Lancashire and South Cumbria Provider Collaborative

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)

11 JANUARY 2023, 12.30pm

BOARDROOM, TRUST HQ / MS TEAMS

AGENDA

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

OPENING MATTERS				
TB/2023/001	**Chairman's Welcome**	Chairman	v	
TB/2023/002	**Apologies** To note apologies.	Chairman	v	
TB/2023/003	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	Information/ Assurance
TB/2023/004	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 9 November 2022.	Chairman	d✓	Approval
TB/2023/005	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2023/006	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2023/007	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2023/008	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information / Approval
QUALITY AND SAFETY				
TB/2023/009	**Patient Story** To receive and consider the learning from a patient story.	Interim Chief Nurse	p	Information/ Assurance
TB/2023/010	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Executive Risk Assurance Group, Committees' and Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Executive Medical Director	d✓	Assurance/ Approval
TB/2023/011	**Board Assurance Framework Review** To receive an update on the Board Assurance Framework and approve revisions based on the Executive Risk Assurance Group, Committees' and the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Director of Corporate Governance	d✓	Assurance/ Approval

TB/2023/012	**Patient Safety Incident Response Assurance Report** To receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP). This report also includes information on maternity specific serious incidents reporting as required by Ockenden recommendations.	Executive Medical Director	d✓	Information/ Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2023/013	**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
STRATEGIC ISSUES				
TB/2023/014	**Health Equity Update**	Executive Director of Integrated Care, Partnerships and Resilience	p✓	Information/ Assurance
TB/2023/015	**Maternity and Neonatal Service Update**	Interim Chief Nurse	p✓	Information/ Assurance
GOVERNANCE				
TB/2023/016	**Trust Charitable Funds Committee Information Report** a) Trust Charitable Funds Update Report b) Charity Annual Accounts and Report **(the Board is meeting as Corporate Trustee for this item).**	Committee Chair Executive Director of Finance	d✓ d✓	Information Approval
TB/2023/017	**Finance and Performance Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/018	**Quality Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information

TB/2023/019	**Audit Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/020	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
TB/2023/021	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2023/022	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2023/023	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2023/024	**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/2023/025	**Date and Time of Next Meeting** Wednesday 8 March 2023, 12.30pm, Boardroom, Trust HQ / MS Teams	Chairman	v	

Lancashire and South Cumbria Provider Collaborative

East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT

Item 4

11 January 2023

Purpose Approval

Title	Minutes of the Previous Meeting

Summary: The minutes of the previous Trust Board meeting held on 9 November 2022 are presented for approval or amendment as appropriate.

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

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

(4) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 1.00PM, 9 NOVEMBER 2022

MINUTES

PRESENT

Mrs P Anderson	Interim Chairman	Chairman
Mr M Hodgson	Chief Executive/Accountable Officer	
Mrs K Atkinson	Interim Director of Service Development and Improvement	Non-voting
Mr S Barnes	Non-Executive Director	
Professor G Baldwin	Non-Executive Director	
Dr F Dad	Associate Non-Executive Director	Non-voting
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
Mrs J Molyneaux	Interim Chief Nurse	
Mr K Moynes	Executive Director of HR and OD	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	
Mrs J Butcher	Staff Guardian	Item: TB/2022/147
Mr D Byrne	Corporate Governance Officer	Minutes
Mr I Devji	Deputy Chief Operating Officer	
Miss K Ingham	Corporate Governance Manager	
Mrs R Malin	Programme Director, New Hospitals Programme	Item: TB/2022/148
Mr M Pugh	Corporate Governance Officer	
Mrs K Quinn	Operational Director of HR and OD	

APOLOGIES

Mrs M Brown	Executive Director of Finance	
Mrs S Gilligan	Chief Operating Officer	
Mrs F Patel	Associate Non-Executive Director	Non-voting
Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council	

TB/2022/133 CHAIRMAN'S WELCOME

Mrs Anderson welcomed attendees to the meeting.

TB/2022/134 APOLOGIES

Apologies were received as recorded above.

TB/2022/135 DECLARATIONS OF INTEREST

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

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

TB/2022/136 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 13 July 2022 were approved as a true and accurate record.

TB/2022/137 MATTERS ARISING

Mrs Bosnjak-Szekeres informed Directors that, due to the cancellation of the September Trust Board, additional information had been added to the minutes from July 2022 regarding the decisions that were required after the meeting, which were dealt with via email to the Board. There were no other matters arising from the minutes of the previous meeting.

TB/2022/138 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/2022/139 CHAIRMAN'S REPORT

Mrs Anderson informed Directors that she was standing in as Interim Chairman following the departure of Professor Eileen Fairhurst at the end of October 2022. She advised that the new Chairman, Shazad Sarwar, would be commencing in post over the coming weeks and stated that she looked forwarded to welcoming him to the Trust.

Mrs Anderson highlighted that the Trust had held a stakeholder seminar with its partner organisations earlier in the week and stated that this should be taken in the context of the increasing challenges that many of them had found themselves facing over recent weeks. She explained that the bulk of this seminar had focused on presentations from the Trust's Executive team as to how these challenges and increases in demand were being managed.

RESOLVED: Directors received and noted the update provided.

TB/2022/140 CHIEF EXECUTIVE'S REPORT

Mr Hodgson provided updates on national headlines and informed Directors that NHS England (NHSE) had published their new Statutory Framework at the start of July 2022, following the establishment of Integrated Care Boards (ICBs) as full statutory bodies. He explained that the framework detailed how NHSE would operate in this new architecture and how they were expected to interface with Integrated Care Systems (ICSs) and ICBs. Mr Hodgson advised that a number of national prescriptive items were coming through to the Trust and that cancer was one area that was currently under significant scrutiny. He highlighted that a letter had recently been sent out to all Trusts outlining what Boards would be required to do with regards to elective recovery and confirmed that he and Mrs Anderson would be signing an accompanying self-certification in relation to this.

Mr Hodgson went on to advise that, following the publication of the report from the Ockenden Independent Maternity Review of maternity services at Shrewsbury and Telford Hospital NHS Trust, a further report had now been published that detailed the findings of a separate investigation into maternity services at East Kent Hospitals University NHS Foundation Trust. He explained that findings of this report had been considered in the closed session of the Trust

Board earlier in the day and confirmed that it would be published on the website. Mr Hodgson stated that the Trust was confident in the quality of its maternity services and that this was supported by a recent visit from the Care Quality Commission (CQC) which had not found any areas of concern.

Mr Hodgson referred to the national industrial action currently being planned and confirmed that the Trust was proactively preparing for it. Directors noted that a new industrial action cell had been formed to consider how the Trust could continue to deliver safe and effective care in the event of any of its staff going on strike and that work was taking place to identify the essential services that would have to remain operational.

Mr Hodgson informed Directors that a number of developments had also taken place at a Lancashire and South Cumbria (LSC) system level, including the establishment of ICBs as statutory bodies in July 2022, referred to earlier in the meeting. He advised that a series of workshops would be taking place over the coming weeks to determine how all provider organisations in the ICS would continue to work together going forward.

Mr Hodgson referred to the recent Panorama documentary detailing the abuse of patients at the Edenfield Centre in Greater Manchester and explained that all provider Trusts had been requested to take stock around whether similar incidents could be happening in their own organisations. He confirmed that a full report detailing the safeguarding mechanisms in place at the Trust would be presented later in the meeting.

Mr Hodgson reported that the financial situation in the ICS was particularly challenging in the current financial year, as all providers had been instructed to achieve efficiency savings of 5%. He confirmed that the Trust was on track to deliver this target and was currently in the process of developing a Board approved financial recovery plan for submission. Directors noted that various opportunities were being considered to release additional savings in the system, including a reduction in the use of temporary staffing.

Mr Hodgson informed Directors that a PCB Away Day event had been held in October 2022 to discuss the establishment of a new joint committee. He added that there had also been some changes to the various committees underpinning the PCB, which were detailed further in his report. Mr Hodgson advised that discussions were continuing regarding the LSC

pathology collaboration, explaining that it was looking less likely that the previously proposed hosted network approach would be used.

Mr Hodgson referred to the recent departure of Professor Fairhurst and extended his thanks to her on behalf of the Board for her years of service to the Trust. He highlighted that there would be some changes to the Trust's Executive team over the coming months, including the appointment of a new Chief Nurse, Pete Murphy, who currently held a similar role at Blackpool Teaching Hospitals NHS Foundation Trust.

Mr Hodgson proceeded to provide an update on the Trust's implementation of its new Electronic Patient Record (EPR) system. He explained that the Board had recently decided to delay the EPR rollout across the Trust in order to maintain patient safety and care and confirmed that work was taking place to finalise a new 'go-live' date, which was likely to be sometime in the summer of 2023.

Mr Hodgson went on to provide a summary of the developments taking place at a Trust level. He stressed that there was clear recognition of the current cost of living crisis and the additional hardships being placed on staff members and confirmed that a range of measures had been put in place to alleviate these, including increases in mileage rate payments and the provision of lower cost meals. Directors noted that the uptake of COVID-19 and flu vaccinations was currently lower than it had been over recent years and that work was taking place to address this.

Mr Hodgson highlighted a number of positive developments, including two Trust teams reaching the finals of the Health Safety Journal patient safety awards and its Research and Development team being announced as the winner of the National Institute for Health and Care Research awards.

Mr Hodgson concluded his update by recommending approval for applications for Safe, Personal and Effective Care (SPEC) status from a number of wards, specifically the Ribblesdale unit, ward C5, ward C10, ward 15 and two new recommendations for Lancashire Women's and Newborn Theatres and Ophthalmology Day Case. Directors confirmed that they were content to approve these applications.

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

TB/2022/141 PATIENT STORY

Mrs Molyneaux provided a brief introduction to the story and explained that it concerned a patient who had been treated in a number of Trust departments during their patient journey.

The patient explained that they had initially had a full replacement of their right knee at Burnley General Teaching Hospital after a number of years of discomfort in their leg, followed by a full replacement of their left knee around three years later. This unfortunately did not resolve their issues and following an accident at home they were admitted to the Emergency Department (ED). The patient ultimately underwent an above-the-knee amputation, after which they were cared for by the occupational therapy team before being discharged home. They reported that they had initially had some issues with pain in their leg but that this had been promptly addressed. The patient concluded by advising that they were due to have more physiotherapy carried out at Pendle Community Hospital and were managing well, with no pain at the site of the amputation.

The patient praised the conduct of the majority of staff throughout their experience and the quality of the care that they had received. The only areas of criticism were in relation to the attitude of some of the agency staff working on the wards that they had stayed on, as well as the poor quality of some of the food provided.

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

TB/2022/142 CORPORATE RISK REGISTER (CRR)

Mr Husain referred to the previously circulated report and requested it be taken as read. He provided assurance to Directors that a significant amount of attention continued to be paid to the CRR on a monthly basis and confirmed that a range of improvements had been made since it was previously presented. Mr Husain explained that the Trust's Executive Risk Assurance Group, chaired by Mr Hodgson, reviewed the CRR on a monthly basis and that each risk now had an assigned Executive lead and risk handler to promote more oversight of actions and the movement of scores.

He went on to report that two new risks had recently been added to the register, specifically risk ID 9251 (recurrent gaps in junior surgical staff rota) and risk ID 9557 (patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provider) and highlighted that the latter was an aggregate of four other risks that had previously

been in place. Mr Husain advised that, following a discussion at the closed session of the Trust Board earlier in the day, it had been agreed for the Trust to move forwarded to registering as a mental health service provider with the CQC. He concluded his update by informing Directors that a substantial amount of improvement work had taken place to reduce the levels of duplication and increase the general quality of open risks and reported that there had been a reduction from 1,709 to 1,277 since January 2022.

Mr Smyth commented that it was pleasing to see the improvements made to the CRR over recent months. He noted that a number of risks had comments included in their list of actions rather than actual actions and urged the colleagues overseeing them to ensure that this was addressed as a priority going forward.
Mr Husain thanked Mr Smyth for his comments and confirmed that these issues would be addressed in future iterations of the CRR.

Professor Baldwin agreed that the improvements made to the CRR were obvious and that he remained assured that the appropriate amount of risk management was taking place. He stated that his only concerns related to some aspects of the presentation of the report and that more consistency in the reporting of risks in future iterations would be beneficial.

Mr Wedgeworth expressed concern regarding risk ID 5791 (Aggregated risk - failure to recruit to substantive nursing and midwifery posts may impact on patient care and finance) and the impact from potential industrial action on the Trust's recruitment efforts.
Mrs Quinn pointed out that reasons for the industrial action related to national pay rates and that this is just one part of the wider context around what made the NHS an attractive employer to work for. She stressed that the Trust was doing a significant amount of work around inclusion and wider health and wellbeing support to promote it as an employer of choice. Mrs Quinn confirmed that maternity was one of the areas that would require continuing cover in the event of industrial action and reiterated that discussions were currently taking place around the potential impact on services.

RESOLVED: **Directors received the report and confirmed that they were content with the assurance provided.**

TB/2022/143 BOARD ASSURANCE FRAMEWORK (BAF)

Mr Bosnjak-Szekeres confirmed that the BAF continued to be revised and updated by the Executive Directors and requested that it be taken as read.

Professor Baldwin commented that it was helpful to see the clear cross referencing between the BAF and CRR and that it made the BAF a much more meaningful and easily understandable document.

Mr Smyth noted that the score assigned to BAF 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) currently stood at 20, with a consequence rating of catastrophic. He requested additional assurance that the situation was not as severe as this rating implied and how confident the Trust was that it would be able to meet the financial challenges outlined.

Mrs Bosnjak-Szekeres acknowledged that the score assigned to this risk was high but stressed that the Trust had robust internal controls in place to mitigate it. She added that the Trust had successfully hit all financial milestones for the year thus far.

Mr Hodgson advised that since the BAF report had been submitted, Mrs Brown and the finance team had reviewed the Trust's cost improvement programme and had substantially increased the number of savings classed as recurrent. He clarified that the main financial risk lay in the wider system position and that this tied into the ICBs request for the formal financial recovery plan referred to earlier in the meeting. Mr Hodgson added that there was some positive movement and assurance in this area but acknowledged that there would be significantly more work to do in the second half of the year to ensure the Trust was able to meet its financial obligations.

RESOLVED: **Directors received, discussed and approved the Board Assurance Framework and confirmed that they were content with the assurances provided.**

TB/2022/144 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) ASSURANCE REPORT

Mr Husain requested that the report be taken as read and provided a brief summary of highlights to members. He confirmed that the PSIRF had now been fully embedded into the Trust's processes and reported that there had been a total 32 Patient Safety Incident Investigations (PSIIs) reported as of the 12 October 2022. Directors noted that 14 of these were currently being investigated by the Trust's PSII team, with a further eight being investigated by the Healthcare Investigation Branch (HSIB). Mr Husain explained that all incidents of moderate or serious harm that did not meet national or local priorities for a PSII were still required to have a Patient Safety Response completed and that recent changes had enabled significant improvements in the allocation, completion and approval of these. He highlighted that there had been no new never events reported since April 2022. Mr Husain advised that a workshop event had taken place on the 11 November to review what the Trust had achieved with its implementation of the PSIRF and which areas still required further improvement.

Mr Rehman referred to the information provided in appendix 3 of the report relating to the use of the Perinatal Mortality Review Tool (PMRT) and the mention of potential delays. He suggested that it would be helpful if more information could be included in future reports as to how long these cases took to complete and whether families were kept informed and involved in the interim. Mr Rehman also enquired if it would be possible for more information to be provided as to whether ethnic communities were more likely to be disproportionately affected by maternity incidents or not.

Mr Husain assured Directors that family liaison officers worked very closely with families during lengthier investigations and highlighted that no complaints had been received in relation to this area. He advised that he would not be able to respond to Mr Rehman's second query as he did not have the relevant information to hand but pledged to contact maternity colleagues after the meeting to ask for the relevant information to be forwarded at a later date.

Mr McDonald informed Directors that work was taking place via the Pennine Lancashire Health Equity Alliance in relation to health inequalities and confirmed that maternity was one of the top priorities in this work.

Professor Baldwin suggested that it may be helpful to include comparisons with other time periods in future reports to provide a clearer picture of whether incident levels had improved or deteriorated.

Mr Husain explained that although the overall number of incidents may be higher than it had been in previous years, the levels of actual harm to patients had remained low. He confirmed that more comparison data would be included in future reports.

RESOLVED: **Directors received the report and received assurance.**
Additional comparative data will be included in future iterations of the PSIRF assurance report.
Additional equality and diversity information from maternity investigations will be circulated to members after the meeting.

TB/2022/145 SAFEGUARDING OF PATIENTS AT ELHT POST EDENFIELD DOCUMENTARY

Mrs Molyneaux referred Directors to the previously circulated report and explained that it had been drafted in response to a letter received from the NHSE Mental Health Director, Claire Murdoch, following the airing of the Edenfield Centre Panorama documentary. She stated that the report confirmed that the Trust had robust mechanisms in place to safeguard patients, including the presence of the Freedom to Speak Up Guardian, advocacy provision and a standard operating procedure (SOP) in place for enhanced care. Mrs Molyneaux also stressed that the Trust had a robust complaints process in place and mandatory safeguarding of adults and children training for all of its staff.

Directors noted that a substantial amount of work was taking place around the restraining of patients and that a new policy was being developed that would focus on enabling staff to de-escalate challenging behaviours to avoid restraint being required. Mrs Molyneaux highlighted that two recommendations had been included at the end of the report to develop staff knowledge and education about restraint and to increase further the visibility and monitoring of potential harm to at risk patient groups. She explained that the report would be forwarded to colleagues in the ICB at a later date, once it had been reviewed by the system.

Mrs Quinn stressed that the Freedom to Speak Up Guardian was well embedded in the Trust and stated that she was confident that staff would feel safe to raise any concerns or issues that they may have.

Mr Smyth observed that the report referred to the fact that external security staff were on occasion required to assist ELHT colleagues in restraining patients and enquired what assurance could be given that they had correct and adequate levels of training to do so.
Mr McDonald confirmed that the Trust did utilise external security companies but stressed that it had strict requirements that all staff had to meet industry standards in relation to control and restraint training. He explained that the Trust was in the process of moving its security provision in-house rather than arranging it through Private Finance Initiative (PFI) partners, but it would have processes in place to respond to any concerns raised around the conduct of external staff in the interim.

In response to a query from Dr Dad regarding the total number of complaints referred to in the report, Mrs Molyneaux clarified that this figure was the total for the Trust at the time of writing and did not refer to any raised in relation to the contents of the report. She advised that the Trust tended to have between 70 and 80 complaints at any one time and commented that this should be considered as positive when considering the large volume of patients treated.

In response to a further query from Dr Dad regarding the figures provided for bullying and harassment within the Trust, Mrs Quinn confirmed that they were accurate and acknowledged that more work was required in this area. She stated that this was one of the reasons why the Trust's Freedom to Speak Up provision was so important in being able to resolve concerns raised and share any relevant learning across other areas.

RESOLVED: **Directors received the report and received assurance regarding the actions being taken to safeguard patients.**

TB/2022/146 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Mr Hodgson reiterated that the Trust was operating under the most difficult of circumstances and in this context it was performing relatively well on many fronts. He referred to the Trust's performance against the 4-hour trolley wait standard and advised that, although similar issues were being seen across the country, consideration was being given to implementing a range

of measures to decompress the ED over the winter months. Mr Hodgson confirmed that the Trust continued to perform well in regard to ambulance handover times and was also on an upwards trajectory with regard to its 62-day cancer backlog.

b) Safe

Mr Husain reported that COVID-19 levels in the Trust had fluctuated considerably over recent weeks and that there were currently 39 COVID-19 positive patients being cared for. He also reported that there had already been a number of patients with flu treated by the Trust over recent weeks. Mr Husain informed Directors that the Trust had been given a trajectory of 54 for clostridium difficile infections for 2022/23 and confirmed that it was well under this, with a current total of 30 infections. He reported that the Trust was currently over trajectory for pseudomonas infections and advised that infection prevention and control (IPC) teams were working closely with divisional colleagues to see where things could be improved. Directors noted that blood culture contamination rates stood at 3.9% and that this was a good result given the considerable pressures on the Trust.

Mrs Molyneaux stated that nurse staffing remained extremely challenging but had improved over recent weeks, with only one ward falling below the 80% safe staffing standard, down from seven the previous month. She stressed that a number of actions had been taken to mitigate any risks and to support further international recruitment efforts. Mrs Molyneaux reported that there had been recent rises in the numbers of pressure ulcer incidents as a consequence of lapses in care and confirmed that work was taking place to address this as a priority. She informed Directors that a full report on pressure ulcers was due to be presented at the next meeting of the Quality Committee and that consideration was being given to producing an annual report about this going forward.

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

c) Caring

Ms Molyneaux referred Directors to the Caring section of the report and highlighted that the friends and family test remained above target for all areas with the exception of the ED. She explained that this was likely due to the significant pressures being seen in the department and the resulting overcrowding and long waits to be seen.

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) remained within expected levels at 1.05 but explained that its Hospital Standardised Mortality Ratio (HSMR) was showing as above expected levels at 113.6. Mr Husain explained that the issues with HSMR were related to palliative care coding and that the Trust actually had a lower level of crude mortality than it had at the same time in 2020 and 2021. Directors noted that the palliative care team were undertaking work to address these issues.

Mr Husain advised that septicaemia, cerebrovascular disease and chronic heart failure were currently alerting, and confirmed that all three were being closely monitored through the Mortality Steering Group.

Mr Husain confirmed that the Trust's medical examiner service continued to review all deaths in the Trust and liaise with families for any cases requiring further investigation. He reported that between 200 and 250 structured judgment reviews were being carried out per year and highlighted that there had been no increases in the numbers of examples of poor or very poor care.

Mr Barnes commented that the rise in mortality seemed to be cause for concern, as well as the groups that were currently alerting. He requested further clarification on whether this was likely to attract the attention of external regulators and what, if any, benchmarks the Trust was at risk of hitting over the coming months.

Mr Husain confirmed that the Trust had regular engagement meetings with the CQC and that they were fully sighted on the mortality figures. He acknowledged that the rise in sepsis cases was worrying but reiterated that it was being closely monitored through the Trust's Mortality Steering Group and appropriate action taken.

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

e) Responsive

Mr Devji reported that there had been 18 patients with an ambulance handover time of 60 minutes or more for September and that the Trust's 4-hour performance had stood at 75.2%. He also reported that in total there had been 627 breaches of the 12-hour trolley wait standard, 592 of which had been due to physical health reasons and 35 due to mental health issues. Mr Devji confirmed that the Trust continued to work closely with colleagues at Lancashire and South Cumbria NHS Foundation Trust to manage patients with mental health disorders. He informed Directors that there were currently no patients waiting 104 weeks or more for treatment and that work continued to reduce the numbers who had waited 78 weeks or more. In response to a query from Miss Malik, Mr Devji reported that the longest wait time for a mental health patient to be transferred to a suitable bed in September had been just over 80 hours.

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 and advised that staff sickness rates were currently between 5.5% and 6%. She highlighted that work was taking place with colleagues from finance, clinical divisions and the Department of Education, Research and Innovation (DERI) to look at new roles and upskilling to try and address the longstanding workforce challenges in the Trust and across the NHS as a whole. Directors noted that a significant amount of improvement work had taken place around bank and agency spend following a value stream analysis exercise carried out in September 2022. Mrs Quinn reported that the Trust's appraisal compliance was starting to improve, and that staff were being encouraged to complete theirs, if they had not already done so.

Mrs Brown provided an update on the Trust's financial position and advised that it was reporting a deficit of £3,300,000 as of month six. She reiterated that the ICB had requested that each Trust Board in the region provide an approved financial recovery plan and confirmed that finance colleagues were working on producing it.

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

TB/2022/147 FREEDOM TO SPEAK UP GUARDIAN ANNUAL REPORT

Mr Moynes referred members to the previously circulated report and provided a summary of highlights to members. He reported that there had been a total of 262 concerns raised from April 2021 to March 2022, an increase of 2.68% from the same period the previous year. Mr Moynes advised that the Trust had now started to carry out cultural reviews in the ED following a number of concerns raised around lack of support and patient safety. He concluded by informing Directors that a new Deputy Freedom to Speak Up Guardian, Alison Sugden. had recently been appointed to support the Trust's Freedom to Speak Up Guardian, Jane Butcher.

Miss Malik commended Mrs Butcher and her team for their work and commented that the feedback provided was a clear demonstration of their dedication to providing a robust service. Mr Rehman stated that he took the increase in reported concerns and whistleblowing incidents as positives overall as it indicated that staff felt comfortable to speak up. He noted that this came with the additional challenge around gaining assurance from the concerns raised and suggested giving consideration around how the Executive team could ensure that the specifics were being understood and that sustainable transformation was taking place to address them. Mr Rehman also noted the number of concerns being raised around bullying and harassment and stated that he would welcome more information regarding a plan of action around this.

Mrs Molyneaux acknowledged Mr Rehman's concerns but stressed that the figures provided for bullying and harassment should be considered in the context of the significant numbers of staff working for the Trust. She advised that she had met with many of the staff members who had raised concerns and explained that the perception of the individuals involved often played a key role.

Mrs Butcher added that the majority of issues raised through the freedom to speak up service did not end up proceeding to formal investigations and as such she was not overtly concerned around the rise in numbers. Mrs Quinn reiterated that many of the issues raised through the Freedom to Speak Up service were down to interpersonal factors but agreed that more work was needed to link it to the Trust's behavioural framework.

Mrs Butcher informed Directors that a substantial amount of work had recently gone into a review of the Trust's ED and its Neonatal Intensive Care Unit (NICU) and explained that this

would be a good example for the Board to be sighted on. She stated that that she would arrange for this to be done after the meeting.

RESOLVED: **Directors received the information within the report and noted the content and assurance provided.**
A summary of the work done by the Staff Guardian team in the ED and NICU will be shared with Directors after the meeting.

TB/2022/148 NEW HOSPITALS PROGRAMME QUARTER 2 BOARD REPORT

Mrs Malin updated members on the recent activities of the New Hospitals Programme (NHP) since the previous meeting. She advised that there had been more of a focus on potential new sites and to ensure that the programme was aligned to its clinical vision. Mrs Malin confirmed that the list of preferred and alternative options had now been published, with the preferred choices being new builds for Royal Lancaster Infirmary and Royal Preston Hospital on new sites and the alternatives being partial rebuilds for both on their existing premises. She informed Directors that these options had been put out into the public domain and that the NHP continued to carry out regular engagement exercise around them.

Mrs Malin explained that work would continue on potential new sites and getting more detail around the shortlisted options over the coming months. She also advised that there would be more of a focus on supporting the national team to submit the overarching business case for the NHP to the Treasury in December 2022.

Mr Hodgson stated that he was confident that there was a strong link between the ICS, PCB and the NHP and explained that his only real concerns were related to the tightness of the timescales involved.

Mrs Atkinson thanked Mrs Malin for continuing to engage with the Board and keep it updated as to the progress of the NHP. She encouraged Directors to visit the NHP website if they wished to obtain more information.

RESOLVED: **Directors received the report, noted the progress of the New Hospitals Programme and the activities planned for the next quarter.**

TB/2022/149 EPRR ANNUAL ASSURANCE STATEMENT AND REPORT 2021/2022

Mr McDonald referred members to the previously circulated report and explained that it summarised the position of the Trust in relation to its Emergency Preparedness, Resilience and Response (EPRR) and business continuity arrangements. He explained that the Trust's statement of compliance was provided in appendix A of the report and advised that more detail regarding the Trust's action plan could be found in appendices B and C. Mr McDonald informed members that the Trust had been compliant with 11 out of 13 standards at the time of submission. He confirmed that the full list of policies and plans that had been reviewed over the previous 12 months was included in the report and provided a brief summary of the business continuity incidents.

Mr McDonald clarified that the Board was being asked to ratify the EPRR statement of compliance submitted in September, to receive the action plan contained within the report and to receive the report as assurance that the Trust had robust EPRR measures in place and was successfully fulfilling its statutory obligations.

RESOLVED: Directors confirmed that they were content to ratify the EPRR statement of compliance, to note the action plans provided and that they were assured that the Trust was fulfilling its statutory EPRR obligations.

TB/2022/150 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/2022/151 QUALITY COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2022/152 AUDIT COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2022/153 TRUST CHARITABLE FUNDS COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2022/154 TRUST BOARD (CLOSED SESSION) INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB2/2022/155 REMUNERATION COMMITTEE REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2022/156 ANY OTHER BUSINESS

Miss Wright informed members that the Trust's Charity organisation, ELHT&me, had been working over the year to develop a new Charity Hub and retail outlet at Royal Blackburn Teaching Hospital and advised that it was due to the open the following week. She encouraged Directors to visit if they were able.

Mrs Bosnjak-Szekeres advised that the Board would have to make two decisions before the next formal meeting in January 2023: the first being to approve the financial recovery plan for submission to the ICB, and the second to approve the business case for a new digital pathology solution. She explained that these would be dealt with through Chair's Action, and formally reported on the second item at the January meeting.

RESOLVED: The update on the submission of the financial recovery plan and a report on the implementation of the new digital pathology solution will be provided at the meeting in January 2023.

TB/2022/157 OPEN FORUM

No questions were submitted prior to the meeting.

TB/2022/158 BOARD PERFORMANCE AND REFLECTION

Mrs Anderson 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 remarked that he felt that both sessions of the Trust Board had covered agenda items in the necessary amount of detail.

Mrs Quinn commented that the extent of the improvement activity taking place within the Trust had been evident in many of the items discussed and that this was testament to the number of activities that the improvement team was currently involved in.

RESOLVED: Directors noted the feedback provided.

TB/2022/159 DATE AND TIME OF NEXT MEETING

Mrs Anderson informed Directors that the next Trust Board meeting would be taking place on Wednesday, 11 January 2023 at 13:00, via MS Teams.

Mr D Byrne, Corporate Governance Officer

TRUST BOARD REPORT

11 January 2023

Item 6

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

(6) 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/2022/144: Patient Safety Incident Response Framework Assurance Report	Additional comparative data will be included in future iterations of the PSIRF assurance report.	Executive Medical Director	January 2023	Update: As part of the PSIRF implementation, all other Trusts in Lancashire and South Cumbria need to implement PSIRF by August 2023. Once all five Trusts are reporting against the new framework the ICB will then facilitate the sharing of comparative date and lessons learnt. This will allow the Trust to benchmark our data and develop the sharing of learning across the patch. Also, as the Trust has now been reporting incidents under the new PSIRF for 12 months, the patient safety team from next

Item Number	Action	Assigned To	Deadline	Status
	Additional equality and diversity information from maternity investigations will be circulated after the meeting.	Executive Medical Director	January 2023	month will be able to start comparing its own yearly / monthly incident investigation data. This data will be included in future iterations of the report. We are awaiting this information and it will be circulated prior to the Board meeting.
TB/2022/147: Freedom to Speak Up Guardian Annual Report	A summary of the work done by the Staff Guardian team in the ED and NICU will be shared with Directors after the meeting.	Freedom to Speak Up Guardian	January 2023	Complete: The report and actions undertaken have been shared with the Board.

Mrs A Bosnjak-Szekeres, Director of Corporate Governance / Company Secretary

Mr D Byrne, Corporate Governance Officer

Lancashire and South Cumbria Provider Collaborative

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

11 January 2023

Item 8

Purpose Information

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

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

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

(8) Chief Executive's Report

1. Background

This report is divided into sections covering the following:

- 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

2. National Updates

Christmas Message from the Chief Executive of NHS England Amanda Pritchard

The Chief Executive of the NHS Amanda Pritchard send a message to all NHS staff on December 23 to thank them for their contributions and went onto share reflections with health care leaders across England later the same day.

The note recognised that 2022 had been a year of real challenge with specific reference to the continued response to the pandemic and the 'long tail taking significant time and effort to rectify while simultaneously dealing with the return to 'business as usual'.'

Amanda added that whilst the shape of the ongoing pandemic was the main 'known unknown' going into the year, the 'unknown unknown' was the economic context and the impact it would have on resources, patients, communities and staff.

Other elements of the update were:

- A recognition of achievements including improvements in the time to treatment for cancer pathways, highlighting that more people than ever before have received urgent cancer checks and more people have been seen since the start of the pandemic than under pre-pandemic plans, with the result that the NHS is catching more cancers early
- The elective waiting list has continued to grow, but the shared goal of eradicating two year waits was met
- Mental health services continued to see more patients of all ages than ever, in most cases meeting or exceeding NHS Long Term Plan trajectories.
- Finances were stretched as a result of inflation and additional demands on the NHS but collectively the system has adjusted to protect frontline care and in the Autumn Statement an improved settlement over the next two years should provide sufficient funding for the NHS to fulfil its key priorities

- A successful transition to a new structure built on partnership and collaboration through Integrated Care Systems and Boards

Amanda added: “Thank you for everything you have contributed to these priorities and many more things that matter to patients and staff in your respective systems over the last year, but also for the contribution you have made nationally to develop and make a success of our new ways of working.

“You can be proud of what you and your teams have done this year in the face of an unprecedented combination of challenges, and of the incredible work you and your colleagues across the NHS do day in, day out, to provide the best possible care for patients. I look forward to continuing to work with you and wish you the very best for 2023.”

Planning Guidance Published on December 24, 2022

NHS England has developed and published the NHS Priorities and Operational Planning Guidance for 2023/24 with fewer objectives designed to align with three key tasks:

- Recovering core services and productivity
- Getting back to delivering the key ambitions in the NHS Long Term Plan
- Continuing to transform the NHS

As set out in the Autumn Statement, NHSE will be publishing further plans for the strategic recovery of urgent and emergency care and of general practice, as well as developing a long term workforce plan which the Government has committed to publishing in Spring following independent verification of the modelling. The team is also working on the development of a single maternity delivery plan.

Winter Plan Update

More than 40 healthcare ‘traffic control centres’ are now live across England, helping to get patients into beds as quickly as possible. The centres use data to respond to emerging challenges and can divert ambulances to another nearby hospital with more capacity or identify hospitals that need extra support.

The move is part of the NHS’s wider winter plan published in October, which also included the rollout of a national falls response team service, new hubs dedicated to serious respiratory infections and additional bed capacity. Each of the 42 integrated care systems in England now has a dedicated 24/7 operation where teams, including senior clinicians, can use data and local insights to make considered decisions in the face of emerging challenges. Sites are also able to

plan for pressures over weekends, bank holidays and other wider public events or dates that can affect services.

Latest National Statistics

NHS England has published its latest statistics for October. The figures show a continued reduction in the number of people on elective waiting lists for 18 weeks and 78 weeks and 63,000 more people received diagnostic tests and checks than in the month before, which topped two million people in total.

The monthly performance statistics also show there were 81,655 category 1 incidents in November – the most serious ambulance callouts – which is the highest November total on record and despite the increased demand, ambulance wait times across all types of call improved in November compared to the previous month. Alongside this, staff working in A&E dealt with more attendances than any previous November on record.

The latest weekly winter update showed there were an average of 712 patients a day occupying beds in hospital with flu, compared to 31 patients per day in the same week of December 2021. Cancer waits have also improved as the NHS continues to refer patients in record numbers as part of the Long Term Plan commitments to catch three-quarters of cancers at stages one and two by 2028. The latest figures show the highest number of checks following a GP urgent referral for any October, with 239,180 people checked.

Vaccine Update

Nearly 19 million flu vaccines have been administered so far this winter but the NHS continues to encourage people to come forward and especially pregnant women and parents of young children following a significant rise of hospitalisations compared to previous years.
More than 143 million doses of the COVID-19 vaccine have now been administered since 8 December 2020, which equates to an average of more than 196,000 doses a day, including 45.3 million first doses, 42.8 million second doses and 55.1 million boosters.

Mental Health Funding

NHS England is investing £10 million in further support for mental health trusts this winter.
The money will fund extra mental health professionals to work within ambulance control centres and accompany paramedics on emergency call outs to treat people who are having a mental health crisis and guidance will ask mental health trusts to deploy staff to work in 999 call centres over the coming months.

Figures from two ambulance trusts show having a mental professional answering or responding to 999 calls could reduce the chances of a patient needing to go to A&E from approximately half down to one fifth. Demand for crisis mental health services has increased by one third since before the pandemic and doubled since 2017. More than 90,000 people a month have been referred to community crisis services. While around 200,000 people a month have also called 24/7 crisis lines. Less than 2% of people who call 24/7 mental health crisis lines then attends A&E for further support.

Hewitt Review

The Secretary of State for Health and Social Care Steven Barclay MP has commissioned a high-level review to be led by the Rt Hon Patricia Hewitt to enable Integrated Care Systems (ICSs) to succeed, balancing much greater local autonomy with robust accountability. The Terms of Reference have now been published and a Call for Evidence announced which will be available shortly online. In establishing the communications and engagement activity around this work Mrs Hewitt has written to colleagues and this is included as an appendix.

Hepatitis C

The NHS is on track to eliminate Hepatitis C by 2025 thanks to a pioneering drug deal that is helping dramatically cut deaths – five years ahead of global targets.

Following a five-year contract worth almost £1 billion to buy antiviral drugs for thousands of patients, deaths from Hepatitis C – including liver disease and cancer – have fallen by 35%. That improvement in outcomes means the NHS has exceed the World Health Organisation's target of 10% by more than three-fold, putting England in pole position to be among the first countries in the world to eliminate the virus as a public health concern.

The ground-breaking NHS scheme has helped find and cure 70,000 people of the potentially fatal disease, and drastically reduced the number of people seeking liver transplants due to Hepatitis C. Within six years, the number of people seeking liver transplants due to the virus is down by two-thirds and the number of annual registrations for a liver transplant in patients with Hepatitis C related diseases reduced from over 140 per year to less than 50 per year in 2020.

This figure is expected to be even lower in 2022 and the NHS is now on track to eliminate Hepatitis C five years before the WHO's overall 2030 target. People in the most deprived communities have seen the biggest benefit, with 80% of treatments provided to the most deprived half of the population.

Children in deprived communities have also benefited significantly. Since the rollout of the pioneering NHS plan to treat children for Hepatitis C last year, more than 100 children received infection-curing antivirals, with 90% of treatments given to the 40% most deprived children. This puts the Hepatitis C elimination programme at the forefront of the NHS' drive to reduce health inequalities, which calls for specific action to address the poorer health outcomes of children in the 20% most deprived areas. Hundreds more children are set to benefit in the coming months and years.

HIV and Hepatitis

More than 800 people living with HIV and Hepatitis but not receiving treatment have been found by the NHS in just six months following the rollout of routine testing in A&E. In April 2022, the NHS made £20 million available over three years to implement routine HIV opt out testing within 33 hospital Emergency Departments, in areas with the highest rates of diagnosed HIV.

Latest NHS data shows the programme is already having success, with 834 newly identified cases of people living with the HIV, Hepatitis B or Hepatitis C found between April and September following its launch – while 153 people, who were previously diagnosed, but were not receiving NHS care, were also identified.

Under the programme, people visiting an Emergency Department are offered a discreet test which screens for the HIV, Hepatitis B and Hepatitis C viruses when full bloods are taken. If the test comes back positive for the HIV, Hepatitis B or Hepatitis C viruses, the person is offered specialist support and a treatment plan is put in place for them.

Data shows that more than two fifths (42%) of HIV diagnoses in the UK are made late, at a point when the immune system has already been significantly damaged. Research suggests that people who get a late HIV diagnosis are eight times more likely to die from the illness, so early identification is key in preventing ill-health, premature death and onward transmission.

The move follows the NHS striking a series of deals for the latest HIV drugs, including a long-acting injection and the first oral drug to combat the disease, as part of its efforts to become the first country in the world to stop new cases of HIV before 2030, by offering a full armoury of HIV-busting drugs.

3. 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 7 December 2022 and the live stream is also available to watch online here **https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers/future-board-meetings/7-december-2022-board-meeting**

The Chief Executive's Report submitted by Kevin Lavery as part of the meeting's papers provides a wider update. Some key areas of focus are included below and the report in full is included as an apprendix.

