exercising Schedule • Evidence of post exercise reports and embedding learning				
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Telephone advice details are in the CBRN file in ED and the CBRN Policy (C117).	Fully Compliant		
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	The CBRN Policy (C117) outlines the Trust CBRN / Hazmat arrangements including the response and management procedures (last reviewed July 2021).	Fully Compliant		

57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous	Y	• Impact assessment of CBRN decontamination on other key facilities	The CBRN Policy outlines systems of work and required competencies of those undertaking a CBRN / hazmat response. This Policy also refers to management of waste	Fully Compliant	
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	The Trust has access to a decontainer (24/7) and has sufficient staff to respond (in ED) The Trust is currently in the process of developing a SOP in relation to the use of the decontainer and related equipment which will support the rota of staff	Partially Compliant	A SOP needs to be developed for the use of the fixed Decontainer Unit . Staff will use this SOP to support the training programme
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-	Y	Completed equipment inventories; including completion date	The equipment inventory was last completed in September 2022. Ancilliary equipment continues to be checked monthly	Fully Compliant	
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	The Trust has the expected number of PRPR available for deployment	Fully Compliant	
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	Routine checks are carried out by the Matron in ED with responsiblity for CBRN - this includes the suits, decontainer, RAM GENEs etc.	Fully Compliant	
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	The decontamination equipment is regularly checked in terms of maintenance, repair and replacement as appropriate. The decontainer is regularly serviced by the service A SOP for the ramgenes needs to be developed to ensure correct usage outside of the training environment	Fully Compliant	Ramgene SOP to be developed to support safe use during an incident
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	PPE is disposed of as per guidance. ELHT also has a Waste Management Policy C071.	Fully Compliant	

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63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	PPE is disposed of as per guidance. ELHT also has a Waste Management Policy C071.	Fully Compliant
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	The CBRN lead role sits within ED. The leads have undertaken all the relevant training.	Fully Compliant
65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	The ED CBRN leads provide a standardised training programme for all responding staff based on good practice and recognised material (JESIP) The training includes PPE and decontamination	Fully Compliant
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	The CBRN lead matintains records of trained decontamination staff	Fully Compliant
67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	There is a conprehensive training programme in place within the Emergency Department to ensure that staff (nursing / clinical / logistics / reception) are trained to provide a response to a CBRN incident. This includes the requirement to isoalte a patient. This is also referenced in the CBRN	Fully Compliant
68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		All relevant staff in ED are trained to use FFP3 masks and these are available within the ED. This has been further enhanced during covid and the requirement for staff to be mask fit tested. Mask fit testing continues to be provided by Division of Education, Research, and Innovation.	Fully Compliant

Appendix C Emergency Preparedness, Resilience and Response (EPRR) Core Standards Action Plan / Work Programme 2022/23
Organisation: East Lancashire Hospitals Trust

Plan owner: Head of EPRR

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
Standard 10	Major Incident Plan	To maintain compliance, the Major Incident Plan needs to be reviewed.	Review Major Incident Plan in next twelve months	Sep 2023
Standard 16	Evacuation and Shelter Policy	To maintain compliance, the Evacuation and Shelter Policy C160 needs be reviewed.	Review the Evacuation and Shelter Policy C160 by Nov 2022	Nov 2022
Standard 18	Official Visitors Access Policy	To maintain compliance, the Official Visitors Policy C137 needs be reviewed.	Review the Official Visitors Policy by August 2024	August 2024
Standard 28	Corporate Business Continuity Plan	To maintain compliance, the Corporate BCP needs to be reviewed.	Review the Corporate BCP by April 2023	April 2023
Standard 51	Business Continuity Audit	To improve compliance, the organisation needs to implement a formal process for internally auditing business continuity plans at planned intervals and then arrange for an external audit.	Business continuity plans audit to be programmed into the annual internal audit process and an audit to be undertaken Schedule an external audit once the internal audit has been completed (MIAA have already been contacted to action this asap)	April 2023 April 2023
Standard 58	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week. However, this needs to be formalised into a SOP and staff rota.	Develop a SOP for the use of the Decontainer	December 2022

