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)

8 MARCH 2023, 1.00pm

BOARDROOM, TRUST HQ / MS TEAMS

AGENDA

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

OPENING MATTERS				
TB/2023/026	**Chairman's Welcome**	Chairman	v	
TB/2023/027	**Apologies** To note apologies.	Chairman	v	
TB/2023/028	**Declarations of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Chairman	d✓	Information/ Assurance
TB/2023/029	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 11 January 2023.	Chairman	d✓	Approval
TB/2023/030	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2023/031	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2023/032	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2023/033	**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/2023/034	**Patient Story** To receive and consider the learning from a patient story.	Interim Chief Nurse	p	Information/ Assurance
TB/2023/035	**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/2023/036	**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/2023/037	**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/2023/038	**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 People and Culture and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
STRATEGIC ISSUES				
TB/2023/039	**New Hospitals Programme Quarter 3 Board Report**	Programme Director, New Hospitals Programme	d✓	Information/ Assurance
TB/2023/040	**Maternity and Neonatal Service Update**	Interim Chief Nurse	d/p ✓	Information/ Assurance
TB/2023/041	**Staff Health and Wellbeing Update Report**	Executive Director of People and Culture	d✓	Information/ Assurance
GOVERNANCE				
TB/2023/042	**Trust Charitable Funds Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/043	**Finance and Performance Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/044	**Quality Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/045	**Audit Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information

TB/2023/046	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
TB/2023/047	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2023/0	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2023/0	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2023/0	**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/2023/0	**Date and Time of Next Meeting** Wednesday 10 May 2023, 12.30pm, Boardroom, Trust HQ / MS Teams	Chairman	v	

TRUST BOARD REPORT		**Item**	**28**
8 March 2023		**Purpose**	Information Approval
Title	Declarations of Interests Report		

Summary: Section 5 of the Trust's Standing Orders describes the duties and obligations of Board Members in relation to declaring interests. The Register is available for public inspection. The presented Directors' Register of Interest will be included in the Trust's Annual Report for 2022/23.

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

Report linkages

Related Trust Goal	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. Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy).

Impact

Legal	Yes	Financial	No
The Trust would be in breach of its own Standing Orders and its regulatory obligations should it omit to have proper arrangements in place for the Directors' declarations of interests.			
Equality	No	Confidentiality	No

Name and Title	Interest Declared	Date last updated/ Confirmed
Shazad Sarwar Chairman (from 05.12.2022)	• Committee member of Together Housing Group (from 01.09.2021) • Non-Executive Director member of the Greater Manchester Integrated Care Board (from 01.02.2022). • Managing Director of Msingi Research Ltd. (from 01.07.2015)	20.02.2023
Martin Hodgson Chief Executive (from 01.09.2022) Interim Chief Executive (until 31.08.2021)	• Spouse is the Chief Operating Officer at Liverpool University Hospital NHS Foundation Trust. • Spouse's son worked at University Hospitals of Morecambe Bay NHS Foundation Trust (from November 2019 to October 2021)	19.04.2022
Patricia Anderson Non-Executive Director Interim Chairman (from 01.11.2022 to 04.12.2022)	• Spouse is a recently retired Consultant Psychiatrist formerly employed at Mersey Care NHS Trust. • Assignment with Knowsley Clinical Commissioning Group, supporting the Accountable Officer for a period of six months (10.05.2019 to 01.10.2019). During this time Mrs Anderson took a leave of absence from the Trust Board at ELHT. • Partnership of East of London Collaborative – Assignment of 1.5 days per month (from 01.12.2020 until 01.02.2021)	21.02.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Kate Atkinson Executive Director of Service Development and Improvement (from 10.02.2023) Interim Executive Director of Service Development and Improvement (to 10.02.2022)	• Brother is the Clinical Director of Radiology at the Trust • Sister-in-law is a Trauma and Orthopaedic Consultant at the Trust • Parent Governor at Blacko Primary School (from 01.04.2022 to 31.03.2026)	20.02.2022
Professor Graham Baldwin Non-Executive Director	• Director of Centralan Holdings Limited • Director of UCLan Overseas Limited • Deputy Chair and Director of UCEA • Chair of Maritime Skills Commission • Member of Universities UK • Treasurer of MillionPlus • Chair of University Vocational Awards Council • Director of Lancashire Enterprise Partnership • Chair of Lancashire Innovation Board	21.02.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Stephen Barnes Non-Executive Director	• Chair of Nelson and Colne College (to 01.05.2023) • Member of the National Board of the Association of Colleges (from to 01.05.2023). • Chair of the National Council of Governors at the Association of Colleges (to 01.05.2023) • Chair of the Nelson Town Regeneration / Deal Board	21.02.2023
Michelle Brown Executive Director of Finance	• Spouse is paramedic at NWAS • Vice Chari of Governors at St Catherine's RC Primary School, Leyland	01.03.2023
Doctor Fazal Dad Associate Non-Executive Director	• Principal and Chief Executive, Blackburn College • Ofsted Inspector • Quality Assurance Agency Reviewer (QAA) • Board Member at Lancashire Skills and Employment Board • Director at The Lancashire Colleges • Trustee of Agnes Eccles Art Award Fund	01.03.2023
Sharon Gilligan Chief Operating Officer Deputy Chief Executive (from 01.01.2023)	• Positive nil declaration	20.02.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Jawad Husain Executive Medical Director Deputy Chief Executive (from 10.11.2021)	• Spouse is a GP in Oldham	20.02.2023
Naseem Malik Non-Executive Director	• Independent Assessor- Student Loans Company- Department for Education - Public Appointment. • Fitness to Practice, Panel Chair: Health and Care Professions Tribunal Service (HCPTS) - Independent Contractor (until 31.07.2020) • Investigations Committee Panel Chair at Nursing and Midwifery Council (NMC) - Independent Contractor (until 30.07.2021). • Relative (first cousin) is a GP. • Relative (brother-in-law) is a registered nurse employed by Lancashire and South Cumbria Care NHS Foundation Trust.	21.02.2023
Tony McDonald Executive Director of Integrated Care, Partnerships and Resilience	• Spouse is an employee of Oxford Health NHS Foundation Trust • Member of Board of Trustees for Age Concern Central Lancashire Charity (to 27.10.2023)	21.02.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Julie Molyneaux Interim Chief Nurse (from 01.08.2022)	• Positive Nil Declaration	20.02.2023
Feroza Patel Associate Non-Executive Director	• Positive Nil Declaration	20.02.2023
Kate Quinn Executive Director of People and Culture (from 01.01.2023)	• Director of Lancashire IoT • Governor at Goosnargh Oliverson's Church of England Primary School	21.02.2023
Khalil Rehman Non-Executive Director	• Director at Salix Homes Ltd • Director at Medisina Foundation. • NED at Leeds Community Healthcare Trust (from 01.12.2020)	07.04.2022
Richard Smyth Non-Executive Director	• Spouse is a Patient and Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary. • Spouse is a Non-Executive Director at Lancashire Teachings Hospitals Foundation Trust as from 04.02.2019.	20.02.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
	• Chair elect of Board of Governors at Bury Grammar School as of December 2022, will commence as Chair of Board of Governors on 27 March 2023.	
Michael Wedgeworth Associate Non-Executive Director	• Board member of Inspire Motivate Overcome (IMO) Charity	20.02.2022
Shelley Wright Joint Director of Communications and Engagement for East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BFWH) (from 04.01.2021)	• Post held jointly with Blackpool Teaching Hospitals NHS Foundation Trust	20.02.2023