Chatbot supporting waiting lists

The Chatbot initiative continues to help trusts manage waiting lists and is on track to contact 30,000 patients before the end of March 2023. Patients on waiting lists are being sent text messages with a series of questions designed by NHS consultants and healthcare experts. It helps determine if they still require treatment and as a result, so far out of 13,583 patients, 9% have indicated they could leave the waitlist and 22% indicated they require an appointment sooner. Following a pilot in Morecambe Bay and Preston, it has now been rolled out to other hospitals and medical specialties in Lancashire and South Cumbria.

Falls Lifting Service

The ICB is leading the way with its Falls Lifting Service, with a 24/7 365 days-a-year falls response and pick up service across Lancashire, Blackburn with Darwen and Blackpool. The service works closely with North West Ambulance Service call handlers to re-route patients from NWAS to the falls lifting service, who have an average response time of under 30 minutes. The alternative would be a category 3 or 4 Ambulance which may take several hours leading to 'long lies' for people on the floor which inevitably result in hospital conveyance/admissions and poor health outcomes.

Across Lancashire, Blackburn with Darwen and Blackpool the service responded to 1,500 call outs in October last year, in effect saving around a thousand ambulance call outs and freeing them up to deal with more urgent ill and injured patients.

The service continues to expand to cover falls within care homes across Lancashire, Blackburn with Darwen, and Blackpool and local authority domiciliary care agencies. Plans are also underway to introduce the service in South Cumbria.

Specialised commissioning

The ICB will start joint working arrangements with NHSE for commissioning specialised services from April this year. NHSE currently commissions 154 prescribed specialised services and from April 2024, this provision will be delegated to the ICB.

Accommodation

In light of changing working practices, the ICB has reviewed its estate and has consolidated its buildings into two headquarters, based at the Lancashire County Council building in the centre of Preston and the Lancaster University Health Innovation Campus. They will also have a series of 'touchdown' spaces across the four ‘places’ in LSC to offer colleagues a space to work that is closer to their home. The changes will save the ICB around £650k a year.

Collaborating across corporate services

Corporate services leaders and staff side partners attended a workshop on 25 November to start thinking about opportunities for improvement through collaboration. More than 80 people attended the event which also considered how colleagues are best engaged and involved as this important work progresses.

The aim is to ensure the corporate services run by the area’s six statutory NHS organisations – the Integrated Care Board (ICB) and the five provider NHS trusts – work together to best support patient care and offer a great place to work, while also removing unnecessary duplication.

Delegates were split into eight professional groups which had representation from all five trusts, the ICB and Staff Side across the professional portfolios of finance, human resources, communications, estates and facilities, procurement, legal and governance, digital and strategy. Some groups were joined by clinicians as well as representatives from the North West Ambulance Service.

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

Pathology services collaboration

A number of face-to-face meetings were held at Burnley and Blackburn Hospitals to update about Lancashire and South Cumbria’s pathology services.

Trusts have been working together to improve pathology services and explore how they can collaborate more. This work is now being led by Professor Anthony Rowbottom MBE, Clinical Director, who arranged the meetings to discuss what has happened to date and what will happen next. The meetings were well attended and received positive feedback.

BMA Rate Card

As part of a national British Medical Association rate card dispute, detailed discussions on pay rates for non-contractual consultant working have been ongoing across all acute trusts in Lancashire and South Cumbria throughout this financial year.

Given the extent of the system wide financial deficit and the wider economic context it was agreed that Provider Collaborative (PCB) members would all continue to keep to a consistent rate within their trusts which we have done to date.

However, following further discussions within organisations, the PCB and the Integrated Care Board (ICB) and in the light of extensive waiting lists and the need for partners to provide mutual aid to help achieve an equitable waiting list position across the system, it has been agreed that the rate will be increased with immediate effect.

Expectations around delivering against key performance targets and ongoing commitments to productivity and different ways of working were outlined as part of the discussion and, given the financial position, it is accepted that this is unsustainable in the longer term so developing more effective and efficient pathways for patients will be essential in the months ahead as part of the development of the system wide Clinical Services Strategy.

4. 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 not been applied to any documents since the last report to the Board.

Changes to the Trust Board and Executive team

There are a number of changes that have been implemented or are ongoing to the Trust Board and Executive team. They include:

- NHS England announced Shazad Sarwar as the new Chair of East Lancashire Hospitals NHS Trust (ELHT) in November. Shazad, who was a Non-Executive Director (NED) at ELHT previously, joined the Trust Board in December. A local man who was brought up and continues to live in Pendle, Shazad was appointed following a robust assessment led by NHSE in line with the national NHS constitution and including colleagues from the Trust, the wider health and social care system in both Lancashire and South Cumbria and the North West, as

well as partners from organisations who work closely with ELHT. 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.

- The Trust appointed a new Chief Nurse, Peter Murphy, to the Board and Executive Team in September. 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. Peter will join the Trust in March. Interim Chief Nurse Julie Molyneaux has agreed to remain in post until that time to enable a smooth handover.
- Executive Director of HR and OD Kevin Moynes has now left the Trust and his tremendous service to the NHS generally, as well as his contribution to ELHT and the Lancashire and South Cumbria system as a whole, was noted as part of the November meeting. Kevin has been an influential and integral part of the team at ELHT, overseeing many improvements that have supported our improved performance during his tenure and we are thankful to have had the benefit of his expertise as part of the Trust Board.
- In December, the Trust supported a robust and thoroughly recruitment process for the appointment of an Executive Director of People and Culture. This included two stakeholder panels featuring colleagues from the Trust, the wider system and key partners, as well as a formal appointment panel. The successful candidate was Kate Quinn who will now move from her role as Operational Director of HR and OD into the Executive role. Congratulations Kate on your appointment.
- In December, colleagues in the Executive team were asked to indicate their expressions of interest in a second Deputy Chief Executive post agreed as part of the structure earlier in 2022. A robust process followed and Sharon Gilligan was appointed into the role with immediate effect. Similarly to the existing Deputy Chief Executive and Executive Medical Director Jawad Husain, Sharon will retain her existing portfolio as Chief Operating Officer for ELHT and lead Chief Operating Officer for the ICB whilst taking on the extra designation. This will provide much needed capacity within the team, as well as providing leadership to the Trust and system, during these challenging times.

Maternity services positive inspection

In November the Care Quality Commission carried out an unannounced inspection, as part of a national inspection of maternity services. They visited three sites - Rossendale and Blackburn Birthing Centres and Lancashire Women and Newborn Centre at Burnley. Feedback was very positive, with particular reference to risk management, multidisciplinary working and an overwhelmingly positive response from our patients. All three services were rated as good for safe and well led, with some evidence of outstanding practice mentioned in the reports. This is a fantastic achievement and yet again demonstrates our teams ongoing commitment to delivering safe, personal and effective care.

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 the team has worked very hard to progress some technical gateways and milestones and it is likely although not confirmed that this important project will be implemented in summer 2023, most likely July. This will be confirmed in due course with the Board.

Work on the programme has continued unabated during this time with the team continually focused on the actions and activities needed to both progress and provide assurance it is working effectively before it is switched on. This will be amplified now as the Trust moves towards 'go live', with a great deal of further activity stood up between now and then. This includes 'ward walkarounds' at all hospital sites and local ambassadors helping to spread the word. Colleagues will be able to see the system in action, ask questions and raise any concerns and formal training and awareness sessions will be provided.

Industrial action

Following the 2022/23 pay award for NHS staff, a number of trade unions have held ballots nationally about whether to take industrial action.

The Royal College of Nursing (RCN), Unison, GMB and Unite went on strike in December 2022 but to date no industrial action has been taken by colleagues in these unions at ELHT.

The Trust has established a team to manage the response to industrial action and this focused on industrial action taken by colleagues at North West Ambulance Service (NWAS) that impacted emergency and non-emergency patient transport on December 21, 2022.

The response was flexible and effective. Teams were put in place to ensure ambulance handovers were quick and colleagues worked together to ensure patient flow, which not only enabled us to continue to provide safe, personal and effective care during the strike but also put the Trust in a good position leading into the Christmas weekend.

Further industrial action has been announced by Unison for 11 and 23 January and GMB for 11 January which will impact NWAS. The RCN has also announced strikes for January 18 and 19 and although this is not expected to involve staff at ELHT it may involve other trusts in the system, where the union has a mandate (Lancashire Teaching Hospitals NHSFT, University Hospitals Morecambe Bay NHSFT and Lancashire & South Cumbria ICB).

We are waiting to hear about future activity, particularly in relation to the Chartered Society of Physiotherapists and Unite members in Pathology, who both have a mandate for industrial action at ELHT.

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 Board was appraised in the November meeting of a working group which had been established, including both clinical and non-clinical colleagues supported by specialists from corporate support teams including finance, the Well and communications teams, which continue to meet regularly.

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. Free tea, coffee, juice, cup-a-soup and breakfast snacks have also been distributed, funded through ELHT&Me through an NHS Charities Together grant and an affordable meal option has been added to our restaurants.

During November a series of Money Worry Tree events were organised, in partnership with Stop Loan Sharks and Blackburn with Darwen Council, where external organisations were on hand to provide advice and guidance to anyone with concerns about finance. It included Beacon Counselling Trust, Jubilee Tower Credit Union, The Oaks Money Advice Centre, Shelter Lancashire and Metro Moneywise.

Operation Christmas Sparkle

The Trust was keen to support colleagues and raise morale during December and a number of initiatives were delivered during the month. These included:

- Ho Ho Home for Christmas
- Christmas Crackers
- Thank you messages from celebrities
- Thank you post box for messages

There was enormous engagement with the activity. Over 900 nominations were put forward suggesting a colleague who had gone above and beyond and deserved a Christmas hamper.

A series of 24 videos were published on our social media channels which had a total reach of over 70,000 and 2,476 engagements (comments, like and shares) on Facebook alone. They featured colleagues and patients across a variety of our services and highlighted work involved

in patient flow and how we are helping ensure as many patients as possible are at home for Christmas.

The most popular was a video featuring the NICU team from Burnley with a mother and her baby, Charlie, who had just learned they would be going home for Christmas. This reached 9,000 people, gained over 600 engagements and was picked up by the Lancashire Telegraph.

ELHT&Me Charity Hub

The Trust's charity ELHT&Me is progressing in leaps and bounds and with the support of the Charitable Funds Committee and a great number of colleagues, patients and their families is going from strength to strength.

In November, 12 months of intense preparation, planning and project management came to fruition when the charity opened a new hub close to the front entrance of Royal Blackburn Teaching Hospital in units formerly occupied by the NW Air Ambulance and Miller Care.

The hub includes retail space, offices and an area where the team can talk to people in confidence about giving including legacies in a prime, high profile and bustling spot.

Some of the work to design and fit the space was funded through a grant from NHS Charities Together but a whole team of people gave their services, skills, energy and enthusiasm for free also to get the project delivered to a high standard. This includes Denise Gee, Demi Houghton, Emma Heinicke and Becca Bartle from the charity itself, as well as colleagues and partners including from our PFI partners Consort, Clancy, DG Builders, Carefoot, Marland Electrical, Polyflor and Thorlux. The Trust is grateful to this brilliant team effort and those involved have received a personal letter of thanks.

The project has not cost the Trust or the charity a penny, allowing ELHT&Me to continue to ensure all fund-raising activity directly benefits really valuable and critical improvements for staff, patients and their families across our services and settings.

UEC campaign

The communications team continues to deliver 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.

This has focused on encouraging people to think about the right service to use, including pharmacies, GPs, NHS 111 online and Minor Injuries Units.

We have continued to use all Trust-owned channels and there has been a particular focus on social media as it offers an immediate gateway for messaging local communities. A new social media framework has been implemented to ensure activity has maximum impact. As a result, our we have increased the reach on our Facebook page by over 50% and Instagram by 121%. We have also established a network of established community pages and groups with relevant audiences for our messages, which is providing us with an additional potential reach of over 450,000 people.

Greater emphasis has been placed on using personal stories from teams and patients to highlight the patient journey, our different services and the positive difference made by choosing the right pathway. This content is not only increasing our social media engagement but also being picked up by local media.

Our campaign has been supplemented by identical messaging and paid advertising organised by the ICB, which includes adverts on public transport, bus shelters, supermarkets, Rock FM, Spotify and social media. This is helping to ensure messaging reaches non-digital audiences.

Flow improvement weeks

A series of improvement weeks have been taking place across the Trust looking at all aspects of patient flow. Colleagues have been designing and testing new ways to make a real difference to patient care and colleague and patient experience.

The improvement activity will take place throughout the winter and each division has identified an area of improvement which they have chosen to focus on, including the admission process, discharge care bundle, in reach support and discharge patient tracking lists.

Infection Prevention Control (IPC)

The Trust continues to enforce mandatory mask wearing across all clinical areas, which means all staff, patients and visitors must wear a face mask in those areas at all times unless they are able to social distance. In addition, due to the logistics of providing masks at the entrances to all wards, clinics and other clinical settings, the decision was made to ask people to wear them in corridors and when moving around public spaces, enabling the Trust to stock key entry points with masks and hand sanitiser.

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.

Vaccination campaign

The vaccination team at the Trust have administered over 3,400 COVID and 3,600 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 and the vaccination hub moved to new premises, at the nearby Barbara Castle Way Health Centre, but finished at the end of December. This team is worthy of recognition and our thanks for everything they have achieved in the past two years. Colleagues have travelled in all weathers, stood in tents, vans, knocked on doors, visited the house bound and vulnerable in our community and this is valued and appreciated.

National NHS Staff Survey 2022

The national NHS Staff Survey for 2022 launched in September and closed on November 25. The survey is one of the largest workforce surveys in the world and 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 is working well.

ELHT encouraged colleagues to take the time to complete the survey and provide their feedback. Whilst we have now received some headline information from the survey, the Trust awaits a full breakdown of the return. This will be shared with the Trust Board in detail in due course.

Celebrating with the Prince's Trust

A celebration event took place in December to showcase a partnership between ELHT and the Prince's Trust. The hospital has been working with the charity since 2017, offering work experience and skills development to young people through its Get Into Hospital Services programme.

Over 100 young people have now completed a work placement, giving them valuable hands-on experience – and a staggering 86% have gone on to secure further paid work with the hospital.

At the event last month, the most recent cohort shared their personal stories and explained how the work placement had helped them.

North West Imaging Academy Radiology Satellite Suite

Our North West Imaging Academy Radiology Satellite Suite officially opened last month. ELHT and Alder Hey Children's Hospital received funds to create the revolutionary facility that will allow us to link to the existing sites at Edge Hill University Medical School - providing increased training opportunities to specialty trainee doctors and allowing them to develop their understanding in specialist areas. Training officially begins this month.

SPEC awards

The Postnatal ward, Emergency Surgical Unit (ESU), and Rakehead Neuro-Rehabilitation Centre have been recommended for a silver Safe, Personal, Effective Care award following a rigorous assessment.

The Nursing Assessment and Performance Framework (NAPF) team carries out mini CQC inspections covering over 60 areas of activity, including training, bedside handovers, environment and patient feedback.

Any teams who receive three consecutive green ratings are invited to present to a SPEC panel to showcase their work and how they have maintained consistently high standards of care. Those who demonstrate safe, personal and effective care at all times are recommended to receive a silver award.

This is the first time the Postnatal ward, Emergency Surgical Unit (ESSU), and Rakehead Neuro-Rehabilitation Centre have been recommended for the award. Several other teams who have already received a SPEC award, achieved a further green NAPF outcome and presented at SPEC panel - Coronary Care, Critical Care, Marsden, C18B, Gynaecology and Breast Care Ward, C6, Elective Care Centre, Wilson Hey Theatre and C18A.

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.

- **ELHT Catering team conclude year with another success**

Our Catering team is one of 14 rising stars honoured by the Vegetarian for Life (VfL) at the Awards for Excellence in Vegetarian and Vegan Care Catering. They were presented with the ‘Hospital Caterer of the Year’ award at a special event at the Houses of Parliament.

- **Hospital Imam honoured**

Hospital Imam Fazal Hassan received a special award from the Mayor of Blackburn with Darwen Council for his services during the pandemic. Imam Fazal Hassan was presented with the Mayoral Award by Mayor Councillor Suleman Khonat. The entire hospital chaplaincy team was praised for their services in a period where patients were often isolated from their family members due to COVID restrictions.

- **Student Doctor of the Year**

Holly Buck, a UCLan medical student based at ELHT, was named Student Doctor of the Year by the Royal College of General Practitioners. Holly recently collected her award from the RCGP Headquarters in London and said she was “incredibly honoured and feeling very grateful”.

- **Mr Saif Hadi continues Orthopaedics’ winning streak**

Mr Saif Hadi, Consultant Orthopaedic Surgeon, was voted North West Rotation Trauma & Orthopaedics Trainer of the Year 2022 by all the Trauma & Orthopaedic trainees in the North West. This is a huge accolade for the Orthopaedic Department, which despite being the busiest Trauma Unit in the North West, can still provide the best training in the region. This makes it a third year in a row that this achievement has been awarded to the Orthopaedic Department at ELHT.

- **From Apprentice to Future Leader**

The Public Finance Future Leader of the Year award was presented to Alex Daykin, Divisional Finance Manager, at the Public Finance Awards last month. Executive Director of Finance, Michelle Brown, congratulated Alex on the win and went on to say: “From a young 16-year-old apprentice to qualified accountant and now Public Finance Future Leader of the Year award winner! Outstanding! So well deserved!”.

- **Joanne gets royal recognition**

Medicine for Older People Matron, Joanne Mohammed, was awarded with a British Empire Medal for her work with raising awareness of disability. She received the award from the Lord-Lieutenant of Lancashire the Rt Hon Lord Shuttleworth at Lancaster Castle. After receiving her award Joanne said: “I love my job as a nurse and happy now to be different and an advocate for more accessible, inclusive workplaces.”

- **Bilal wins customer excellence award**

Haematology Manager Bilal Patel has been awarded the Siemens Healthineers Customer Excellence Award. Bilal was awarded the accolade for his presentation to Siemens Healthineers

representatives which gave valuable insights into the challenges of a Haematology Manager from an NHS perspective - ensuring the voice of the NHS is heard during product development and local launches.

- **Memory boxes supporting mothers**

Midwives Louise Slaters and Natalie Woodruff have been recognised for their work helping create connection boxes for women who are at risk of being separated from their baby at birth. They were presented with a National Safeguarding Star for Outstanding Practice from NHS England. The boxes help families capture important memories prior to separation and promote ongoing connection between them and their baby post-separation whilst court proceedings consider longer term plans for the child. They aim to minimise the trauma parents experience when they are separated from their baby at birth due to a court decision.

ENDS

Shelley Wright
Join Director of Communications
January 3, 2023

TRUST BOARD REPORT

11 January 2023

Item	**10**
Purpose	Information Action Monitoring

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

Summary: (summarise the key points from the report and what the committee is being asked to do)

The purpose of this report is to provide an overview of risk management performance activity and of risks presented onto the Corporate Risk Register.

Recommendation: (advise the Board/Committee of a suggestion or proposal as to the best course of action.)

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.

Report linkages

Related Trust Goal *(Delete as appropriate)*	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 *(Delete as appropriate)*	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 *(delete yes or no as appropriate and give reasons if yes)*

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by:

N/A

Executive Summary

1. The purpose of this report is to provide an overview of risk management performance activity and of risks presented onto the Corporate Risk Register (CRR).
2. Key points of note since the last meeting.
   a) The total number of risks held on the CRR has reduced from 21 to 18 risks.
   b) A 32% reduction in numbers of open risks held on the risk register has been achieved since January 2022, along with an 81% reduction in overdue risks for the same period.
   c) Strengthening strategic and operational risks in line with organisational strategy, objectives, targets and board assurance frameworks remains ongoing.

Introduction

3. 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)

4. Key points of note since the last meeting.
   a) The total number of risks held on the CRR has reduced from 21 to 18 risks.
   b) This reduction is due to a full quality improvement review being undertaken of DATIX ID 8441 *managing the risks of coronavirus outbreak* and DATIX ID 9251 *recurrent gaps in junior surgical rota* which has resulted in risk scores being reduced to 12 and their subsequent removal from the CRR. In addition, a full quality improvement review of DATIX ID 2636 *inability to maintain establishment*

of consultant histopathologists has resulted in the amalgamation of this risk with DATIX ID 8941 *potential delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology* that is already on the CRR.

c) The Risk Assurance Meeting (RAM) and Executive Risk Assurance Group (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)

5. Key points of note since the last meeting.

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

b) The total number of open risks held on the risk register continues to reduce, from 1,709 risks in January 2022 to 1,170 risks at present, a percentage reduction of 32%. For the same period, the total number of closed risks has increased, from 7,100 risks to 8,032 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 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 with risk handlers and or risk leads.

e) Highest numbers of open risks held on the risk register continue to remain within Surgical and Anaesthetic Services (SAS) (26%), closely followed by Diagnostic and Clinical Support (DCS) (25%) and Corporate Services (CS) (23%).

f) Numbers of open risks held on the risk register within Divisions are expected to significantly reduce as more focused attention is given to improving the profiling and mapping of strategic and operational risks, along with better utilisation of lead specialisms 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 54% of the total number, followed by health and safety risks with a percentage of 27%.

h) A breakdown of clinical risks shows patient safety risks (32%) remain the highest risk sub type category, followed by risks associated with medical devices (16%).

i) Improving the standardisation of risks associated with delayed transfers, missed diagnosis and the provision of sub-optimal care has been targets for review by Divisions before the next RAM.

j) 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.

k) Work has commenced with lead specialists or subject matter experts within the fields of medical devices, infection control, medication, information governance and finance to review the quantity and quality of risks held within their areas of work activity.

l) A review of workforce/staffing risks has highlighted the majority relate to safer 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. This has been targeted for review by Divisions before the next RAM.

m) 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.

n) The total number of overdue risks has significantly reduced, from 230 in Dec 2021 to 144 at present, a percentage reduction of 37%. Less than 1% of overdue tolerated risks have surpassed their review date.

o) 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.

p) 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 introduction of the Trust Quality Management System (RADAR).

q) The performance management and monitoring of risks scoring 15 or above not identified on the CRR is undertaken at RAM, with escalation by exception as required.

r) The risk management framework and escalation process has been reaffirmed to members of RAM, Divisional Quality and Safety Leads, Risk Handlers and Leads.

Conclusion of report

6. 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 quantity and quality of risks held.

Next actions

7. A summary of key focused activity due for completion before the next meeting.

a) Targeted work with lead specialisms 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) Review of all risks held across SAS and Estates and Facilities (E&F) Divisions.

c) Work with services in addressing the 817 foreseeable risks due for review over the next three months.

d) 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 delayed due to service delivery pressures, competing priorities and limited resources. Initial discussions have taken place with members of the Core and Essential Skills Quality Group to embed risk management (including risk assessment) training as part of the Core and Statutory Training (CAST) and or as part of the Management Competency Framework. The focus of risk management training will be aimed at senior managers, lead specialisms and or subject matter experts responsible for developing, implementing and monitoring systems and processes and will be further complimented as part of the delivery of training on the new Trust Quality Management System (RADAR).

e) Continuation of strengthening strategic and operational risks in line with organisational strategy, objectives, targets and business assurance framework etc.

How the decision will be communicated internally and externally

8. Progress in monitoring the quality and integrity of open risks held, in particular, those with a current score of fifteen or above, is undertaken at the monthly RAM, Senior Leadership Group (SLG) and or ERAG meetings.

Appendices

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

J Houlihan, Assistant Director of Health, Safety and Risk Management
03 January 2023

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	9222	Trust Wide	Failure to implement the NHS Green Plan	**16**	**Limited**	⟺
8	8941	Trust Wide	Delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology	**16**	**Limited**	⟺
9	6190	SAS	Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales	**16**	**Limited**	⟺
10	8960	FC	Risk of undetected foetal growth restriction and preventable stillbirth due to non-compliance with pulsatility index ultrasound guidance	**15**	**Limited**	⟺
11	8839	SAS	Failure to achieve performance targets	**15**	**Limited**	⟺
12	8257	DCS	Loss of transfusion service	**15**	**Limited**	⟺
13	8808	Corporate	BGH - breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke	**15**	**Adequate**	⟺
14	7764	Corporate	RBH - breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke	**15**	**Adequate**	⟺
15	7165	Corporate	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	**15**	**Limited**	⟺
16	7008	Trust Wide	Failure to comply with 62 day cancer waiting time target	**15**	**Limited**	⟺
17	5791	Corporate	Aggregated risk - failure to recruit to substantive nursing and midwifery posts may impact on patient care	**15**	**Adequate**	⟺
18	4932	Trust Wide	Patients who lack capacity to consent to placements in hospital may be being unlawfully detained	**15**	**Limited**	⟺

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

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		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.		**Potential actions to further mitigate risk**		1. A more formalised service level agreement with LSCFT is to be developed prior to the registration taking effect on 01/04/2023. This will include: • Routine support from LSCFT Psychiatrists who will retain the Responsible clinician role, coordinating medication and mental health care planning. • Escalation pathways for urgent support. • Training on the management of challenging behaviour and de-escalation techniques 2. The recruitment of a Band 7 MH Coordinator role to 'administer' and 'oversee' implementation of the MHA in line with Approved Codes of Practice and Guidance. This post will sit within the Safeguarding Adults team. 3. A task and Finish group is being established to identify and agree MH pathways and risk assessments to support the safe delivery of care. 4. Key Performance Indicators and assurance reporting to be integrated into Patient Safety Group 5. LTHT MH strategy to be reviewed and adapted for ELHT
Controls and Assurances in place		1. Collaborative working arrangements in place between East Lancashire Hospitals NHS Trust (ELHT) and Lancashire and South Cumbria Foundation Trust (LSCFT). 2. A pathway for the management of mental health patients in Emergency Care has been developed. 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 completed. 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 and trends. 10. Wellbeing reporting and conversations in place. 11. Mental Health Liaison Nurses based within the Emergency Department. 12. CQC and Integrated Care Board (ICB) awareness of current ongoing process to risk assess application for registration. 13. Daily Gold call escalates concerning cases at system level. 14. Health and Safety Team monitor incidents of environmental harm to patients. 15. Mental Health Unit Assessment Centre (MHUAC) functional since February 2021				
Update since the last report		**Update 13/12/2022** Risk reviewed. No change in risk score. Application for registration with the CQC has been submitted. A vacancy to support the application for registration has been approved job description being banded for advert. **Next Review Date 13/01/2023**		**Date last reviewed**		**13/12/2022**
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
							20	
				8-week score projection	20			
				Current issues	3 months to implement required actions			

No	ID	Title				
2	9439	**Failure to meet internal and external financial targets for the 2022-23 financial year**				
Lead		Risk Lead: Charlotte Henson Exec Lead: Michelle Brown	**Current score**	**20**	**Score Movement**	⟷
Description		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 the ability to invest in services. 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 controlled by Integrated Care Systems who agree allocation to system partner organisations. 2. A 5% efficiency target is set for 2022/23 financial year to reduce costs by £28.8m, a level that has never been achieved. 3. The unknown extent of increased living costs, inflation rates and the impact of the COVID19 pandemic within this financial year. 4. A system financial gap that still needs to be closed.		**Potential actions to further mitigate risk**	1. Work is ongoing to close the gap further. There remains a risk regarding achievement of the 5% workforce recovery plan, elective recovery monies and of mitigating the system planning gap, with other financial risks emerging associated with meeting the elective recovery plan, use of temporary workforce due to vacancies and sickness absence, continued pressures within the emergency department, numbers of COVID19 cases, implementation of the EPR system, increased rates of pay and industrial action. 2. Ongoing review of the capital financial plan, with a risk that completion of the emergency village work may slip into the new financial year 2023/24	
Controls and Assurances in place		1. The Trust and LSCICS have agreed a 2022-23 breakeven revenue financial plan. 2. Robust financial planning arrangements in place to ensure targets are achievable and agreed based on accurate financial forecasts. 3. Financial performance reports distributed across the Trust to allow senior management and service managers to monitor financial performance against plans, supported by the finance department. 4. Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments incurred are made within delegated limits. 5. Monitoring and improving delivery of waste reduction programme. 6. Provision of training and guidance for budget holders. 7. Presence of senior financial lead as part of external and internal conversations influencing direction of travel. 8. Financial regime along with any identified gaps is being managed at system and Trust wide level. 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 10. A higher efficiency target than has ever been achieved in the past is in place to ensure all services are fully engaged and playing a role in reducing inefficiencies.				
Update since the last report		**Update 28/12/2022** Risk reviewed. No change in risk score. The Trust is reporting a deficit year to date of a reduced system planning risk (£6.2m) against an annual reduced gap (£9.1m) and is still forecasting a breakeven revenue financial plan. **Next Review Date 20/01/2023**		**Date last reviewed**	**28/12/2022**	
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
					20	20	20	
				8-week score projection	20			
				Current issues	System wide external influences			

No	ID	Title				
3	9336	**Lack of capacity across the Trust can lead to extreme pressure resulting in a delayed care delivery**				
Lead		Risk Lead: Michelle Montague Exec Lead: Sharon Gilligan	**Current score**	**20**	**Score Movement**	⟷
Description		A lack of capacity is leading to extreme pressure resulting in delayed delivery of optimal standard of care. At times of extreme pressure, increasing patient numbers across the emergency pathway makes the provision of care difficult, impacts on clinical flow, increases the risk of nosocomial infection spread as a result of overcrowding and poor patient experience leading to complaints. Staffing requirements are not calculated as standard to be able to care for increased patient numbers and complexity, with inadequate capacity within specialist areas such as cardiology, stroke etc. to ensure adequate clinical flow and optimum care.		**Potential actions to further mitigate risk**	1. Discussions ongoing with commissioners in providing health economy solutions and help with attendance avoidance. 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. 2. A review of skill mix has led to increased flexibility of new roles and recruitment ongoing. 3. Patient Experience Champions recruitment in second wave. 4. Daily meeting with Executive Team continue with concerns of winter resilience based on current pressures raised by Head of Nursing. Escalation daily through Gold system meeting. 5. Focused incident dashboard being built to monitor impact of ongoing pressures with executive, division and directorate visisiblity 6. Ethics Committee stood up to provide additional assurance under intense pressure
Controls and Assurances in place		1. Operational Pressures Escalation Levels (OPEL) triggers and actions completed for Emergency Department (ED) and Acute Medical Units (AMU). 2. Extreme escalation 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.			
Update since the last report		**Update 23/12/2022** Risk reviewed. No change in risk score. Service demand continues to remain very high and pressures remain regarding overcrowding, meeting ambulance handover times, 60 minute breaches and of delays for patients waiting to be seen, with increased waiting times for mental health up to 60 hrs and physical health up to 30 hrs. **Next Review Date 23/01/2023**		**Date last reviewed**	**23/12/2022**	
				Risk by quarter 2022/23	**Q1**: 20	**Q2**: 20	**Q3**: 20	**Q4**:
				8 week score projection	20			
				Current Issues	Impact of COVID-19 pandemic and restoration pressures			

No	ID	Title				
4	8126	**Aggregated Risk - Potential to compromise patient care due to the lack of a Trust-wide advanced Electronic Patient Record (EPR) System**				
Lead		Risk Lead: Mark Johnson Exec Lead: Michelle Brown	**Current score**	**20**	**Score Movement**	⟷
Description		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.	**Potential actions to further mitigate risk**	1. A business case for continued support has been submitted with plans remaining in place and new go live date set along with additional testers required.		
Controls and Assurances in place		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.				
Update since the last report		**Update 21/12/2022** Due to interface challenges, the EPR system go live date has been extended from November 2022 to Spring 2023. **Next Review Date 20/01/2023** **A full quality improvement review of this risk is currently being undertaken**	**Date last reviewed**	**21/12/2022**		
			Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
				20	**20**	**20**	
			8 week score projection	**20**			
			Current issues	Work remains ongoing with Cerner on implementation.			

No	ID	Title
5	8061	Aggregated Risk - Management of Holding List

Lead	Risk Lead: Victoria Hampson Exec Lead: Sharon Gilligan	Current score	20	Score Movement	⟺

Description	Patients are waiting past their intended date for review appointments and subsequently coming to harm due to a deteriorating condition or from suffering complications as a result of delayed decision making or clinical intervention.	**Potential actions to further mitigate risk**	1. Patients added to the holding list from other sources such as theatres, wards etc. need to have a RAG identified in line with those from OPD who routinely move onto the holding list after a fixed period. 2. Specialities continue to review patients waiting over 6 months and those rated as red to ensure they are prioritised appointments. 3. 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. 4. Updates provided weekly to Executive Team.
Controls and Assurances in place	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.		
Update since the last report	**Update 19/12/2022** The size of the holding list remains a challenge with significant numbers of patients still overdue an appointment - 3,592 within ophthalmology, 1,592 in urology, 1,038 in ear, nose and throat services, 1,138 in general surgery and 1,120 in oral and maxillofacial surgery. Discussions are ongoing about the ongoing impact of partial booking on the size of the holding list **Next Review Date 20/01/2023** **A full quality improvement review of this risk is currently being undertaken**	**Date last reviewed**	**19/12/2022**

Risk by quarter 2022/23	Q1	Q2	Q3	Q4
	20	20	20	

8 week score projection	20
Current issues	Impact of COVID-19 pandemic and restoration pressures

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.	**Potential actions to further mitigate risk**	1. Urgent requests are being treated as routine as referral cannot be to agreed turnaround times. 2. Work remains ongoing in terms of overcoming delayed results impacting on treatment and addressing increasing staff workloads due to referring out more samples than anticipated.		
Controls and Assurances in place		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 23/12/2022** Risk reviewed. No change in risk score. 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 along with the laboratory having no control regarding the allocation of reagents or their arrival. No early intervention for urgent requests as tests referred out take significantly longer to produce. There is no feasible option to send high volume of samples for certain tests. **Next Review Date 20/01/2023**	**Date last reviewed**	**23/12/2022**		
			Risk by quarter 2022/23	**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	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.	**Potential actions to further mitigate risk**		1. 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. 2. Review of staff resources, knowledge, skills, experience and training etc. to be able to deliver actions required. 3. Review of energy efficiency equipment e.g. gas boilers before 2032, heating and ventilation units etc. 4. Capital Plan will reflect resource required to support capital projects and increased costs of materials and services required to meet NHS sustainability strategy needs and standards under BREEM. 5. Budget commitments to deliver zero carbon plan is significant but will need to be factored into wider plans.
Controls and Assurances in place		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 29/12/2022** No change to risk scoring. First step implemented on 01 April 2022 by means of 10% weighting of sustainability requirement in procurement contracts. **Next Review Date 27/01/2023** **A full quality improvement review of this risk is currently being undertaken.**	**Date last reviewed**		**29/12/2022**	
			Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
				16	**16**	**16**	
			8 week score projection	**16**			
			Current issues	Commitment of adequate resources to deliver the NHS Green Plan			

No	ID	Title				
8	8941	**Potential delays to cancer diagnosis due to inadequate reporting and staff capacity in cellular pathology**				
Lead		Risk Lead: Neil Fletcher Exec Lead: Kate Quinn	**Current score**	**16**	**Score Movement**	⟺
Description		The cellular pathology department is not able to meet existing turnaround times (TAT's) required for cancer diagnosis and NHS screening services due to staffing levels and workload causing potential delays to patient diagnosis and treatment of serious illnesses such as cancers.	**Potential actions to further mitigate risk**	1. Lack of equipment is being partially addressed by capital funding. 2. A 5 year plan is currently being mapped out as part of workforce planning meetings to support recruitment and retention. 3. Work remains continuous to actively recruit. A total of 3 consultants have now been appointed awaiting clearance, contracts of employment and start dates. 4. Some breaches in compliance are outside the control of the Trust e.g. patients breaching targets due to complexities in pathways, comorbidities or patient choice. 5. Increased focus and attention on backlog reduction to support performance recovery is showing signs of improvement, however, issues continue to remain challenging.		
Controls and Assurances in place		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.				
Update since the last report		**Update 23/12/2022** 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. **Next Review Date 20/01/2023** **This risk has been amalgamated with DATIX ID 2636 *inability to maintain establishment of consultant histopathologists* and scored accordingly.**	**Date last reviewed**	**23/12/2022**		
			Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
				16	**16**	**16**	
			8 week score projection	**16**			
			Current issues	National shortage of histopathologists			

No	ID	Title
9	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.	**Potential actions to further mitigate risk**	1. 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 2. Ability to flex theatres to outpatient departments and vice versa but opportunities are limited. 3. Funding and difficulties recruiting additional medical staff and equipment so as to be able to increase activity e.g. medical, nursing, admin etc. 4. 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. 5. Getting It Right First Time (GIRFT) report to be created for patient waiting times above 25% within recommended timescales for review.
Controls and Assurances in place	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 20/12/2022** No change in risk scoring. The holding list remains a major concern with similar numbers awaiting review of appointments which are unable to be accommodated. Awaiting recruitment to support capacity. Staffing gaps anticipated to be filled in January / February 2023. **Next Review Date 24/01/2023**	**Date last reviewed**	**20/12/2022**

Risk by quarter 2022/23	Q1	Q2	Q3	Q4
	16	16	16	
8 week score projection	16			
Current Issues	Impact of COVID-19 pandemic and restoration pressures			

No	ID	Title				
10	8960	**Risk of undetected foetal growth restriction and possible preventable stillbirth given non-compliance with national ultrasound guidelines**				
Lead		Risk Lead: Tracy Thompson Exec Lead: Julie Molyneaux	**Current score**	**15**	**Score Movement**	⟷
Description		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.		**Potential actions to further mitigate risk**	1. Following service redevelopment there is a plan to introduce pulsatility index into clinical practice from February 2023 supported by education and or training of staff prior to implementation. 2. There is a longer term plan needed to further increase the midwifery sonography workforce by one whole time equivalent so as to ensure effective service provision is maintained in the event of planned or unplanned future absence. 3. Awaiting publication of new guidance issued by the Royal College of Obstetricians and Gynaecologists recommending use of pulsatility index for umbilical artery doppler assessment.	
Controls and Assurances in place		1. Procurement of ultrasound equipment readily available 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.				
Update since the last report		**Update 06/12/2022** Risk reviewed. No change in risk scoring. 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. **Next Review Date 05/01/2023**		**Date last reviewed**	**06/12/2022**	
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**15**	
				8-week score projection	**15**			
				Current issues	Capacity issues and operational pressures have impacted on the mitigation of the risk.			