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
Standard 62	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date RAM GENE (radiation monitor).	Develop a SOP for the use of the Ramgene monitors	December 2022
Depp Dive	Evacuation and Shelter	Patient tracking and dispersal	A business case has been presented for a SMART patient tracking package. This must be approved to enable the Trust to meet this standard.	December 2022
Deep Dive	Evacuation and Shelter	Community Evacuation	To be referenced in the Evacuation and Shelter Policy C160	December 2022

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TRUST BOARD REPORT

Item	150
Purpose	Information

9 November 2022

Title	Finance and Performance Committee Information Report
Executive sponsor	Mr S Barnes, Non-Executive Director, Committee Chair

Summary: The report details the agenda items discussed in the Finance and Performance Committee meetings held on 27 June, 25 July, 22 August, 26 September and 31 October 2022.

Recommendation: The Board is asked to note the report.

Related Trust Goal	-
Related to key risks identified on assurance framework	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

(150) Finance and Performance Committee Information Report

East Lancashire Hospitals
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Finance and Performance Committee Update

At the meeting of the Finance and Performance Committee held on 27 June 2022, members considered the following matters:

1. Members received an update on the system financial performance, noting that a request had been made to the system to submit a breakeven position. Members were informed that each Trust in the system had been asked to achieve a recurrent 5% savings target. Members noted the Trust's month 2 position showed a £3.3 million deficit. They noted that the Trust held a cash balance of £60 million and that capital spend currently showed some slippage against plan that would re-align during the year.
2. Members received an improvement presentation on the waste reduction programme (WRP) performance to date. Members noted that a plan had been submitted with £6.1 million of savings identified.
3. The Committee received the Integrated Performance Report, noting that the staff sickness level had decreased to 5.5% due to a reduction in COVID-19 sickness. Members noted that the vacancy rate has improved, and international recruitment had recommenced. Members that the number of attendances had increased in the Emergency Department in June.
4. An update on the Trust's Private Finance Initiative (PFI) partners was provided, along with current work being undertaken. Members noted that work continues with the PFI partners at both sites.
5. Members were updated on the Corporate Risk Register (CRR), noting that work continued to reduce the number of open risks and improve the quality of recorded risks. Members noted that further work is taking place to refine the language used within the CRR and that when taken with the Board Assurance Framework (BAF), significant assurance is received.
6. The Committee received the new BAF, noting the increase to 12 risks and the application of improvement methodology and an updated risk appetite statement. Members approved the new BAF for presentation at the Trust Board.

At the meeting of the Finance and Performance Committee held on 25 July 2022, members considered the following matters:

1. Members received an update on the system financial performance, noting that the 5% efficiency target equated to a system wide target of £187 million. Members were

updated on the Integrated Care Board (ICB) 5 priority areas, noting that these should provide financial savings and also improve quality. Members were informed that each Trust in the system had been asked to achieve a recurrent 5% savings target. Members noted the Trust's month 3 position was £5 million behind plan, and the cash balance and capital spend were both on plan. Members were updated on the NHS pay award, noting that full guidance was still to be received. In addition, plans to tackle agency staffing costs were discussed.

2. Members received an improvement presentation around the Urgent and emergency Care plan, showing strategic improvements across inflow, flow and outflow. Members were also informed about the decision for the Trust to become the sole provider of Intensive Home Services in the area which would help provide higher levels of care to patients.
3. The Committee received the Integrated Performance Report, noting that the Trust's 4-hour position within the Emergency Department had improved for the fifth consecutive month. Members noted that the Trust continued to support colleagues across Lancashire and South Cumbria and would be offering mutual aid to Lancashire Teaching Hospitals by repatriating any patient with a postcode within the ELHT catchment area. Members noted the trust had achieved 102% of elective restoration for the week ending 26 June.
4. Members received a presentation from the Directorate of Education, Research and Innovation (DERI), listing the achievements to date for 2022, as well as the future vision. Members requested an update on the work undertaken to be provided in the next quarter.
5. An update on the Trust's Private Finance Initiative (PFI) partners was provided with members noting work continues with the PFI partners at both sites.
6. Members received a brief update on the Corporate Risk Register (CRR), noting that work continues to avoid duplication and reduce the number of open risks.