Members of the Trust Board who left the Trust during the 2022/23 year

Name and Title	Interest Declared	Date last updated
Professor Eileen Fairhurst MBE Chairman (to 31.10.2022)	• Honorary Doctorate UCLan awarded 2018 • Visiting Professor, Chester University • Members of the Good Governance Institute Faculty	13.04.2022
Christine Douglas Executive Director of Nursing (to 31.07.2022)	• Seconded to Manchester Health Care Commissioning as Clinical/Nursing Board member for 4 days per month (from 01.12.2019)	31.03.2022
Kevin Moynes Executive Director of Human Resources and Organisational Development (to 31.12.2022)	• Spouse is a very senior manager at Health Education England (from 02.10.2017) • Governor of Nelson and Colne College (until 01.02.2018). • Joint Appointment as Executive Director of HR and OD at East Lancashire Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust (10.10.2018 until 31.01.2022)	14.04.2022

TRUST BOARD REPORT		**Item**	**29**
8 March 2023		**Purpose**	Approval
Title	Minutes of the Previous Meeting		

Summary: The minutes of the previous Trust Board meeting held on 11 January 2023 are presented for approval or amendment as appropriate.

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

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 1.00PM, 11 JANUARY 2023
MINUTES

PRESENT

Mr S Sarwar	Chairman	Chair
Mr M Hodgson	Chief Executive / Accountable Officer	
Mrs P Anderson	Non-Executive Director	
Mrs K Atkinson	Interim Director of Service Development and Improvement	Non-voting
Mr S Barnes	Non-Executive Director	
Professor G Baldwin	Non-Executive Director	
Mrs M Brown	Executive Director of Finance	
Dr F Dad	Associate Non-Executive Director	Non-voting
Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive	
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	
Mrs F Patel	Associate Non-Executive Director	Non-voting
Mrs K Quinn	Executive Director of People and Culture	
Mr K Rehman	Non-Executive Director	
Mr R Smyth	Non-Executive Director	
Mr M Wedgeworth	Associate Non-Executive Director	Non-voting
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)	Non-voting

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary	
Mr D Byrne	Corporate Governance Officer	Minutes
Dr C Gardner	Deputy Medical Director (Quality and Safety)	
Miss K Ingham	Corporate Governance Manager	
Mr A Patel	Associate Director of Technology-Enabled Care	Item: TB/2023/014
Mr M Pugh	Corporate Governance Officer	

Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council	
Miss T Thompson	Head of Midwifery	Item: TB/2023/015

APOLOGIES

Mr J Husain	Executive Medical Director / Deputy Chief Executive

TB/2023/001 CHAIRMAN'S WELCOME

Mr Sarwar welcomed Directors to the meeting. He extended his thanks to everyone at the Trust for the warm welcome that he had received since commencing in post and to those colleagues working in patient facing areas for managing the significant difficulties seen over the recent weeks.

TB/2023/002 APOLOGIES

Apologies were received as recorded above.

TB/2023/003 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/2023/004 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 9 November 2022 were approved as a true and accurate record.

TB/2023/005 MATTERS ARISING

There were no matters arising.

TB/2023/006 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. The following update was provided:

TB/2022/144: Patient Safety Incident Response Framework Assurance Report – Mrs Molyneaux explained that providing the information requested at the previous meeting as to whether patients from ethnic or minority backgrounds were more disadvantaged in terms of maternity incidents had proven to be a more substantial piece of work than originally envisaged. She confirmed that this update would be provided at the next Board meeting and would include more information regarding other contributory factors.

RESOLVED: Directors noted the position of the action matrix.
An update on the information requested in relation to maternity incidents will be provided at the next meeting.

TB/2023/007 CHAIRMAN'S REPORT

Mr Sarwar provided a summary of his activities since formally commencing in his role as Chairman on the 5 December 2022. He reported that he had had a number of 1:1 meetings with Board members and had been to visit colleagues in the Trust's Emergency Department (ED) to see first-hand the unprecedented situation there. Mr Sarwar commented that although the pressures and demands being placed upon staff had been clear, so had the high-quality care, kindness and calmness being shown. He informed Directors that he had also recently attended a meeting during which several examples of the outstanding research and development work taking place in the Trust had been demonstrated.