No	ID	Title				
11	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 COVID19 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.	**Potential actions to further mitigate risk**		1. Micromanagement of all 52 week breaches remains ongoing at weekly PTL meetings and patients continue to be seen in order of clinical priority. 2. A revised clinical harm process is being implemented to ensure patient safety.	
Controls and Assurances in place		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 19/12/2022** Risk reviewed. No change in risk scoring. There is a total of 569 52 week breaches at present within the 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. **Next Review Date 20/01/2023** **A full quality improvement review of this risk is currently being undertaken**	**Date last reviewed**		**19/12/2022**	
			Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
				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			

No	ID	Title
12	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 of the above 4 scenarios there would be no access to 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 due to 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.	**Potential actions to further mitigate risk**	1. Numbers of fire safety incidents, in particular, the activation of alarms, are being closely monitored. 2. A review of fire safety risk assessment and business continuity plan is being undertaken to help mitigate this risk. 3. Purchase of the blood tracking system has been completed however, the system requires installation and validation testing which can take up to 12 months to complete and subsequently, the laboratory remains prone to the risk until the blood tracking system has been rolled out and successfully implemented in line with guidance.
Controls and Assurances in place	1. An options appraisal has been carried out regarding the purchase of a single unit, under bench blood fridge within a remote site that would reduce this risk, however, this would present greater risks regarding monitoring and maintenance of blood stock levels, increasing staff time and resources, limited numbers of units stored or available for transfusions weighted against delivery timescales, units needing to be 0+ and 0- and the track and traceability of bloods. 2. Meetings held with the project lead for haemonetics regarding systems set up and testing. 3. Emergency bloods can be stored in temporary insulated boxes for a period of time. 4. The Bio-Medical Scientist (BMS) would station themselves outside the entrance to the laboratory where they could issue emergency units out. 5. If level 0 was out of bounds, the clinical flow room would be the point of contact for skilled staff. 6. As validation 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. 7. A fridge has been enabled on the Burnley General Hospital (BGH) site and label print runs have been successfully carried out.		
Update since the last report	**Update 20/12/2022** Risk reviewed. No change to risk scoring. This risk is expected to reduce in score as the installation and validation testing of the blood tracking system is successfully rolled out. **Next Review Date 20/01/2023** **A full quality improvement review of this risk is currently being undertaken**	**Date last reviewed**	**20/12/2022**

Risk by quarter 2022/23	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				
13	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.		**Potential actions to further mitigate risk**	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	
Controls and Assurances in place		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.				
Update since the last report		**Update 14/12/2022** No change to risk scoring. LFRS have issued enforcement action. Improvement works being monitored and reviewed at the weekly Fire Safety Meetings.		**Date last reviewed**	**14/12/2022**	
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**15**	

	Next Review Date 13/01/2023	**8 week score projection**	**15**
		Current issues	Impact of COVID-19 pandemic and restoration pressures

o	ID	Title				
14	**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.		**Potential actions to further mitigate risk**	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.	
Controls and Assurances in place		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 14/12/2022**		**Date last reviewed**	**14/12/2022**	

	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 13/01/2023**	**Risk by Quarter 2022/23**	**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
15	7165	**Failure to ensure legislative compliance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013**

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

Description	Failure to provide quality assurance of legislative compliance regarding the reporting of certain types of injuries, diseases and dangerous occurrences to the HSE within set timescales	**Potential actions to further mitigate risk**	1. The process of determining RIDDOR reportable incidents and ensuring legislative compliance is being let down by deficiencies in the incident management process and of utilising lead specialisms or subject matter experts more effectively. This will be remedied upon introduction of RADAR from Apr 23 2. More in-depth review of accidents and incidents and their investigation continues to improve compliance. However, this is resource heavy and identifying further process issues. This is being addressed through the Health and Safety Committee. 3. More focused attention, the outcome of quality improvements made and a reduction in numbers of RIDDOR reportable incidents when compared to previous financial year to date totals has increased legislative compliance, from 11% during the COVID pandemic to 53% at present.
Controls and Assurances in place	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. 4. Targeted RIDDOR awareness training provided to Lead Specialisms and or Subject Matter Experts, members of the Health and Safety Committee, Divisional Quality and Safety Leads and Occupational Health, with cascade training across Divisions and Groups etc. 4. A process of escalation has been agreed across Divisions to ensure consistency in approach and improve service responses. 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. 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. 8. Monitoring of all accidents and incidents, more in depth investigation, improved thematic review and performance management undertaken by the health and safety team. 9. 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.		

Update since the last report	**Update 16/12/2022** Challenges arising as a result of the recovery and restoration stages of the COVID19 pandemic 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 legislative timescales being met. A review of this risk is to be presented at the next Health and Safety Committee meeting for review. The meeting of the Health and Safety Committee was stood down in December 2022 due to	**Date last reviewed**	**16/12/2022**			
		Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
			15	15	15	
		8 week score projection	12			
		Current issues	COVID pandemic and restoration pressures			

	significant operational pressures, with the next meeting scheduled to take place in February 2023. **Next Review Date 16/01/2023**		

No	ID	Title
16	7008	**Failure to comply with the 62 day cancer waiting time targets**

Lead	Risk Lead: Matthew Wainman Exec Lead: Sharon Gilligan	Current score	15	Score Movement	

Description	There is a risk of the Trust failing to meet its key performance indicator of achieving the national target for all cancer treatment pathways, set as being 85%, for patients commencing their first treatment within two months (62 days) following an urgent GP referral which may result in clinical harm to patients and organisational reputational damage should treatment be delayed.	**Potential actions to further mitigate risk**	1. Many areas are experiencing excessive waiting times due to difficulties recruiting to key posts as a result of national shortages. A 5 year plan is currently being mapped out as part of workforce planning meetings to support recruitment and retention. 2. Some breaches in compliance are outside the control of the Trust e.g. patients breaching targets due to complexities in pathways, comorbidities or patient choice. These are being monitored and reported on accordingly 6. Increased focus and attention on backlog reduction to support performance recovery is showing signs of improvement, however, issues continue to remain challenging.
Controls and Assurances in place	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.		
Update since the last report	**Update 13/12/2022** Risk reviewed. No change in risk scoring. Increased focus and attention on backlog reduction to support performance recovery is showing signs of improvement however issues continue to remain challenging. **Next review date 13/01/2023**	**Date last reviewed**	**13/12/2022**

Risk by quarter 2022/23	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				
17	5791	**Aggregated Risk - Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care**				
Lead		Risk Handler: Jane Pemberton Exec Lead: Kate Quinn	**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.		**Potential actions to further mitigate risk**	1. Next cohort of international nurses submitted and approved in November 2022 awaiting progression. 2. A bid for 2 x Band 6 part time staff to aid newly registered staff awaiting approval. 3. A 5 year plan is currently being mapped out as part of workforce planning meetings to support recruitment and retention.	
Controls and Assurances in place		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 and escalation of bank and agency rates. 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. Review of business continuity plans remains 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 19/12/2022** Risk reviewed. No change in risk score. Nurse staffing levels continue to remain extremely challenging. Although temporary staffing and recruitment into the Trust continues, along with active progression of identified recruitment programmes, it may not be possible 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 within the Emergency Department (ED) **Next review date 23/01/2023**		**Date last reviewed**	**19/12/2022**	
				Risk by quarter 2022/23	Q1: 15 / Q2: 15 / Q3: 15 / Q4:	
				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				
18	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.	**Potential actions to further mitigate risk**			1. The 'Supervisory Body' 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. Following internal audit a DoLS improvement plan has introduced a clear management system for the management of DoLS applications. This enables timely and accurate recording of applications made, to enable the Trust to demonstrate appropriate application of the MCA in the absence of the LA review. 3. Plans to change DoLS to Liberty Protection Safeguards (LPS) remains ongoing. No date has been set for their implementation or subsequent publication of new National Approved Codes of Practice.
Controls and Assurances in place		1. The Local Authority, acting as the 'Supervisory Body' have been made aware of this risk. 2. Policy and procedural arrangements relating to the Mental Capacity Act (MCA) and DoLS updated to reflect the 2014 Supreme Court judgement ruling. 3. Arrangements contained within policy and or procedure are being adhered to by wards, along with applications being made in a timely manner. 4. Applications are being tracked by the Safeguarding Team 5. Changes in patient status relayed back to the 'Supervisory Body'. 6. Mandatory training on the MCA and DoLS is available to all clinical professionals. 7. Additional support and training available for all ward based staff and is provided by the MCA Lead and members of the Safeguarding Team. 8. Legal advice and support readily accessible and available. 9. A quarterly review of risk is undertaken by the Internal Safeguarding Board. 10. Despite challenges presented by 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 20/12/2022** Risk reviewed. No change in risk score. A continuous increase in the number 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 20/01/2023**	**Date last reviewed**	**20/12/2022**		
			Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
				15	**15**	**15**	
			8-week score projection	**15**			
			Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

TRUST BOARD REPORT

11 January 2023

Item	**11**
Purpose	Information Action

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

Summary: The Executive Directors have reviewed the BAF, and it was presented to the Finance and Performance Committee for review, discussion and recommendation to the Trust Board at the meeting in January 2023.
The risk scoring and risk appetite for each of the risks have been reviewed, including updates to the actions due in this reporting cycle.

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 and changes to the risk scores for risks 2a and 6 in this round of reviews. In addition, the wording of risks 2a, 4a and 4b have been revised.

The proposed revisions to the two risk scores are as follows:
BAF 2a: there is a proposal to **increase** the risk score **from 15** (C5 x L3) **to 20** by increasing the likelihood score to 4 (C5 x L4).
BAF 6: there is a proposal to **increase** the risk score **from 20** (C5 x L4) **to 25** (C5 x L5), due to the challenging financial situation at Trust and system level.

The proposed revised wording to the three BAF risk descriptors are as follows:
BAF 2a: The Trust is unable to **fully** deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter.
BAF 4a: The volume of activity that the Trust is able to deliver is insufficient to achieve the required **elective care** targets and eradicate backlogs.
BAF 4b: The Trust is unable to see, treat and discharge/admit/transfer **emergency care** 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.

Recommendation: The Board is asked to review and discuss the revised BAF and approve it, including the rewording of risks 2a, 4a and 4b and the revised scores of risks 2a and 6 as set out above.

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.

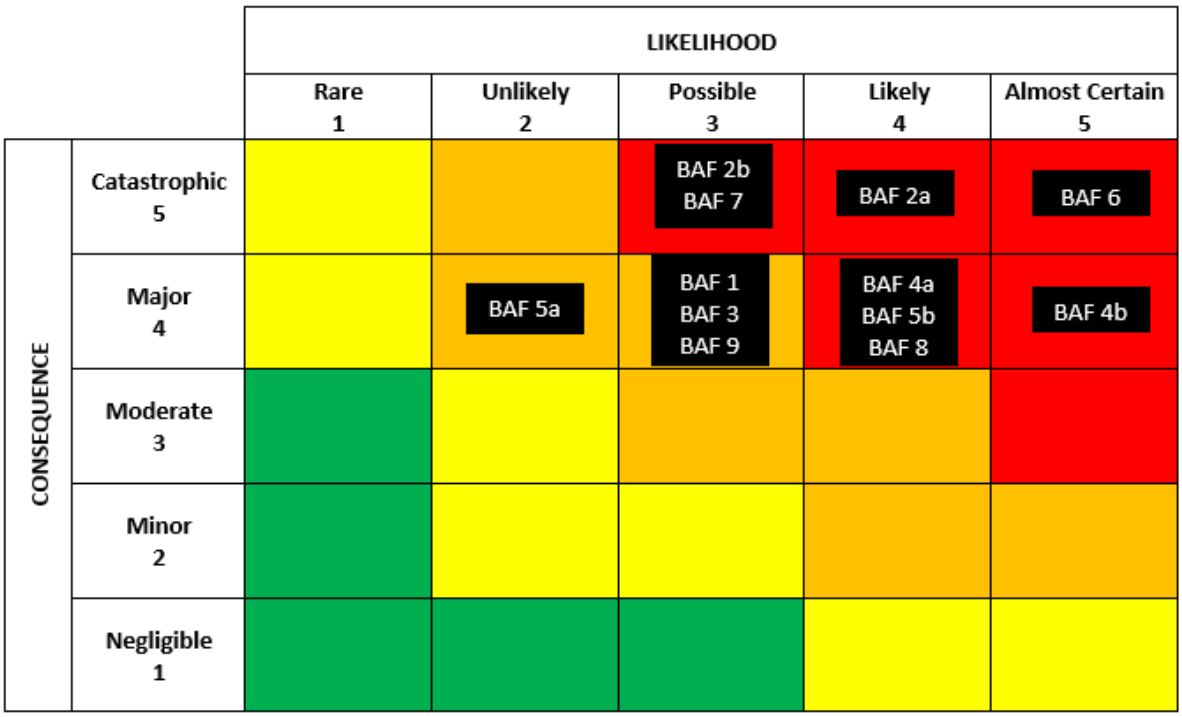
Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by:
Executive Directors (November/December 2022)
Finance and Performance Committee (19 December 2022)
Executive Risk Assurance Group (ERAG) was stood down due to operational pressures (22 December 2022)

Introduction

1. The Executive Directors with BAF risks assigned to them have met individually with the Corporate Governance Manager and the Director of Corporate Governance to review and revise the individual risks.
2. This document sets out the changes that have been made to the BAF since the Board meeting that took place in November 2022, including any updates to the actions, assurances and controls.
3. The full BAF has been presented to the Finance and Performance Committee for completeness and information, however, the Committee was only asked to discuss the risk scores, mitigations and actions for the risks that are within its 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 we have produced the following heat map of the BAF risks for 2022-23 below.



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 Actions:** there have been a number of updates to the actions, including:

   a) Work is underway with the Integrated Care Board (ICB) to redefine the key programmes of work at both ICB and Place levels and the associated establishment of a Programme Management Office.

   b) The proposed removal of the gap in control and associated action regarding the ICB programmes for community, discharge and intermediate care. The rationale for this proposal is that it is too operational for inclusion in the BAF.

   c) The confirmation of launch of the Engineering Better Care programme across Lancashire and South Cumbria, frailty is the first test area.

   d) The confirmation that initial stakeholder workshops have been undertaken and more are planned for early 2023.

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. There is a proposal to revise the wording of the risk descriptor to the following: The Trust is unable to **fully** deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter.

8. **Risk Score:** there is a proposal to **increase** the risk score **from 15** (C5 x L3) **to 20** by increasing the likelihood score to 4 (C5 x L4).

9. **Updates to Controls:** there have been three updates to the controls, the first one relates to the agreement of the priorities for the Trust's Quality Strategy 2023-24 and the development of the associated key performance indicators (KPIs). The second confirms that the investigation of the previously identified priorities of the Trust's Patient Safety Incident Reporting Plan have been completed. The third confirms the implementation of the Trust's Extreme Escalation Policy.

10. **Updates to Assurances:** there have been a number of updates to the assurances section of this risk, including but not limited to, admission avoidance by the use of the Intensive Home Support Service (IHSS), receipt of funding from the ICB to maintain Ward 22 as a winter escalation area, the initiation of clinical harms reviews for patients on waiting lists, and the completion of an emergency planning exercise to prepare for the winter period. The changes to this section are set out in red text in the detailed BAF risk which is appended to this report.

11. **Updates to Actions:** 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) The confirmation that RADAR (the Trust's new incident reporting and management system) have designed the key modules relating to audit, mortality, medical examiners and complaints and they are ready for testing with further modules which are in the process of being developed.
    b) In relation to the Trust's ongoing management of patients requiring input from mental health services, the job description for the mental health lead post has been received and they will report into the Trust's safeguarding team. In addition, the Trust has received confirmation from the CQC about the registration of the Trust prior to the post being filled.
    c) The confirmation of the annual Patient Safety Incident Response Framework (PSIRF) training (levels one and two) being mandated across the Trust.

d) The identification of possible Patient Safety Partners is currently being undertaken by the Volunteer Services Manager, with a plan to have these posts filled from April 2023.

e) The completion of the actions related to items 10 (mobilisation of the 24/7 Intensive Home Support Service) and 11 (securing of funding for Ward 22 from the ICB), which will be/have been moved to sources of assurance.

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). During this review, discussion took place regarding the potential to revise the risk score, however it was felt that this would be premature. It was agreed that further consideration would be given to revising the score as part of the next review round.

13. **Updates to Assurances:** there have been three new sources of assurance included, they are:

    a) The formation and embedding of the Executive Risk Assurance Group (ERAG) which is held on a monthly basis to review risks.

    b) The Trust's Health and Safety Committee which oversees matters relating to health, safety and the associated risks.

    c) The ongoing review of the fire remediation work at the two main Trust sites by the Trust's Incident Management Team and PFI partners.

14. **Updates to Actions:** there have been a small number of updates to this section, including the planned presentation of the overarching health and safety framework for the Trust at the Health and Safety Committee on 21 December 2022. A number of the actions under this risk have been completed and moved into the sources of assurance section and are indicated in red on the detailed BAF sheets.

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 Assurances:** there have been two new additions to the assurances, as follows:
    a) The commencement in post of the Public Health Registrar in November 2022.
    b) The establishment of the Lancashire Health Equity Alliance.
17. **Updates to Actions:** there have been updates to the majority of the actions. Actions 3, 4 and 9 have been completed and will move to sources of assurance 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 sheets.

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

There is a proposal to revise the wording of the risk descriptor to the following: The volume of activity that the Trust is able to deliver is insufficient to achieve the required **elective care** targets and eradicate backlogs.

18. **Risk Score:** remains at 16 (C4 x L4).
19. **Updates to Controls:** The confirmation that the diagnostic modality level demand and capacity model has been completed across the ICS with a trajectory to deliver by March 2025. Secondly, the governance processes have been reviewed regarding theatre utilisation and 'support and challenge' sessions have been introduced. These sessions are led by the Chief Operating Officer and Deputy Medical Director for Performance and are held with any specialty areas which do not meet the trajectory requirements.
20. **Updates to Assurance:** The actions which had been marked as complete in the last round of updates have now been moved to the assurances section. These relate to the sign off of the Clinical Strategy and the ongoing alignment of the Trust's strategy to that of Lancashire and South Cumbria.
21. **Updates to Gaps in Control and Actions:** there have been a number of updates to the progress sections of the gaps in controls, including confirmation that the action 7 has now been completed.

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.

There is a proposal to revise the wording of the risk descriptor to the following: The Trust is unable to see, treat and discharge/admit/transfer **emergency care** 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.

22. **Risk Score:** remains at 20 (C4 x L5).
23. **Updates to Controls:** there has been a minor update to one of the controls to provide additional context and this can be seen in red text in the detailed BAF sheets.
24. **Updates to Actions:** there have been updates to the progress of a number of the identified actions for this risk. In addition, actions 1 and 6 have been completed and will move to the sources of assurance section at the next review.

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:** remains at 8 (C4 x L2).
26. **Updates to Controls:** Confirmation of the frequency of the meetings and membership of the Workforce Assurance Group has been included.
27. **Updates to Assurances:** minor updates to two of the assurances have been made and three new sources of assurance have been added, they are:
    a) The Trust's Leadership Forum has been established, which seeks to engage with stakeholders across the Trust and wider system
    b) Connections made and introductory meetings held with the ICB Equality, Diversity and Inclusion lead.
    c) Regular reporting to the ICB People Board to provide assurance and address areas of challenge.
28. **Updates to Actions:** There have been progress updates and/or revisions to the timelines for the majority of the actions within this risk. The approval and roll-out of the Leadership Strategy has been delayed due to no Quality Committee meeting being held in December 2022. In addition, actions under numbers 2 and 5 have been completed and will move to the assurances section at the next review.

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 Controls:** there has been one addition to the controls, which is the agreement that the Integrated Care Partnership (ICP) Workforce Strategy will be managed and delivered through the ICP People Board.

31. **Updates to Assurances:** there have been two new sources of assurance, they are as follows:
    a) The implementation of a Bank and Agency Delivery Group at Lancashire and South Cumbria (LSC) level.
    b) The implementation of the LSC wide Bank and Agency Oversight Group which seeks to ensure delivery against the value stream analysis (VSA) outputs.

32. **Updates to Actions:** it is proposed that the updates relating to actions 1, 2a and 2b are consolidated into one overarching action as the gaps in control that they are attempting to address are closely interlinked. As a result, a new action has been developed and included in the document. The action relates to the development of the People Strategy and an Attraction and Retention Strategy which is being developed for presentation to the Finance and Performance Committee in the new year. A number of other updates have been included and can be seen in red text in the detailed risk sheets.

33. **Updates to Gaps in Control:** A further new gap in control has been included, which is the risk of loss of service due to potential industrial action. A detailed update on the actions being undertaken to mitigate this risk include, but are not limited to:
    a) The establishment of an Industrial Action Cell to plan for any industrial action.
    b) Co-ordination at an ICS level of all responses to industrial action.
    c) Regular meetings between senior managers and Staff Side colleagues to ensure continued positive working relationships.

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.

34. **Risk Score:** there is a proposal to **increase** the risk score **from 20** (C5 x L4) **to 25** (C5 x L5), due to the challenging financial situation at Trust and system level.

35. **Updates to Assurances:** There has been an update to one of the sources of assurance relating to the work being undertaken to address the planning gap.
36. **Updates to Actions:** There have been a number of updates to the actions, particularly some of the timelines for actions to be completed. The majority of the actions where timelines have been revised are outside the control of the Trust.

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

37. **Risk Score:** Remains 15 (C5 x L3).
38. **Updates to Actions:** There had been a number of timeline revisions to the actions, this is due to the current operational pressures that are being experienced and the associated impact on capacity within teams to deliver this work.

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.

39. **Risk Score:** Remains at 16 (C4 x L4).
40. **Updates to Controls:** The Trust is in the process of determining a new go live date for the Electronic Patient Record (EPR) system following the Gateway Review that took place at the end of November 2022.
41. **Updates to Actions:** The formalisation of the 'Northern Star' approach is being undertaken and an action plan is being developed as a result.

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.

42. **Risk Score:** Remains at 12 (C4 x L3).
43. **Updates to Controls:** There has been one new control added, this relates to the Engineering Better Care programme for frailty and respiratory services being underway at LSC level. From a local perspective, there is a team in place at Pennine Lancashire level to deliver the programme.

44. **Updates to Actions:** There have been a number of updates to the actions within the risk, including:

a) The completion of one of the actions relating to the ongoing strategy deployment framework development (5a), which will be moved to sources of assurance at the next review.

b) The inclusion of a new action point (5b) which relates to the work being undertaken to complete the organisational and system planning requirements for the 2023-24 year, this action is due for completion by April 2023.

c) The completion of action 7a which related to the reinstatement of the Executive Wall. A new action has been included regarding the ongoing refinement of the Executive Wall as part of the Trust's Accountability Framework.

Connection with the Corporate Risk Register (CRR)

45. 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. **ID 9336:** Lack of capacity can lead to extreme pressure resulting in a delayed care delivery. **ID 8126:** Risk of compromising patient care due to lack of electronic patient record (EPR) system. **ID 9296:** Inability to provide routine or urgent tests for biochemistry requests. **ID 8960:** Risk of undetected foetal growth restriction and preventable stillbirth due to non-compliance with pulsatility index ultrasound guidance.	20 20 20 16 15 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.	
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 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

46. The Board is asked to review and approve the revised BAF and approve the risk score changes to risks 2a and 6. In addition, the Board is asked to approve the changes to the wording of the risk descriptors for risks 2a, 4a and 4b.

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: 7 December 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 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:

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)

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.

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 organisational strategies have been developed/in development to clearly outline ELHT priorities for development as a partner in the wider system. • 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. Work underway with ICB to redefine key programmes of work at ICB and Place and establishment of a Programme Management Office.	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.	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.	Chief Executive/ Executive Director of Integrated Care, Partnerships and Resilience	No date yet agreed – ongoing review underway	Further review of community services provision to continue from September 2022 with timescales thereafter to be confirmed.	G
5.	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	Engineering Better Care for L&SC launched and being tested as the system for improvement with Frailty as first programme area.	G
6.	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
7.	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. Initial stakeholder workshops held to identify opportunities for improvement/collaboration and further workshops planned for early 2023.	A

BAF Risk 2a

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

Executive Director Lead: Executive Medical Director and Interim Executive Director of Nursing

Strategy: Quality Strategy

Date of last review: Executive Director: 6 December 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 2022.

Links to Key Delivery Programmes: Quality and Safety Improvement Priorities

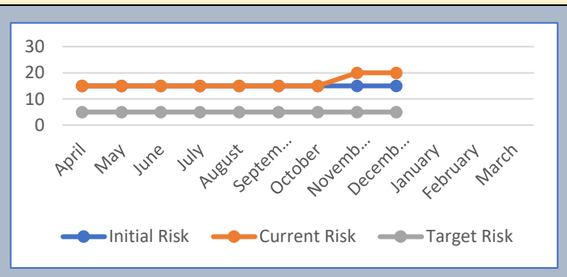
Lead Committee: Quality Committee

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

Current Risk Rating: **C5 x L4 = 20**

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.
- The Quality Strategy priorities for 2023-24 are currently being agreed, with associated KPIs. Progress against the 2022-23 priorities was reviewed by the Executive team on 30 November and a progress update is planned for presentation a minimum of quarterly via a presentation and update of the Executive Improvement Wall.
- The Patient Safety Incident Reporting Plan identified 5 priorities for investigation during 2022-23, the investigations now complete are moving to thematic review for organisational learning. New PSIRP priorities are planned to be identified via an inclusive workshop in January 2023.

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 co-ordinate the operational implementation of the priorities which are reported and monitored through respective assurance groups, and exceptions reported to Quality Committee via TWQG.
- Implementation of the Extreme Escalation Policy which replaces beds with trolleys in clinical spaces to assist the transfer of patients from ED into AMU/more appropriate environment. This in turn assists the capacity within the ED to see and treat other patients.

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.
- Direct patient referrals into Same Day Emergency Care (SDEC) pathways to help bypass urgent care and ED.
- Admission avoidance through the use of Intensive Home Support Service (IHSS) in ED.
- Acute Care Team feeding into resus in ED.
- Funding received from ICB to maintain ward 22 at BGTH as a winter escalation area.
- Use of 24/7 ambulatory care on an intermittent basis to assist acute care (staffing dependent).
- Work is being undertaken with colleagues in primary care regarding patient pathways.
- Medical Examiners review the care provided to patients who have died in the Trust and can make recommendations or seek further action dependent upon their findings.
- Clinical Harms Review to be initiated for patients on waiting lists in mid-December 2022 for roll over to specialties to assist in the management and prioritisation of waiting lists.
- Complex Case meeting has been introduced weekly to monitor and allocate for investigation any patient/staff safety incidents identified.
- The Patient Safety Incident Response Framework implementation was reviewed through a workshop with Non-Executives present in November. This confirmed learning from the first 12 months and a core focus on continuing to improve systems and culture during 2023-24.
- Monthly complaints and inquest drop-in sessions now in place with each Division to monitor performance and highlight risk

Specialist support, policy and procedure setting, oversight responsibility:

- Integrated Care Board (ICB) have confirmed their contract requirements in relation to Quality reporting. Internal systems have been updated to ensure timely data and exception submission. First submission completed at the end of Q2.
- ICB has split the assurance and safety functions with new leadership and focus.
- Monthly Quality Review Meetings with ICB Quality Team have recommenced
- 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.
- Arctic Willow winter specific EPRR exercise undertaken to ensure the NHS is adequately prepared for the winter period.

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.
- Elective Care Recovery Board which includes regional and ICS level representation and scrutiny.

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 June 2023.	RADAR purchased and implementation plan under development. Radar have designed key modules relating to Audit / Mortality / Medical Examiners and Complaints. These are ready for testing. The Events module (which will replace Incidents) is being designed with a plan to launch these in the Spring.	G

					6 month Radar Trainer post has now been recruited and starts in the New Year. Twice monthly meetings with RADAR have been established to support the implementation 6-month extension for current Datix license agreed in order to allow for co-running, staff training and current governance activity to be closed down. Procurement exercise undertaken and streamlined the integration of the system into CERNER and once EPR is in place the new system will be fully functional.	
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. LSCFT have provided key contacts to support the development of such an agreement. 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 which has now been provided. Job Description for mental health lead post received, which will report within the Safeguarding Adults structure, CQC have confirmed a preference for the Trust to register before having this post in place, to enable the registration inspection to be completed.	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 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). (Please see updates included in action 4 above).	G
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. Funding approved; team now at full complement after successful recruitment to posts. 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	GA

					further work. Feedback from workshop informing development of update incident policies and processes. Updating PSIRF and incident policies in line with final publication documents from NHSE due to be completed and approved early 2023. 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 Tier 1 and 2 for PSIRF training will be mandated for all relevant staff with a rollover period of 12 months. Development work ongoing with DERI.	
		b) COVID-19 Independent Inquiry will require significant resource to co-ordinate.	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. Module 3 of the Inquiry has recently begun recruiting core participants, however no contact has yet been made with ELHT. Our panel solicitors have not yet suggested we put ourselves forward. Information gathering is being co-ordinated through our EPRR team. In readiness	A
		c) Introduction of Liberty Protection Safeguards.	Executive Director of Nursing/ Executive Medical Director/	Before October 2023	Awareness raising ongoing Nationally the implementation of LPS has been delayed until October 2023, allowing greater time to prepare Potential significant workload associated to cover approx. 260 annual applications. The impact of LPS remains unknown. The business case used at LTHT to map potential impact has been provided by the incoming newly appointed Head of Safeguarding. The ICB have appointed a system lead for LPS who has offered to support the Trust to assess the potential impact and potential resource requirements. This will be an issue across the PCB and the ICB have been asked to identify if a system approach could support a joint response.	A
7	Need to increase patient/public engagement and influence	Introduction of Patient Safety Partners.	Executive Director of Nursing	New date of Q1 23-24 proposed. This is in line with the national challenges being experienced with the introduction of this role across the NHS.	Funding for these permanent posts will be required Role Descriptions completed A business case to fund the posts completed. Project Lead briefed Trust staff groups and some external organisations regarding the role and how to apply. Public engagement to continue until 2023, with a focus on awareness raising and ensuring an inclusive approach. Project Lead and the Trust's Communications Team have created a draft website in respect of communication package	A

				We are attempting to offer this PSP role as an opportunity to volunteers who are already engaged with the organisation.	to support the implementation of PSPs. Website to 'go live' if business case agreed. The volunteer service manager has agreed to identify potential candidates who may consider taking on the PSP role within the Trust. To facilitate this a briefing session has been organised to outline the role of the PSP, with a view to introducing these roles from April 23. It is suggested that a PSP representative could be invited to sub-committees of the Board during the 23-24 period.	
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. Positive improvement being seen in the trajectory and position but the Trust remains on Tier 1 cancer performance.	G
9	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 per week. This action is complete and will be moved into sources of assurance at the next review	~~B~~A

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: 30 November 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 2022.

Links to Key Delivery Programmes: Quality and Safety Improvement Priorities

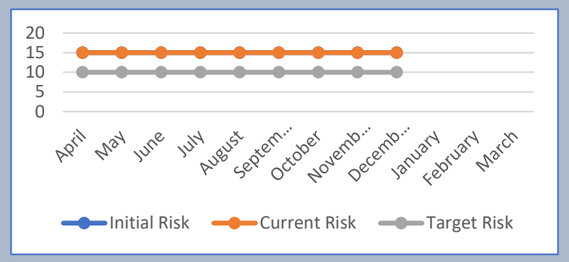
Lead Committee: Quality Committee

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)

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

- 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.
- The Trust has implemented and embedded an Executive Risk Assurance Group (ERAG) which meets on a monthly basis to review risks.
- The Trust has a Health and Safety Committee in situ to oversee matters relating to health, safety and associated risk.
- The Trust's Incident Management Team and PFI Partners continue to meet on a two weekly cycle to complete the required improvements at both RBTH and BGTH regarding fire remediation.

<u>Specialist support, policy and procedure setting, oversight responsibility:</u>

- 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: • 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 co-operation and co-ordination, resulted in the issue of an improvement notice in May 2022 with a deadline for completion of 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 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 of which Staff Side representatives form part of the membership.

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) Improve senior management awareness and overview of health and safety legal responsibilities, current safety landscape and what is driving and influencing change.	Executive Director of Integrated Care, Partnerships and Resilience	December 2022	Plan underway to agree actions and timescales This will be covered under the framework referenced in action 2.	G
		b) 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 This will be covered under the framework referenced in action 2.	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.	Executive Director of Integrated Care, Partnerships and Resilience	December 2022	Framework agreed and development of strategy underway. Will go to H&S Committee on 21 December 2022 for approval.	G
		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.			Framework agreed and development of strategy underway. Will go to H&S Committee on 21 December 2022 for approval.	G

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) 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	a) 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	May 2024	a) Identified need for increased resource to support implementation has been approved and is underway.	A
				April 2023	b) 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: 30 November 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 2022.

Links to Key Delivery Programmes: Tackling Health and Care Inequalities

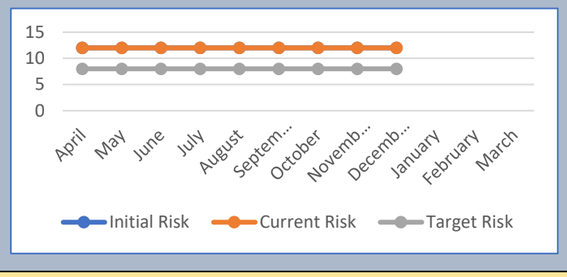
Lead Committee: Finance and Performance Committee and Quality Committee

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.)

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

- 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
- Public Health Registrar now in post

<u>Specialist support, policy and procedure setting, oversight responsibility:</u>

- 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.

<u>Independent challenge on levels of assurance, rick and control</u>

- 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.
- Pennine-Lancashire Health Equity Alliance established in June 2022, regular meetings are scheduled, and a core membership established.

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.	G

			Partnerships and Resilience		An outline of the proposed strategy was presented at the Health Equity Alliance meeting in September, with consensus to progress. This now requires finalising along with some outlined workstreams that cover the identified areas of focus. Outline of key priorities have been tabled and approved at the Health Equity Alliance meeting in December.	
2	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. This is in place and will be moved to the assurances section in the next review round.	B
3	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	This has been completed and will be moved to the assurances section in the next review round.	B
4	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	March 2023	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 The initial report - though perfectly acceptable - is being reviewed to delve deeper into the data and a new formulary is being developed in partnership with UCLan and is still due by the end of November.	A
5	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	March 2023	New cohort of medical students have been tasked to review the previous survey (in September 2022) and look into new methods of patient (and staff) engagement exercises. This will be an ongoing project.	A
6	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. Information portal and Comms campaign tabled and approved as part of December's Health Equity Alliance meeting in December. Action complete but a Comms working subgroup will be formed across Pennine Lancs that continues working on the health equity agenda.	G

BAF Risk 3

7	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	Candidate has now started and reviewing the Personalised Care and Health Equity agenda as part of their induction. This will be moved to assurances at the next review.	B

BAF Risk 4a

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

Executive Director Lead: Chief Operating Officer

Strategy: Clinical Strategy

Date of last review: Executive Director: 13th December 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 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.
- Diagnostic modality level demand and capacity model completed across the ICS with trajectory to deliver 95% < 6 weeks by March 2025.

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

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.
- Completion of scoping and agreement of detailed timescales and plans for agreed areas of focus.

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 to include extended data sets as per Tier 1 and 2 letter.
- 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.
- The clinical strategy has been signed off and 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.

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.
- Tier 1 meetings are now held on a two-weekly basis with NHSE and national cancer leads.

BAF Risk 4a

- Weekly monitoring of Referral to Treatment (RTT) and cancer wait time position using performance dashboard at specialty/tumour site level.
- Governance Processes have been reviewed around theatre utilisation and introduced support and challenge sessions with the Chief Operating Officer and Deputy Medical Director for Performance for any specialties that do not achieve trajectory.

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 March 23	Although a Tier 1 Trust, the Trust has made progress in relation to backlog clearance. In November 2022 the update provided was that performance was ahead of trajectory, however this is no longer the case. Timeline extended to March 23 in line with the final trajectory.	A
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	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. Enhanced rate of pay has been agreed across the ICS This will be moved into sources of assurance at the next review.	B
6	Improved performance data to support the outpatient transformation programme	Developing an outpatient utilisation dashboard	COO	March 2023	In process of developing the dashboard, anticipated to be in place by March 2023	G
7	Increase capped theatre utilisation to 85% by March 23	Agreed and improvement trajectory for theatre utilisation which will result in meeting the required target of 85% by March 2023	COO	March 2023	The Trust has achieved as planned for November 2022 and was slightly ahead of trajectory.	G

BAF Risk 4b

Risk Description: The Trust is unable to see, treat and discharge/admit/transfer emergency care 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 December 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 2022.

Links to Key Delivery Programmes: Urgent and Emergency Care Improvement

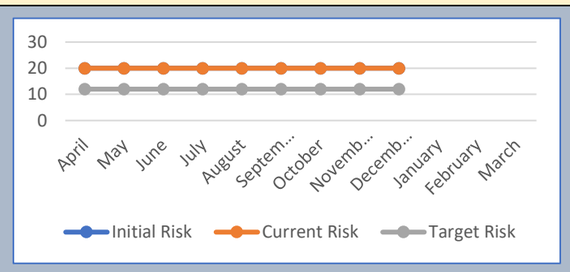
Lead Committee: Finance and Performance Committee

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)

<u>Overall planning and delivery processes:</u>

- 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.

<u>Operational Management processes:</u>

- 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. This includes activation of enhanced escalation during surge and work is in progress to finalise the process for boarding on wards.
- 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.)

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

- 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
- The Trust had received confirmation of funding for ward 22 from the ICB in relation to winter escalation (related to NHSE letter received on 12 August 2022).

<u>Specialist support, policy and procedure setting, oversight responsibility:</u>

- 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

<u>Independent challenge on levels of assurance, risk and control:</u>

- 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 and commenced on 2 December 2022. Completed, this will move to assurances in the next round	~~A~~B
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 March 2023	Pathways agreed but capacity not yet available. Refer to BAF 2a actions 5. Risk remains. Deadline changed to March 23.	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 January 2023	Reconfiguration of ED/UCC flows completed. Further work scoped to strengthen ED and admitted flows. Enhanced escalation process in place, where patients who wait in excess of 18 hours for a bed are moved to either the AMU or inpatient ward as an additional patient. Work in progress for +1 patient per ward during high surge (Boarding). Timeline for completion now Jan 23.	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 Feb 2023	Re-enforcing agreed discharge care bundle. This work is ongoing. Further improvement cycles planned in Dec 22 and Jan 23 through the daily every day matters supported by the QI methodology. Timeline changed to Feb 23.	A
5	Total understanding of bed requirements required.	Completion of bed modelling to consider required capacity.	Chief Operating Officer	End of Jan 23	Commissioned the bed modelling and initial draft has been shared for validation.	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 per week. This action is complete and will move to assurances in the next review.	~~A~~B
7	Winter planning	Development and deployment of a winter plan	Executive Director of Integrated Care Partnerships and Resilience	March 2023	Winter plan in place however limited funding available to support schemes. Some schemes will be delivered on an 'at risk' basis.	G

BAF Risk 4b

					The winter plan is developed and deployed however risks remain given the challenges outlined in this BAF.	

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: 5 December 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 2022.

Links to Key Delivery Programmes: People Plan Priorities

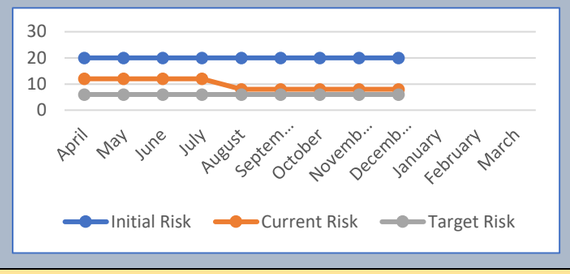
Lead Committee: Quality Committee

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.
- Workforce Assurance Group, which meets monthly with representatives from across the Divisions.

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

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

- The Trust's Staff Safety Group oversees the day-to-day operational risks and interventions to ensure staff safety matters are addressed.
- Six ~~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
  Muslim
- 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. Recent MIAA (internal) audit of the FTSU service gave substantial assurance.
- 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.
- The Trust's Leadership Forum has been established in September 2022 and seeks to engage stakeholders across the Trust and system.

<u>Specialist support, policy and procedure setting, oversight responsibility:</u>

- 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. • Connections made and introductory meetings held with the ICB EDI lead. <u>Independent challenge on levels of assurance, risk and control:</u> • WRES and Workforce Disability Equality Standard (WDES) standards are monitored nationally and reported to the 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. • Requirement to report regularly to the ICB People Board to provide assurance and address areas of challenge.

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	January 2023	The Strategy has been to Executive Team and Senior Leadership Group. The OD team are working with a number of teams across the Trust to develop bespoke leadership development interventions. The Trust will launch the Leadership Strategy and Programme in January 2023 following presentation to the Quality Committee in the same month. The timeline for this action has been revised due to there being no Quality Committee in December 2022.	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	The inaugural meeting took place in October 2022 and meetings are held monthly This will be moved into the assurances section at the next review.	B
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	December 2022	A paper has been developed to provide a rationale for supporting the networks with protected time and a small budget and will be discussed at the Executive Team in December 2023.	G
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. This action has been completed and will be moved into the sources of assurance at the next review.	B

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: 5 December 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 2022.