At the meeting of the Finance and Performance Committee held on 22 August 2022 members considered the following matters:

1. Members received an update on the system financial performance including the 5% efficiency target. Members noted the Trust's month 4 position showed a £5 million deficit along with a healthy cash balance of £47 million. Members noted that £11.5

million had been transacted through the WRP. Members were updated on the new agency staff financial ceilings, noting that work continues to reduce agency spend.

2. Members received an update on the improvement work taking place in the Trust, noting that Outpatient improvement and transformation will be a key priority as part of elective recovery. Members were informed that all teams are being encouraged to register a quality improvement project, with 29 live improvement projects focussed on elective care.
3. The Committee received the Integrated Performance Report, noting that work continues to improve 'clock stops'. Members were informed that the Trust would be providing mutual aid to Lancashire Teaching Hospitals by repatriating patients with postcodes within the ELHT catchment area. Members noted that the Trust was receiving increasing numbers of cancer referrals.
4. Members received the Quarterly Workforce Plan, noting that staff absence was now stabilising around 5.5% following increases during the Covid-19 pandemic. Members were informed about ongoing recruitment activity and how the Trust was looking to streamline the process to encourage people to apply. Members noted that the NHS Staff Survey was due to commence on 20 September 2022, and that work was taking place across Lancashire and South Cumbria to try to increase usage of bank staff.
5. The Committee were updated on the work being undertaken by the Lancashire Procurement Cluster (LPC) to deliver savings and mitigate inflationary increases. Members noted that 30% of savings had been delivered against plan and that the plan is predominantly backloaded. Members noted that the LPC is looking to take advantage of joint collaborative savings across the system to enable better cost reduction through standardisation.
6. An update on the Trust's PFI partners was provided with members noting the work taking place at the Burnley and Blackburn sites.
7. Members received an updated on the CRR, noting that 2 additional risks had been added since the previous meeting. Members noted that there had been a further reduction in the rating and number of open risks that are either overdue or due to become overdue for review.
8. Members received the BAF, noting a reduction to the risk rating of Risk 5a and Risk 9. The Committee agreed that any risk to the Trust as a result of changes within the system should be reflected in the BAF and referred the issue to the Executive team for consideration.

At the meeting of the Finance and Performance Committee held on 26 September 2022 members considered the following matters:

1. Members noted that the revenue forecast for the Trust would be a breakeven position and that the capital forecast shows that the Trust is expected to meet the plan. Members noted that there is a risk attached to the capital funding if it is unable to be spent by the end of the financial year. Members received an update on the forecast outturn scenarios, noting what the best, worst and likely outcomes would be.
2. A presentation on the Quality Strategy Improvement Practice Development Plan for 2022 to 2025 was shown to members, noting that this had now been signed off. Members were advised that there would be a focus on improvement activities that can be worked on collectively across the trust to support improved outcomes and a robust measurement plan for improvement.
3. Members received the IPR, noting there had been improvements against the 4-hour target since the previous month. Members noted that cancer remains a significant focus for the Trust and that the Trust was close to meeting the 28-day faster diagnosis standard, with an agreed trajectory for the 62-day cancer backlog. Members were informed that the unplanned bank holiday for the Queen's funeral had had an impact on restoration, however approximately half of Outpatient clinics and theatre lists were run on the day, and all Endoscopy lists and the majority of other diagnostics took place.
4. Members received a presentation about the model hospital and patient level information and costing system data, noting that the Trust had moved to a new system. Members were informed that a gap analysis had been undertaken to see how close the Trust is to costing standards, noting that there is year on year improvement.
5. The Committee were informed about a collaboration between the Trust and Lancashire and South Cumbria NHS Foundation Trust to provide an Occupational Health service. Members noted that ELHT would be the host Trust, with support from Blackpool Teaching Hospital NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust for delivery of the service.
6. Members received an update about ongoing tender activity the Trust is involved in. Members noted that following the Covid-19 pandemic, activity is starting to increase for service tenders and that the Trust has 11 contracts that will be due for retendering over the coming year.