Mr Sarwar advised that he had, alongside Mr Hodgson, attended a recent Prince's Trust Programme event and stated that this had been a positive celebration of the diversity and talent in the local community. He stated that the onus was now very much on the Trust to enhance and develop this partnership going forward, adding that it was a good example of its role as an anchor institution.

Mr Sarwar concluded his update by confirming he had attended the recent meeting of the Provider Collaboration Board (PCB) as well as the PCB Annual Event on the 15 December 2022. He stated that he looked forward to further meetings with the leaders of local voluntary organisations and with other leaders at the Trust.

RESOLVED: Directors received and noted the update provided.

TB/2022/008 CHIEF EXECUTIVE'S REPORT

Mr Hodgson referred to the previously circulated report and noted that its length was reflective of the high levels of activity currently being seen in the NHS.

Mr Hodgson went on to provide a summary of national headlines to Directors. He highlighted that the Trust was performing well in a number of areas, including its four-hour Accident and Emergency (A&E) waiting time targets, ambulance handovers and levels of delayed discharges. Mr Hodgson stated that this was testament to the efforts of the Trust's staff, as they had responded incredibly well to the pressures seen over the Christmas period. He acknowledged that the Trust had not been able to provide the level of care that it would have wanted to in every case but stressed that its general response had been exemplary. Mr Hodgson explained that the Trust had had to resort to less palatable measures than it would have normally but had successfully managed to maintain all elective activity. He referred to the Christmas message by the Chief Executive of NHS England (NHSE), Amanda Pritchard, and stated that it was right to recognise that the NHS had risen to the majority of asks put to it despite pressures that it had experienced.

Mr Hodgson informed Directors that new National Planning Guidance for 2023-24 had been received just before Christmas and had been generally welcomed. He clarified that 31 key targets had been outlined in this guidance and that elective recovery would be key to achieving many of these. Mr Hodgson also advised that the Trust had performed well in relation to a series of asks outlined in the NHS Winter Plan published in October 2022, with all initiatives now successfully in place.

Mr Hodgson went on to highlight the progress made by the NHS in eliminating Hepatitis C, with 70,000 people cured of the potentially fatal disease since the inception of a pioneering drug deal. He confirmed that the Trust continued to play an active role in this process, with its work being led by one of its Consultant Gastroenterologists, Dr Ioannis Gkikas.

Mr Hodgson informed Directors that a number of developments had also taken place at a Lancashire and South Cumbria (LSC) system level, including the meeting of the Provider Collaboration Board (PCB) in December 2022. He explained that discussions had taken place around virtual ward initiatives within Pennine Lancashire. Mr Hodgson advised that a significant amount of activity was taking place around corporate collaboration and that an event had taken place on the 25 November 2022 with all providers in the Integrated Care System (ICS) to look at how they could come together more effectively to deliver core services.

Directors noted that discussions were also ongoing regarding the LSC Pathology Collaborative and which areas would need to be focused on as part of maturing the network. Mr Hodgson highlighted that an agreement had been reached by the PCB regarding remuneration for non-contractual consultant working as part of a wider dispute around the British Medical Association (BMA) rate card. He observed that the payment rate agreed was a fair balance in terms of affordability and maintaining elective recovery.

Mr Hodgson went on to provide a summary of the developments taking place at Trust level. He informed Directors that Peter Murphy, currently the Executive Director of Nursing, Midwifery, Allied Health Professionals (AHPs) and Quality at Blackpool Teaching Hospitals NHS Foundation Trust had recently been appointed as Chief Nurse for the Trust. Mr Hodgson thanked Mrs Molyneaux for serving as Interim Chief Nurse over recent months and for her achievements during a particularly difficult time. He also referred to the recent retirement of Kevin Moynes from the Board and advised that he would continue to work with the Trust in his new role in the PCB. Directors noted that Mrs Quinn had been substantively appointed into her new role as Executive Director of People and Culture and that Mrs Gilligan had been appointed as a second Deputy Chief Executive, alongside Mr Husain.

Mr Hodgson went on to report that the Care Quality Commission (CQC) had carried out an unannounced inspection of the Trust's maternity services across three different sites in November 2022. He highlighted that the immediate feedback provided had been very positive and that the Trust had recently received the CQCs formal report, showing that all three services had been rated as 'Good' with some areas of 'Outstanding'. Mr Hodgson stated that this was an even more impressive accomplishment given the significant challenges being seen nationally and that the team members involved should be very proud of what they had achieved.

Mr Hodgson informed Directors that the Trust had recently passed a significant gateway review as part of implementing its new Electronic Patient Record (EPR) system. He confirmed that a new 'go-live' date of the 19 June 2023 had been approved by the Board earlier in the day.

Mr Hodgson highlighted that a that a new ELHT&me Charity Hub and Retail Outlet had now opened on the Royal Blackburn Teaching Hospital (RBTH) site.

Mr Hodgson concluded his update by presenting the applications for silver Safe, Personal and Effective Care (SPEC) awards for the Trust's Postnatal ward, Emergency Surgical Unit (ESU),

and Rakehead Neuro-Rehabilitation Centre. Directors confirmed that they were content for these awards to be granted.

Professor Baldwin thanked Mr Hodgson for his report and commented that it was encouraging to see the number of positive developments taking place in the Trust against the recent backdrop of negativity around health services in general.

Mr Sarwar agreed with Professor Baldwin's comments and noted that it was a reminder that all of the good work taking place in the Trust was due to its workforce. He referred to a number of recent incidents in which Trust staff had received abuse during their work and stressed that this was something that would need to be addressed as a priority.

Mrs Quinn stressed that the Trust had a zero-tolerance approach to abuse towards staff and confirmed that reminders were being sent to staff that they were protected in this manner.