Links to Key Delivery Programmes: People Plan Priorities / R&D, Education and Innovation

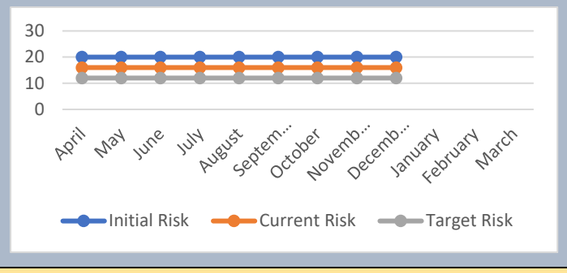
Lead Committee: Finance and Performance Committee

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).
- There is an agreed ICP Workforce Strategy that will be managed and delivered through the ICP People Board.
- 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.)

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

- 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.
- The Workforce Assurance Group provides Divisional and organisational focus on workforce priorities and enables co-ordination of activities across multiple teams. The Group reports to the Trust's Quality Committee.
- There is a Bank and Agency Delivery Group in place across the PCB.

<u>Specialist support, policy and procedure setting, oversight responsibility:</u>

- 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.

<u>Independent challenge on levels of assurance, risk and control:</u>

- 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. • 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. • There is a Bank and Agency Oversight Group in place across the PCB to ensure delivery against the Value Stream Analysis (VSA) outputs.

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 a recruitment plan to support delivery of the 2022-23 workforce plan~~ The action above has been replaced with the text below and consolidated with actions 2a As part of the People Strategy the development of an Attraction and Retention Strategy will be completed and presented to the Trust's Finance and Performance Committee.	Director of HR and OD	March 2023	~~Plan has been agreed but required refinement based on current workforce transformation activity.~~ ~~The plan remains under constant review~~. This action has superseded the action above and the date for delivery has moved to March 2023 due to operational pressures and capacity within the team. Operational activity to reduce the vacancy gap continues to take place.	~~G~~
2	~~Achieve zero nurse vacancy position~~	~~a) 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. The team have refreshed the exit interview process and has been renamed the 'Moving On' survey. The information gained will help identify any hot spot areas and key actions required to aid retention. Some of the output data has been incorporated in the quarterly Workforce Report that is presented to the FPC. The Workforce Innovation team are about to undertake 'stay interviews' with staff approaching retirement and those staff within the first 12 months of service to determine what the organisation can do to ensure we are able to retain staff.	G
		~~b) 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 (30) international nurses has recently been agreed via Executive Team. These staff will be commencing in post in three groups of 10 over Q4 of the 2022-23 year. ~~The Trust has been successful in securing circa £110,000 against three recent HEE bids, for upskilling funding.~~ The Trust continues to undertake and participate in international recruitment as part of its ongoing workforce strategy. This action will be closed and incorporated within action 2A (above).	B~~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. Pilots in CIC have	G

					worked well and we are now exploring wider opportunities for teams to maximise the benefits around flexible working. 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.	
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 out of the hands of the Trust. Through the ICP Workforce Strategy we will be exploring opportunities to create a blended workforce and upskill existing staff groups to ensure more effective use of people resources. An outline plan will be developed by April 2023.	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	A programme of work has been developed and will be presented to the LSC Growing Occupational Health and Wellbeing Together Collaborative Workshop on 14 December 2022. A wellbeing website has been delivered providing consistency across the ICS. – this will move to sources of assurance Following the exploration phase proposals to spend the £1.5m awarded to the ICS are being developed and will co-incide with the model, date to be confirmed. The winter wellbeing offer is in place and will be moved to sources of assurance and is being promoted across the Trust 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. and will be moved to sources of assurance and is being promoted across the Trust. The initiatives include Wagestream, Enhanced mileage rates, affordable food within Trust canteens and financial wellbeing advice etc. The OD and Well team are continuing to explore how staff can be further supported during this period of unprecedented demand.	G
6	Risk of loss of service due to national industrial action.	Establishment of an Industrial Action Cell to ensure planning and business continuity.	Executive Director of Integrated Care, Partnerships and Resilience	December 2022	The cell has been established and is meeting weekly to plan for any industrial action and associated disruption/loss of services. The cell includes representatives from across the Divisions. The ICS will co-ordinate a system wide response to any industrial action.	G

BAF Risk 5b

					The Deputy Director of HR and OD is working with colleagues from across the PCB to co-ordinate information and response on behalf of providers. The Director of HR and OD is meeting regularly with Staff Side colleagues to ensure good working relationships throughout any industrial action. Of the ballots that have been returned to date, ELHT remains unaffected by any industrial action.	

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: 14 December 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 2022.

Links to Key Delivery Programmes: Waste Reduction Programme

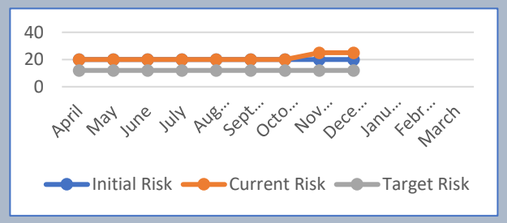
Lead Committee: Finance and Performance Committee

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

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

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)

<u>Organisation</u>

- Financial Recovery plan (short term) in place including additional controls
- 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.

<u>System</u>

- 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.)

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

- 2021-22 financial targets achieved in accordance with agreed plan.
- 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 8 reported due to system planning gap. Planning gap with providers to address. Remaining gap of £9.1m for ELHT. Assumed system support/working for gap not materialised.
- 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.

<u>Specialist support, policy and procedure setting, oversight responsibility:</u>

- 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.

<u>Independent challenge on levels of assurance, risk and control:</u>

- 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.	R
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 10% of total. 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 undertaken 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	January 2023	Presented to SLG December 2022. Meeting structure to be put in place.	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	December 2022	Support from system work not materialised. Trust being challenged to achieve break even. £10.8m further non-recurrent identified. £9.1m remains. Programme of works identified and the Executive Director of Finance 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

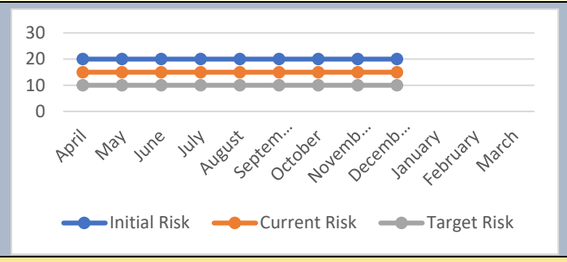
Risk Description: The Trust fails to deliver the strategic objectives set out in its NHS Green Plan	**Executive Director Lead:** Executive Director of Finance
Strategy: Wider sustainability (NHS Green Plan)	**Date of last review:** Executive Director: 13 December 2022 ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 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)

<u>Strategy Development:</u>

- 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.

<u>Strategy Delivery:</u>

- 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.)

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

- Green Plan target setting achieved in accordance with agreed timescales
- Current audit underway to review against first year targets
- 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)

<u>Specialist support, policy and procedure setting, oversight responsibility:</u>

- 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)

<u>Independent challenge on levels of assurance, risk and control:</u>

- 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	Q4 2022-23	Governance in place – first year system audit underway	A

					Delayed to Q4 due to operational pressures	
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 Finance Assurance Board (FAB). Current gap is around 10% of total. To be reviewed monthly May 2022 not met due to operational pressures and the level of savings requirement.	A
3	Fully identified programme to meet annual targets for NHS Green plan	Underway – linked to governance in point 1	Executive Director of Finance	January 2023	In process of being pulled together. Will be included in presentation to Execs/SLG Delayed to January 2023 due to operational pressures	A
4	Trust wide sustainability group paused through covid	To be re-established	Executive Director of Finance	January 2023	Revised TORs in development – Inaugural meeting September/early October Delayed to January 2023 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: 14 December 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 2022.

Links to Key Delivery Programmes: eLancs Programme / EPR

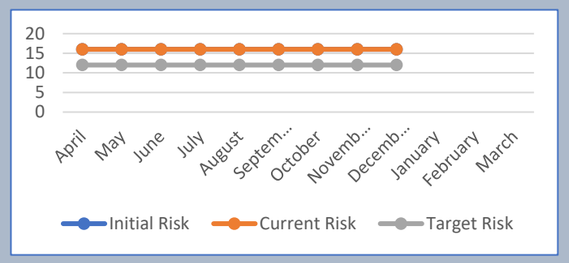
Lead Committee: Finance and Performance Committee

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:

	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)

<u>eLancs/ePR programme</u>

- 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 following Gateway review during the week commencing 28 Nov 2022.

<u>ICS strategic ePR developments:</u>

- 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.

<u>Core infrastructure and Cyber defences</u>

- 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.

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

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

- 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. Next Gateway wc 28th Nov 2022.
- 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.

<u>Specialist support, policy and procedure setting, oversight responsibility</u>

- 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.
- 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).

<u>Independent challenge on levels of assurance risk and control</u>

- Employment of an external outside expert group to monitor progress and advise on corrective actions if required.

BAF Risk 8

- 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. The corporate collaboration piece was discussed by all the regional CIO's and the new Regional Digital Director – Asim Patel on Wed 9th Nov. To be discussed further at the next ICB meeting.
- 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.

- 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	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
2	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
3	Policies / procedures / SOP's and Locsips not yet updated to reflect change in systems.	Co-ordinate 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
4	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 2023	Document in development, regularly updated, final version to be published on completion of ePR go live.	G
5	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. Formalisation of the Northern Star approach is being undertaken with action plans being drawn up to being formally consolidating services.	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: 7 December 2022

ERAG: Reviewed by Director of Corporate Governance on 3 January 2023 as ERAG was stood down in December 2022.

Links to Key Delivery Programmes: Overarching all Key Delivery Programmes

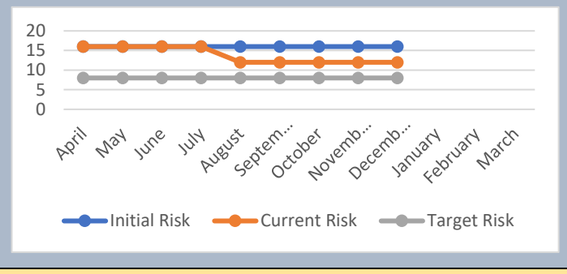
Lead Committee: Finance and Performance Committee

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:

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)

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 and team capacity aligned to agreed priorities.
- 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.
- Engineering Better Care for L&SC underway for Frailty/Respiratory. Pennine Lancashire team in place and programme underway.

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

BAF Risk 9

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	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	March 2023	Plan developed and shared with Executive. Trust Board development session to now be planned for early 2023.	A
2	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
3	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	Autumn 2023	Ongoing participation in Engineering Better Care for L&SC Programme and further refine of system improvement model.	G
4	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 enabling strategies in accordance with agreed timeline. Organisational plans for operational planning established and agreed via planning workshop with Senior Leadership Group. System planning workshop completed to agree alignment of planning processes for 2023-24.	B
				April 2023	Participate in and successfully complete organisational and system planning requirements for 2023-24 in line with local and national requirements.	G
5	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
6	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	Executive wall meetings established weekly.	B
				March 2023	Ongoing review and refinement of Executive Wall as part of the new Trust Accountability Framework.	G

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

11 January 2023

Item	**12**
Purpose	Information Assurance

Title	Patient Safety Incident Response Assurance Report
Executive sponsor	Mr J Husain, Executive Medical Director

Summary: The Trust Board is asked to receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP). This report includes information on maternity specific serious incidents reporting as required by Ockenden recommendations. The reports also provides an overview of the first 12 months of implementation of PSIRF.

Recommendation: The Board is asked to receive the included update on the implementation of 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. Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce. 5. Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy). 6. 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:

1. Incidents reported under the Patient Safety Incident Response Framework (PSIRF) from 1st December 2021 to 21st December 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 21 December 2022 the Trust has reported a total of 38 PSIIs.

1.1.2 Of the 38 reported PSIIs:

- 17 are currently being investigated by the PSII team, Terms of Reference and timescales have/or are being agreed with divisions/patients and families.
- 13 investigations have been completed and closed following approval at PSIRI and 2 are awaiting final approval of report and safety actions.
- The PSII Team are currently reviewing 8 incidents to establish that they meet the criteria under a local priority for investigation.

1.1.3 A further 6 Incidents are currently being investigated by the Healthcare Investigation Branch (HSIB) on average these take 6 months before the Trust receive the final report

Appendix 1 provides a breakdown of 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 or have key safety issues identified, that do not meet the national or local reporting priorites for a PSII are required to have a Patient Safety Response (PSR) completed and are managed within division.

Appendix 2 provides a breakdown of the types of PSR investigations and numbers undertaken as of 21st December 2022.

1.2.2 Learning from PSRs are shared at the Divisional Patient Safety Incidents Requiring Investigation (DPSIRI) panels and though divisional and directorate patient safety groups.

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.

2.2 As of 21st December 2022, there remain 4 open investigations:

- The Incidents and Policy Manger has met with the ICB to review the remaining queries and has been informed that 2 have been closed (confirmation is awaited from the ICB).
- The remaining two incidents the Incidents and Policy Manager is seeking some further information that will facilitate their closure.

3 Never Events

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

3.2 The Trust has not reported any new Never Event since April 2022.

4 Patient Safety Incident Requiring Investigation (PSIRI) Panel Overview

4.1 To date the panel has reviewed 13 completed PSII reports:

- 3 reports were approved with minor amendments awaited
- 10 investigations have had minor amendments completed following PSIRI and are now closed. These final reports and safety action plans have been shared with patient and/or families involved.

5 PSIRI Learning from Investigation Reports Approved

5.1 During November and December 7 PSII reports were presented and approved at the Trusts PSIRI panel. Safety improvement plans are now being monitored at the Trusts Lessons Learnt Group.

5.2 A summary of learning identified for each incident is provided below:

Category	Division	Findings
Patient death identified as being more than likely due to problems in care with ED (National priority).	MEC	Learning with regards to early warning scores, poor documentation in relation to ongoing care, lack of daily safety equipment checks and ECG pattern identified alongside presenting symptoms should have prompted further investigations.
Patient death multi-organ failure after surgery for a massive haemorrhage from their tracheostomy and free flap (National priority).	SAS	Learning was identified within the investigation with regards to escalating concerns between CCU and OMFS team, appropriate knowledge and understanding in the clinical observation of free flaps and signs of failure, improved handovers in CCU to ensure key information is being shared and specific recommendations are agreed and assigned
Fall leading to Facture neck of Femur (Local priority).	CIC	This investigation found that this incident could not have been prevented. Incidental learning was identified, and safety actions have been developed with regards to availability and education of flo-jac equipment which should have been used to move the patient from floor after fall.
A Diabetic Eye Screening Incident (National priority).	SAS	Due to the COVID-19 pandemic NHS England/Improvement published guidance for rescheduling Diabetic Eye Screening. When restoration of the service was almost complete, and a decision was taken to return to the pre COVID-19 methods it was identified that 45 digital screening patients had been lost to recall. System failures with the dashboard were identified and have been fully rectified which should ensure this failure does not happen again.
A Neonatal Death investigated by HSIB (National Priority).	FC	There were no safety recommendations as the findings from the investigation completed by HSIB did not contribute to the outcome. Incidental learning was identified regarding birth options and potential implications and discussed and documented with mothers who potentially are having larger babies.

A Stillbirth at 31 weeks and 2 days PMRT completed Grade C (National priority).	FC	The investigation highlighted safety issues with regards to pre-eclampsia/eclampsia not being managed according to national or local guidance and delay in diagnosis. The division have update PROMPT maternity training to include recognition of symptoms of pre-eclampsia and the management of it using scenario-based learning which is being rolled out to all appropriate staff.
Death of patient after return to theatre due to catheter issues (National priority).	CIC	The investigation found that the need for surgery was due to a combination of concurrent different circumstances which resulted in a life-changing situation following a urinary catheter insertion. The paraphimosis and subsequent need for surgery might have been avoided if the paraphimosis had been identified earlier. A number of recommendations were identified with regards to the Urinary Catheter Policy, information booklet for patients and recommendation with regards to trail without catheter SOP which have all had safety improvement actions developed.

Safety Improvement action plans have been developed in line with all safety recommendations from each report. These have all been approved at PSIRI panel and action completion is monitored through Divisions and corporate Lessons Learned group.

6 Maternity specific serious incident reporting in line with Ockenden recommendations

6.1 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 48 maternity related incidents have been reported on StEIS of which:

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

6.2 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, the update for quarter 3 will be included in the next report.

Appendix 1: Priority and category of incidetns accepted for PSII as of 21st December 2022

PSIIs (National or Local Priority)	Categories (report since 1st Dec 2021 to 20th December 2022)	No: reported	No: under investigation	No: awaiting approval	No: closed
National	Never Events	2	0	0	2
	Learning from Deaths (due to problems in care)	15	11	0	4
	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	1	0	1
	Neonatal Death (HSIB)	3	1	1	1
	Unexpected term admission to NICU (HSIB)	5	4	0	1
	Incidents in screening programmes	1	0	0	1
Local	Fall leading to #NOF	2	1	0	1
	DNACPR communication with patient/family	1	0	1	0
	Nil by mouth in venerable adult (6 days)	4	3	0	1
	ED internal transfer / problems / issues	2	1	0	1
	104 Cancer Breach causing moderate or above harm	1*	1*	0	0
Total		**38**	**23**	**2**	**13**

★ (The 1 investigation for 104 cancer breach is a cluster review of 6 individual cases which would bring the total to 43 separate incidents being reported under National and Local priorities)

Appendix 2: Patient Safety Response tools used as of 21st December 2022

No. of PSRs	
Investigation tool	No.
Immediate actions	1
Open discussion	6
Rapid review	181
Risk assessment	1
Falls checklist	32
Pressure checklist	649
Clinical/Peer review	56
Cluster review	10
Concise report	80
SJR	1
Specialised reviews	77
Timeline mapping	12
Round table	16
Awaiting to be assigned	38
Total	1160

Part 2 - ELHT Patient Safety Incident Response Plan 12-month Overview

1. Early Adoption.

1.1 The Trust has been an early adopter of the new National Patient Safety Incident Response Framework (PSIRF) since 1st December 2021. All other NHS England Trusts are required to have PSIRF fully implemented before August 2023.

1.2 The ELHT Patient Safety Incident Response Plan has required a full review of the Incidents Management Policy (ELHT policy C175) and provides the internal framework for how the Trust now manages incidents under PSIRF.

2. Investigations completed.

2.1 In the first 12 months the Trust has reported 38 StEIS incidents (1 StEIS incident is a cluster of 6 104-day cancer breaches, which would bring the total to 43 incidents being investigated) that either meet the National or Local priorities that require full patient safety incident investigations, of these 9 are HSIB investigations. Details provided in Part 1 of this report.

3. Resource to support the new model.

3.1 The Trust has funded a new Patient Safety Incident Investigation Team who are responsible for investigating and completing safety reports on all incidents that meet the National and Local priorities under PSIRF.

3.2 The team are now fully trained in the new investigation methodology and are due to complete their Human Factors training in Feb 2023 which supports the investigation process.

4. Systems adaptation.

4.1 To support the implementation of PSIRF, the Patient Safety team has introduced

1. A new incident management process for incidents causing harm (Appendix 3),
2. A new Patient Safety Investigation Response Process to ensure incidents are investigated at the appropriate level (Appendix 4)

3. Fully reviewed and updated the assurance reporting structure supporting investigations processes and introduced a weekly complex case meeting. (Appendix 5).

5. Patient/Family involvement in investigations.

5.1 A key element of PSIRF is to ensure patient, family and/or carers are supported after an incident occurs and are offered the opportunity to be fully engaged in the investigation process. As part of the PSIRF all patients, families and/or carers are now appointed a Family Liaison Officer by Divisions who are responsible for ensuring appropriate support is offered and to confirm any questions of concern they may have which needs to be included as part of the investigation process.

5.2 All patients, families and/or carers are offered the opportunity to meet with the PSII Lead to provide information for the investigation and offered the opportunity to check draft reports for factual accuracy.

6. Improvements in Patient Safety Culture

6.1 Since the implementation of PSIRF the Patient Safety team have developed several publications and events to help share learning across the Trust.

- Patient Safety Alerts – 2 have been published (LocSSIPs and Mental Health awareness in pregnant ladies)

- Patient Safety Bulletins – issue one published in October, second bulletin due January 2023.

- Patient Safety Events – two events have been held with Theatre staff across Blackburn and Burnley hospitals.

- A Patient Safety Sharepoint site – currently under development which will allow all staff to access and review PSII reports, learning, alerts etc.

7. A focus on learning and improvement

7.1 The Patient Safety Team are working closely with Quality Improvement on identifying key learning from the 5 local priorities. The first improvement project has been agreed with regards to communication when transferring patients using the

SBAR tool. Patient Safety and QI have further meetings book for January to review and agree other key local priority improvement projects.

7.2 A PSIRF Local Priorities Workshop has been booked for 23rd February and invites sent out to key stakeholders in the Trust and external key stakeholders to review and update our current local priorities for the ELHT Patient Safety Incident Response Plan (PSIRP).

8. Profile raising

8.1 Patient Safety Team are supporting and attending a Northwest Collaborative for national implementation of PSIRF by August 2023.

8.2 The team have also presented how the Trust has implemented PSIRF to the CQC, ICB Quality Committee and 30 other Trusts in the last 12 months.

8.3 This has happened to raise the profile of ELHT across NHS England with regards to patient safety.

9. Next Steps.

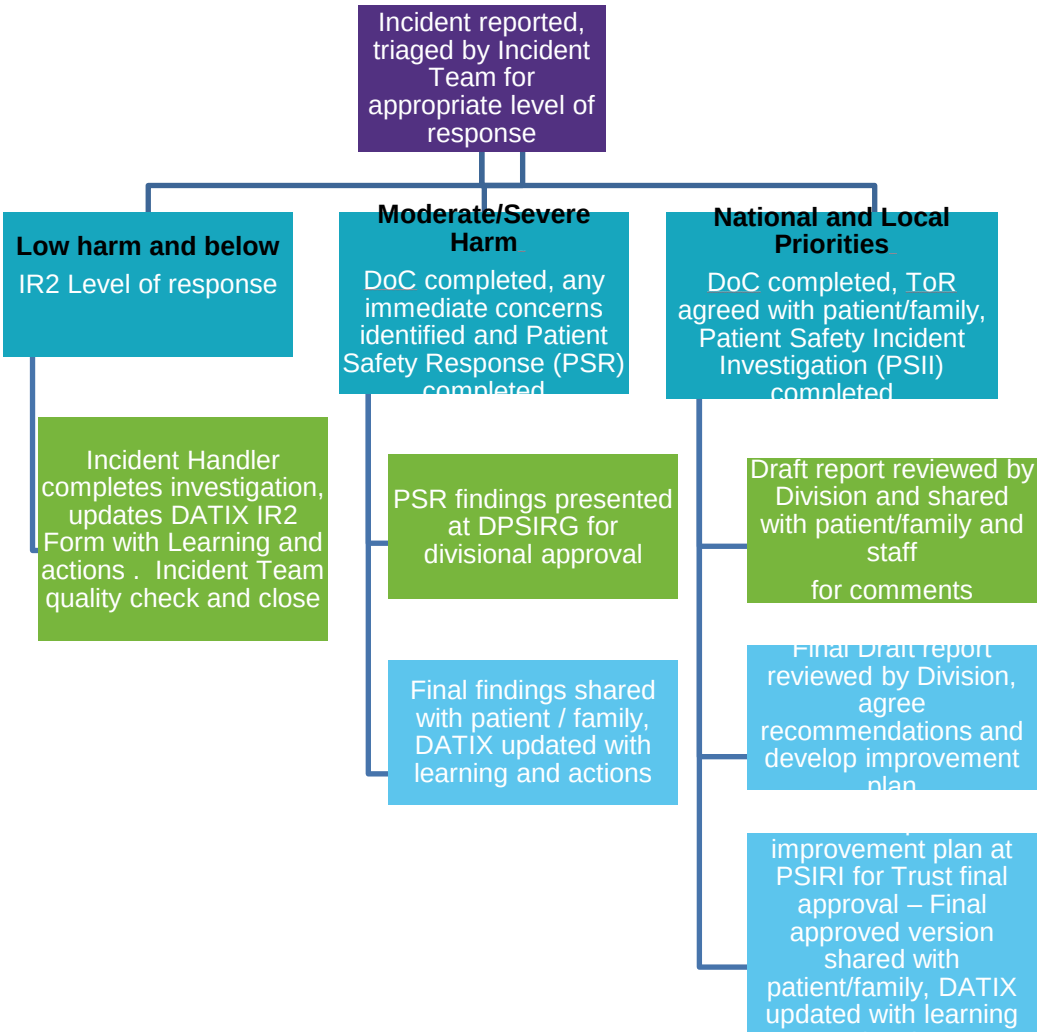
9.1 In August 2021 NHS England Patient Safety Team published the final Patient safety Incident Response Framework with template documents. The Trusts Patient Safety Team are currently working on updating several policies including the PSIRP, Incident Reporting, Incident Management, Duty of Candour to ensure they are fit for purpose and in line with national requirements.

9.2 Over the next 12 months the focus will be on further embedding the PSIRP and national framework, ensuring key learning is being actioned and monitored for improvements to support enhancing the patient safety culture within the Trust.

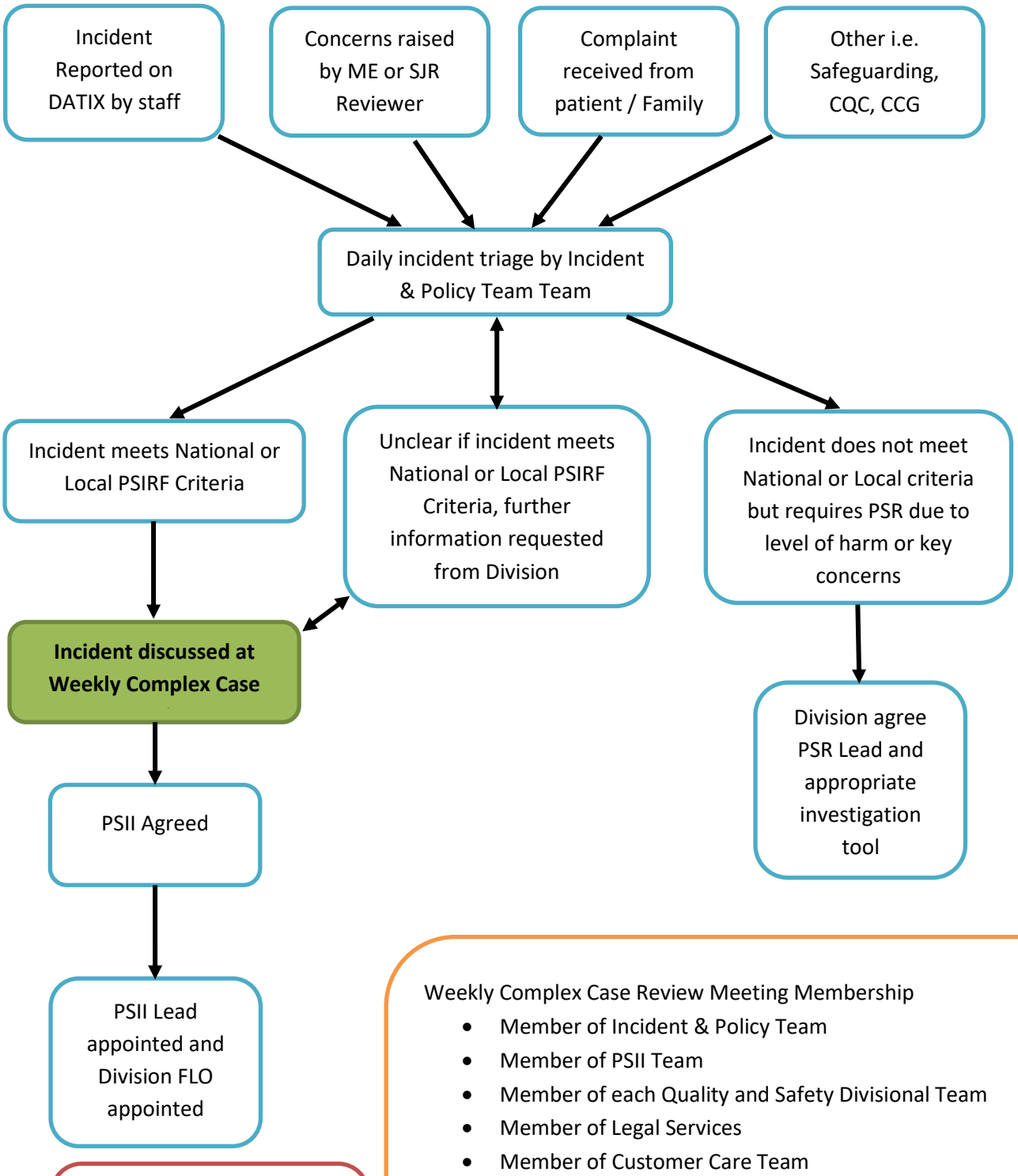
9.3 As part of the PSIRF implementation all other Trusts in Lancashire and South Cumbria need to implement PSIRF by August 2023. Once all 5 Trusts are reporting against the new framework the ICB will be facilitating the sharing of comparative date and lessons learnt. This will then allow the Trust to benchmark our data and develop the sharing of learning across the patch.

Also, as the Trust has now been reporting incidents under the new PSIRF for 12 months, the patient safety team from next month will be able to start comparing our own yearly / monthly incident investigation data. This will be included in the next report.

Appendix 1: Incident Management Flowchart



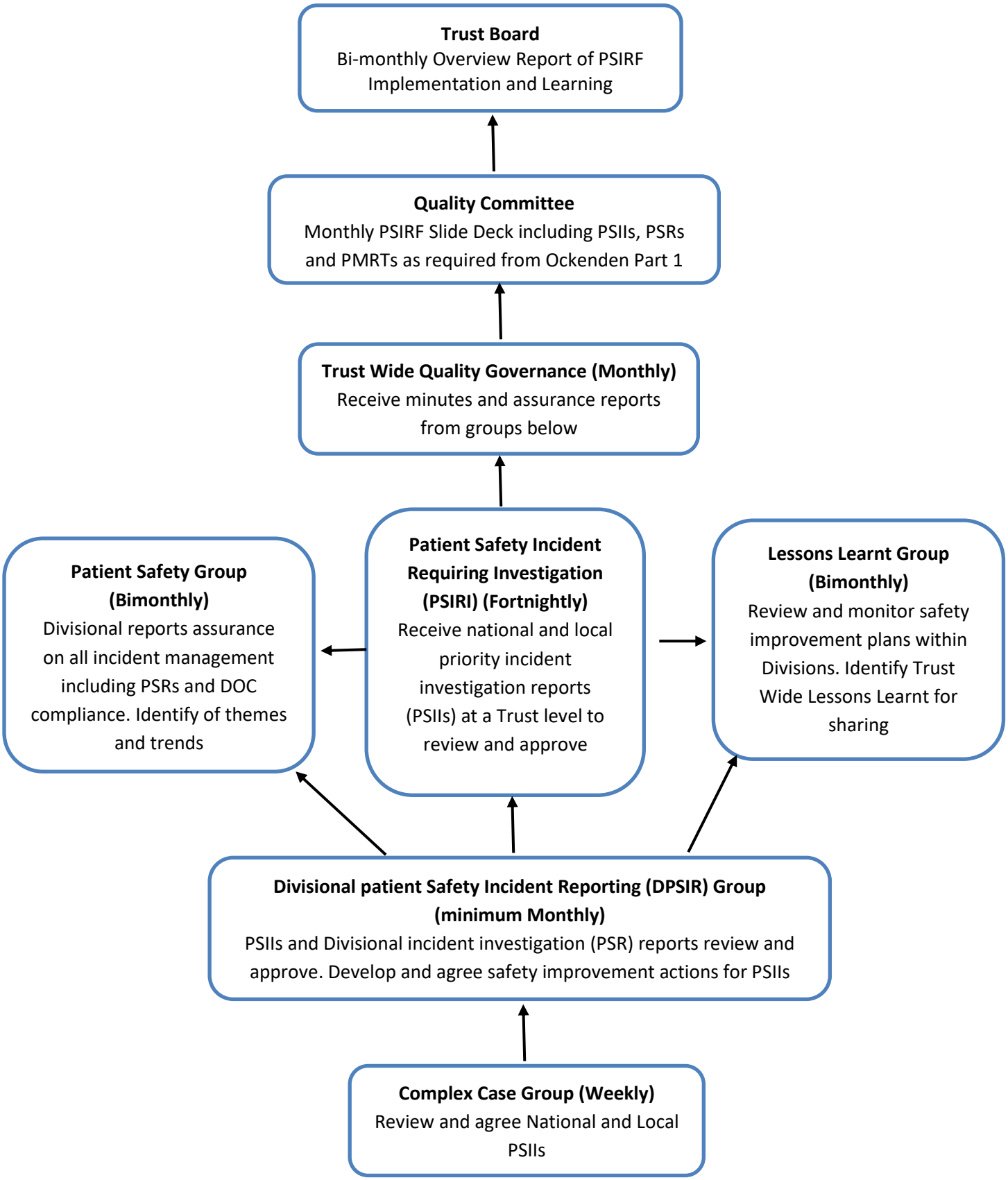
Appendix 2: Patient Safety Investigation Response Process



Weekly Complex Case Review Meeting Membership

- Member of Incident & Policy Team
- Member of PSII Team
- Member of each Quality and Safety Divisional Team
- Member of Legal Services
- Member of Customer Care Team
- At least one of the following
  - Assistant Director of Patient Safety & Effectiveness
  - Medical Director of Quality Governance
  - Assistant Director of Patient Experience

Appendix 3: Assurance Committees and Groups



TRUST BOARD REPORT

11 January 2023

Item 13

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

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 remain above threshold this month and are similar to pre covid levels.
- The complaints rate remains below threshold, and is showing no significant variation.
- The trust turnover rate has returned to normal levels at 7.2% in November and remains below threshold.

Areas of Challenge

- There were seven incidents reported in month which met local or national priorities and were reported onto steis. This includes 2 maternal deaths
- There were 2 mixed sex breaches in November.
- There were 2 healthcare associated clostridium difficile infections, 10 post 2 day E.coli bacteraemia, 0 P.aeruginosa, and 2 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 November at 73.3%.
- There were 857 breaches of the 12 hour trolley wait standard (26 mental health and 831 physical health), which is a significant deterioration.
- There were 371 ambulance handovers > 30 minutes and 18 > 60 minutes. Following validation, 6 of the 18 were actual ELHT breaches and 12 were due to non-compliance with the handover screen. The trend is showing significant improvement.

- Performance against the cancer 62 day standard remains below threshold in October at 63.2%.
- The 28 day faster diagnosis standard was not met in October at 65.5% and is still showing significant deterioration from normal variation.
- There were 16.5 breaches of the 104 day cancer wait standard.
- The 6wk diagnostic target was not met at 12.9% in November.
- In November, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 48,605, and the number over 40 weeks has increased to 3,060.
- In November, there were 843 breaches of the RTT >52 weeks standard.
- There were 62 operations cancelled on the day (non-clinical). This is now showing an improvement on previous levels
- In November, there was 1 breach of the 28 day standard for operations cancelled on the day.
- Length of stay - non-elective is showing deteriorating performance this month, however is in in quartile 2 (lowest 50%) nationally (Model Health data)
- Sickness rates are above threshold at 6.6% (November).
- The Trust vacancy rate is above threshold at 6.5%, however this is a significant improvement on previous levels.
- 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 13%.
- The Trust is reporting a year-to-date adjusted deficit of £6.1m in month 8, which is £6.2m behind plan and relates to the unmitigated element of the system planning gap held by the Trust. A financial recovery plan is now in place to ultimately aim to meet a breakeven financial plan by the end of the financial year.

No Change

- The emergency readmission rate is within the normal range.
- The Summary Hospital-level Mortality Indicator (SHMI) has remained as expected at 1.04.
- Venous Thromboembolism (VTE) risk assessment performance remains above threshold.
- 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.

Introduction

This report presents an update on the performance for November 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	2		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)	54	42		
M65	MRSA	0	0		
M124	E-Coli (HOHA)	n/a	10		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	0		
M157	Klebsiella species bacteraemia (HOHA)	n/a	2		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	2		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	7.0		
M69	Serious Incidents (Steis)	No Threshold Set	7		
M70	Central Alerting System (CAS) Alerts - non compliance	0	0		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	99%		

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	95%		
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	42%		
C40	Maternity Friends and Family - % who would recommend	90%	95%		
C42	A&E Friends and Family - % who would recommend	90%	70%		
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	6%		
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	0.19		
M52	Mixed Sex Breaches	0	2		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.04		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at Aug-22)	Within Expected Levels	113.9		
M74	Hospital Standardised Mortality Ratio - Weekday (as at Aug-22)	Within Expected Levels	111.8		
M75	Hospital Standardised Mortality Ratio - Weekend (as at Aug-22)	Within Expected Levels	120.3		
M73	Deaths in Low Risk Conditions (as at Aug-22)	Within Expected Levels	N/A		
M159	Stillbirths	<5	1		
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

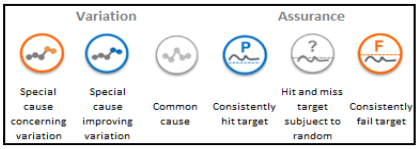
	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95.0%	71.9%		F
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95.0%	73.3%		F
M62	12 hour trolley waits in A&E	0	857		F
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	371		F
M84	Handovers > 60 mins (Arrival to handover)	0	18		F
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	48.3%		
C3	Referral to Treatment (RTT) non admitted pathways: percentage within 18 weeks	No Threshold Set	68.9%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	42222	48,605		
C4.2	Referral to Treatment (RTT) waiting times Incomplete pathways -over 40 wks	No Threshold Set	3060		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	480	843		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1.0%	12.9%		?
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	63.2%		?
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	77.4%		?
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	90.7%		?
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	96.0%		P
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	93.3%		?
C36	Cancer 62 Day Consultant Upgrade	85.0%	80.2%		?
C25.1	Cancer - Patients treated > day 104	0	16.5		?
C47	Cancer - % Waiting over 62 day (Urgent GP Referral)	N/A	13.79%		
C46	Cancer - 28 Day faster diagnosis standard	75.0%	65.5%		?
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	1		?
M138	No.Cancelled operations on day	No Threshold Set	62		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re admissions within 30 days	No Threshold Set	12.4%		
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%	7.2%		P
M78	Trust level total sickness rate	4.5%	6.6%		?
M79	Total Trust vacancy rate	5.0%	6.5%		F
M80.3	Appraisal (Agenda for Change Staff)	90.0%	75.0%		F
M80.35	Appraisal (Consultant)	90.0%	96.0%		?
M80.4	Appraisal (Other Medical)	90.0%	98.0%		?
M80.2	Safeguarding Children	90.0%	95.0%		P
M80.21	Information Governance Toolkit Compliance	95.0%	93.0%		?
F8	Temporary costs as % of total paybill	4%	13.0%		F
F9	Overtime as % of total paybill	0%	0%		
F1	Variance to H1 financial performance surplus / (deficit) (£m)	£0.0	-£6.2		
F2	Variance to H1 Waste Reduction Programme (WRP) achieved (£m)	£0.0	£0.0		
F3	Liquidity days	-12.4	(£14.1)		
F4	Capital spend v plan	85.0%	59.0%		
F18a	Capital service capacity	1.4	1.1		
F19a	H1 Income & Expenditure margin	0.0%	-1.3%		
F21b	Variance to agency ceiling (in millions) *	£0.0	-£4.5		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	92.5%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	96.7%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	97.0%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	99.1%		

NB: Finance Metrics are reported year to date.