7. Members received an overview about the Clinically Led Workforce Redesign Programme Procurement, noting that the programme had been developed and funded through Health Education England and was being hosted by the Trust.
8. Members received an update on the work taking place with the Trust's PFI partners across Blackburn and Burnley. It was noted that a new project director to work with the PFI partners had been appointed and would commence in the role at the end of September 2022
9. Members received the CRR, noting that 637 open risks had been closed by the Divisions since the last report. Members were informed that risks would be reviewed using a risk profiling perspective with the view to create a Trust wide risk, rather than an individual risk.

At the meeting of the Finance and Performance Committee held on 31 October 2022 members considered the following matters:

1. Finance Reporting
2. Improvement Update
3. Integrated Performance Report
4. COVID-19 & Restoration Update
5. Endoscopy Workforce Investment Business Case
6. Private Finance Initiative Update
7. Corporate Risk Register
8. Board Assurance Framework
9. Committee Self-Assessment Results

A more detailed report from this meeting will be provided at the next Board meeting.

Martyn Pugh, Acting Corporate Governance Team Leader, 9 November 2022

East Lancashire Hospitals
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TRUST BOARD REPORT

Item 151

9 November 2022

Purpose Information

Title	Quality Committee Information Report
Executive sponsor	Mrs T Anderson, Committee Chair

Summary: The report sets out the summary of the papers considered, and discussions held at the Quality Committee meetings held on 29 June, 27 July and 29 September 2022.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal	-
Related to key risks identified on assurance framework	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Quality Committee Update

At the meeting of the Quality Committee held on 29 June 2022 members considered the following matters:

1. Members were informed that there had been a surge in the numbers of mental health patients coming into the Trust which were exacerbating the already significant delays being seen in emergency pathways. It was confirmed that discussions were taking place with system colleagues to determine what further measures could be taken to alleviate the issues being seen.
2. An update was provided to members on the Patient Safety Incident Response Framework (PSIRF). It was noted that there had been no breaches of Duty of Candour and that the Trust had met external requirements to upload its incidents onto the National Reporting and Learning System. Members were also informed that weekly calls were taking place with Clinical Commissioning Group colleagues to close any outstanding Never Events before the end of July 2022.
3. Members received an update on the Trust's maternity services. It was confirmed that the Trust was on track to achieving the ten safety standards outlined in the Clinical Negligence Scheme for Trusts for the current year and that a final submission had been sent off for the Birth Rate Plus scheme to support the implementation of the actions and recommendations laid out in the second Ockenden Report.
4. A presentation was provided to members summarising the expected challenges involved in the move from Deprivation of Liberty Standards to Liberty Protection Safeguards. It was noted that this would result in a significant increased volume of activity coming into the Trust and that it would now become the responsible body for the process, rather than local authorities as it had been previously.
5. Members were informed that the system review of emergency and urgent care pathways had concluded and that the full report was expected to be made available on the 15 July 2022.
6. An update was provided to members on the Trust's People Plan. It was confirmed that there had been a strong response to the staff survey for 2021-22 and that an action plan had been developed to address any areas where scores had fallen relative to previous years. Members were also informed that the Trust had appointed a new Associate Director for Organisational Development and that a new draft Leadership Strategy was being developed to build capacity in this area.
7. A quarterly report on safe working hours for doctors and dentists in training was provided to members. It was reported that the majority of exception reports submitted

by junior clinicians had been in relation to long working hours, lack of sufficient development time and staffing shortages on wards. Members noted that despite the number of exception reports submitted, there had been no serious concerns raised during the period covered by the report.