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

TB/2023/009 **PATIENT STORY**

Mrs Molyneaux provided a brief introduction to the story and explained that it had been provided by an individual whose parents had both been admitted to the Trust on the 5 and 9 September 2022 respectively. She explained that the individual's father had ultimately passed away on the 10 September and had received care from the Trust's palliative care team. Mrs Molyneaux advised that the story gave significant praise for Trust staff at all stages of the parents' care, particularly in arranging for them to spend time together on their father's ward when his condition began to deteriorate. She noted that although the overall outcome of the story was a sad one, it clearly showed how Trust staff were willing to go the extra mile.

Mr Sarwar thanked Mrs Molyneaux for presenting the story and stated that it touched on the points raised earlier in the meeting regarding the importance of kindness and compassion. He added that enabling patients to die with dignity was equally important and agreed that the story was a reflection of the strong values that Trust staff adhered to.

Dr Dad enquired how the Board could go about communicating its thanks to the staff members referred to in the story.

Mr Hodgson explained that the Trust did have a process in place to recognise colleagues who had received compliments for the care they had provided. He highlighted that a good number of compliments for Trust staff had been received over recent weeks despite the challenging circumstances they were having to work in.

Miss Wright added that Team Brief sessions were held every Tuesday and confirmed that a substantial part of this was recognising staff and their achievements.

Mrs Anderson commended the clear compassion and use of common sense displayed by Trust staff in the story and emphasised the importance of recognising and supporting colleagues in being flexible with rules or guidelines when it was appropriate to do so.

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

TB/2023/010 **CORPORATE RISK REGISTER (CRR)**

Dr Gardner requested that the previously circulated report be taken as read and provided a summary of highlights to Directors. He confirmed that the CRR had been revised as per the feedback provided at the previous Trust Board meeting, with controls and assurances now combined and actions more clearly focused on next steps. Dr Gardner reported that there had been a reduction of 32% in the number of open risks and a reduction of 81% in the number of overdue risks, adding that this was a real testament to the work done by the Trust's Assistant Director of Health, Safety and Risk Management, John Houlihan.

Dr Gardner drew Directors' attention to risk ID 9336 (Lack of capacity can lead to extreme pressure resulting in a delayed care delivery) and explained that there were significant concerns around this due to the current pressures being seen in the Trust's emergency care pathways. He stressed that the Trust was fully confident in its risk assessments and that extensive mitigations were being worked on to ensure that patient safety and flow would be maintained.

Mr Smyth commented that the iteration of the CRR being presented was a vast improvement from its format a number of months earlier, particularly in terms of the consistency shown in its approach. He noted that it was clear that risks continued to be reviewed on a monthly basis and extended his thanks to all colleagues for their efforts in this area.

Mrs Anderson agreed that previous versions of the CRR had been difficult to read and understand correctly. She stated that she appreciated the more focused approach now being taken to risks and how they were presented both to the Board and at its Sub-Committees.

Professor Baldwin concurred that the quality of the CRR had improved significantly over recent months. He noted that the scores assigned to some of the risks on the register did not seem to change despite the addition of new mitigations and stated that it would be helpful for the

initial pre-mitigation risk scores to be included in future reports to provide a clearer picture of the impacts that mitigations were having.

RESOLVED: **Directors received the report and confirmed that they were content with the assurance provided.**
Pre-mitigation scores for risks will be added to future iterations of the Corporate Risk Register from May 2023.

TB/2023/011 BOARD ASSURANCE FRAMEWORK (BAF)

Mr Bosnjak-Szekeres requested that the previously circulated report be taken as read and provided a summary of highlights to Directors. She advised that it had been presented at the most recent meeting of the Finance and Performance Committee and had been updated following the feedback provided there. Directors noted that the scores assigned to risks 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) and 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) had been increased from 15 to 20 and 20 to 25 respectively.

Mrs Bosnjak-Szekeres explained that the wording for risks 2a, 4a (the volume of activity that the Trust is able to deliver is insufficient to achieve the required elective care targets and eradicate backlogs) and 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) had been revised and requested confirmation from Directors that they were content to approve these changes.

Mr Hodgson commented that he felt it was right to increase the scores assigned to risk 2a and 6 due to the current difficult national context and the requirement for the ICS to achieve a breakeven financial position by year end.

Mrs Brown also stated that she agreed with raising the score for risk 6 as it more accurately reflected the Trust's situation in relation to national asks.

Mr Barnes confirmed that he was content with the changes made to the BAF but stated that he felt that the wording assigned to risk 1 (the partnership arrangements across the ICS for Lancashire and South Cumbria, including the PCB and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and

wellbeing for our communities) may need further consideration and revision to more accurately reflect the more formal collaborative working arrangements now in place across the ICS.

Mr Smyth agreed that BAF risk 6 did accurately describe the current financial context but pointed out that risk ID 9439 (failure to meet internal and external financial targets for the 2022-23 financial year) on the CRR was still being scored at 20 and seemed to indicate that the Trust would meet its budgetary targets. He asked how this would be reconciled going forward.
Mrs Brown agreed that this discrepancy could appear confusing and that a further review of both risks should be done through the Board's sub-committees.

Dr Dad requested further clarification on how long any risks at the maximum score of 25 were expected to remain there.
Mr Hodgson explained that there was a balance to be maintained between how far the Trust could extend itself and how this aligned with other organisations within the ICS. He stressed that the Trust would never compromise on patient safety and agreed that any risks scoring 25 would need to be mitigated as much as possible.
Mrs Brown added that the Trust had implemented additional financial controls and had seen a reduction in its own deficit forecast for year but explained that there was still a significant risk in relation to the system position. She agreed that more consideration was required as to how this could be managed.

At Mr Sarwar's request, Directors confirmed that they were content with the increases to the scores assigned to risk 2a and 6 and the revisions to the wording used for risks 2a, 4a and 4b.