KEY

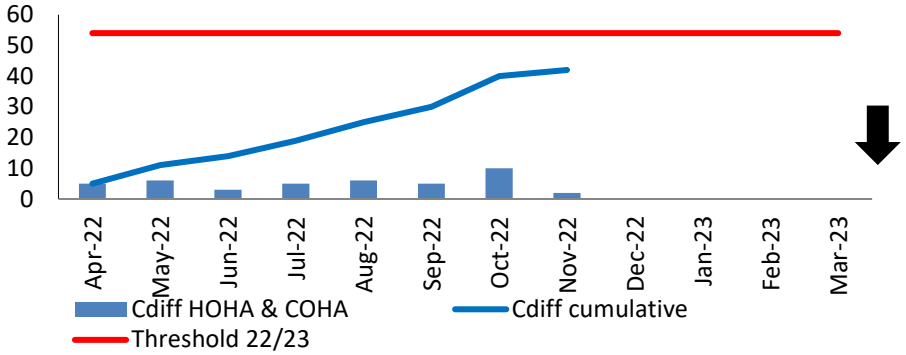


SPC Control Limits

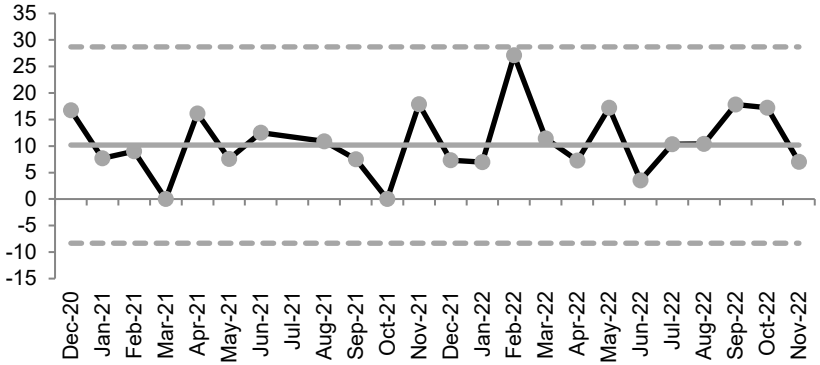
The data period used to calculate the SPC control limits is Apr 18 - Mar 20.

SAFE

C Difficile (HOHA &



C Diff per 100,000 Occupied Bed Days (HOHA)



There were no post 2 day MRSA infection reported in November. 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.

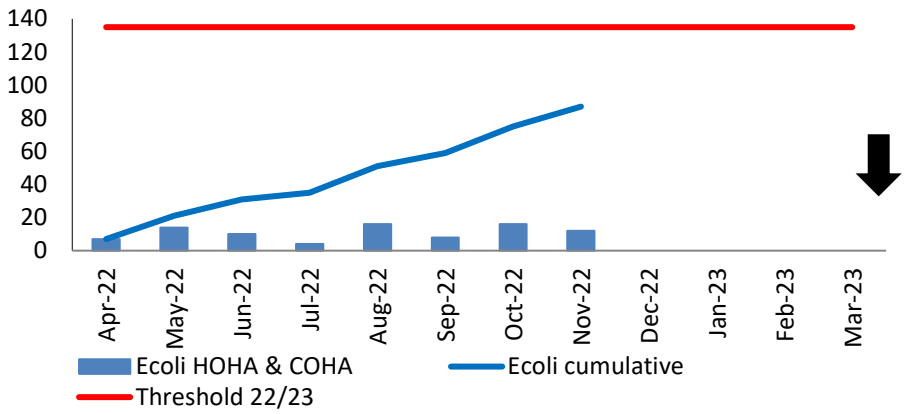
There were 2 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in October. Both were HOHA.

The year to date cumulative figure is 42 (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 November.

SAFE

E. Coli (HOHA & COHA)



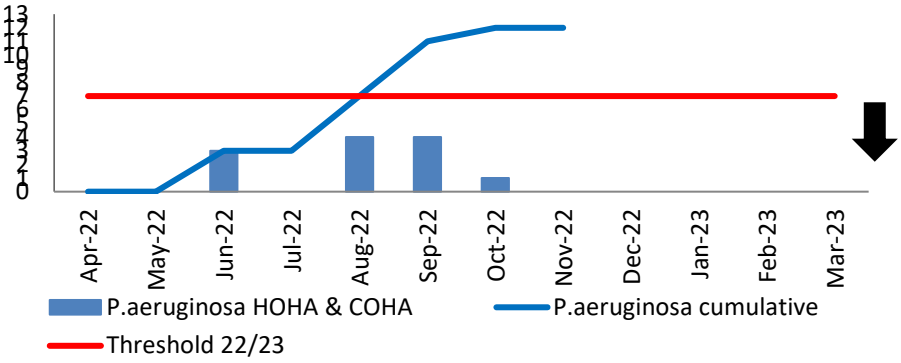
The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

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

There were 12 reportable cases of E.coli bacteraemia identified in November. 10 of which were HOHA and 2 were COHA.

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

P.aeruginosa



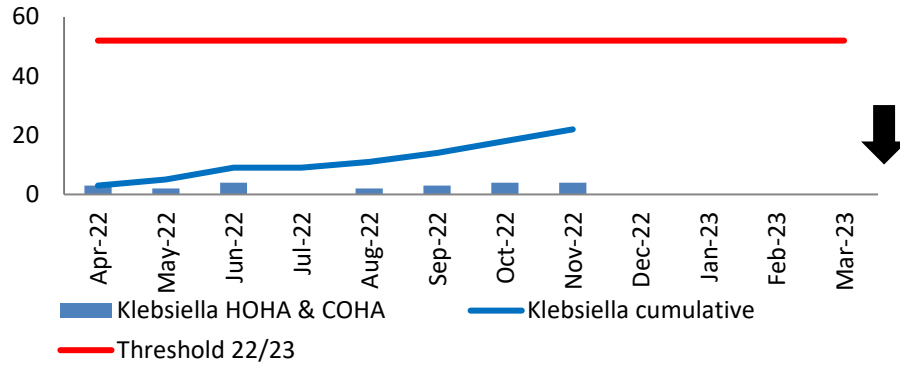
From 21/22 a trajectory was been introduced for Klebsiella and Pseudomonas. The Trust should have no more than 7 cases for Pseudomonas and 52 cases this year for Klebsiella.

There were 0 reportable cases of Pseudomonas identified in November.

There were 4 reportable cases of Klebsiella identified in November. 2 of which were HOHA and 2 COHA.

Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

Klebsiella

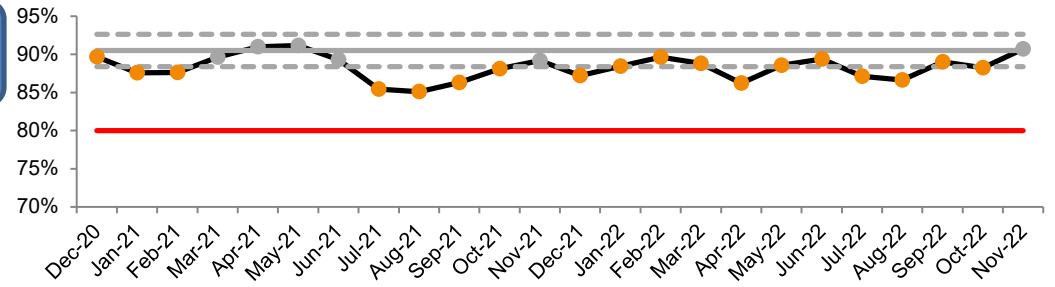


The work on catheter care, prevention of line infections, sepsis and improving hydration will help prevent healthcare associated bloodstream infections.

SAFE

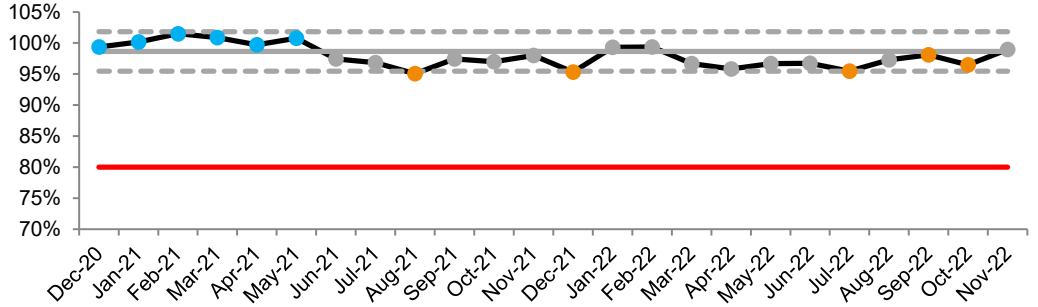
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



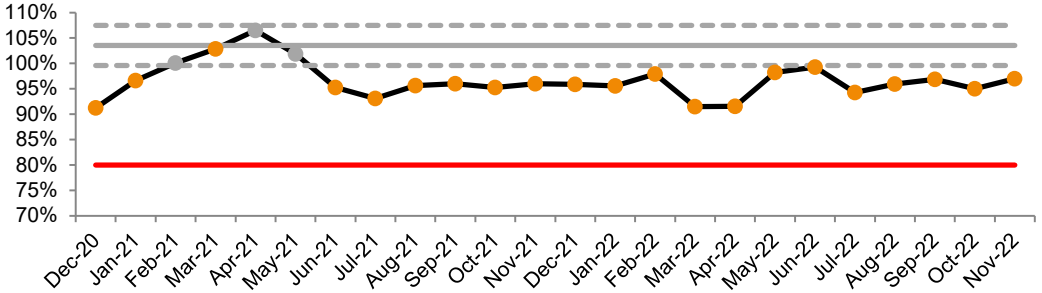
The average fill rate for registered nurses/ midwives during the day has returned to previous levels and based on current variation will consistently be above threshold.

Registered Nurses/ Midwives - Night



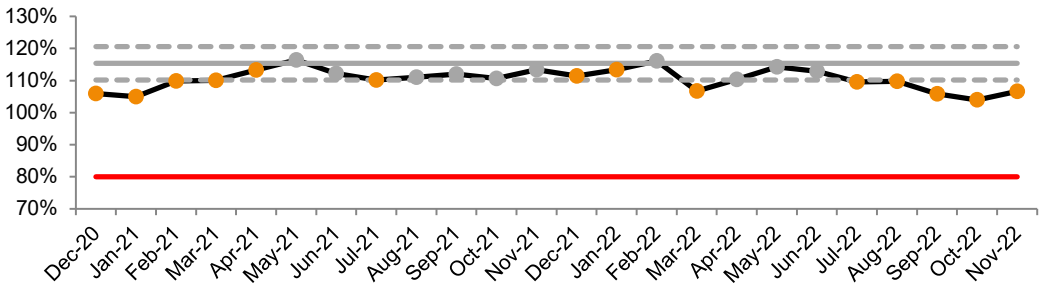
The average fill rate for registered nurses/ midwives at night is showing a return to previous levels, however based on current variation will consistently be above threshold.

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.

SAFE

Staffing in November 2022 remains a challenge, 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 November 2022, 1 ward fell below the 80% for Registered Nurses/Midwives for the day shifts. This is the same as the 2 previous months. However, there is still the on-going consequence of Covid, maternity leave, sickness and vacancies. Bank and agency remains challenging, with high numbers of last-minute cancellations or no shows.

MEC

Ward C5- 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
Nov-22	90.7%	97.0%	98.9%	106.6%	28,374	8.65	1	1	1	1

SAFE

Monthly Trend

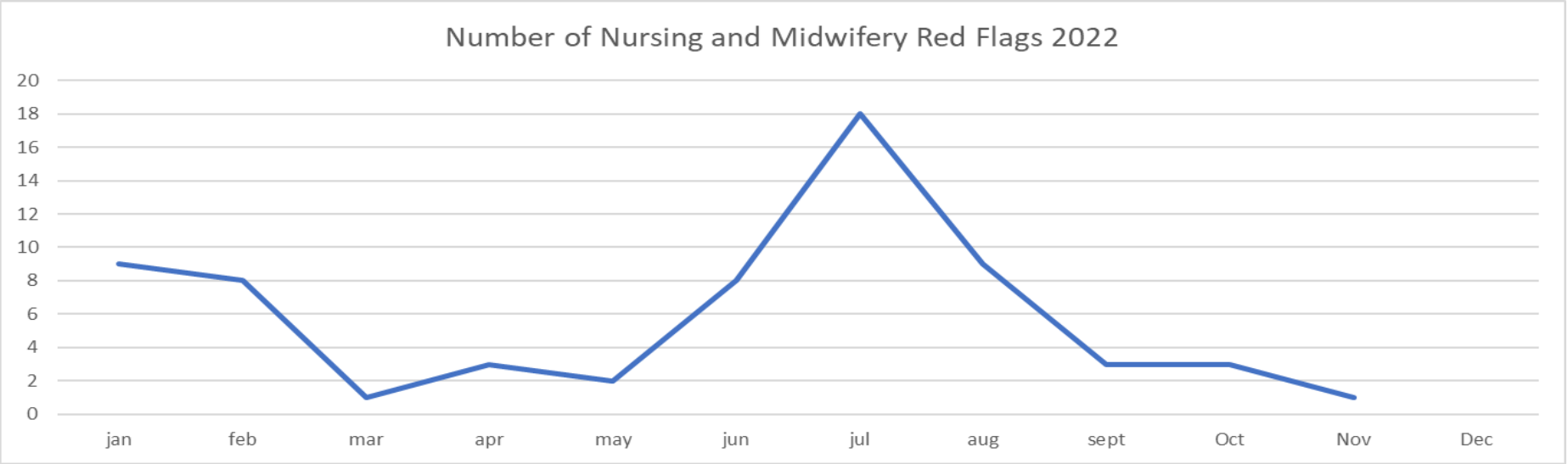
	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
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
Oct-22	88.2%	95.0%	96.5%	103.9%	28,989	8.52	1	1	1	2
Nov-22	90.7%	97.0%	98.9%	106.6%	28,374	8.65	1	1	1	1

SAFE

National Nursing Red Flags
On reviewing Datix in November 2022 there was 1 incident in total reported as a Nursing Red Flags. This is 2 less than last month.

SAS
- **C18a** - Fewer than 2 registered nurses present on a ward during any shift. This was due to an agency nurse going home mid-shift leaving one substantive RN on the ward. Delays in critical medication but no Harm to patients as a result of delays. Appropriate escalation channels followed. An RN was moved to support and the issue was resolved within 30 minutes

The graph below demonstrates the total number of reported **Nursing and Midwifery** Red Flags per month in 2022



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. Improvements to the ELHT recruitment webpage have commenced with notable increase in visits and time spent on the 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

- Reservist list work has commenced. This is an NHSE scheme to support periods of high activity with identified reservist registered nurses. The initial trial period will be in CIC, to date we have recruited 7 RNs, 9 HCAs and 8 admin.

- The ELHT Mass Vaccination Centres at Blackburn and Burnley are closing in December. HR&OD have held aspirational interviews with all the staff. 12 RNs, 1 HCA have been supported to receive bespoke training and secured post at ELHT. They commence in January 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
9 October 2022
3 November 2022

We are expected to bring over:

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 as demonstrated in the table below.

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	6	2	
SAS	5	2	2	1	0	2	0	0	1	2	0	
FC	0	1	2	1	0	0	0	0	2	0	0	
CIC	3	1	4	0	5	1	2	4	1	1	1	
Total	12	7	18	7	11	12	10	11	9	9	3	

SAFE

Family Care Staffing Summary – November 2022

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

Maternity (Midwife to Birth Ratio)

Month	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Staffed to full Establishment	01:26	01:27	01:27	01:28	01:27	01:27	01:27	01:28	01:27	01:28	01:28
Excluding mat leave	01:27	01:27	01:27	01:29	01:29	01:28	01:27	01:28	01:27	01:29	01:27
With gaps filled through ELHT Midwife staff bank	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage
Per week	42.28	17.33	18.76	14.79	15.80	14.87	23.90	16.10	20.75	30.56	21.74

Maternity- November bank filled hours filled as above

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 in periods of extreme staffing pressures to mitigate throughout maternity services; midwives were redeployed to other areas to support acuity and activity as and when required, bank uptake was in great demand as reflected in the monthly figures, highest recorded. Local midwifery red flags noted at each handover.

Daily and weekend staffing plans are summarised with a further review of skillset and experience for each midwife/ Maternity support worker prior to redeployed all plans these are all available on share point

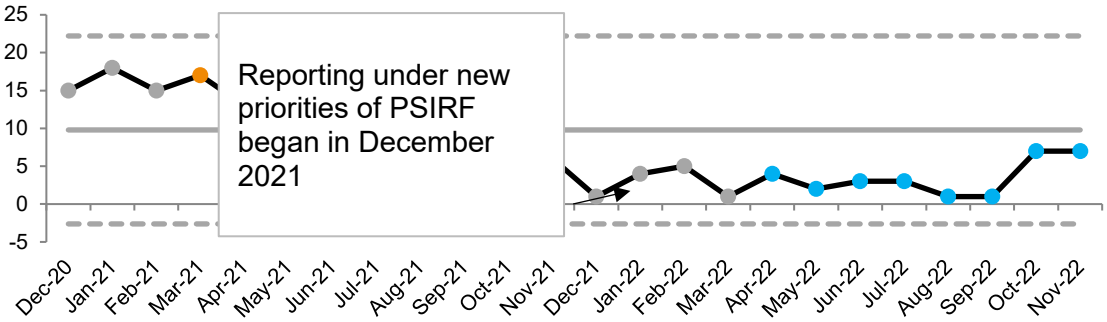
Neonatology – No exceptions/staffing reviews continue to be part of the daily maternity safety huddles. Bank and agency covered although minimal agency cover. X2 nightshifts only. Enhanced bank rate to continue until March. No closures.

Paediatrics- No exceptions.

Gynaecology – No exceptions

SAFE

Serious Incidents



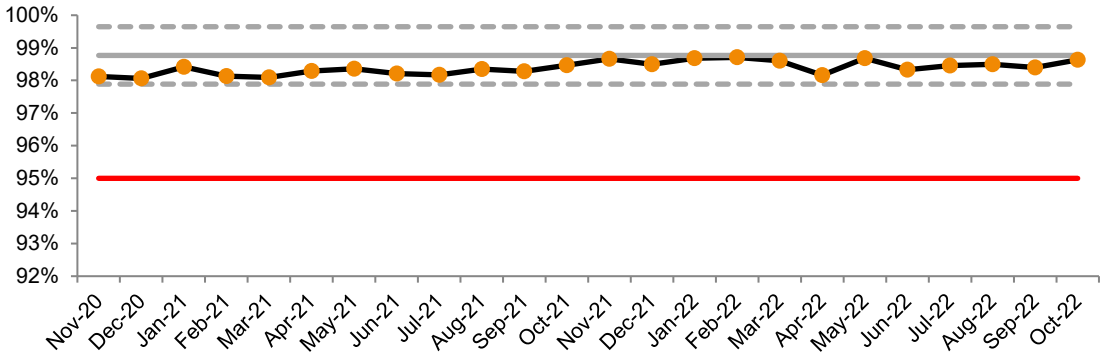
There were no never events reported in November.

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

PSIRF Category	No. Incidents
Maternal Death	2
Every Baby Counts	2
Child Death	1
Incident resulting in death	1
Vulnerable adults - nil by mouth	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

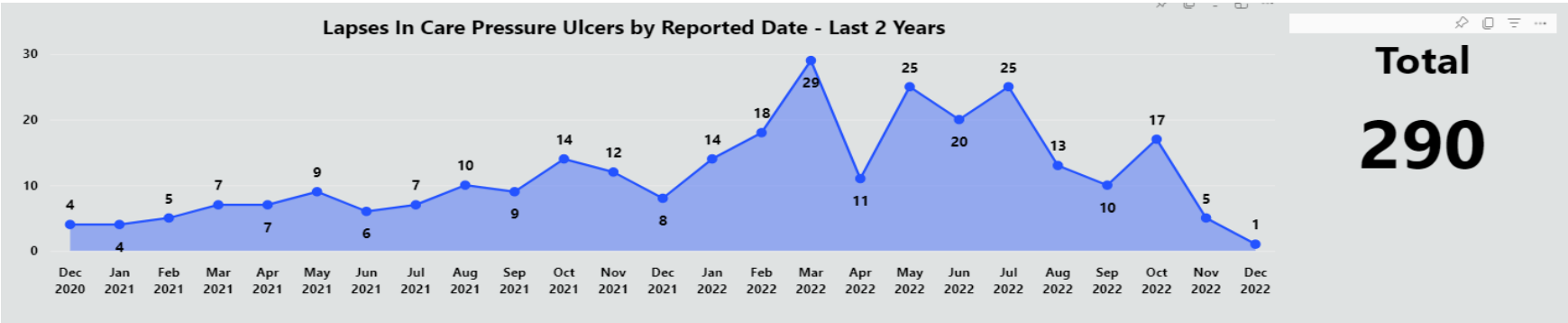


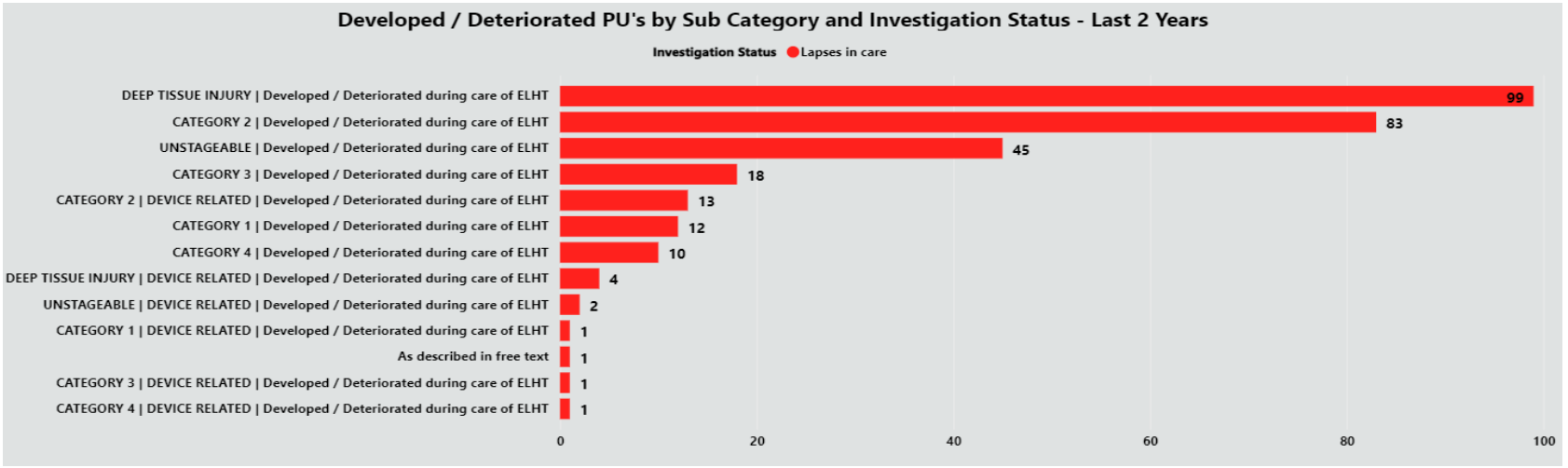
The Venous Thromboembolism (VTE) assessment trend continues to be below previous levels, however is still above the threshold.

SAFE

Pressure Ulcers

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





Over the past 2 years, we have had 3501 datix reports submitted for pressure damage. Of the 3501, 104 are still under investigation. The remainder 3397 have all undergone vigorous investigation, 290 have been found to have lapses in care.

Moisture Associated Skin Damage has been the largest incident category reported, of all incidents reported over the last 12 months with an average of 242 per month. The total number reported has followed an increasing trend over the last 12 months. However 60.9% of these have been present on admission.

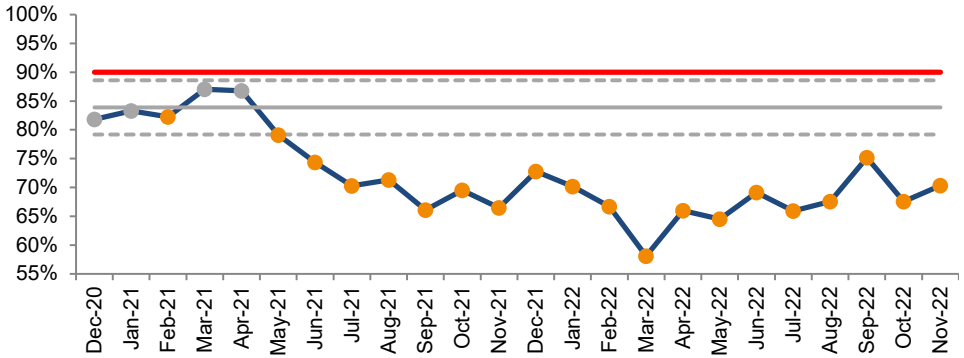
A review in the new year will establish how we identify pressure ulcer incidents for investigation based on the opportunities for learning, under the

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.

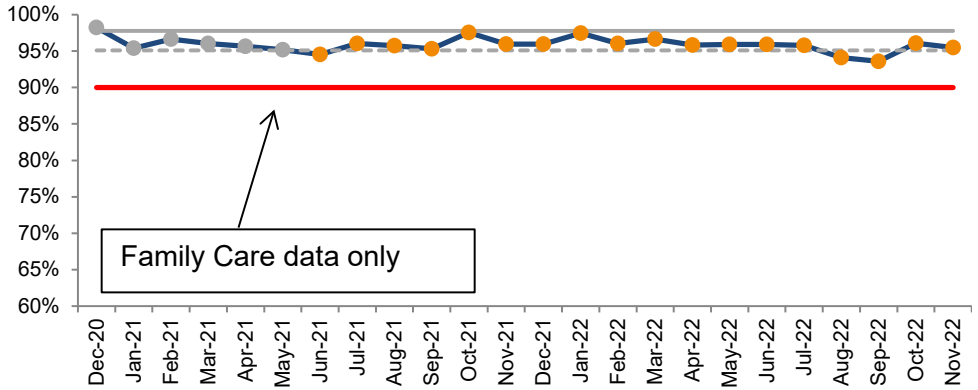
Inpatient data collection was suspended April 20 - Sep 20 due to COVID

Friends & Family A&E



A&E scores are showing a significant deterioration from previous levels. Based on current variation this indicator is not capable of hitting the target routinely.

Friends & Family Inpatient

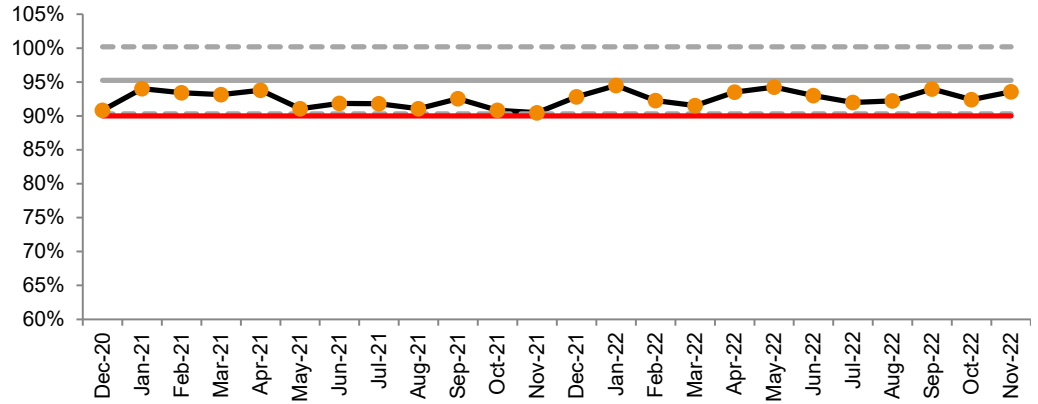


Inpatient data was suspended April - September 20 due to the COVID pandemic. Paper surverys were resumed in Family Care from 1st August 20 and across all areas from 1st September 20.

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

CARING

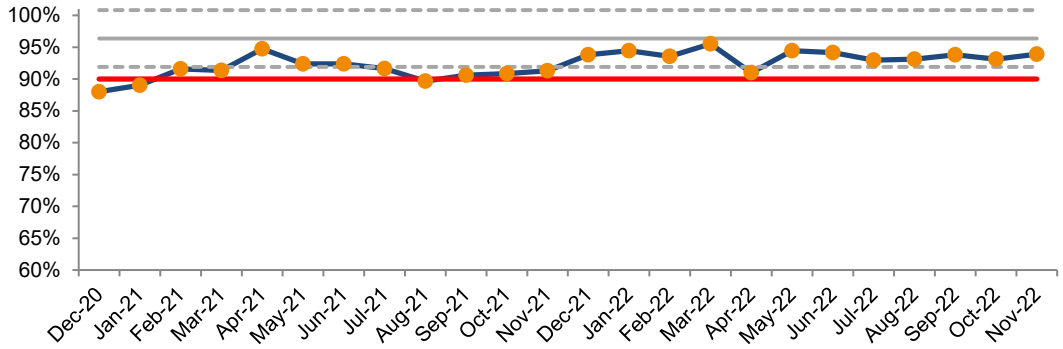
Friends & Family Outpatients



Outpatient scores continue to be below usual levels, however remain above target.

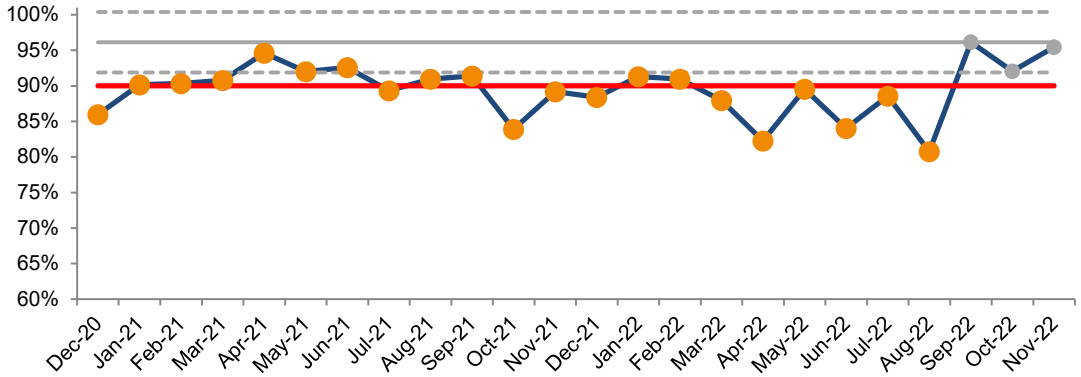
Based on current variation this indicator should consistently hit the target.

Friends & Family Community



Community scores are above target this month but are showing continued deterioration from previous levels. Based on normal variation this indicator should consistently hit the target.

Friends & Family Maternity

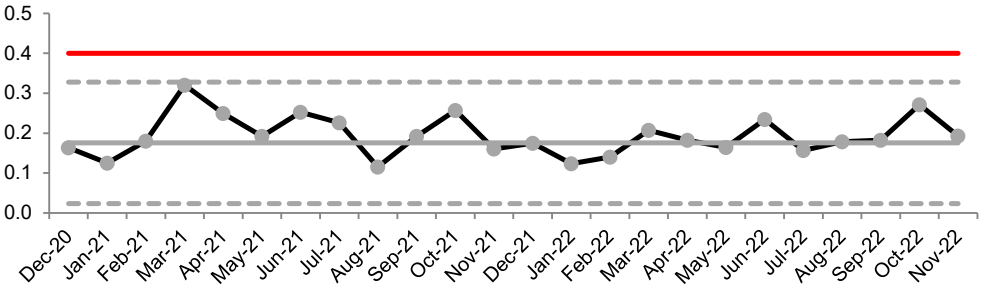


Maternity scores are above target this month and has returned to within the usual range.

Based on normal variation this indicator would consistently hit the target.

CARING

Complaints per 1000 contacts



The Trust opened 21 new formal complaints in November.

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 November the number of complaints received was 0.19 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	100	100	100	96.81	98.39
Community	Community and Intermediate Care Services	95.94	94.21	93.23	97.97	95.19
Community	Diagnostic and Clinical Support	100	94.16	99.33	100	96.63
Community	Family Care	100	-	-	94.7	95.78
Community	Surgery	99.59	97.31	-	-	97.95
Delivery	Family Care	100	-	100	100	100
Inpatients	Community and Intermediate Care Services	90.11	83.52	85.46	86.35	86.3
Inpatients	Diagnostic and Clinical Support	99.57	80.36	91.27	94.18	92.11
Inpatients	Family Care	91.48	89.06	89.22	92.5	90.4
Inpatients	Medicine and Emergency Care	90.93	80.75	85.83	88.33	86.35
Inpatients	Surgery	93.89	88.03	90.58	93.14	91.24
OPD	Diagnostic and Clinical Support	98.53	95.66	98.25	96.02	96.9
OPD	Family Care	89.47	87.84	89.61	87.18	88.55
OPD	Medicine and Emergency Care	100	97.84	97.11	96.56	97.67
OPD	Surgery	98.15	90.91	95.66	99.61	95.86
Other	Surgery	90.91	90.91	95	68.18	87.39
Postnatal	Family Care	95.45	97.5	100	94.92	96.45
SDCU	Family Care	92.39	90.48	92.97	94.23	92.42
	Total	**96.24**	**93.42**	**91.76**	**93.99**	**93.83**

The table demonstrates divisional performance from the range of patient experience surveys in November 2022.

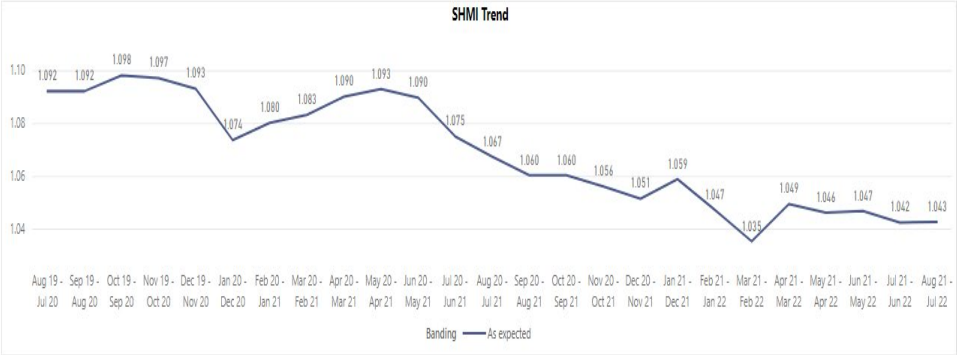
The threshold is a positive score of 90% or above for each of the 4 competencies.

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

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

EFFECTIVE

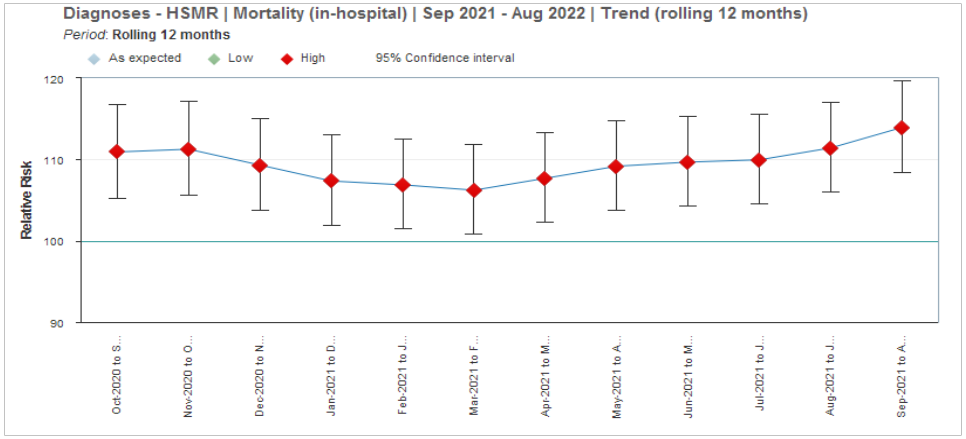
SHMI Published Trend



Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month Sep 21 – Aug 22
	ALL
TOTAL	113.9
Weekday	111.8
Weekend	120.3
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 Aug 21 to July 22 has remained within expected levels at 1.04, as published in December 22.

The latest indicative 12 month rolling Hospital Standardised Mortality Ratio (HSMR), (Sep 21 – Aug 22) has increased from last month and is 'above expected levels' at 113.9 against the monthly rebased risk model.

The benchmark model has been adjusted this month to account for data up to May 22, meaning risk scores are increasingly adjusted for changes seen during the pandemic.

There are currently five HSMR diagnostic groups with a significantly high relative risk score: Acute cerebrovascular disease, Septicemia (except in labour), Congestive heart failure nonhypertensive, Secondary malignancies and Malignant neoplasm without specification of site.

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

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	Oct-22	Nov-22	TOTAL
Deaths requiring SJR (Stage 1)	46	212	250	262	214	163	14	10	13	14	20	13	26	17	110
Allocated for review	46	212	250	262	214	162	14	10	13	14	19	13	20	6	103
SJR Complete	46	212	250	262	214	160	14	10	13	13	18	8	9	3	85
1 - Very Poor Care	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0
2 - Poor Care	8	19	22	34	35	22	4	1	2	3	3	2	5	1	20
3 - Adequate Care	14	68	70	70	65	47	3	4	3	5	8	3	2	0	28
4 - Good Care	20	106	133	129	103	78	6	5	7	5	6	3	2	2	34
5 - Excellent Care	3	18	25	29	10	12	1	0	1	0	1	0	0	0	3
Stage 2															
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	4	1	2	3	3	2	5	1	20
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	0	0	0	0	0	0	1	0	1
Allocated for review	6	18	21	30	35	22	4	1	2	3	3	2	4	1	19
SJR-2 Complete	6	18	21	30	35	22	4	1	0	3	2	2	1	0	13
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0	0	0	0	0	1
2 - Poor Care	3	6	7	13	13	10	2	1	0	2	1	1	1	0	8
3 - Adequate Care	2	10	13	13	21	10	1	0	0	1	1	1	0	0	4
4 - Good Care	0	1	0	2	1	1	0	0	0	0	0	0	0	0	0
5 - Excellent Care	0	0	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	Oct-22	Nov-22	Total
stage 1 requiring allocation	0	0	0	0	0	1	0	0	0	0	1	0	6	11	7
stage 1 requiring completion	0	0	0	0	0	2	0	0	0	1	1	5	11	3	18
Stage 1 Backlog	0	0	0	0	0	3	0	0	0	1	2	5	17	14	25
stage 2 requiring allocation	0	0	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	2	0	1	0	0	0	3
Stage 2 Backlog	0	0	0	0	0	0	0	0	2	0	1	0	0	0	3

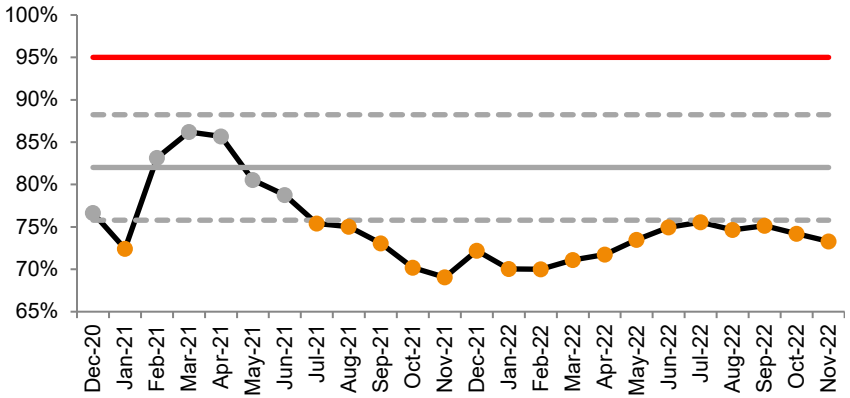
EFFECTIVE

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

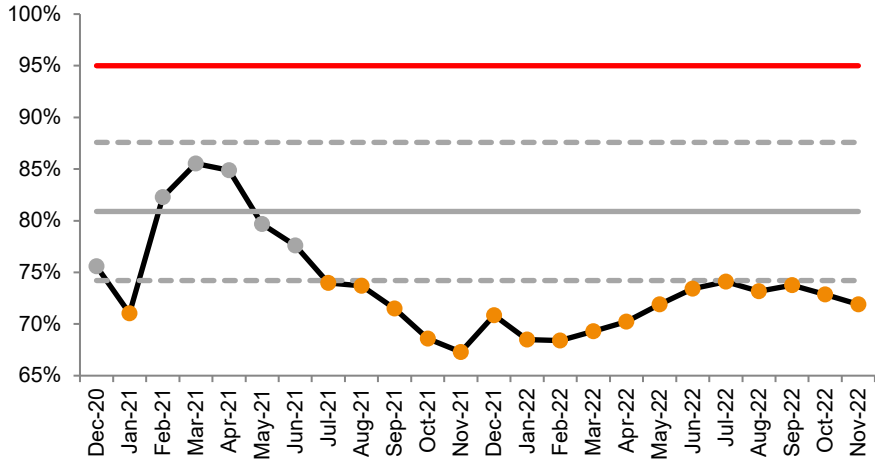
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 73.28% in November, which is below the 95% threshold.