8. The Committee received an update on the recent activities of the Patient Participation Panel (PPP). Members were informed that a workshop event was being planned for the 26 August 2022 to take stock and consider how the PPP could improve its engagement and ensure that it was making an effective a difference as possible.
9. A summary of the improvement work taking place throughout the Trust was provided to the Committee. Members noted that the Trust Strategy had been refreshed for 2022-23 and that improvement methodology was being used to underpin a number of programmes. Members were also informed that a new comprehensive training offer had been developed to support staff in developing their skills in delivering improvement practice.
10. In addition to the above items the Committee also received a number of standing agenda items, including the Infection Prevention Control Report, Integrated Performance Report and a summary of the most recent meeting of the Trust Wide Quality Governance Group.
11. There were no items raised for escalation to the Audit Committee.

At the meeting of the Quality Committee held on 27 July 2022 members considered the following matters:

1. The Committee was informed that there had been a rise in the number of COVID-19 patients coming into in the Trust and that there was a significant proportion of incidental diagnoses in addition to patients admitted due specifically to their COVID symptoms. It was reported that there were a small number of COVID patients being treated in critical care. Members noted that work had already commenced on the autumn vaccine booster campaign.
2. An annual report for the Trust's transfusion service was provided to the Committee. A summary of the main risks affecting the service was given as well as the actions being taken to mitigate them. It was agreed for a further update to be provided to members in six months' time.

3. The annual speaking up report was presented to the Committee. Members noted that just over 1,100 concerns had been raised since the service had been put in place in April 2016 and that five whistleblowing concerns had been raised since October 2021. It was confirmed that any concerns were responded to as quickly as possible and that action plans were put in place to address any issues if required.
4. An update on the Getting It Right First Time process was provided to members. It was noted that work was ongoing to highlight areas of best practice, with a total of 45 priority actions in progress.
5. The Committee received an update on the work taking place to manage the Trust's holding lists and clinical harms reviews. It was noted that this would include splitting patients into three distinct categories to ensure that the significant volume of patients on the lists could be worked through effectively. Members agreed for a further update to be provided in six months' time.
6. An update was provided to members on the Parliamentary and Health Service Ombudsman complaints process. Members were informed that 12 recommendations had been made to strengthen the complaints process which were mostly focused on tweaking internal systems.
7. Members received an update on recent activity in relation to claims and inquests and noted that work was taking place to close historic claims. They were also informed that the numbers of inquests taking place over recent months had increased significantly, due in part to them being adjourned for a six-month period during the COVID-19 pandemic. It was noted that the terms of reference for the national COVID-19 enquiry had now been agreed and was expected to run over the next three years.
8. In addition to the above items the Committee also received a number of standing agenda items, including the Maternity Floor to Board Report, Patient Safety Incident Assurance Report and Integrated Performance Report.
9. There were no items raised for escalation to the Audit Committee.

At the meeting of the Quality Committee held on 28 September 2022 members considered the following matters:

1. The Committee discussed the recent changes and updates to the Trust's Board Assurance Framework (BAF), specifically in relation to risks 2a (The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the

NHS Constitution and relevant legislation, and Patient Charter), 2b (The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive), 3 (The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities) and 5a (Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce). Members noted that more information regarding the eight steps for winter planning outlined by NHS England would be included in future iterations of the BAF, as would more information regarding the ongoing development of Integrated Care Boards.

2. Members also received an update on the changes and additions made to the Trust's Corporate Risk Register (CRR). It was noted that 21 open risks remained on the CRR and that work was taking place to link a number of them together in order to reduce repetition. Members were informed that each risk had now had an Executive lead assigned to them and that they regularly met with the Trust's Assistant Director of Health, Safety and Risk Management to review them.

3. The Committee was informed that the Trust's urgent and emergency care pathways were still experiencing significant pressures due to the volume and acuity of patients presenting there. Members noted that staff shortages were exacerbating these issues and that a number of issues, including an ongoing dispute regarding a new pay card produced by the British Medical Association for their members, were contributing to this.

4. A medicines management annual report was presented to the Committee. Members noted that a total of £46,500,000 had been spent on medicines in the 2021-22 financial year, with 75.3% of this being used on high-cost drugs. Members were also informed that a new Medicines Strategy for the Trust was in development both to better support the needs of the Trust and as part of a greater focus in the pharmacy directorate in embodying its values.