RESOLVED: **Directors received, discussed and approved the Board Assurance Framework and confirmed that they were content with the assurances provided.**
Directors confirmed that they were content with the increases to the scores assigned to risk 2a and 6 and the revisions to the wording used for risks 2a, 4a and 4b.

TB/2023/012 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) ASSURANCE REPORT

Dr Gardner referred members to the previously circulated report and highlighted that that the PSIRF had now been in place at the Trust for 12 months. He explained that this would allow thematic reviews to be undertaken going forward. Dr Gardner confirmed that Patient Safety Incident Investigations continued to be monitored through the Trust's Lessons Learned Group and that any action plans were being closely monitored and closed as appropriate. He clarified that the most important part of the PSIRF process was being able to take any learning from incidents and ensure that it was applied throughout the Trust. He noted that the improvements in patient safety culture referred to the in the report were a good example of this.

Mr Wedgeworth observed that some troubling themes were coming through some of the incidents referred to in the report, specifically in relation to pressure ulcers and maternity. He stated that while he felt it was right to celebrate the Trust's achievements, it was also important to focus on any areas requiring improvement.

Mr Sarwar thanked Mr Wedgeworth for his comments and agreed that it was key to recognise the accomplishments of staff whilst also recognising when more work was needed.

Mrs Molyneaux explained that the Trust would be expected to provide an action plan in relation to any areas of concern identified in the recent CQC inspection of its maternity areas and would be closely monitored against this. She also pointed out that no 'must do' actions had been identified and that this should be considered as a positive. Mrs Molyneaux acknowledged that there were concerns around the upwards trajectory of pressure ulcers and that a full update was due to be provided to the Quality Committee in the near future to provide assurance around this.

Mr Rehman referred to the information provided in paragraph six of the report relating to maternity specific incidents and requested clarification on how more assurance could be gained on how the learning from these had been embedded.

Dr Gardner explained that this was continuously measured by maternity colleagues, adding that the robustness of this work was clear to see in the outcomes recently provided by the CQC. He stated that more information regarding this would be provided in future reports or through the Board's Sub-Committees.

Mr Rehman clarified that his concerns related to the fact that CQC reports, and other forms of triangulation were a snapshot in time and that, due the importance of the issues around the

Ockenden report and maternity services, he felt it was the vital for the Board to receive a more cohesive update on this.

Dr Gardner reiterated that an important part of the PSIRF for the current year would be the development of thematic analyses. He explained that 160 Patient Safety Response (PSR) investigations would be used to develop this and inform the five priorities for the PSIRF for 2023-24. Dr Gardner added that the strength of this approach was gaining themes whilst also accounting for the fact that they would inevitably change over time and that PSRs would play a key role in facilitating this. Directors also noted that the trust was on track to delivering and implementing its new RADAR incident reporting system which would enable easier triangulation of this information.

Mrs Brown informed Directors that there had been a disproportionate increase in the Trust's insurance premiums for the coming year and pointed out that this was directly linked to claims and risks. She requested that this was factored into any future triangulation discussions around incidents going forward.

Mr Sarwar summarised that the points being raised were fundamentally related to assurance. He noted that Mrs Brown had already raised an important point around triangulation and suggested that there was a need to consider how this was done.

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

TB/2023/013 **INTEGRATED PERFORMANCE REPORT (IPR)**

a) Introduction

Mr Hodgson referred to the previously circulated report and confirmed that it covered data up to the end of November 2022. He reiterated that the Trust was performing relatively well in terms of its four-hour performance, ambulance handover times, elective waiting position and in a number of other areas, including fill rates for nurses and midwives and Friends and Family Test (FFT) scores. Mr Hodgson acknowledged that there were areas requiring improvement, particularly in relation to the Trust's 12 hour wait time performance and its 62-day cancer backlog, but stated the situation was as good as it could be given the wider pressures being seen.

b) Safe

Dr Gardner highlighted that the numbers of Pseudomonas infections had started to level off. He confirmed that the Trust's Infection Prevention and Control (IPC) team was in the process of reviewing any infections and identifying themes.

Mrs Molyneaux reported that nurse staffing had remained challenging throughout the month, with one ward falling below the 80% safe staffing level for registered nurses. She confirmed that actions were in place to mitigate any risks but stated that it remained an ongoing source of challenge.

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. She acknowledged the concerns raised around pressure ulcers earlier in the meeting and advised that she was planning to meet with colleagues in the near future to facilitate expanding the information provided around this in future iterations of the IPR. Mrs Molyneaux also stressed that there had not been any significant increase in patient harm.

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

d) Effective

Dr Gardner reported that the Trust's Summary Hospital Mortality Indicator (SHMI) continued to be within expected levels and that its crude mortality was currently at historically low levels. He informed Directors that its Hospital Standardised Mortality Ratio (HSMR) performance was currently outside of expected levels and explained that this was due in part to issues with palliative care coding. Dr Gardner confirmed that a significant amount of work was going into addressing this and that changes were due to be made to clinical coding. He also confirmed that actions plans remained in place for any alerting groups such as sepsis and that mortality in general continued to be closely monitored through the Mortality Steering Group.

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

e) Responsive

Mrs Gilligan reported the Trust's four-hour performance at 72.64% for the month to date. She conceded that this was not where the Trust wanted to be but pointed out that it was still in the top 30 performers for all types of attendances nationally. Mrs Gilligan also highlighted that the Trust continued to perform well in terms of ambulance handovers, despite it receiving the highest number of conveyances in the North West over recent weeks. She reported that there had recently been six validated breaches of the 60-minute handover target and confirmed that work was taking place to address this. Mrs Gilligan also confirmed that the Trust would continue its policy not to hold ambulances. She acknowledged that this did increase the risks associated with corridor care but stated that she believed it was the right thing both for the Trust and for the local population.