The trend continues to show a deterioration on previous performance and based on current variation is not capable of hitting the target routinely.

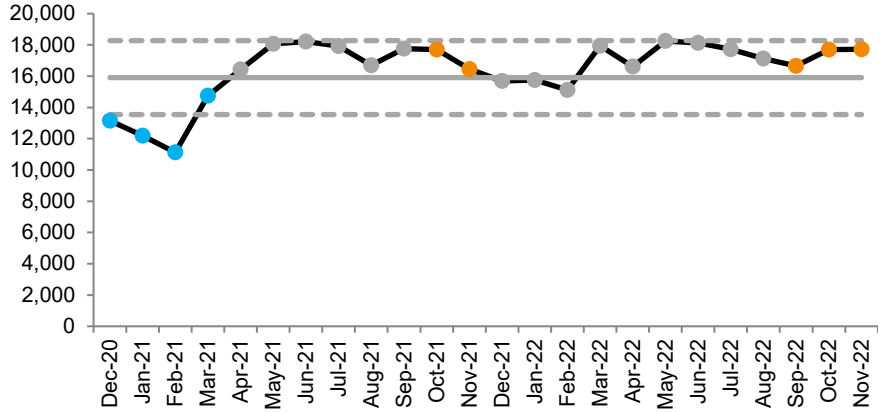
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 71.90% in November.

The national performance was 68.9% in November (All types) with 0 of the 110 reporting trusts with type 1 departments achieving the 95% standard.

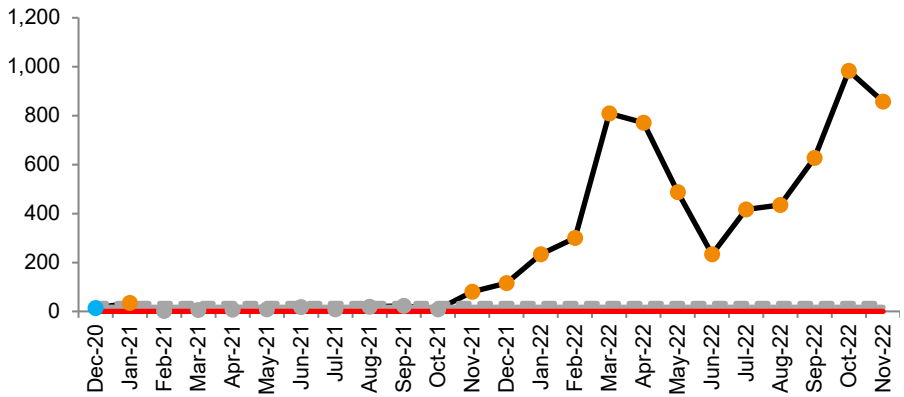
A&E Attendances - Trust



The number of attendances during November was 17,720, which is now showing a significant increase on previous levels.

RESPONSIVE

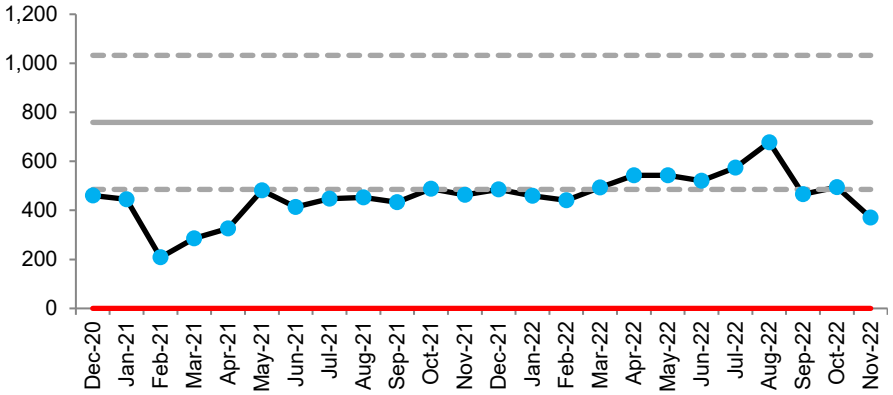
12 Hr Trolley Waits



There were 857 reported breaches of the 12 hour trolley wait standard from decision to admit during November, which is higher than the normal range. 26 were mental health breaches and 831 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.

Ambulance Handovers - >30Minutes

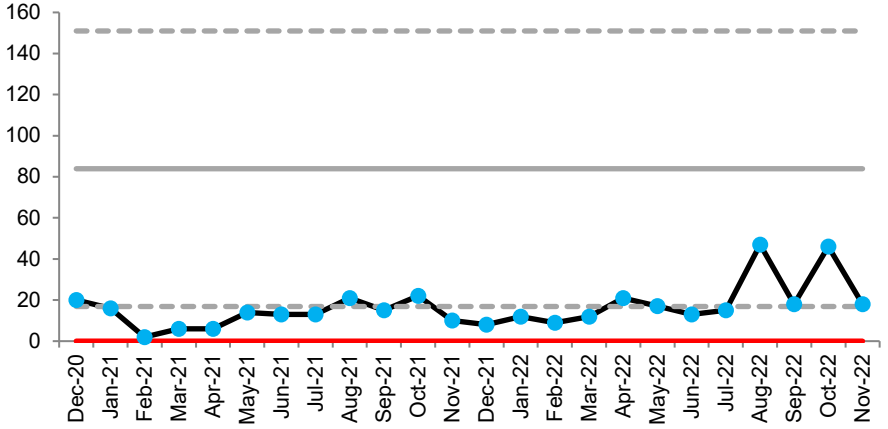


	Mental Health	Physical Health
No. 12 Hr Trolley Waits	26	831
Average Wait from Decision to Admit	41hr 58 min	18hr 17 min
Longest Wait from Decision to Admit	94hr 01 min	62hr 35 min

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 371 ambulance handovers > 30 minutes in November. 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 November, which continues to demonstrate a signifcant improvement. Following validation, 6 of the 18 were actual ELHT breaches and 12 were due to non-compliance with the handover screen.

The average handover time was 21 minutes in November and the longest handover was 2hr 27 minutes.

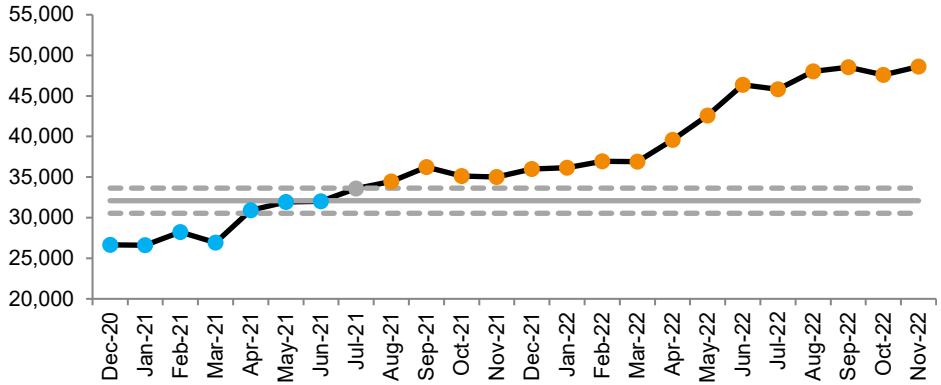
RESPONSIVE

At the end of November, there were 48,605 ongoing pathways, which has increased on last month and is above pre-COVID levels.

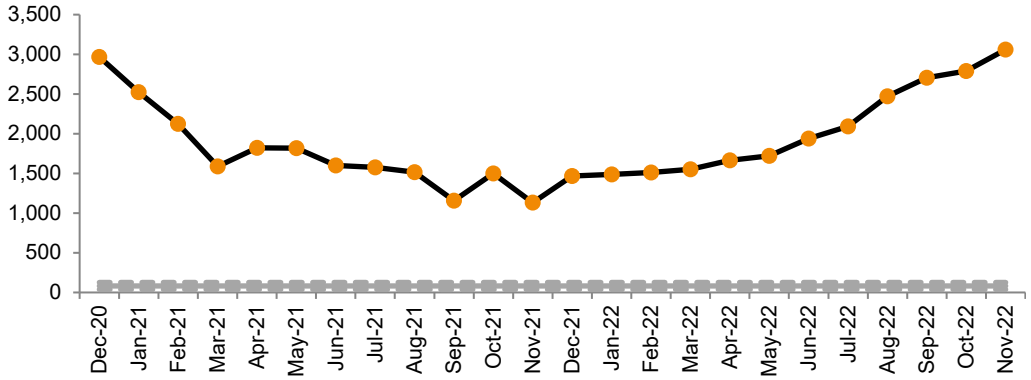
The number of pathways over 40wks increased in November with 3060 patients waiting over 40 wks at month end.
There were 843 patients waiting over 52 weeks at the end of November which has increased on last month and is above trajectory.
There were 14 patients waiting over 78 weeks which was within trajectory.

No patients were waiting over 104 weeks.

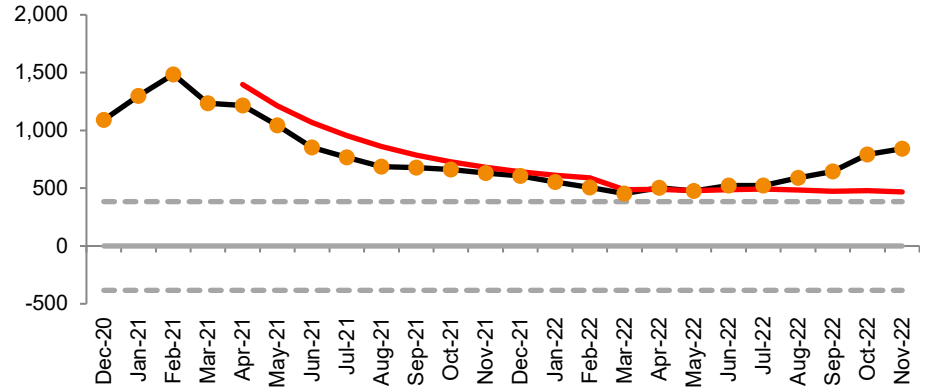
Referral to Treatment (RTT) Total Ongoing



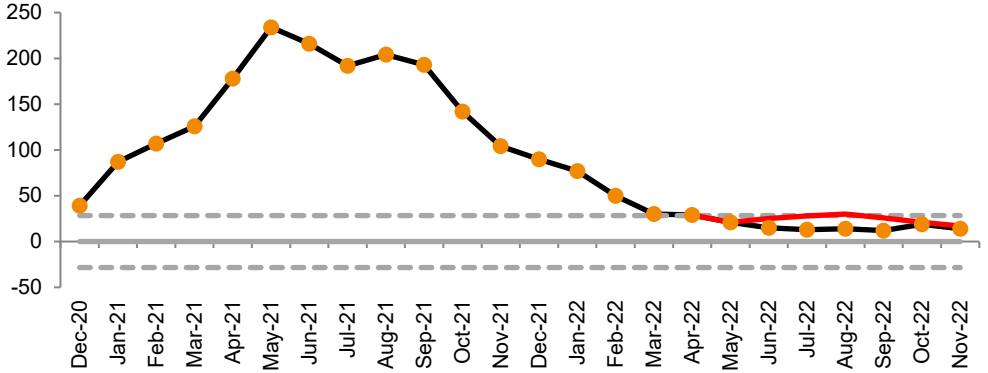
RTT Total Over 40 wks



RTT Total Over 52 wks



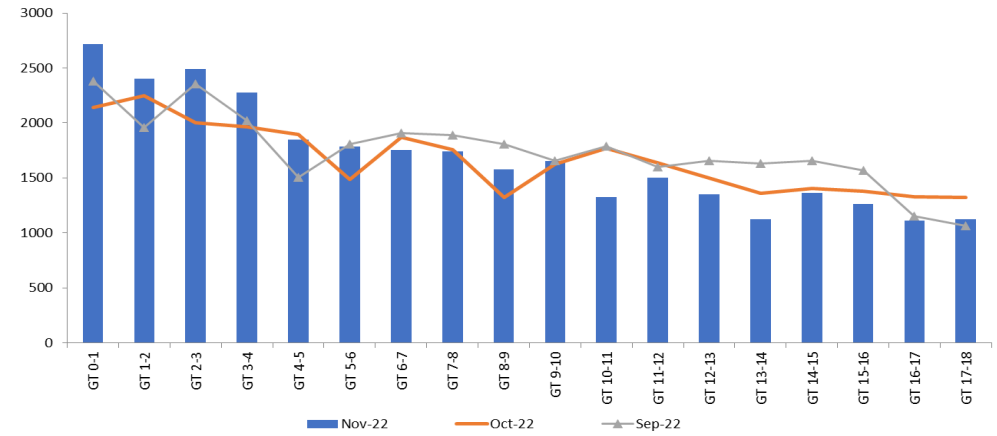
RTT Total Over 78 wks



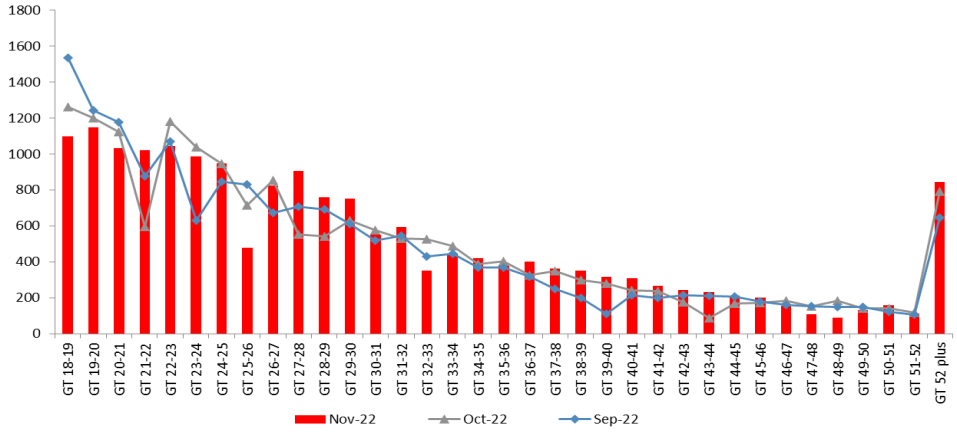
RESPONSIVE

The bar charts show the numbers of RTT ongoing pathways by weekband, compared with previous 2 months.

RTT Ongoing 0-18 Weeks

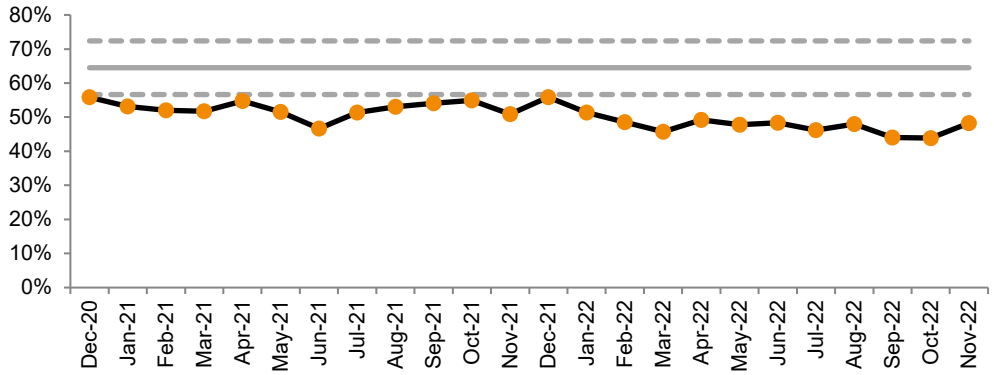


RTT Over 18 weeks

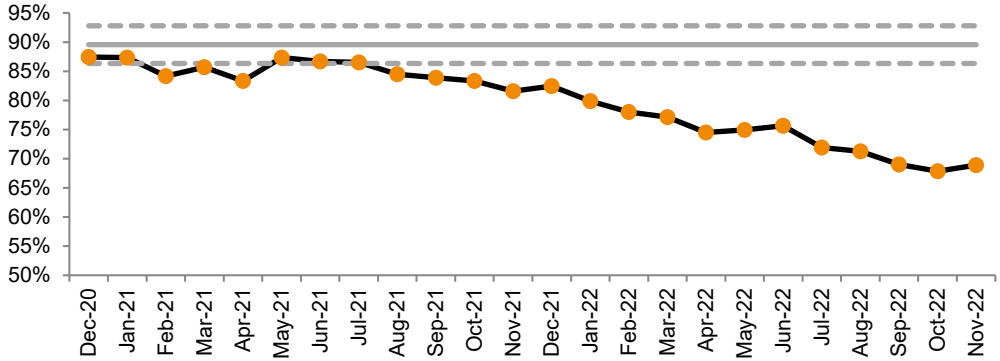


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted

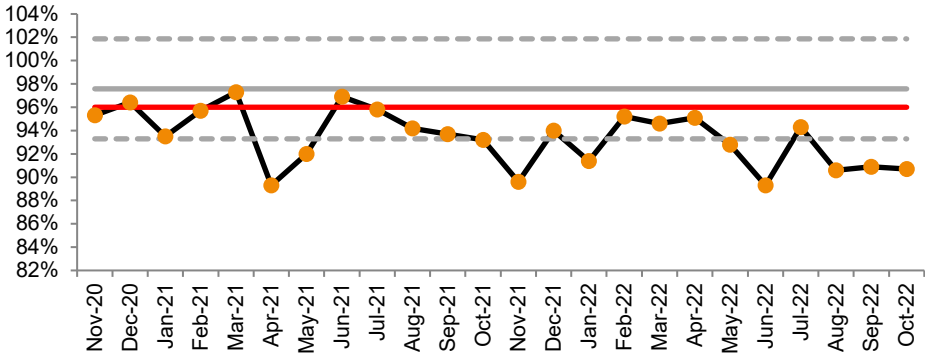


RTT Non-Admitted



RESPONSIVE

Cancer 31 day



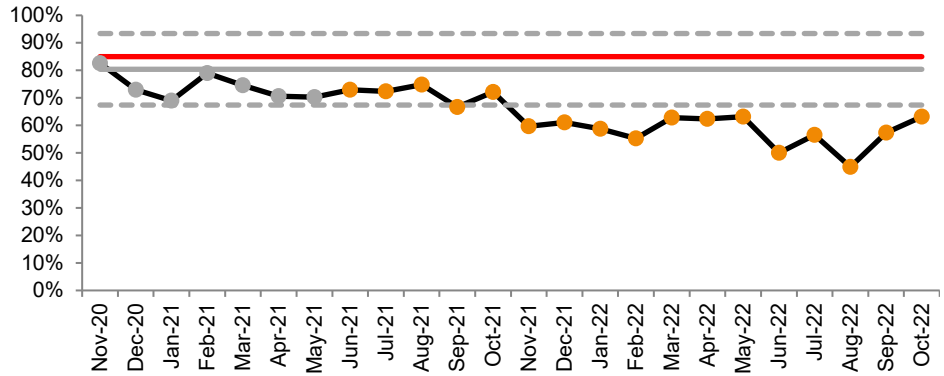
The 31 day standard was not achieved in October at 90.7%, below the 96% threshold.

National position - 91.1%

Q2 was not achieved at 91.9%

The trend is showing deteriorating performance and based on current variation, the indicator is at risk of not meeting the standard.

Cancer 62 Day



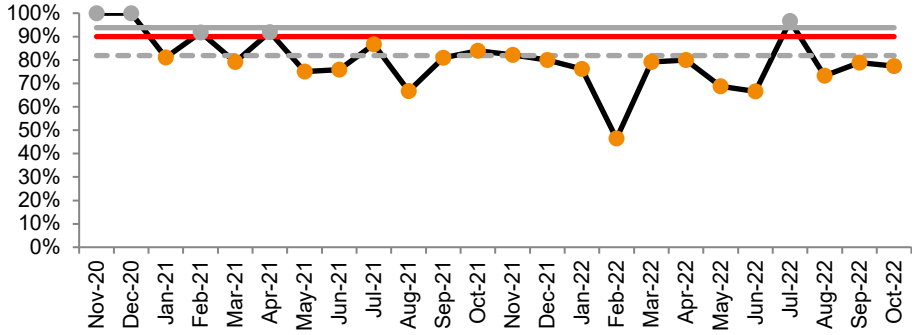
The 62 day cancer standard was not achieved in October at 63.2% below the 85% threshold.

National position - 60.5%

Q2 was not achieved at 57.3%

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 not achieved in October at 77.4%, below the 90% threshold.

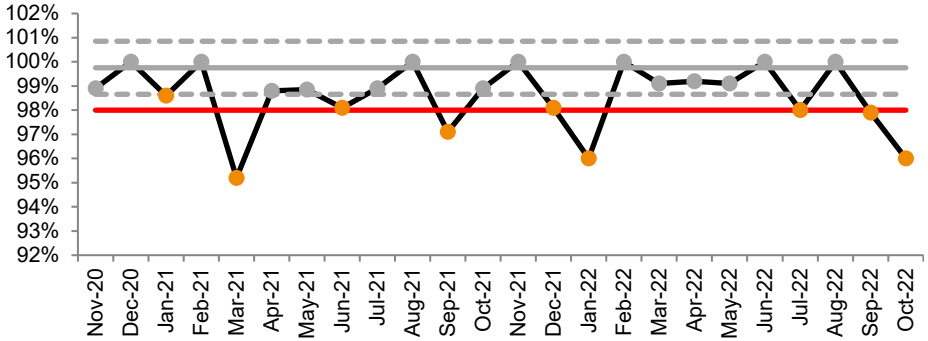
National position - 67.6%

Q2 was not achieved at 83.3%

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)



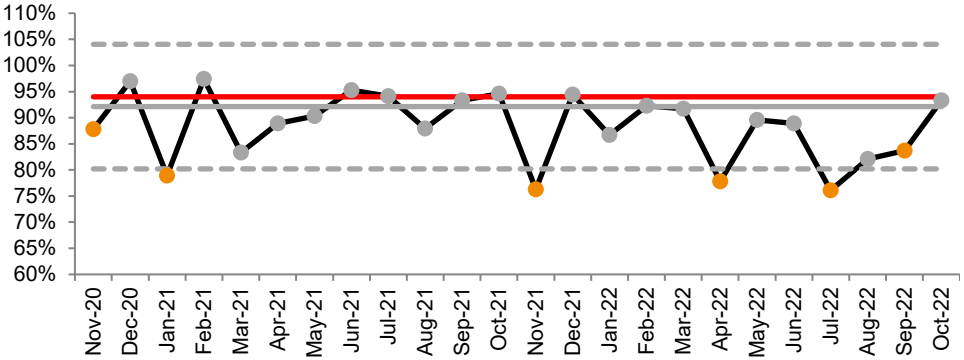
The subsequent treatment - drug standard was not met in October at 96.0%, below the 98% threshold.

Q2 was achieved at 98.8%

* 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 a significant deterioration, however based on the normal variation, the indicator should consistently achieve the standard.

Cancer - Subsequent treatment within 31 days (Surgery)

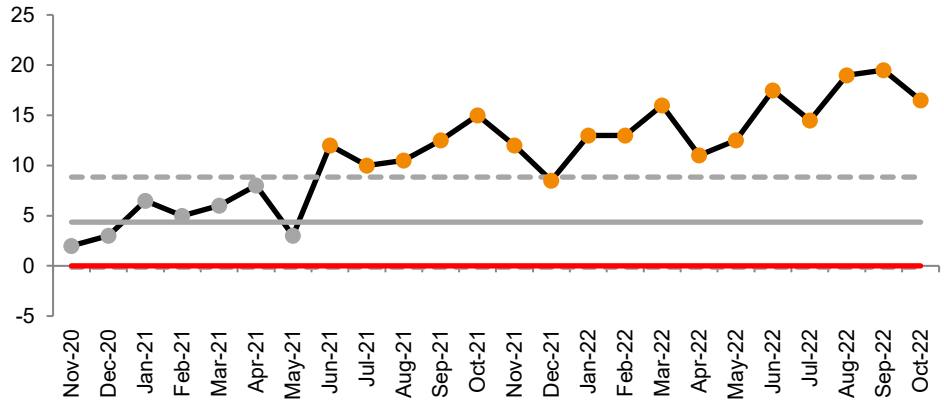


The subsequent treatment - surgery standard was not met in October at 93.3%, below the 94% standard.

Q2 was not achieved at 80.5%

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

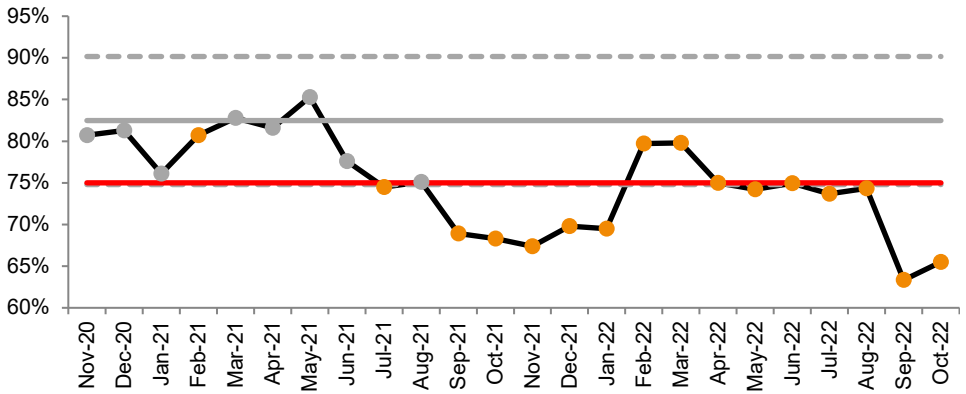


There were 16.5 breaches allocated to the Trust, treated after day 104 in October and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the consultants involved in the pathway as required.

The trend is showing a significant increase this month.

RESPONSIVE

Cancer 28 Day faster diagnosis



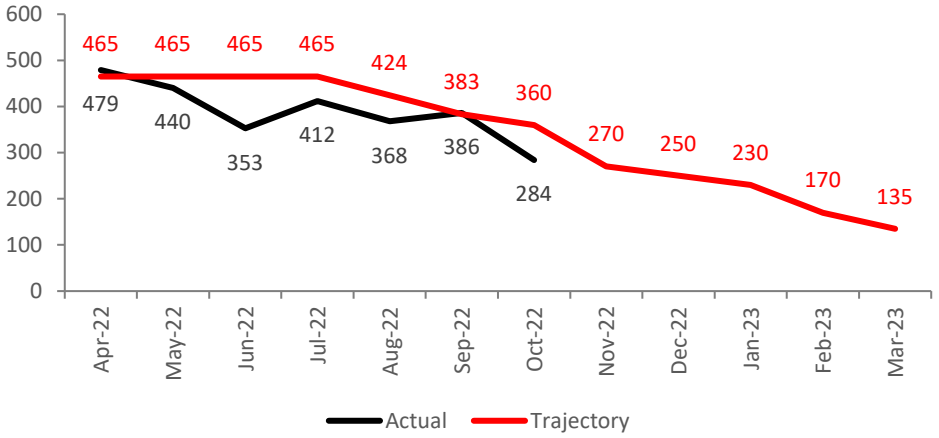
The 28 day faster diagnosis standard did not acheive the target in October at 65.5%

National position - 67.2%

Q2 was not achieved at 71.4%

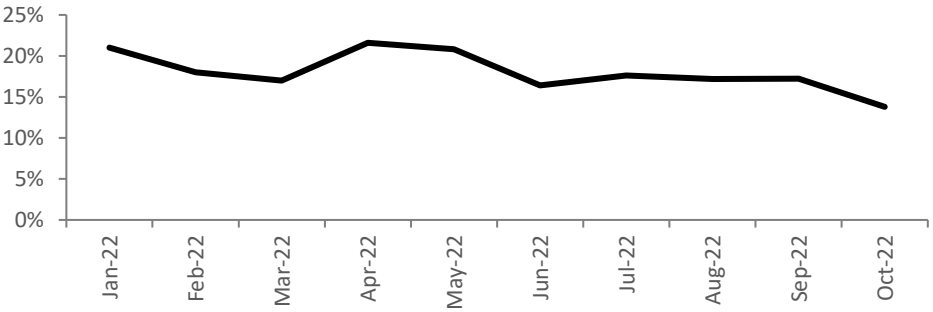
The trend is showing significant deterioration over the last 12 months.

Cancer >62 day vs trajectory



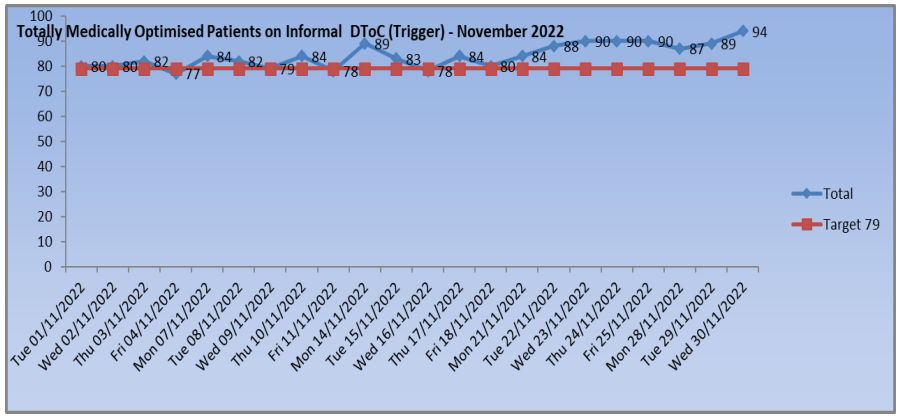
At the end of October the number of patients >62 days was 284 vs 360 trajectory. This was 13.79% of the total wait list.

Cancer % Waiting >62days (Urgent GP Referral)



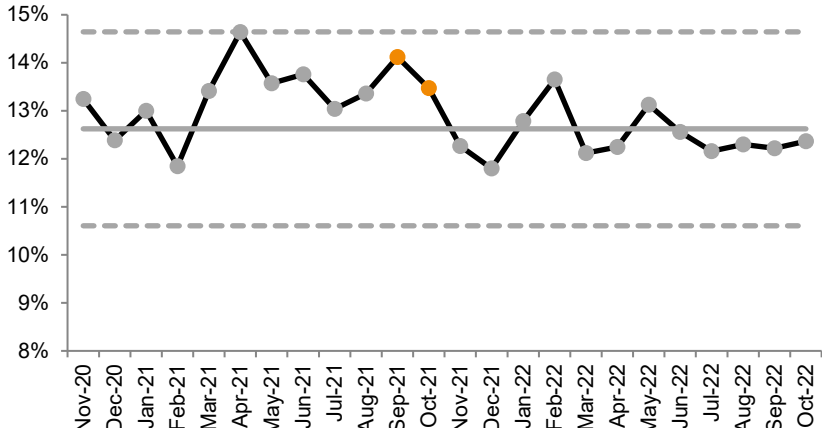
RESPONSIVE

Delayed Discharges



We continue to discharge patients using the rapid discharge principles set out in the Hospital discharge and community support: policy and operating model government guidance revised guidance of 01/07/2022, utilising pathways 0-3. Pathways are being used to ensure patients have a discharge plan identified from admission, with pathway 0 and 1 being our strongest and most rapid response.

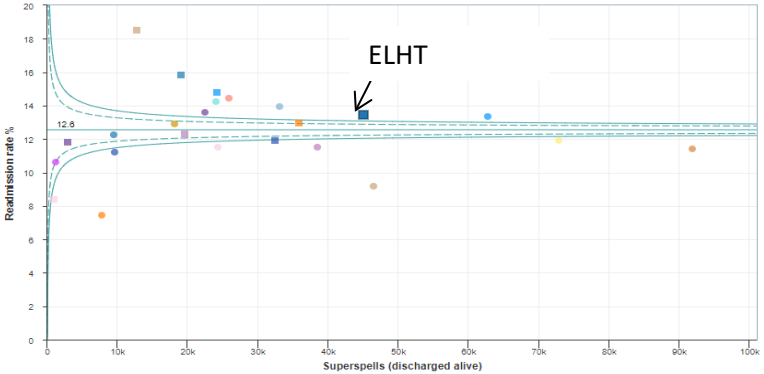
Emergency Readmissions



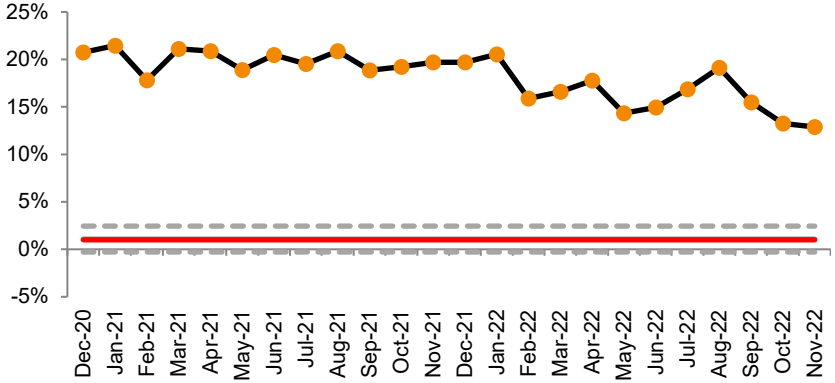
The emergency readmission rate trend is within the normal range.

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 November, 12.88% 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 27.5% in October (reported 1 month behind).

RESPONSIVE

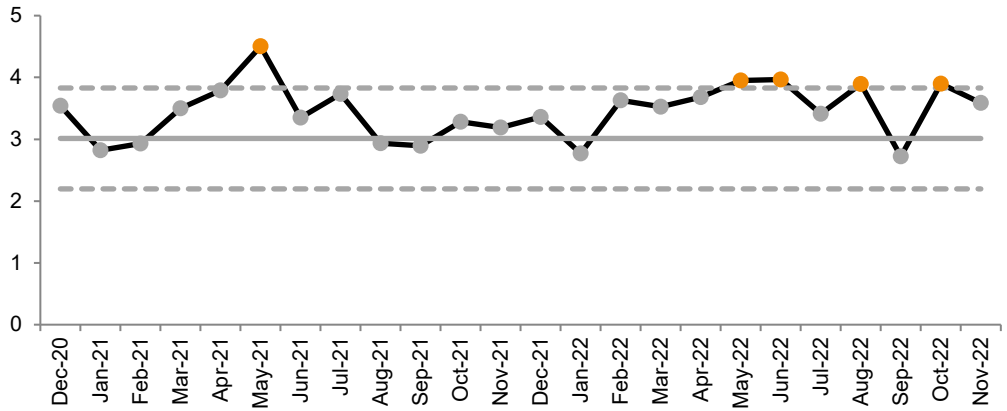
Average length of stay benchmarking

Dr Foster Benchmarking Oct 21 - Sep 22

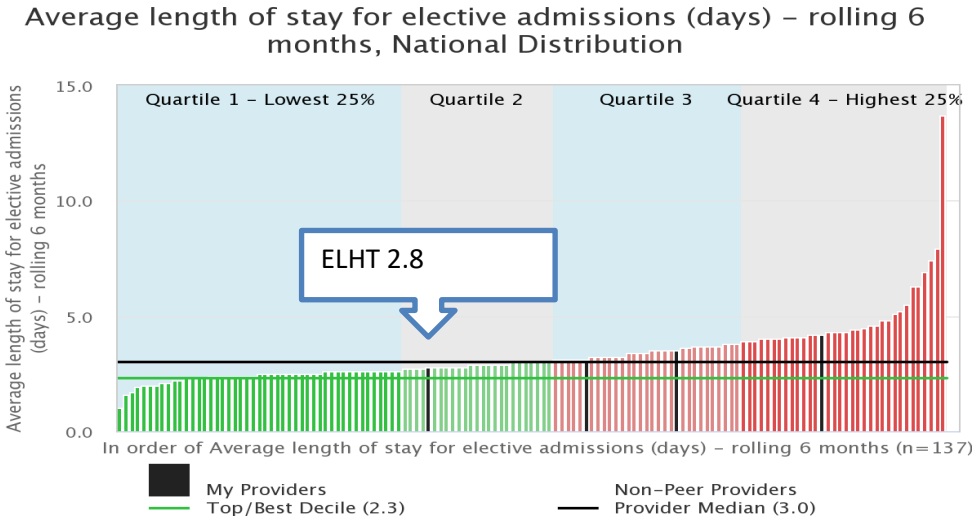
	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	60,648	10,211	50,437	3.4	2.5	-0.9
Emergency	62,684	62,684	0	4.0	4.4	0.3
Maternity/ Birth	13,258	13,258	0	2.3	2.2	-0.1
Transfer	211	211	0	8.2	23.1	14.9

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 - elective

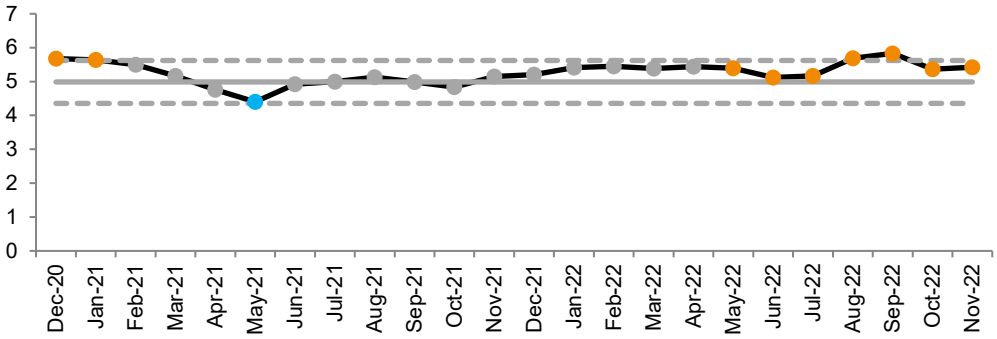


The Trust elective average length of stay is within normal range this month.

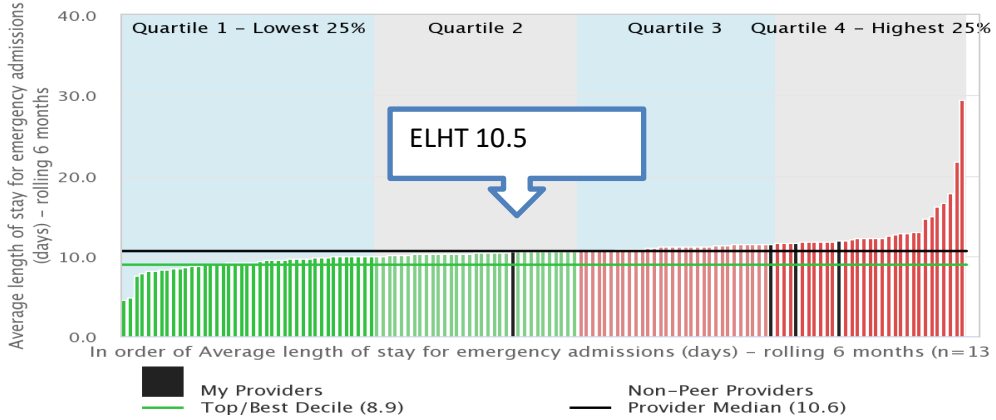


Data up to Sep 22 from the model health system shows ELHT in the second quartile for elective length of stay. Excludes day case.