5. Members received a doctors annual revalidation report. It was highlighted that 96.3% of the Trust's 626 doctors had had their appraisals successfully carried out between April 2021 and March 2022 and that the remaining 3.7% had been agreed as exceptions.

6. The Committee was updated on the findings from the previous year's winter planning and the work currently taking place to develop the plan for 2022/23. Members were informed that there was a total of 48 schemes planned for the current year, 26 of which were deemed as critical, and would require just over £10,000,000 in funding to mobilise.
7. An update on the Trust's Nursing Assessment Performance Framework was provided to members, as well as a proposal to change the current Safe, Personal and Effective Care (SPEC) awarding process to be less onerous for those participating in the associated panels.
8. The Committee received an update from the Trust's Guardian of Safe Working and were informed that, although there had been a number of issues reported by junior clinicians in the Trust, there had not been any serious concerns raised.
9. In addition to the above items the Committee also received a number of standing agenda items, including the Maternity Floor to Board Report, Patient Safety Incident Assurance Report and Integrated Performance Report.
10. There were no items raised for escalation to the Audit Committee.

Dan Byrne, Corporate Governance Officer, 1 November 2022.

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TRUST BOARD REPORT

Item 152

9 November 2022

Purpose Information

Title	Audit Committee Information Report
Executive sponsor	Mr R Smyth, Non-Executive Director, Committee Chair

Summary: The report details the agenda items discussed in the Audit Committee meetings held on 18 July 2022 and 17 October 2022.

Recommendation: The Board is asked to note the report.

Related Trust Goal	-
Related to key risks identified on assurance framework	-

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

(152) Audit Committee Information Report

Audit Committee Update

At the meeting of the Audit Committee held on 18 July 2022, members considered the following matters:

1. The Committee received the Correct Consultant Audit report. It was noted that significant assurance was provided from the audit with 99% of patients audited having the correct responsible consultant on the bed board. Members were informed that monthly audits would continue, with a further update to be provided in 6 months for assurance.
2. Members received the Cyber Security Assurance update, noting that the Trust's systems and mitigations continue to help prevent cyber-attacks.
3. Members received the Internal Audit Progress report. Members were informed that the report covered the period May to July 2022 with 7 reports being finalised from the previous meeting. Members were informed that 2 reports had received a rating of outstanding for well-led and for financial sustainability and improvement.
4. The Committee received an update on the work undertaken by the External Auditors, Mazars, who confirmed that all intended work for 2022/23 had been completed.
5. Members received the Anti-Fraud Service Progress Report for quarter 1, noting the work being taken to increase awareness of fraud amongst staff.
6. Committee members were presented with the Corporate Risk Register (CRR) and noted the work taking place to improve the quality of risks on the register. Members noted an Executive Risk Assurance Group had been established to look at improving the quality of risks and see where risks could be amalgamated to avoid duplication.
7. Members were provided a copy of the Waivers Report. It was noted that there were 2 waivers, the first for continuity of service whilst recruitment takes place and the second to continue a contract whilst a procurement exercise takes place to allow standardisation across the Lancashire Procurement Cluster partner Trusts.
8. Committee members were presented with a short presentation about the Register of Interests. Members were informed these are published monthly on the Trust website and all staff at band 8b and above need to complete a declaration annually. Members noted that work continues to increase overall compliance for declarations.
9. Committee members also received copies of the minutes from the Quality Committee, the Finance and Performance Committee and the Information Governance Steering Group.

At the meeting of the Audit Committee held on 17 October 2022, members considered the following matters:

1. Management Response to Internal Audit on Catering Services
2. Management Response to Internal Audit on Risk Management
3. Current Financial Position
4. Financial Sustainability Assessment
5. NHS Green Plan
6. Internal Audit Progress Report
7. External Audit Update
8. Anti-Fraud Service Progress Report
9. Corporate Risk Register
10. Waivers Report
11. System Issues
12. Annual Review of Standing Orders and Standing Financial Instructions.