Mrs Gilligan went on to inform Directors that there were currently 30 COVID-19 positive patients being treated in the Trust and four cases of paediatric Respiratory Syncytial Virus. She noted that this was a significant improvement from the numbers being seen a month earlier.

Mrs Gilligan advised that the Trust was currently ranked at 16th nationally in terms of the proportion of its cancer patients that had waited more than 62 days for treatment. She highlighted that good progress was being made in this area, with 400 less patients currently on cancer pathways than at the start of December 2022. Directors noted that fortnightly meetings with national colleagues remained in place and that they were content with the progress being made.

Mrs Gilligan concluded her update by reporting that the Trust was currently managing seven patients who had waited over 78 weeks to be seen, adding that this was the third lowest in the North West. She confirmed that the Trust was continuing to provide support to other organisations in the system in this area.

In response to a query raised by Miss Malik, Mrs Gilligan reported that the longest wait experienced by patients for a suitable mental health bed had been just over 94 hours in November 2022,105 hours in December 2022 and 61 hours in January 2023. She also reported that the longest waits for patients with physical health issues had been 62 hours, 41 hours and 43 hours in November, December and January respectively. Responding to a further query from Miss Malik, Mrs Gilligan explained that the main contributing factor to these long waits was the lack of suitable beds to meet the specific needs of the patients involved. She informed Directors that the Trust was working better than ever before with colleagues at

Lancashire and South Cumbria NHS Foundation Trust and that they had been extremely responsive to recent requests.

Mr Hodgson advised that a good example of the challenges that the Trust would be facing over the coming months was colorectal cancer, as all organisations in the region were experiencing similar pressures in this area. He conceded that mutual aid was likely to make the Trust's individual position worse in some areas and noted that this was part of the wider tension in system working and close collaboration.

Mr Sarwar agreed and stated that the main issue for the Trust would be how it responded to this. He acknowledged that many of these issues would be resolved as mutual aid between organisations developed further but stated that there likely to be some difficult decisions to be made regarding system working over the coming years.

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 currently stood at 6%, which was above threshold. She explained that mental health related sickness was an ongoing area of concern but highlighted that the Trust had a robust occupational health and wellbeing offer in place, including the recent reinstatement of its Early Access to Support for Employees (EASE) service. Mrs Quinn also pointed out that staff sickness was typically a reflection of general population health and that the recent increases were likely to be reflection of this in a number of ways.

Mrs Quinn reported that the Trust's vacancy rates had improved but continued to be a challenge. She informed Directors that the Trust was focused on strengthening its improvement and retention agendas and that this would involve developing a flexible working offer and workforce transformation. Mrs Quinn went on to highlight that a substantial amount of work was taking place to reduce bank and agency spend and that several significant improvements had already been made. She added that two key strands had been established through the PCB related to agency spend caps and managing the wider market.

Mrs Brown reported that the Trust's deficit was currently forecast to be £6,700,000 by year end, adding that this was still some way from the breakeven position requested by NHSE. She

confirmed that work continued with ICS colleagues to agree and improve the system forecast and agree a revised total with national colleagues. Mrs Brown explained that a significant amount of non-recurrent funding was being used in the current year which would lead to additional challenges in 2023-24. She advised that the Trust was already working on efficiency plans in preparation for this and was likely to focus on workforce challenges such as theatre productivity.

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

TB/2023/014 HEALTH EQUITY UPDATE

Mr Patel presented a series of slides to Directors to update them on the activities and work taking place in the LSC Health Equity Alliance (HEA). He explained that the main aims of the Alliance were to identify areas where it had influence, identify the resources available to it to effect change and finally to make use of its insight and evidence to reduce inequalities in health need and healthcare access. Mr Patel stated that the Trust had a key role to play in this work as an anchor institution and that it was focused on all areas that affected its patients in terms of their access to treatment. He informed Directors that the HEA was operating within "Core20PLUS5 (+)", a national approach being taken by NHSE to support the reduction of health inequalities at a national and system level, and that a shortlist of themed priorities had been developed. Mr Patel clarified that these were all interlinked and influenced the health equity agenda. He added that one of the other goals of the HEA was to get Trusts to stop thinking of themselves as single institutions and work with system partners to enhance services and empower communities to better manage their own health.

Mr McDonald extended his formal thanks to Mr Patel for his leadership in relation to the work being done by the HEA. He stressed the importance of health equity as well as ensuring civil leadership in the process, as different organisations were likely to lead in different areas. Mr McDonald reassured Directors that the Trust was working closely with its ICB and PCB colleagues on population health and reported that good progress was being made. He explained that it would be vital to maintain the balance of needs at system, place, neighbourhood and organisational level as the programme moved forward, because the solutions to health inequalities would ultimately be found in communities in which patients resided rather than hospitals. Mr McDonald stated that he would welcome an opportunity to develop the Trust's health equity agenda further at a future development session.

Mr Hodgson informed Directors that he had attended a meeting the previous day between ICB, PCB and public health colleagues, during which a potential health equity model had been discussed.

Mr Rehman commented that Mr Patel's presentation had provided a good insight into health equity but noted that no information had been provided around any internal inequities. He stated that he would be interested in seeing the data for patients who felt that they couldn't access the Trust's services due to their background and enquired if a timeline for delivery could be provided.

Mr Patel clarified that a timeline for the HEAs work was likely to be formalised later in the year and advised that the Trust was working with colleagues at the University of Central Lancashire (UCLan) to facilitate this and on how to present data more tangibly.

Mrs Gilligan informed Directors that more hard data was expected to be available by the end of the following week. She agreed with Mr McDonald's suggestion to arrange a follow-up development session to discuss health equity further.

Mr Sarwar noted that it would be difficult to progress beyond conversations around health equity without an accompanying equity or inequality strategy to underpin the Trust's Clinical Strategy.