Average length of stay - non elective



Average length of stay for emergency admissions (days) – rolling 6 months, National Distribution

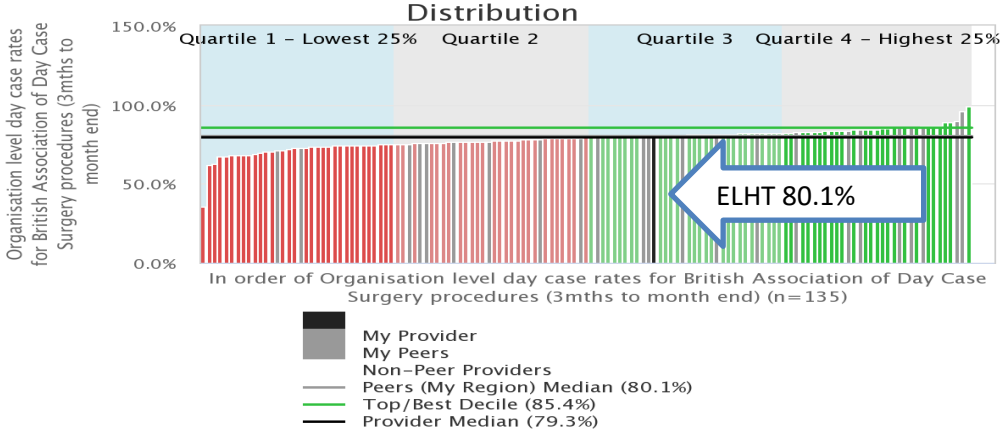


The Trust non-elective average length of stay is showing deteriorating performance this month.

Model health system data up to Sep 22 shows ELHT in the second quatile for non-elective length of stay. Data excludes length of stays of 0 or 1 day.

Daycase Rate

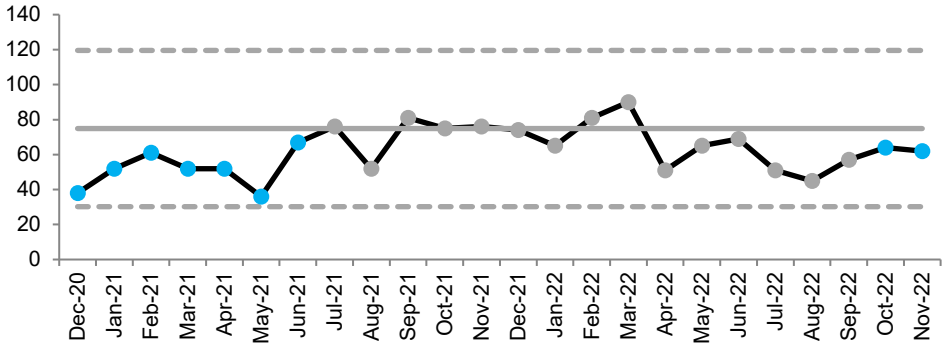
Organisation level day case rates for British Association of Day Case Surgery procedures (3mths to month end), National Distribution



Model health system data based on latest 3 months up to Aug 22, shows ELHT in the third quatile for daycase rates at 80.1%. Data is for adults only

RESPONSIVE

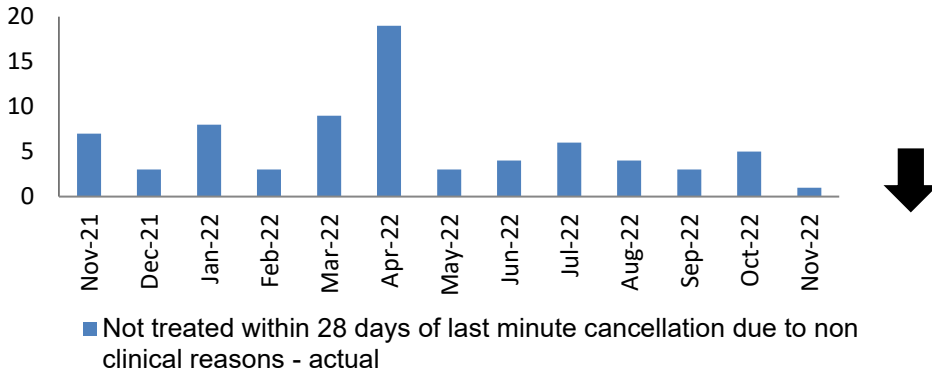
Operations cancelled on day



There were 62 operations cancelled on the day of operation - non clinical reasons, in November.

The trend is showing a reduction on previous levels.

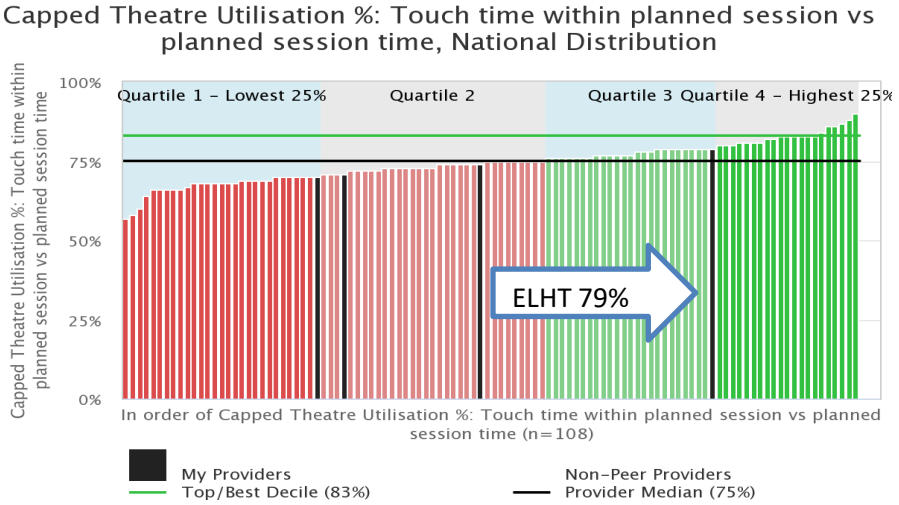
Operations cancelled on day - breaches of 28 day



There was 1 'on the day' cancelled operations not rebooked within 28 days in November.
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.

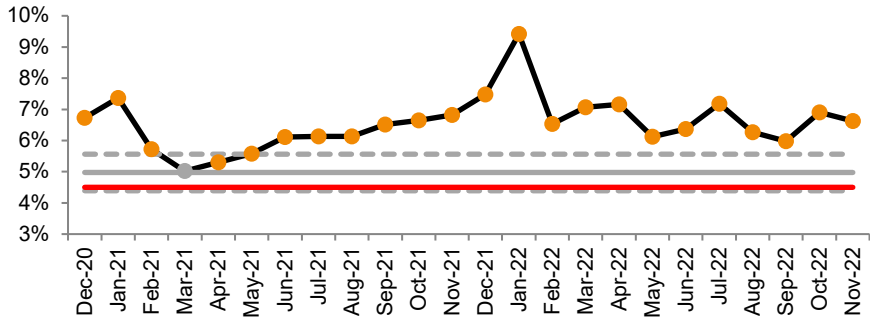
Theatre Utilisation



Data taken from 'The model hospital' shows capped theatre utilisation at 79% for the latest period to 20th November 22. This is in the third quartile nationally, with 4 being the highest and 1 the lowest.

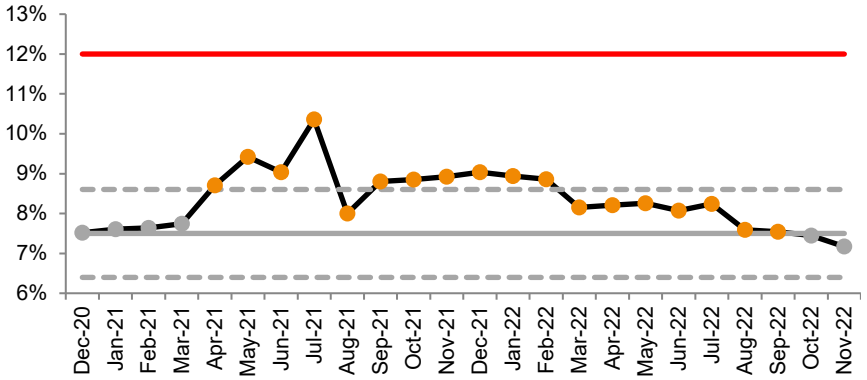
WELL LED

Sickness



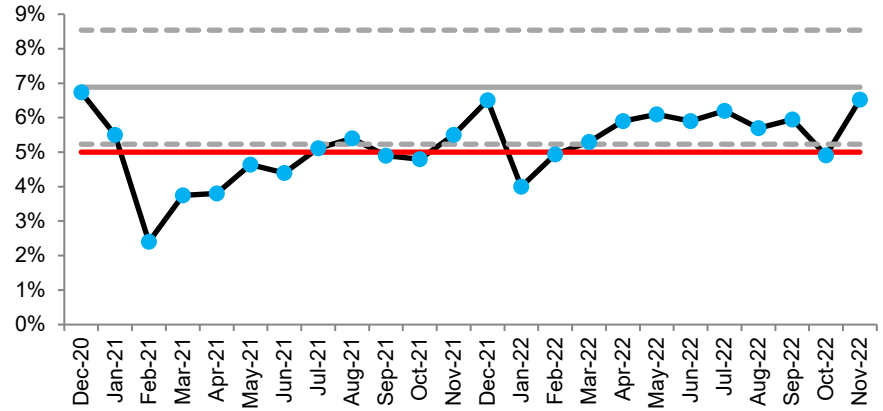
The sickness absence rate was 6.6% for November which is above the threshold of 4.5%. The trend is showing a significant increase and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate has returned to normal levels at 7.2% in November and remains below threshold. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



The vacancy rate is 6.5% for November 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.

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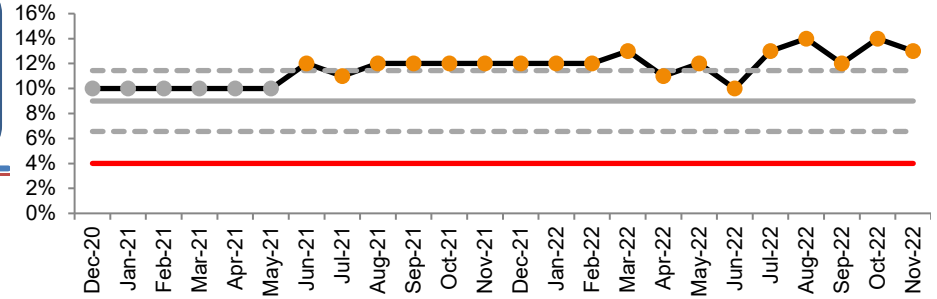
Temporary costs and overtime as % total pay bill

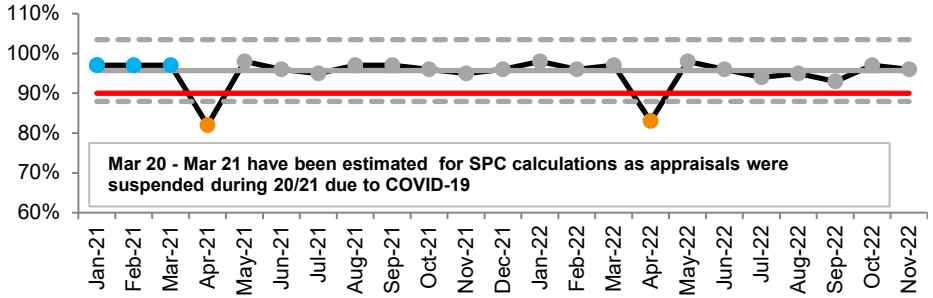


In November 2022, £5.4 million was spent on temporary staff, consisting of £2.0 million on agency staff and £3.4 million on bank staff.

WTE staff worked (9,744 WTE) was 62 WTE more than is funded substantively (9,682 WTE).

Pay costs are £1.2m more than budgeted establishment in November.

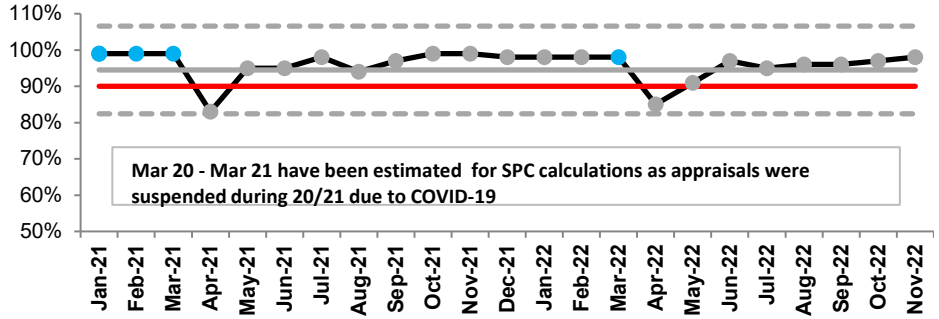
Appraisals, Consultant



At the end of November 22 there were 612 vacancies

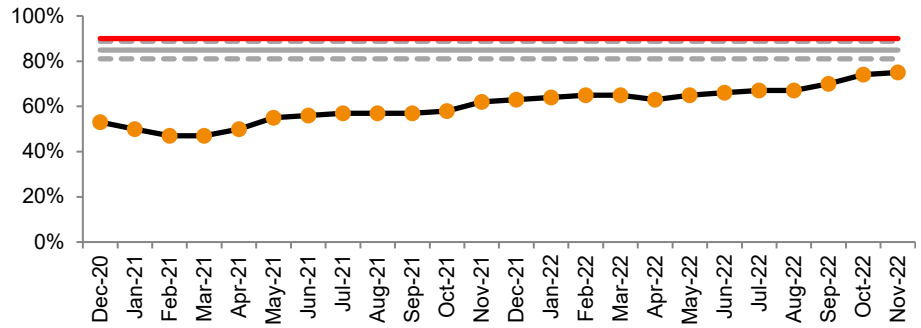
The temporary staffing cost trend shows a significant increase and is not capable of hitting the target.

Appraisals, Other Medical



The appraisal rates for consultants and career grade doctors are reported cumulative year to date to November 22 and reflect the number of reviews completed that were due in this period. They both continue to be above target.

Appraisals Agenda for Change (AFC) Staff



The AFC appraisal rate continues to be reported as a rolling 12 month figure and remains below threshold. Appraisals were suspended until March 21, due to COVID pressures.

The trend is significantly lower than previous levels and based on current variation the indicator is not capable of achieving the target

There has been a range of Trust wide actions to support compliance which are on-going. These actions are monitored through the Finance & Performance Committee.

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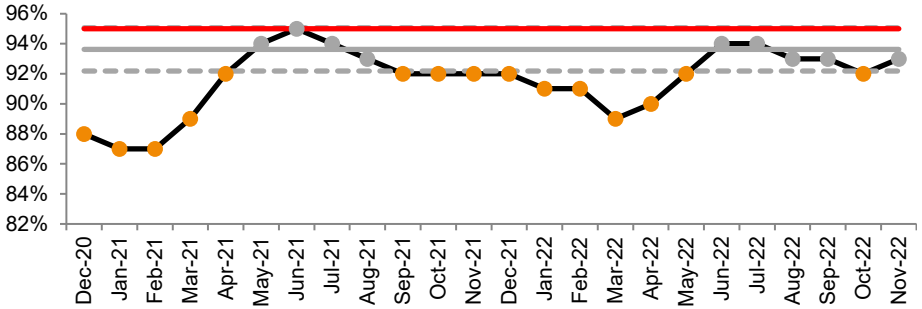
Job Plans

Stage	Consultant	SAS Doctor
Not Published	0	0
Draft	38	7
In discussion with 1st stage manager	137	25
Mediation	0	0
Appeal	0	0
1st stage sign off by consultant	28	1
1st stage sign off by manager	41	7
2nd stage sign off	21	2
3rd stage sign off	46	9
Signed off	46	33
Locked Down	1	0

As at November 2022, there were 358 Consultants and 84 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 92% in October which is below the 95% threshold. The trend is showing normal variation this month and is at risk of not meeting the target.

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%

Information Governance is currently below threshold at 93%

Core Skills Training % Compliance

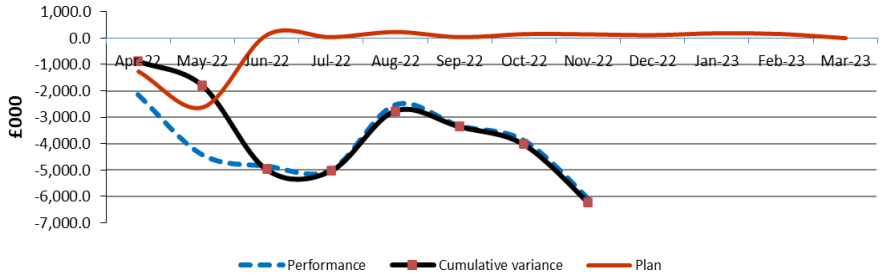
	Target	Compliance at end November
Basic Life Support	90%	91%
Conflict Resolution Training Level 1	90%	96%
Equality, Diversity and Human Rights	90%	95%
Fire Safety	95%	95%
Health, Safety and Welfare Level 1	90%	94%
Infection Prevention L1	90%	95%
Infection Prevention L2	90%	92%
Information Governance	95%	93%
Prevent Healthwrap	90%	95%
Safeguarding Adults L1	90%	93%
Safeguarding Children L1	90%	95%
Safer Handling Theory L1	90%	94%

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

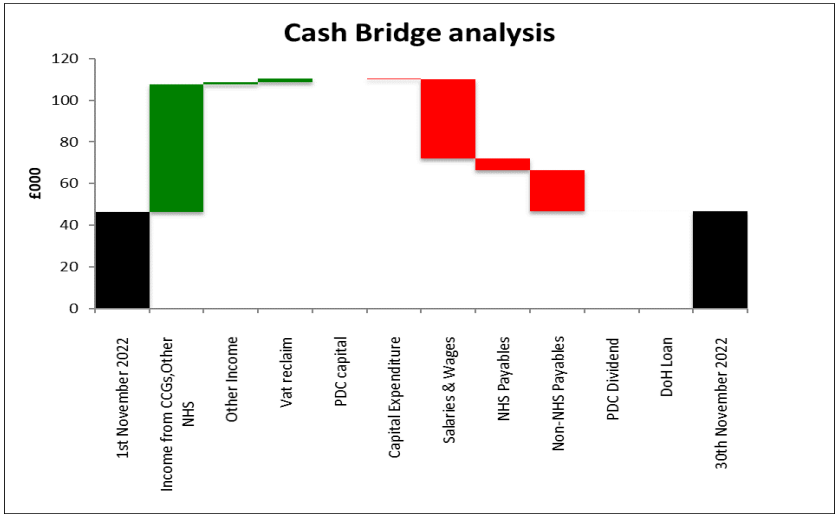
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



The Trust's financial performance is showing a £6.1 million deficit performance year to date against a breakeven financial plan.

Cash



The Trust's cash balance is £46.8 million as at 30th November 2022.

The Trust is reporting a year-to-date adjusted deficit of £6.1m in month 8, which is £6.2m behind plan and relates to the unmitigated element of the system planning gap held by the Trust.

The ICB have undertaken a review of potential schemes to mitigate the overall system planning gap of £178.7m. Consequently we have reduced our forecast outturn gap for 2022-23 by £10.8m, resulting in a £9.1m deficit. 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. A financial recovery plan is now in place to ultimately aim to meet a breakeven financial plan by the end of the financial year.

The cash balance on 30th November 2022 was £46.8m, £0.2m higher than the previous month. The main reasons for this increase are the £5.0m reduction in NHS receivables, which has been offset by the £2.2m in month deficit and a £2.2m reduction in deferred income.

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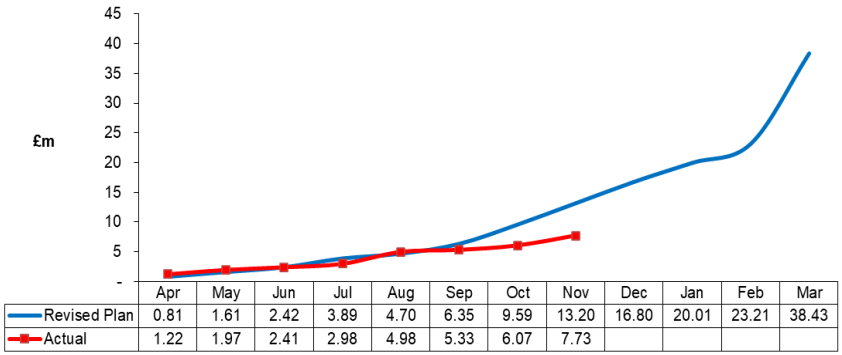
Capital expenditure

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	38.43
Actual	1.22	1.97	2.41	2.98	4.98	5.33	6.07	7.73				

The WRP target at month 8 was £19.2m. 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 £19.2m at month 8, in line with plan. It has been necessary to non-recurrently support this position by £12.6m.

The Trust is £5.5m behind its planned capital spend as at 30th November 2022.

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	631	0	903	577	957	**1,533**	1,129
Surgical & Anaes Services	3,108	138	0	1,131	2,115	**3,246**	3,677
Family Care	386	137	0	207	316	**523**	1,882
Primary Care	0	0	0	0	0	**0**	75
Diagnostic & Clinical Support	254	597	70	144	777	**921**	2,785
Estates & Facilities	1,009	46	577	556	1,076	**1,632**	1,564
Corporate Services	2,949	703	377	3,099	930	**4,029**	1,050
Education, Research & Innov'N	255	0	0	12	243	**255**	270
Further 2% Non Recurrent Savings	12,617	1,450	1,474	7,407	8,134	**15,541**	13,078
Total	21,323	4,077	3,400	14,180	14,620	**28,800**	28,800

Schemes to the value of £28.8 million have been identified, of which £21.3 million has been transacted to date.

Lancashire and South Cumbria Provider Collaborative

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

11 January 2023

Item 16

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

(16) Trust Charitable Funds Committee Information Report

Trust Charitable Funds Committee Update

At the meeting of the Trust Charitable Funds Committee held on 14 November 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 September 2022 stood at £349,000 and that total expenditure amounted to £259,000. The Charity's overall financial position was noted to be £1,900,000. Members noted that the Trust's investment portfolio had shown a loss since the previous meeting but were informed that its Fund Investment Managers had stated that they were confident that recent changes they had made would stand it in good stead over the coming months and years.
2. The Committee received an update on the fundraising activity that had taken place in quarter one of 2022-23. Members noted that every opportunity to raise funds was being taken and that ELHT&me had established a solid platform in East Lancashire with which to engage local businesses to encourage further donations.
3. An update on the recently opened Charity Hub and Retail Outlet was also provided to members. It was noted that a significant amount of work had gone into opening the outlet and that it had done so both on time and within budget. The Committee was informed that it had already brought in a substantial amount of custom and that it would feature heavily in the Charity's festive fundraising plans.
4. A discussion took place amongst members as to how to utilise charitable funding to properly recognise and thank staff for their efforts throughout the year. It was agreed that a small separate task group would be formed to discuss potential options and agree on the best way to proceed.
5. The draft audited accounts for the Charity were presented to members. Pending some minor amendments, members confirmed that they were content to recommend that the Trust Board, as a Trustee of the Charity, approve the accounts at the next meeting on the 11 January 2023.

Dan Byrne, Corporate Governance Officer, 29 December 2022.

TRUST BOARD REPORT

Item **16b**

11 January 2023

Purpose Action

Title	ELHT&me Annual Report and Accounts 2021-22
Executive sponsor	Mrs M Brown, Executive Director of Finance

Summary: The 2021-22 Annual Report and Accounts for ELHT&Me are presented for review and approval by the Trust Board, as Corporate Trustee, prior to submission to the Charity Commission.

Recommendation: The Charitable Funds Committee recommends the Trust Board to approve the 2021-22 Annual Report and Accounts for ELHT&Me for submission to the Charity Commission.

Report linkages

Related Trust Goal	Deliver safe, high-quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on assurance framework	None

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Annual Accounts – Audited

FOR THE YEAR ENDED

31st March 2022

Charity Registration Number 1050478

ELHT&Me

ELHT&Me Accounts 2021-22

STATUTORY BACKGROUND

ELHT&Me, for which East Lancashire Hospitals NHS Trust is the sole Corporate Trustee, is registered with the Charity Commission.

The Corporate Trustee has been appointed in accordance with the National Health Service Act 2006.

MAIN PURPOSE OF THE CHARITY

The main purpose of the Charity is to apply income for any charitable purpose relating to the National Health Service wholly or mainly for the services provided by East Lancashire Hospitals NHS Trust.

Statement of Trustee responsibilities

Under the trust deed of the charity and charity law in England and Wales, the Corporate Trustee is required to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year and of its financial position at the end of the year.

In preparing these financial statements, the Trustee is required to:

- Select suitable accounting policies and then apply them consistently;
- Make judgements and estimates that are reasonable and prudent;
- State whether the applicable accounting standards and statements of recommended practice have been followed, subject to any material departures disclosed and explained in the financial statements; and
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue its activities.

The Trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. The Trustee is responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at the time, and enable the Trustee to ensure that any statements of accounts comply with the requirements of regulations under the provision. The Corporate Trustee has general responsibility for taking steps as are reasonably open to it to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

These financial statements were approved by order of the Corporate Trustee on ..... and were signed on its behalf by:

……..	……..
Stephen Barnes Non-Executive Director Charitable Funds Committee Chair East Lancashire Hospitals NHS Trust	Michelle Brown Executive Director of Finance East Lancashire Hospitals NHS Trust

ELHT&Me Accounts 2021-22

Statement of Financial Activities

	Note	2021-22 Unrestricted funds £'000	2021-22 Restricted funds £'000	2021-22 Total £'000	2020-21 Total £'000
Income from:	3				
Donation and legacies		**619**	**173**	**792**	833
Other trading activities		**168**	**0**	**168**	116
Investments		**36**	**0**	**36**	48
Total		**823**	**173**	**996**	997
Expenditure on:	4				
Raising funds		**(9)**	**0**	**(9)**	(14)
Charitable activities		**(787)**	**(15)**	**(802)**	(1,526)
Total		**(796)**	**(15)**	**(811)**	(1,540)
Net gains / (losses) on investments		**55**	**52**	**107**	194
Net income / (expenditure)		**82**	**210**	**292**	(349)
Transfers between funds		**0**	**0**	**0**	0
Net movement in funds		**82**	**210**	**292**	(349)
Reconcilation of funds:					
Total funds brought forward		**1,633**	**32**	**1,665**	2,014
Total funds carried forward		**1,715**	**242**	**1,957**	1,665

ELHT&Me Accounts 2021-22

Balance Sheet

	Note	31 March 2022 £'000	31 March 2021 £'000
Fixed assets			
Investments	9	**1,785**	1,689
Current assets			
Debtors	7	**128**	25
Cash at bank and in hand		**224**	174
Total current assets		**352**	199
Liabilities			
Creditors: amounts falling due within one year	8	**(180)**	(223)
Net current assets		**172**	(24)
Total assets less current liabilities		**1,957**	1,665
Total net assets		**1,957**	1,665
The funds of the Charity:			
Restricted income funds		**242**	32
Unrestricted funds		**1,715**	1,633
Total Charity funds		**1,957**	1,665

The notes at pages 4 to 10 form part of these accounts.

Approved by order of the Corporate Trustee on …….. and signed on its behalf by:

Stephen Barnes
Non-Executive Director
Charitable Funds Committee Chair
East Lancashire Hospitals NHS Trust

……..

Michelle Brown
Executive Director of Finance
East Lancashire Hospitals NHS Trust

……..

Statement of Cashflows

	Note	2021-22 £'000	2020-21 £'000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities		**37**	(240)
Cash flows from investing activities			
Dividends and interests from investments	3	**36**	48
Purchase of investments		**(196)**	(842)
Proceeds from the sale of investments		**173**	1,136
Net cash inflow from investing activities		**13**	342
Net cash inflow before financing		**50**	102
Cash flows from financing activities		**0**	0
Net cash outflow from financing activities		**0**	0
Change in cash and cash equivalents in the reporting period		**50**	102
Cash and cash equivalents at beginning of the year		**174**	72
Cash and cash equivalents at end of the year		**224**	174

Reconciliation of net income/(expenditure) to net cash flow from operating activities

Net income/(expenditure) for the reporting period (as per the statement of financial activities)		**292**	(349)
Adjustments for:			
(Gains) on investments		**(73)**	(225)
Dividends and interest from investments	3	**(36)**	(48)
(Increase) / decrease in debtors	7	**(103)**	335
Increase / (decrease) in creditors	8	**(43)**	47
Net cash provided by (used in) operating activities		**37**	(240)

Notes to the Accounts

1 Basis of preparation

1.1 Basis of accounting

These accounts have been prepared on the basis of historic cost, with the exception of investments which are shown at market value, in accordance with:

- Accounting and Reporting by Charities: Statement of Recommended Practice (FRS 102);
- the UK Generally Accepted Accounting Practice and the Charities Act 2011; and
- the organisation's Charity Commission registration.

1.2 Going Concern

The Trustees have considered all information available to them and are of a view that there are sufficient reserves to secure the immediate future of the Charity for the next 12 to 18 months. On this basis, the charity continues as a going concern.

2 Accounting policies

2.1 Recognition of income

Income is recognised in the Statement of Financial Activities (SOFA) based on the following criteria:

a) entitlement - arises when a particular resource is receivable or the Charity's right become legally binding
b) probability - when receipt of the income is probable; and
c) measurement - when the monetary value can be measured with sufficient reliability.

2.2 Income with related expenditure

Where income has related expenditure (as with fundraising or contract income) the income and the related expenditure are reported gross in the SOFA.

2.3 Grants and donations

Grants and donations are only included in the SOFA when the charity has unconditional entitlement to the resources.

2.4 Tax reclaims on donations and gifts

Incoming resources from tax reclaims are included in the SOFA at the same time as the gift to which they relate.

2.5 Contractual income and performance related grants

These are only included in the SOFA once the related goods or services have been delivered.

2.6 Gifts in kind

Gifts in kind are accounted for at a reasonable estimate of their value to the charity or the amount actually realised. Gifts in kind for sale or distribution are included in the accounts as gifts only when sold or distributed by the charity. Gifts in kind for use by the charity are included in the SOFA as incoming resources when receivable.

2.7 Legacies

Legacies are accounted for as incoming resources when a part or final distribution is received from the executors of the estates(s), or when the factors specfied in 2.1(a) above can be met. Where the exact monetary value is not known, an assessment will be made based on known facts and potential liabilities and disbursement due from the estate, to provide a reasonable estimation of the amount due to the Charity.

2.8 Donated services and facilities

These are only included in incoming resources (with an equivalent amount in resources expended) where the benefit to the charity is reasonably quantifiable, measurable and material. The value placed on these resources is the estimated value to the charity of the service or facility received.

2.9 Volunteer help

The value of any voluntary help received is not included in the accounts but is described in the annual report.

2.10 Investment income

This is included in the accounts when received. Investment Income is allocated to funds on a basis of the average fund balances over the year.

Notes to the Accounts

Accounting policies cont.

2.11 Liability recognition
The funds held on trust accounts are prepared in accordance with the accruals concept. Liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to pay out resources.

2.12 Governance costs
Governance costs comprise costs incurred in the governance of the charity. These costs relate to the independent examination.

2.13 Grants with performance conditions
Where the charity awards a grant with conditions for its payment being a specific level of service or output to be provided, such grants are only recognised in the SOFA once the recipient of the grant has provided the specified service or output.

2.14 Grants payable without performance conditions
These are only recognised in the accounts when a commitment has been made and there are no conditions to be met relating to the grant which remain in the control of the Charity.

2.15 Support costs
Support costs include central functions and have been allocated to funds on a basis of the average fund balances over the year.

2.16 Fixed assets for use by charity
The Trust has no tangible or intangible assets.

2.17 Realised gains and losses
All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sale proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between opening market value and closing market value for the year. Gains and losses are allocated to funds based on the average fund balance for the year.

2.18 Investments
Investments quoted on a recognised stock exchange are valued at market value at the year end.

2.19 Stocks and work in progress
These are valued at the lower of cost or market value.

2.20 Structure of funds
Where there is a legal restriction on the purpose to which a fund may be used, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds.

2.21 Trustee indemnity insurance
There is no Trustee indemnity insurance.

2.22 Loans or guarantees secured against assets of the Charity
There are no loans or guarantees against assets of the Charity.

2.23 Related party transactions
East Lancashire Hospitals NHS Trust is considered a related party of the Charity since the Trust Board is the Corporate Trustee of the Charity. During the year none of the members of the Trust Board or parties related to them, undertook any material transactions with the Charity.

2.24 Leases
A lease is classified as a finance lease if it transfers substantially all the risks and rewards incidental to ownership. All other leases are classified as operating leases. All Charity leases are operating leases, payments for which are recognised as expenditure on a straight-line basis over the lease term.

2.25 Critical accounting judgments and key sources of estmation uncertainty
The Trustees have not made any significant judgements in the process of applying the accounting policies and there are no areas of estimation uncertainty that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities

Notes to the Accounts

3 Analysis of Income

	2021-22 Unrestricted Funds £'000	2021-22 Restricted Funds £'000	2021-22 Total £'000	2020-21 Total £'000
Income from donation and legacies				
* Donations	**408**	**173**	**581**	607
Legacies	**0**	**0**	**0**	28
Grants	**211**	**0**	**211**	198
	619	**173**	**792**	833
Income from other trading activities				
Income from training activities	**103**	**0**	**103**	45
Other income	**65**	**0**	**65**	71
	168	**0**	**168**	116
Income from investments				
Investments listed on the London Stock Exchange	**36**	**0**	**36**	48
Interest on cash / bank	**0**	**0**	**0**	0
	36	**0**	**36**	48

* Donations for 2021-22 include £13,000 of notional income for gifts in kind received (2020-21: £244,000). The corresponding notional expenditure entry is shown in note 4 to these accounts.

4 Analysis of Expenditure

	2021-22 Activities Undertaken Directly £'000	2021-22 Support Costs £'000	2021-22 Total £'000	2020-21 Total £'000
Expenditure on raising funds				
Investment management and admin fees	**9**	**0**	**9**	14
	9	**0**	**9**	14
Expenditure on charitable activities				
Fund raising expenses	**35**	**10**	**45**	35
Gifts in kind	**13**	**4**	**17**	273
Staff welfare / training / amenities	**70**	**20**	**90**	68
Retirement gifts and long service awards	**53**	**15**	**68**	36
Building and engineering	**4**	**1**	**5**	0
Furniture and equipment	**13**	**4**	**17**	50
Printing and stationary	**11**	**3**	**14**	0
Computer / office equipment	**7**	**2**	**9**	8
Training	**45**	**13**	**58**	58
Medical and surgical equipment	**304**	**86**	**390**	846
Other expenditure	**69**	**20**	**89**	152
	624	**178**	**802**	1,526

Notes to the Accounts

5 Details of certain items of expenditure

5.1 Support Costs

	2021-22 £'000	2020-21 £'000
Finance and administration costs	**174**	156
Banking charges	**1**	2
Fees for examination or audit of the accounts	**3**	3
	178	161

5.2 Trustee expenses and remuneration

None of the members of the Trust Board were paid expenses or received remuneration during the year ended 31 March 2022 (2020-21: £nil) when acting on behalf of the of the Trust Board as a Corporate Trustee of the Charity.

5.3 Staff costs

The Charity did not employ any staff or incur any staff costs during the year ended 31 March 2022 (2020-21: £nil). The costs asscociated with the administration of the charitable funds have been disclosed under support costs in accordance with the stated accounting policy of the Charity.

6 Operating leases

	2021-22 £'000	2020-21 £'000
Operating lease expense		
- Minimum lease payments	**178**	238
Future minimum lease payments due:		
- not later than one year	**0**	238
- later than one year and not later than five years	**0**	951
- later than five years	**0**	159
	0	1,348

The minimum lease payments relate to two surgical robots which were funded until the 30 November 2021 by the Charity.

7 Debtors - falling due within one year

	31 March 2022 £'000	31 March 2021 £'000
Trade debtors	**107**	12
Prepayments and accrued income	**21**	13
	128	25

Notes to the Accounts

8 Creditors - falling due within one year

	31 March 2022 £'000	31 March 2021 £'000
Trade creditors	**(3)**	(2)
Amounts due to East Lancashire Hospitals NHS Trust	**(108)**	(41)
Accruals and deferred income	**(69)**	(180)
	(180)	(223)

9 Investment assets

9.1 Fixed assets investments

	2021-22 £'000	2020-21 £'000
Market value at 1 April	**1,689**	1,758
Add: additions to investments at cost	**196**	842
Less: disposals at carrying value	**(173)**	(1,136)
Add: net gain / (loss) on revaluation	**60**	173
Investment cash	**13**	52
Market value at 31 March	**1,785**	1,689

9.2 Analysis of investments

	2021-22 £'000	2020-21 £'000
Investments listed on a recognised stock exchange or held in common	**1,692**	1,609
Other investments	**93**	80
Market value at 31 March	**1,785**	1,689

9.3 Material investment holdings

Material investment holdings are holdings with a market value of more that 4% of the total market value of investments as at 31 March 2022, which is approximately £71,000 (31 March 2021: £68,000).

	2021-22		2020-21	
Investment	**Holding**	**Market Value £'000**	Holding	Market Value £'000
Ishares II Plc	**9,772**	**126**	9,772	134
BNY Mellon FD MNGR GBL Dynamic	**75,316**	**71**	62,096	61
Twentyfour AM Corporate Bond	**917**	**88**	798	83
Robeco	**852**	**86**	815	87
Ishares Physical	**3,657**	**105**	4,353	105
Fidelity	**10,697**	**74**	10,697	62
BNY Mellon FD MNGR North American	**51,091**	**77**	51,091	62
Schroder	**93,361**	**97**	44,453	38
FIL INV SVCS	**83,754**	**79**	49,907	51
Ishares II USD	**15,947**	**88**	15,010	80
Muzinich Funds GBL Tactical Credt HGD	**707**	**70**	583	61

Notes to the Accounts

10 Related party transactions

East Lancashire Hospitals NHS Trust is considered a related party of the Charity since the Trust Board is the Corporate Trustee of the Charity. However, responsibility for the monitoring and approval of activities relating to charitable fund raising and the uses to which charitable funds are applied has been delegated by the Trust Board to the Charitable Funds Committee.

The transactions with the Trust relate to support costs, as disclosed in note 5 to these accounts with details of debtors and creditors given in notes 7 and 8 respectively. During the year, none of the members of the Charitable Funds Committee or parties related to them, undertook any material transactions with the Charity.

11 Endowment, restricted income funds & major fund movements

11.1 Restricted Funds held

Fund Name	* Site	Fund Purpose
Clinical Education Fund	ELH	For use by the Directorate of Education, Research and Innovation (DERI).
R Jackson Fellowship Fund	ELH	For the education of non-medical professionals and their students in ELHT and other health care employers in East Lancashire.
Elsie Metcalfe Cancer Fund	RBTH	For the treatment of cancer patients at RBH.
Thomas Egan Physiotherapy Fund	RBTH	Legacy for the general use of physiotherapy at RBH.
Godfrey Morris Pathology Fund	RBTH	For the benefit of Pathology Service BRI.
Harold Wardley Pathology Fund	RBTH	For the benefit of Pathology Service BRI.
Chemo Unit - Rosemere Fund	RBTH	For the Chemotherapy unit.
Childrens Ward Bgh M Airey Leg Fund	RBTH	General use heart and lung unit at RBH.
H Eastwood Childrens Resp Fund	ELH	Specifically for children with breathing difficulties.
PCH General Purpose Fund	PCH	General purpose of PCH.