A more detailed report will be provided for this meeting at the next Trust Board meeting.

Martyn Pugh, Acting Corporate Governance Team Leader, 14 September 2022

TRUST BOARD REPORT

Item 153

9 November 2022

Purpose Information

Title	Trust Charitable Funds Committee Information Report
Executive sponsor	Mr S Barnes, Non-Executive Director

Summary: The report sets out the matters discussed, and decisions made at the Trust Charitable Funds Committee meetings held on 1 August 2022.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related Trust Goal	-
Related to key risks identified on assurance framework	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

(153) Trust Charitable Funds Committee Information Report

Trust Charitable Funds Committee Update

At the meeting of the Trust Charitable Funds Committee held on 1 August 2022 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.

1. Members were updated on recent applications to use funds requests and the overall performance of the charitable funds. It was noted that the Charity's total income as of 30 June 2022 stood at £69,000 and that total expenditure amounted to £111,000. The Charity's overall financial position was noted to be £1,800,000. A draft three-year plan for the Charity's finances was also presented to the Committee for comments and feedback.
2. The Committee received an update on the fundraising activity that had taken place in quarter one of 2022-23. Members noted that a range of activities were planned in the run up to the festive period and that good progress was being made with the development of the new Charity Hub and Retail Outlet.
3. An update on the Charity Hub business plan was presented to members. It was noted that the finances included in the plan had been revised following feedback provided at previous meetings and that it would be presented at a future meeting of the Trust's Senior Leadership Group for information.
4. The Trust's Appropriate Use of Charitable Funds policy was presented to the Committee for review. A single change relating to the approval of requests for charitable funds over £10,000 was requested to the policy and members confirmed that they were content for this to be done.
5. Members were informed that the draft audited accounts for the Charity would be presented at the next meeting for approval pending completion of the audit.

Dan Byrne, Corporate Governance Officer, 5 September 2022.

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TRUST BOARD REPORT

Item	**154**
Purpose	Information

9 November 2022

Title	Trust Board (Closed Session) Information Report
Executive sponsor	Mrs T Anderson, Interim Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 13 July 2022.

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	-
Related to key risks identified on assurance framework	-

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	Yes

(154) Trust Board (Closed Session) Information Report

Trust Board Part Two Information Report

1. At the meeting of the Trust Board on 13 July 2022, the following matters were discussed in private:
   a) Round Table Discussion: ICB / PCB and Pennine Lancashire Place Based Care Update
   b) Pharmacy Robot and Infusion Pump Replacement
   c) Feedback from CQC Inspection
   d) Responsible Officer's Report to Trust Board Regarding Doctors with Restrictions
   e) Electronic Patient Record Progress Update
   f) Nosocomial Infections Update
   g) Pathology Update
   h) Industrial Action Update
2. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to part 1 of Board Meetings at the appropriate time.

Mr D Byrne, Corporate Governance Officer

TRUST BOARD REPORT

Item 155

9 November 2022

Purpose Information

Title	Remuneration Committee Information Report
Executive sponsor	Mrs T Anderson, Interim Chairman

Summary: The list of matters discussed at the Remuneration Committee meetings held on 13 July, 28 July and 12 October 2022 are presented for Board members' information.

Recommendation: This paper is brought to the Board for information.

Report linkages

Related Trust Goal	-
Related to key risks identified on assurance framework	-

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	Yes

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 13 July 2022 members considered the following matters:
   a) Arrangements for Substantive CEO Appointment
   b) Arrangements for Interim Chief Nurse and Proposal for Substantive Recruitment

Remuneration Committee Information Report

2. At the meeting of the Remuneration Committee held on 28 July 2022 members considered the following matters:
   a) National Pay Award 2022/23

Remuneration Committee Information Report

3. At the meeting of the Remuneration Committee held on 12 October 2022 members considered the following matters:
   a) Ratification of the appointment of the Chief Executive and remuneration.
   b) Ratification of the appointment of Chief Nurse and remuneration.
   c) Fit and Proper Persons Test Annual Report

Mr D Byrne, Corporate Governance Officer