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

A Board Development / Strategy Session on Health Equity will be arranged for a later date.

TB/2023/015 MATERNITY AND NEONATAL SERVICE UPDATE

Miss Thompson provided a summary of the activities of the Trust's maternity services. She informed Directors that the Trust was currently 90% compliant with Year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), with the only area of assurance outstanding relating to the Perinatal Mortality Review Tool.

Miss Thompson reminded Directors that the first part of the Ockenden report had been published in December 2020 and reported that, following a review in April 2022, the Trust had been found to be 100% compliant against this. She advised that a second Ockenden visit to the Trust was planned to take place in April 2023 following the publication of the Full Ockenden Report in September 2022. Miss Thompson confirmed that the Trust had also commenced a

gap analysis exercise against the findings of the report published in October 2022 following the Independent Investigation into East Kent Maternity Services.

Miss Thompson informed Directors that following the conclusion of a BirthRate+ exercise, a final report had been provided to the Trust in September 2022. She advised that, in accordance with safety action five of the CNST (Midwifery Workforce), an action plan had been agreed to achieve the required uplift in funding. Miss Thompson highlighted that the Trust had implemented its own Midwifery Workforce Programme, which was intended to support providers to develop their own band 5 and band 6 midwives. She confirmed that the Trust still had a number of midwife vacancies but currently had the lowest vacancy rate in the North West.

Miss Thompson concluded her update by providing a summary of the Maternity and Neonatal Safety Improvement Programme.

Mr Hodgson commented that the volume of hard work that gone into maternity services in the Trust was clear to see from Miss Thompson's update.

Mr Sarwar suggested that maternity updates should be included on the cycle of business for Trust Board meetings going forward.

Mrs Bosnjak-Szekeres advised that discussions had already taken place around future maternity updates and confirmed that this would be progressed after the meeting.

RESOLVED: **Directors noted the update provided.**
Maternity updates will be added to the cycle of business for the Trust Board.

TB/2023/016 **TRUST CHARITABLE FUNDS COMMITTEE INFORMATION REPORT**

a) Trust Charitable Funds Update Report

The report was presented to the Board for information.

b) Charity Annual Accounts and Report (the Board met as a Corporate Trustee for this item)

Directors confirmed that they were content to approve the Trust's Charity Annual Accounts and Report for submission to the Charity Commission.

RESOLVED: **Directors approved the Charity Annual Accounts and Report for submission to the Charity Commission.**

TB/2023/017 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/2023/018 QUALITY COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2023/019 AUDIT COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2023/020 TRUST BOARD (CLOSED SESSION) INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB2/2023/021 REMUNERATION COMMITTEE REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2022/022 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2023/023 OPEN FORUM

Directors were informed that a question had been raised by a member of the public prior to the meeting regarding engagement from NHS discharge and community colleagues with providers around solutions to support rapid discharges. The following response was provided:

"We are not able to specifically endorse individual businesses unless these have followed the appropriate procurement and contractual requirements but would wish to assure you that we actively engage with a range of organisations, including public sector, voluntary organisations and independent businesses, to facilitate and enable a range of activities such as discharge and home-based care to support our patients, their loved ones and our local communities.

Within East Lancashire Hospitals we are fortunate to have low numbers of patients delayed for discharge within our acute hospital services and work collaboratively with system partners to minimise and address such delays as early as possible. Where we do have delays for discharge these are often for specialist care or placement due to mental health or complex needs or specific housing requirements."

TB/2023/024 BOARD PERFORMANCE AND REFLECTION

Mr Sarwar sought feedback from Directors as to whether they felt the Board had appropriately addressed and fulfilled its objectives in relation to its communities, staff and stakeholders. He commented that he felt that the meeting had reflected the Trust's values with its emphasis on kindness and compassion and that all Directors had had sufficient opportunity to contribute.

Mr McDonald commented that the patient story had been particularly powerful and was a good reminder of what Directors and other colleagues in the Trust were working for.

RESOLVED: Directors noted the feedback provided.

TB/2023/025 DATE AND TIME OF NEXT MEETING

Mr Sarwar informed Directors that the next Trust Board meeting would be taking place on Wednesday, 8 March 2023 at 13:00.

Mr D Byrne, Corporate Governance Officer

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**30**
8 March 2023		**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

(30) 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/2023/006: Action Matrix	Patient Safety Incident Response Framework Assurance Report - An update on the information requested in relation to whether patients from ethnic or minority backgrounds were more disadvantaged in terms of maternity incidents had proven to be a more substantial piece of work than originally envisaged. She confirmed that this update would be provided at the next Board meeting and would include more information regarding other contributory factors.	Interim Chief Nurse	March 2023	This update will be provided as part of the report for item number: TB/2023/040: Maternity and Neonatal Service Update.
TB/2023/010: Corporate Risk Register (CRR)	Pre-mitigation scores for risks will be added to future iterations of the Corporate Risk Register from May 2023.	Executive Medical Director	May 2023	The pre-mitigation scores will be included in the report from May 2023 and as part of the annual review.

Item Number	Action	Assigned To	Deadline	Status
TB/2023/014: Health Equity Update	A Board Development / Strategy Session on Health Equity will be arranged for a later date.	Executive Director of Integrated Care, Partnerships and Resilience	Q2 2023-24	Board Strategy/Development Session Agenda Q2 2023-24
TB/2023/015: Maternity and Neonatal Service Update	Maternity updates will be added to the cycle of business for the Trust Board.	Corporate Governance Team	March 2023	Complete: Maternity Updates will be presented to the Board at each of its future meetings.

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

Mr D Byrne, Corporate Governance Officer

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**33**
8 March 2023		**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 strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

1. Background

This report is divided into sections covering the following:

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

2. National Updates

Urgent and Emergency Care Recovery Plan

The NHS and the government have published a blueprint to help recover urgent and emergency care services, reduce waiting times and improve patient experience. As part of the Urgent and Emergency Care recovery plan, frontline capacity will be boosted by 800 new ambulances, including 100 specialist mental health vehicles, and 5,000 more sustainable hospital beds backed by a £1 billion dedicated fund.