** RBTH Royal Blackburn Hospital*
ELH East Lancashire Hospitals NHS Trust
PCH Pendle Community Hospital

11.2 Transfer between funds

The administration support costs for 2021-22 of £89,000, (2020-21: £127,000) have been apportioned to the individual funds in accordance with Note 2.15 .

Notes to the Accounts

11.3 Movements of major funds

Major funds are funds with a balance of £25,000 or more.

Fund	1 April 2021 £'000	Income £'000	Expenditure £'000	Transfers £'000	Gains & losses £'000	31 March 2022 £'000
Pharmaceutical Directorate	56	2	(6)	0	2	**54**
Pharmacy Endowment	23	15	(6)	0	1	**33**
Staff Gym	59	1	(29)	0	1	**32**
Trust General	376	235	(174)	(159)	16	**294**
Nhs Charities Together	0	212	(42)	155	5	**330**
Alan Shorrock Legacy	146	2	(13)	0	4	**139**
Diabetes	42	1	(8)	0	1	**36**
Dcs General Purpose	36	1	(3)	0	1	**35**
Clinical Education	0	141	(6)	0	2	**137**
Ef - R Jackson Fellowship	0	30	(3)	0	48	**75**
ELHT Cardiac Training	33	2	(5)	0	1	**31**
Life Support Training Rbh	24	96	(33)	0	2	**89**
Dr Newsomes Leukemia	60	1	(7)	0	2	**56**
ELHT Robotic Surgery	159	7	(167)	1	0	**0**
Rbh Larascopic	0	69	(15)	0	1	**55**
Community Neurodevelopmental	5	0	0	33	1	**39**
Maternity General Purpose	60	12	(63)	0	1	**10**
General NICU	88	14	(47)	0	2	**57**
Fetal Medicine	26	8	(5)	0	1	**30**
ELHT Lottery Distribution	73	67	(49)	0	2	**93**
Victoria Nurses Assistance	41	1	(7)	0	1	**36**
CCH General Purposes	54	1	(37)	0	1	**19**
Maternity General Purpose	60	12	(63)	0	1	**10**
Other funds	244	66	(23)	(30)	10	**267**
Total	**1,665**	**996**	**(811)**	**0**	**107**	**1,957**

ELHT&me
your local NHS hospital charity

Trust Charitable Funds

Annual Report 2021–22

Contents

Chairman's Report

As Chairman of the East Lancashire Hospitals NHS Trust, the sole corporate trustee of the Trust's charity, ELHT&Me, I am pleased to present the Charity's Annual Report for the period 01 April 2021 to 31 March 2022.

The charity is dedicated to advancing and enhancing care at East Lancashire Hospitals NHS Trust. We have continued to support our hospital teams' response to the ongoing COVID-19 pandemic, while simultaneously pressing forward with key developments to further support the provision of safe, personal and effective care. Our dedicated colleagues, who wholeheartedly embody our vision, values, behaviours and goals, have made this possible.

While 2021–22 began with a phased easing of lockdown measures, it was not long before the emergence of the Omicron variant tightened them again. Even though all government-mandated COVID-19 restrictions had been lifted before the end of the year, our hospitals had no time to draw breath. Facing increasing pressure to manage the backlog of cases delayed by the pandemic, we knew it was vital to use our resources to support colleagues, including funding a variety of roles, spaces and services dedicated to improving the wellbeing of our colleagues.

We are very grateful to our supporters – you have been exceptional this year, supporting the charity and its work at the most critical time, with donations, legacies, volunteering or in other ways to show how much you care. As a result, we have continued to fund all the commitments made, and completed the year well placed to continue our work transforming the lives of local community from conception to end of life.

I would like to pay a special tribute to the Charity Team in these trying times of Covid. They have applied themselves with commitment and determination to confront the challenging circumstances they have found themselves in and are to be congratulated. As a Board, we can be confident that our charity will continue to flourish and to serve the community regardless of what difficulties we encounter.

I look forward to seeing the positive impact of the charity's support, made possible by the hard work and generosity of our volunteers and donors, for colleagues and patients at East Lancashire hospitals over the coming year.

As many colleagues will know, I am leaving the Trust to take up another role at the Northern Care Alliance. I am quite sure that the impact of your work will continue, and I wish you all the best'.

Professor Eileen Fairhurst
Chairman

Foreword from the Non-Executive Director and Charity Committee Chairman

This reporting year has been an extraordinary year for everyone living in the UK. The pandemic touched ever element of life for our colleagues, patients and our local communities. East Lancashire Hospitals NHS Trust has been, and continues to be, at the front line, working with partner organisations and residents, finding ways to succeed and always putting patients and their families first. East Lancashire Hospitals NHS Trust's colleagues and volunteers worked tirelessly, and we are incredibly proud of their contribution both in our hospitals and out in the communities, to ensure that we continue to provide safe, personal and effective care, despite all the challenges.

Objectives and Activities

ELHT&Me was launched in 2016 and the object of the Charity is 'for any charitable purpose or purposes relating to the general or any specific purposes of the East Lancashire Hospitals NHS Trust or the purposes of the National Health Service'.

As a public benefit entity, the main charitable activities of the Charity are to fund

- Improvements to the services provided to patients, primarily through the purchase of equipment that would be outside the NHS funding, as well as improvements to the patient environment and experience.
- Training for Trust staff and to help to develop and improve staff amenities.

The trustees have considered the Charity Commission's guidance on public benefit when reviewing the Charity's aims and objectives and in planning future activities and setting the grant making policy for the year.

To achieve our aims and objectives ELHT&Me will actively seek and apply for grants, become front facing through the charity hub creation at Royal Blackburn Teaching Hospital and increase corporate relations. The charity will also design and deliver large scale events whilst establishing legacies to generate income.

Our Purpose

Our hospitals are here for everyone, saving the lives of the people you love. Our hospitals are at the heart of all our work.

ELHT&Me's purpose is to support East Lancashire Hospitals NHS Trust to enhance the experience of patients, families, colleagues and the wider community served through our five hospitals and community services, beyond that achieved by routine NHS funding. ELHT&Me supports the strategic priorities of East Lancashire Hospitals NHS Trust in providing the best possible healthcare for its combined population of approximately 530,000. From the smaller things, like providing music on wards, to larger projects, such as funding state-of-the-art medical equipment, ELHT&Me is here to make a positive difference.

Achievements and Performance

ELHT&Me is the official charity for the five hospitals that make up East Lancashire Hospitals NHS Trust – Royal Blackburn and Burnley General Teaching Hospitals and community hospitals Clitheroe, Pendle and Accrington Victoria.

ELHT&Me is immensely proud to have been able to play a pivotal role in supporting NHS, patients and wider communities throughout the year 2021–2022; this could not have been achieved without the brilliant support from all of the donors, fundraisers and partners and supporters of our charity. This has enabled us to support a wide range of important projects throughout the year.

The COVID-19 pandemic shone a spotlight on the NHS in a way never seen before. As stories of the bravery and commitment of NHS colleagues were shared across mainstream and social media, our role as a local NHS charity came to the fore. While the public praised our healthcare professionals as heroes we were there, providing support for them, every step of the way. Focusing on improving people's wellbeing demonstrations our passion to enhance the existing provision of facilities, research and treatments for patients in hospital. Whether young or old, as outpatients or staying on wards, patients and their families are at the heart of our care. Importantly, as an NHS charity we are also in a truly unique position to be able to work directly with frontline NHS teams. This means we can provide the right support at the right time and in the right way to help and support them to continue the vital work they do.

The Charity helps transform our hospitals, funding the very latest medical equipment, innovative research and specialist training for clinical colleagues. Fundraising, donations and gifts in wills also help to improve the hospital environment for patients and our colleagues who care for them, making wards, waiting rooms, colleague areas and hospital spaces more welcoming and comfortable. The charity also supports the wellbeing of hospital colleagues – providing rest areas, drinks facilities and other simple enhancements. ELHT&Me works across the whole organisation, with every ward, service and department able to benefit from the positive impact of charitable support. This is all thanks to thoughtful and generous groups and individuals who donate to make a difference in their local community.

Equipment

Helping provide the best possible care for patients is at the heart of what we do. While the NHS provides essential equipment and facilities, we are here to provide the added extras that truly enhance the experience of patients at our hospitals.

RITA, which stands for Reminiscence Interactive Therapy Activities, is an innovative, evidence-based, state-of-the-art digital therapy system which allows patients to use apps, games and other leisure activities as part of their hospital recovery. Used primarily for our elderly patients with cognitive impairments, such as dementia, the user-friendly technology is proving extremely popular across East Lancashire Hospitals Trust and has shown to be effective in calming distressed or anxious patients.

The early pregnancy unit supports women experiencing complications of early pregnancy therefore the use of ultrasound scanning is absolutely essential for the service to reassure patients that their pregnancy is developing as it should be, but also diagnoses complications that need urgent medical attention. Without the amazing new ultrasound machines the unit wouldn't be able to provide safe personal effective care to our patients.

These are just examples of how the charity can greatly enhance areas of the hospital by funding additional items over and above core NHS funding and/or equipment with a higher specification and increased functionality. The charity has also funded specialist beds, chairs, shower chairs, birthing beds which, while they seem small enhancements, all have the potential to vastly improve the treatment and care of our patients.

Hera W9 ultrasound unit with probes

Health and Wellbeing

Given the extraordinary pressures on the NHS and the significant impact of the pandemic on colleagues, ELHT&Me supported colleagues across all sites in a number of new and creative ways. Initiatives include the refurbishment of quiet room spaces, colleagues' meals and entertainment at Christmas, recognition for nurses and midwives as part of International Nurses and Midwives Day, celebrations of thanks to our emergency departments and long service awards ceremonies as a thank you for their commitment and dedication.

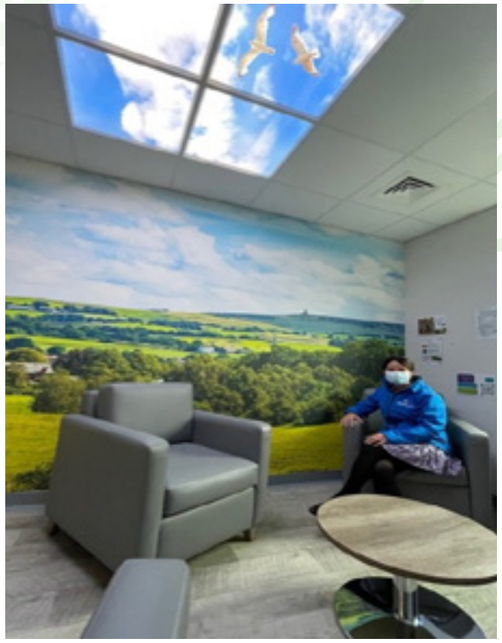
In January 2021, the Duke and Duchess of Cambridge were welcomed at Clitheroe Community Hospital, as they came to speak with colleagues about their incredible contributions caring for patients throughout the COVID-19 pandemic.

In their role as Royal Patrons for independent charity, NHS Charities Together, they heard how ELHT&Me helped to support exhausted colleagues at the Trust, including funding a new therapy puppy, Alfie, who was introduced during their visit.

Environment

In 2021–22 we have supported some fantastic projects that enhance the patient and family environment. Projects include the refurbishment of dedicated family rooms and wards, the installation of bespoke dignity screens, wall art and ambient lighting systems. Charity funding has ensured patients have access to devices such as DAB radios, televisions and iPads. Over the past year, these devices have been even more important given the visitor restrictions and the sense of isolation felt by patients.

Our aim is to make hospital stays more comfortable and less daunting for patients – young and old alike – by improving facilities and equipment at East Lancashire Hospitals.



Our Amazing Supporters

The last two years have seen many in our community and beyond come together to show their support of the NHS by raising funds for ELHT&Me. The fundraising team has been truly privileged to hear from individuals, groups and businesses who want to show their appreciation of NHS colleagues during its toughest of years.

Plans for Future Periods

To further deliver our strategy we will increase our level of fundraising to achieve our target that has not been exceeded previously. We will become front facing via Hub creation at Royal Blackburn Teaching Hospital, develop new fundraising events and activities and build on corporate relations with legacy gifting a focus.

Financial Review

Annual review of income and expenditure

The principal source of funding for the charity is income from donation and legacies, including grant funding, which are used to fund improvements to the services provided to patients, patient environment and experience, as well as to fund training for Trust staff and to help to develop and improve staff amenities, in line with the Charity's purpose.

Through its membership of NHS Charities Together, the Charity was successful in its applications for grant funding totalling £209,000 for the health and wellbeing of staff.

£171,000 was also received from the Mackenzie Medical Centre charity to establish two funds for clinical educational purposes.

Analysis of income	2021–22 £000	2020–21 £000
Income from donations and legacies		
Donations	581	607
Legacies	0	28
Grants	211	198
	792	833
Income from donations and legacies		
Income from training activities	103	45
Other income	65	71
	168	116
Income from investments		
Investments listed on the London Stock Exchange	36	48
Interest on cash/bank	0	0
	36	48
Total	**996**	**997**

Total expenditure for 2021–22 of £811,000 compares to £1,540,000 in the previous financial year. At £391,000 expenditure on medical and surgical equipment representing the largest use of charitable funds, including £178,000 relating to lease payments on two robotic surgical systems used by the Trust.

The Charity entered into a seven-year contract for these two systems in December 2019, which represented the principal risk faced by the Charity. However, with the Trust having secured funding for the remaining contract term, the contract has been novated to the Trust with effective from 1 December 2021 and so no longer represents a risk to the Charity.

Analysis of expenditure	2021–22 £000	2020–21 £000
Expenditure on raising funds		
Investment management and administration fees	9	14
	9	14
Expenditure on charitable activities		
Gifts in kind	17	273
Staff welfare/training/amenities	90	68
Retirement gifts and long-service awards	68	36
Furniture and equipment	17	50
Training	58	58
Medical and surgical equipment	391	846
Other expenditure	161	231
	802	1,526
Total	**811**	**1,540**

When net gains on investments of £107,000 are taken into account, fund balances have increased by £292,000 in 2021–22 to £1,957,000, £1,715,000 of which is unrestricted with £242,000 held in designated funds.

The market value of the Charity's investment portfolio as at 31 March 2022 was £1,785,000, £1,692,000 of which is managed by Charity Investment Managers. The performance of these funds was 6.1% above FTSE 100 and British Government Securities (BGS) Benchmark and the £31,000 of related investment income equates to a gross yield of 1.91%.

The Charitable Funds Committee aims to turn over the majority of charitable funds, excluding specific long-term legacies, once every three years.

Investment Strategy and Policy

The aim of the investment strategy is to 'invest funds so as to provide as high a current income as possible, consistent with the objective of at least preserving the income generating value of capital over the long term'. The balance of investments after taking into account the reserved funds are managed in an investment portfolio designed to provide a return in the medium to longer term. The Charitable Funds Committee is assisted in this aspect by the professional advice of independent Investment Managers.

The Trustees believe that companies which act in a socially responsible way are more likely to flourish and to deliver the best long-term balance between risk and return. In developing the ethical investment principles, the Charitable Fund Committee has considered the aims and objectives of the charity, the NHS Constitution, the NHS' purposes and fundamental principles and the Trust's responsibilities as a good corporate citizen.

The Trustees believe that the following principles are consistent with these considerations and where exclusions are applied it is on the basis of inconsistency with one or more of the responsibilities or guidance outlined below:

Investment will not be permitted in companies or organisations manufacturing, promoting and/or distributing alcohol and tobacco products, arms and armaments.

Investment will also not be permitted in companies or organisations which may bring criticism to the Trust in its health promotion and educational roles or where Charitable Fund Committee members have reason to believe the human rights of those employed are not respected and upheld.

The Trust will seek to make socially responsible investments in companies or organisations having a regard to their environmental management, policies and reporting practices, as well as investments in locally based companies where they are considered to be an acceptable financial risk and fall within the overarching principles detailed above.

The Trust is an apolitical organisation and will seek to avoid investment in politically motivated organisations and companies

Risk Management

Since the Charity's key systems are designed and implemented by East Lancashire Hospitals NHS Trust, the Charity therefore benefits from the Trust's robust internal control and risk management framework.

Where significant risks and uncertainties are identified for the Charity, they are considered at meetings of the Charitable Funds Committee, together with mitigating actions.

Income and expenditure is monitored by the Charitable Funds Committee as part of the risk management process to avoid unforeseen calls on reserves and to ensure that the Charity is well-positioned to meet its objectives throughout the year.

Reserves Policy

The Charity derives its income mainly from donations and legacies, the level of which cannot be accurately predicted year on year.

Since the charity aims to spend the income it receives for its charitable purpose, there are a number of reasons why it needs to retain a proportion of the income it receives as reserves, which include:

- ensuring income from donations and legacies are spent in line with the donors' wishes, particularly where restrictions have been placed on its use.
- ensuring sufficient funds are available to fund planned future projects;
- for gifts of endowment where the charity has no power to treat the monies as income to fund charity related expenditure; and
- meeting current or anticipated expenses such as management, administration and governance costs, including examination costs.

For these reasons, the Charity holds reserves at a minimum level of £500,000.

Structure, Governance and Management

The Charity which was formerly known as the East Lancashire Hospitals NHS Trust Charitable Fund and other related charities is now known as ELHT&Me.

The Charity was created under a Trust deed executed on 28 January 2004 and constituted with East Lancashire Hospitals NHS Trust as sole corporate trustee. This deed consolidated a number of charitable funds held by the former Burnley Healthcare and Blackburn, Hyndburn, and Ribble Valley Health Care NHS Trusts prior to their merger to form the East Lancashire Hospitals NHS Trust. A deed of the amendment was executed on 11 July 2018 to provide clarity as to the purposes for which the charitable funds are held and to simplify the administration of the Charity.

As ELHT&Me has a corporate trustee, in accounting terms, it is controlled by the Trust and is, therefore, its subsidiary. Financially, the Charity is not material to Trust, so it is not consolidated into its accounts.

The Trust is funded by the Charity to employ a Charity Manager and a Community Fundraising Officer to support ELHT&Me. These posts reflect the important role that fundraising has to play in the enhancement of the patient experience and patient and public engagement.

Charitable funds received by the charity are accepted, held, and administered as funds and property held on Trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990.

In practice, responsibility for the monitoring and approval of activities relating to charitable fundraising and the uses to which charitable funds are applied has been delegated by the Trust Board (Corporate Trustee) to the Trust's Charitable Funds Committee. The terms of reference for the Committee are reviewed annually by the Trust Board and compliance with these terms of reference is also assessed on an annual basis by the Committee and reported back to the Trust Board as part of the reporting from the Charitable Funds Committee.

Membership of the Charitable Funds Committee is drawn from the Trust Board and comprises a Non-Executive Director Chair of the Committee, one further Non-Executive Director/Associate Non-Executive Director member, the Executive Director of Finance (as lead director for the Committee), the Executive Director of Nursing and the Executive Director of Communications and Engagement. The Associate Director of Corporate Governance/ Company Secretary, together with the Deputy Director of Finance or Financial Controller and the Fundraising Manager attend meetings of the Committee to provide advice and assistance.

All Trust Board members are entitled to attend the meeting and have sight of the supporting documents. The Committee provides regular reports of its decisions to the formal Trust Board meetings.

There are a number of individual funds within the umbrella of the Charity, each of which has a designated funds manager with day-to-day responsibility for the administration of the fund, being involved in fundraising activities, and decisions on how donations should be expended within the financial framework of the charity.

The decision-making process is aligned to financial limits, as outlined in the scheme of delegation for the Charity.

Fund managers have delegated authority to incur expenditure below £3,000. Expenditure above £10,000 is approved by the Charitable Funds Committee, with expenditure between these limits approved by either the Executive Director of Finance or Deputy Director of Finance.

Director Recruitment, Appointment, Induction and Training

There are different recruitment and appointment processes for the Executive and Non-Executive members of the Trust Board.

From 1 April 2016, NHS Improvement has had responsibility for the appointment of Non-Executive members to NHS Trust Boards on behalf of the Secretary of State for Health and Social Care.

Executive members of the Board are subject to the recruitment and appointment processes of the Trust.

All Directors are subject to the induction and training processes of the Trust.

Committee Membership

The members of the Trust Charitable Funds Committee for 2021–22 were:

- Stephen Barnes (Chairman of the Committee)
- Richard Smyth
- Christine Douglas
- Michelle Brown
- Shelley Wright

The Members of the Corporate Trustee (Board) for 2021–22 were:

- Professor Eileen Fairhurst, Trust Chairman
- Mr Kevin McGee, Chief Executive (until 31 August 2021)
- Mr Martin Hodgson, Deputy Chief Executive (until 31 August 2021) and Interim Chief Executive (from 1 September 2021)
- Mrs Trish Anderson, Non-Executive Director
- Mr Stephen Barnes, Non-Executive Director
- Mr Richard Smyth, Non-Executive Director
- Miss Naseem Malik, Non-Executive Director
- Mr Khalil Rehman, Non-Executive Director
- Professor Graham Baldwin, Non-Executive Director
- Mrs Feroza Patel, Associate Non-Executive Director
- Mr Mike Wedgeworth, Associate Non-Executive Director
- Mr Harry Catherall, Associate Non-Executive Director (until January 2022)
- Mr Jawad Husain, Executive Medical Director
- Mrs Sharon Gilligan, Chief Operating Officer
- Mrs Michelle Brown, Executive Director of Finance
- Mr Tony McDonald, Executive Director of Integrated Care, Partnerships and Resilience
- Ms Christine Douglas, Executive Director of Nursing
- Mrs Kate Atkinson, Interim Director of Service Development and Improvement
- Mr Kevin Moynes, Executive Director of HR and OD
- Ms Shelley Wright, Joint Executive Director of Communications and Engagement

Declaration

The Corporate Trustee declares that it has approved the Annual Report of ELHT&Me for 2021–22.

Stephen Barnes
Non-Executive Director
Charitable Funds Committee Chair
East Lancashire Hospitals NHS Trust

Michelle Brown
Executive Director of Finance
East Lancashire Hospitals NHS Trust

Reference and Administrative Details

Registered charity name:
ELHT&Me

Charities Charity Registration Number:
1050478

Principal Office Address:
East Lancashire Hospitals NHS Trust,
Trust Headquarters,
Royal Blackburn Teaching Hospital,
Haslingden Road BB2 3HH

Trustee:
East Lancashire Hospitals NHS Trust

Key Management Personnel:
Trust Charitable Funds Committee

The following key professional services are provided to the Charity by external organisations:

Charity bankers:
Governing Banking Service c/o NatWest,
Bolton Customer Service Centre,
PO Box 2027 Parklands, De Havilland Way,
Horwich, Bolton BB6 4YU

Charity independent examiner:
Nicola Wakefield, Mazars, One St Peter's Square,
Manchester M3 3EB

Charity investment managers:
Brewin Dolphin, 1 The Avenue,
Spinningfields Square, Manchester M3 3AP

Charity solicitors:
Hempsons, City Tower Piccadilly Plaza,
Manchester M1 4BT

Charity internal auditors:
Mersey Internal Audit Agency (MIAA),
Regatta Place, Brunswick Business Park,
Summers Road, Liverpool L3 4BL

ELHT&me
your local NHS hospital charity

ELHT&Me
Royal Blackburn Teaching Hospital
Haslingden Road
Blackburn
Lancashire
BB2 3HH

Telephone 01254 732140
Email fundraising@elht.nhs.uk

www.elht.nhs.uk/charity

@ELHTandMe

Charity registration number 1050478

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Enquiries to Allen Graves
Telephone No. 01254 732631
Ext: 82631
Email allen.graves@elht.nhs.uk

Royal Blackburn Teaching Hospital
Haslingden Road
Blackburn
BB2 3HH

11 January 2023

Mazars LLP
One St Peter's Square
Manchester
M2 3DE

Dear Sir/Madam,

ELHT&Me – independent examination of the financial statements for the year ended 31st March 2022

This representation letter is provided in connection with your Independent Examination of the financial statements of the Fund for the year ended 31st March 2022.

We confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the following representations to you.

Our responsibility for the financial statements and accounting information

We believe that we have fulfilled our responsibilities for the true and fair presentation and preparation of the financial statements in accordance with applicable law and the applicable Financial Reporting Framework.

Our responsibility to provide and disclose relevant information

We have provided you with:

- access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other material;
- additional information that you have requested from us for the purpose of the Independent Examination; and
- unrestricted access to individuals within the charity you determined it was necessary to contact in order to obtain Independent Examination evidence.

We confirm as trustees that we have taken all the necessary steps to make us aware, as trustees, of any relevant Independent Examination information and to establish that you, as examiners, are aware of this information.

As far as we are aware there is no relevant information of which you, as examiners, are unaware.

Accounting records

We confirm that all transactions undertaken by the charity have been properly recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all management and trustee meetings, have been made available to you.

Accounting policies

We confirm that we have reviewed the accounting policies applied during the year in accordance with the requirements of applicable law and applicable Financial Report Framework and consider them appropriate for the year.

Accounting estimates, including those measured at fair value

We confirm that any significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

Contingencies

There are no material contingent losses including pending or potential litigation that should be accrued where:

- information presently available indicates that it is probable that an asset has been impaired or a liability had been incurred at the balance sheet date; and
- the amount of the loss can be reasonably estimated.

There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the charity have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with applicable law and applicable Financial Reporting Framework.

Laws and regulations

We confirm that we have disclosed to you all those events of which we are aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

We have complied with all aspects of contractual agreements that would have a material effect on the financial statements in the event of non-compliance.

Fraud and error
We acknowledge our responsibility as trustees of the charity, for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

We have disclosed to you:

- all the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- all knowledge of fraud or suspected fraud affecting the charity involving:
- management and those charged with governance;
- employees who have significant roles in internal control; and
- others where fraud could have a material effect on the financial statements.

We have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the charity's financial statements communicated by employees, former employees, analysts, regulators or others.

Legacies and other income

We confirm that there have been no legacies or other income received after the year end that should be accrued for at the year end.

Related party transactions

We confirm that all related party relationships, transactions and balances, (including sales, purchases, loans, transfers, leasing arrangements and guarantees) have been appropriately accounted for and disclosed in accordance with the requirements of applicable law and the applicable Financial Reporting Framework.

We have disclosed to you the identity of the charity's related parties and all related party relationships and transactions of which we are aware.

Impairment review

To the best of our knowledge, there is nothing to indicate that there is a permanent reduction in the recoverable amount of the fixed assets below their carrying value at the balance sheet date. An impairment review is therefore not considered necessary.

Charges on assets
All the charity's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

We have no plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

COVID-19

We have considered the uncertainty associated with the charity's future prospects, performance and funding in regard to COVID-19 and are not aware of any significant impact to the charity as a result. We confirm that provisions in relation to the impact of COVID-19 have been recognised in the financial statements as appropriate. We confirm that we have paid particular attention to the going concern status of the charity and whether there are any events after the balance sheet date that would require highlighting to you.

Subsequent events

We confirm all events subsequent to the date of the financial statements and for which the applicable law and applicable Financial Reporting Framework require adjustment or disclosure have been adjusted or disclosed.

Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, we will advise you accordingly.

Audit requirement

We confirm that there are no specific requirements for an audit to be carried out in the governing document of the charity, in any special trusts associated with the charity or as a condition of any grants made to the charity.

Yours faithfully

Trustee ……..

Date ……..

TRUST BOARD REPORT

11 January 2023

Item 17

Purpose Information

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 31 October, 28 November and 19 December 2022.

Recommendation: The Board is asked to note the report.

Related Trust Goal

Related to key risks identified on assurance framework

Impact

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

Previously considered by:

(17) Finance and Performance Committee Information Report

Finance and Performance Committee Update

At the meeting of the Finance and Performance Committee held on 31 October 2022, members considered the following matters:

1. Members received an update on the system financial performance, noting that draft guidance had now been received explaining what would happen should the financial position not be achieved. Members noted the system forecast was significantly away from the required position. The Committee noted that the Trust was in a more favourable position compared with some of the Trusts in the system, and would try to hold a lot of pressures through the use of non-recurrent in year savings. Members noted the Trust's month 6 position showed a breakeven forecast. They noted that the Trust currently had a £3.3 million deficit and had met half of the Cost Improvement Programme (CIP) target. In addition, a healthy cash balance was held, and capital spend was £1 million below plan.
2. Members received an improvement presentation on the Emergency Care improvement work undertaken. Members were informed about the operational challenges, including increased attendances and trolley waits. Members were updated on the work to improve discharges, particularly at the weekend, and the planned improvement weeks that would be taking place across Winter.
3. The Committee received the Integrated Performance Report, noting that the staff sickness level had increased slightly to 6% due to an increase in COVID-19 sickness. Members noted that the Accident and Emergency (A&E) 4-hour target was recorded at 74% and that the Trust was consistently in the top 50 in the country for type 1 attendances, and in the top 30 for all other types. Members that the number of patients waiting 52 weeks or more was above trajectory, and included patients that had been transferred from Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR). Members noted that work continued to improve elective and day case restoration. Members received a brief presentation showing the Trust's cancer performance. It was noted that the cancer backlog is reducing and that there had been a significant increase in referrals.
4. The Endoscopy Workforce Investment business case was presented to members, noting that this would represent a long-term saving for the Endosopy service. Members gave their approval to the business case and recommended it was presented to the Trust Board.

5. 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.
6. Members were updated on the CRR, noting the work to reduce the number of open risks and improve the quality of recorded risks. Members were informed that discussions take place in the Executive Risk assurance Group (ERAG) and all risks scoring 15 and above were to be reviewed monthly.
7. The Committee received the Board Assurance Framework (BAF), noting that there had been no changes to the scores of the risks. Members noted that the Trust had received a letter regarding Winter planning and received assurance that this would be reflected and addressed within the BAF.

At the meeting of the Finance and Performance Committee held on 28 November 2022 members considered the following matters:

1. Members received an update on the system financial performance including the 5% efficiency target. Members noted that the Trust was on plan to achieve the initial 5% savings target as set out at the beginning of the 2022/23 financial year, however this did include a number of schemes which would release non-recurrent savings which would add further pressure to the 2023/24 financial year. Members noted that the capital plan was being updated and worked through in partnership with the national teams.
2. Members received an update on the progress being made in relation to the Trust's improvement programme. Members noted that actions that had been carried out and were planned to address the requirements of the recent letter from NHS England regarding elective care recovery and to address the matters within the Trust's cancer improvement plan.
3. The Committee received the Integrated Performance Report, containing the current performance metrics including the 4-hour A&E target, 12-hour breaches and the work to reduce the number of patients on 52, 78, and 104 week waiting lists. Members noted that the Trust compared favourably in relation to other Trusts at both a system and regional level.
4. Members received the Quarterly Workforce Plan, noting that staff absence had now stabilised back to 5.5%. Members were informed about the recent ballots for industrial action from the Royal College of Nursing, noting that the Trust did not have a mandate to proceed with strike action. Members noted that should the Trust be

affected by industrial action, the Trust's Communications team would maintain information flows to patients.

5. The Committee received the Digital Pathology business case and provided their support and approval.
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 were presented with the findings from the Committee Self-Assessment results, noting that the feedback received was reflective of the feedback received from the other sub-committees of the Board.

At the meeting of the Finance and Performance Committee held on 19 December 2022 members considered the following matters:

1. Finance Reporting
2. Improvement Update
3. Integrated Performance Report
4. COVID-19 & Restoration Update
5. Private Finance Initiative Update
6. Corporate Risk Register
7. Board Assurance Framework

A more detailed report from this meeting will be provided at the next Board meeting.

Mr M Pugh, Acting Corporate Governance Team Leader, 11 January 2023

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

Item 18

11 January 2023

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 26 October 2022 and 30 November 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:

(18) Quality Committee Information Report

Quality Committee Update

At the meeting of the Quality Committee held on 26 October 2022 members considered the following matters:

1. Members were informed that the pressures on the Trust's urgent and emergency care pathways continued to be significant, with a much higher number of physical health breaches than would normally be seen. They were informed a new Standard Operating Policy was currently in development to enable more rapid decompression of the emergency department and that other work was taking place to assess what additional support could be provided to staff.
2. The Committee received an update on the recent activities and achievements of the East Lancashire Child and Adolescent Service (ELCAS). Members were informed that ELCAS had come about from the merger of three separate Child and Adolescent Mental Health Services (CAMHS) across Lancashire and South Cumbria in 2015 and operated from 08:00 to 22:00 seven days per week. They noted that the service had received a rating of 'Outstanding' from the Care Quality Commission and accreditation with the Quality Network for Community CAMHS.
3. An Annual Mortality Report was presented to members. They were informed that the report was intended to provide an overview of all main areas and the ways in which the Trust learned from deaths. Members also noted the assurance provided by the report that any suspected incidents were looking into robustly and that the findings were shared candidly with relatives.
4. The Committee was provided with an update on the work taking place to implement the actions that had come about following audits of a number of Trust services by the Mersey Internal Audit Agency. Members noted that 13 audits had been carried out in 2022/23 and that all had come back with moderate or substantial assurance.
5. Members were briefly updated on the Trust's recent cancer performance and noted that it was starting to show significant improvement from its position earlier in the year. They were informed that a more substantial update would be provided at a future meeting.
6. 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.
7. There were no items raised for escalation to the Audit Committee.

At the meeting of the Quality Committee held on 30 November 2022 members considered the following matters:

1. The Committee was informed that the numbers of patients coming through the Trust's urgent and emergency care pathways were rapidly becoming unmanageable, leading to lapses in care and increases in complaints. Members also noted that a shortage of mental health beds was leading to more patients with complex needs arriving into the Trust which was, in turn, creating a number of additional difficulties.
2. An update was provided to members on the progress made with developing the Trust's bereavement and end of life service. Members noted that the main priorities over the coming months were enabling access to a seven-day specialist palliative care service, embedding a suitable care model, improving recognition of dying patients and advanced care planning.
3. The Infection, Prevention and Control Annual Report was provided to, and noted by, members
4. The Committee received an update on pressure ulcer incidents in the Trust. Members were informed that the numbers of reported pressure ulcers had effectively doubled from November 2021 to November 2022. They were also informed that there had been a rise in damage occurring due to the substantial waits currently being experienced by patients in the emergency department and the complexity of patients on acute wards and in the community. It was confirmed that work was taking place to address these issues and that pressure ulcers would continue to be closely monitored over the coming months.
5. Members were advised that the Trust had received a report following the inspection of its maternity services by the Care Quality Commission earlier in the month. The Committee noted that preparatory work continued for a potential well-led inspection of the Trust at a later date.
6. The Committee was apprised of recent developments in the Trust's Nursing Assessment Performance Framework (NAPF), including the implementation of a new Safe, Personal and Effective Care (SPEC) panel process. Members were informed that NAPF inspections were now being carried out community areas and were utilising a modified version of the existing framework due to the different nature of the teams working there.
7. An update was provided on recent work that had taken place to review staffing on the Trust's Neonatal Intensive Care Unit (NICU). It was explained that this update was one of the requirements of the Clinical Negligence Scheme for Trusts Maternity

Incentive Scheme and that additional funding provided had enabled the Trust to increase its funded nursing establishment.

8. The Committee received an update on the activities of the Trust's Department of Education, Research and Innovation. It was noted that a significant amount of funding would be required to implement the staff and facilities required to develop the department further and that this was proving difficult due to the ongoing financial challenges across the NHS.

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. Members agreed to escalate the NICU staffing paper to the Board to advise that the Committee had received assurance on this area.

Dan Byrne, Corporate Governance Officer, 29 December 2022.

TRUST BOARD REPORT

11 January 2023

Item 19

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 meeting held on 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

(19) Audit Committee Information Report

Audit Committee Update

At the meeting of the Audit Committee held on 17 October 2022, members considered the following matters:

1. Members discussed the Management Response to Internal Audit on Catering Services and requested that an update showing that assurance is being maintained following the outcomes of the audit is presented at the January 2023 meeting of the Audit Committee.
2. Members were updated on the Management Response to Internal Audit on Risk Management, noting that a number of recommendations had been provided and were in the process of being implemented. Members noted that a full quantifiable review of the Corporate Risk Register (CRR) had taken place and that the escalation process for risks that had scored 15 or higher had been reaffirmed to all Divisional leads. Furthermore, work continued to reduce the number of overdue risks, improve risk profiles and reduce and duplicate risks. Members noted that an Executive Risk Assurance Group had been established to assign an Executive lead to oversee risks scoring 15 and above, and that work continued to migrate the Trust to a new risk management system.
3. Members discussed the Trust's Current Financial Position, noting that all Trust's within Lancashire and South Cumbria had planned for a breakeven position, along with a 5% efficiency saving. Members were informed that a significant proportion of savings had been identified, however the majority comprised of non-recurrent savings.
4. The Committee was updated on the Financial Sustainability Assessment that the Trust had been asked to complete. Members noted that following the submission of the self-assessment checklist, the Trust had scored 4.1 out of a possible 5, with the amber element of the "Red-Amber-Green" checklist relating to the Cost Improvement Programme savings mostly being non-recurrent.
5. The Committee received an updated on the Trust's commitment towards the NHS Green Plan, noting that as part of the work, the Trust had moved to 100% renewable energy, that trials of new technology had commenced that would allow all anaesthetic gases to be recaptured and processed with the potential for recycled use in the future, and that electric vehicle charging via solar panels was being investigated.
6. Members received the Internal Audit Progress report, noting that all work for the 2021/22 Internal Audit Plan had now been completed and that work for the 2022/23 reviews was progressing.

7. The Committee received an update on the work undertaken by the External Auditors, noting that work on the Trust's Charity accounts had commenced and would be completed in December 2022. Members noted that work would then progress to the 2022/23 audit year and that a plan of action would be presented to the Trust prior to the financial year end.
8. Members received the Anti-Fraud Service Progress Report, noting the activities that had been undertaken to reduce the potential for fraud in the Trust.
9. Committee members were presented with the CRR, noting that there had been a small increase in the number of risks recorded. In addition, work continued to standardise and amalgamate risks were possible.
10. Members were provided with a copy of the Waivers Report, nothing that there had been one waiver for the provision of a no win, no fee service to ensure the Trust is paying the right level of VAT
11. An update was provided to members on any system risks or issues that had the potential to affect the Trust. Members noted that a key risk is corporate collaboration and where decision making is occurring.
12. The Committee were informed that both the Standing Orders and Standing Financial Instructions policies were due to undergo their annual review. Members were advised that these were to be aligned to the same renewal date and that workshop had been held to review the documents at which a number of areas had been identified to be addressed.

Mr M Pugh, Acting Corporate Governance Team Leader, 11 January 2023

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

11 January 2023

Item 20

Purpose Information

Title	Trust Board (Closed Session) Information Report
Executive sponsor	Mr S Sarwar, 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

- 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	No
Equality	No	Confidentiality	Yes

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: National, ICB / PCB and Pennine Lancashire Update
   b) Round Table Discussion: Fire Safety
   c) CQC Registration for Mental Health Patients
   d) NHSE Elective Care Board Self-Certification
   e) Initial Trust Response to East Kent Maternity and Neonatal Services Report
   f) Service Development Update
   g) Responsible Officer's Report to Trust Board Regarding Doctors with Restrictions
   h) Electronic Patient Record Progress Update
   i) Nosocomial Infections Update
   j) Pathology Update
   k) Industrial Action Update
   l) Any Other Business: Proposed Board and Sub-Committee Dates 2023-24
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, 29 December 2022.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

Item 21

11 January 2023

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 9 November 2022 and 14 December 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

(21) Remuneration Committee Information Report

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 9 November 2022 members considered the following matters:
   a) Chief Nurse Remuneration

Remuneration Committee Information Report

2. At the meeting of the Remuneration Committee held on 14 December 2022 members considered the following matters:
   a) Ratification of the Appointment and Remuneration of the Executive Director of People and Culture
   b) Retrospective Fit and Proper Persons Test Annual Report 2020 and 2021

Mr D Byrne, Corporate Governance Officer, 29 December 2022.