The two-year plan aims to stabilise services to meet the NHS's two major recovery ambitions, to help achieve A&E four-hour performance of 76% by March 2024 and improve category two ambulance response times to an average of 30 minutes over the next year, with further improvement in the following year. These ambitions represent one of the fastest and longest sustained improvements in emergency waiting times in the NHS's history.

Urgent care provided in the community will be expanded to ensure people can get the care they need at home, without the need for a hospital admission. These services will run for at least 12 hours a day – responding to calls normally requiring an ambulance crew – and will mean people who have fallen or are injured can get care and treatment at home within two hours.

Same day emergency care units, staffed by consultants and nurses, will be open in every hospital with a major A&E, helping to transform patients' experiences and allowing thousands of people each week to avoid an overnight hospital stay. Freeing up space in hospitals and speeding up discharge for those who are medically fit to leave are key parts of the blueprint, which will see pilots of a new approach to NHS step down care across the country – where patients will receive rehabilitation and physiotherapy including at home.

This scheme will ensure people have a smooth transition out of hospital, reducing the chances of re-admission while also potentially reducing long term demand on social care. The success of

‘virtual wards’, with 7,000 virtual ward beds already in the community and up to 50,000 patients a month expected to benefit by the end of 2023/24.

Expansion of NHS 111 to transform patient access

NHS 111 will include increased access to specialist paediatric advice for children and direct access to urgent mental health support, to help recover urgent and emergency care services. Parents and carers will have increased access to specialist advice, including support from paediatric clinicians who can help them manage illness at home or decide the best route for their care. This will see some children referred directly to a same-day appointment with a specialist rather than attending A&E. Direct access to urgent mental health support using NHS 111 is also being rolled out right across the country – with people being able to select the mental health option when they call up for help.

NHS surgical capacity boost

An estimated 780,000 additional surgeries and outpatient appointments will be provided at 37 new surgical hubs, 10 expanded existing hubs and 81 new theatres dedicated to elective care. The news was published a year on from the Elective Recovery Plan and after the elimination of two-year waits for care. Surgical hubs enable tests and operations to continue separately to emergency care. The Targeted Investment Fund (TIF) will provide almost 600 new beds (584) specifically for elective care, dozens of elective theatres and nearly 90 more critical care beds across the country. Since the elective recovery plan was published last year, the NHS has performed almost 120 million diagnostic tests – 6% higher than in the same period last year – and offered 13.5 million elective appointments and treatments – 9% higher than in the same period last year. Elective care was delivered for 70,000 more patients in November compared to the same period pre-pandemic, meaning the waiting list dropped by almost 30,000 compared to the month before.

NHS Digital and NHS England merger

NHS England and NHS Digital have merged into a single organisation, creating a closer link between the collection and analysis of data to help drive improvement to patient outcomes. The transfer, which will include all existing protections for data, sees NHS England become the custodian of national health and social care datasets and the single executive non-departmental public body with responsibility for digital technology, data and health service delivery in the NHS.

Life-saving Gene Therapy on the NHS

A 19-month-old baby girl called Teddi was the first child in the UK to receive life-saving gene therapy treatment for metachromatic leukodystrophy (MLD). The revolutionary treatment, listed

to cost £2.8 million, was provided to the NHS at a significant confidential discount but remains the most expensive drug licensed in Europe.

The genetic disease causes severe damage to the affected child's nervous system and organs, resulting in a life expectancy of between just five and eight years. The treatment is available on the NHS as a specialist service. It is being delivered within Royal Manchester Children's Hospital – in collaboration with Manchester's Centre for Genomic Medicine at Saint Mary's Hospital – as one of just five European sites and the only site in the UK. The life-saving gene therapy works by removing the child's stem cells and replacing the faulty gene that causes MLD before re-injecting the treated cells into the patient.

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 1 February 2023. A recording of the meeting is available to watch online here https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers/future-board-meetings/1-february-2023-board-meeting

The Chief Executive's Report submitted by Kevin Lavery as part of the meeting's papers provides a wider update. The report in full is included as an appendix.

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

The PCB met on 19 January 2023, and received updates on pressures within the acute and mental health trusts, finances, research and innovation, corporate services collaboration, the clinical programme board, workforce resilience and sustainability, cancer services and pathology.

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

The Joint Committee had been established to give the PCB a mechanism via which to make decisions on a number of areas as agreed with Trust Boards.

System pressures – acute

Urgent and acute care services remain extremely busy, with a collective position of 71.5% on the A&E four hour waiting time target. This is above the regional average and during January the position had risen to 76%. There had been some extremely positive examples of mutual aid over the last four weeks, particularly in relation to ambulance diverts from Blackpool Teaching Hospitals to Lancashire Teaching Hospitals and Morecambe Bay.

The Royal College of Nursing (RCN) industrial action had been well handled with positive working with staff side to ensure that patients remained as safe as possible during the strike. Some elective activity had been stood down with a varied picture across Trusts and there was some best practice learning to be had.

Planning was already underway for the industrial action set to take place in March. This was likely to be more challenging than the January strikes as some of the North West Ambulance Service (NWAS) and RCN action was due on the same date. The possible Junior Doctors strike would also have a significant impact if it proceeded.

With the exception of a number of agreed exemptions, there are no patients waiting 104 weeks within the system. Collectively trusts are on track to meet the 78 week waiting time target by the end of March although challenges remain around this including the as yet unknown impact of ongoing industrial action.

The biggest risk sits with Lancashire Teaching Hospitals due to the volume of patients on their lists, however all Trusts are committed to working together to achieve the target. This meant that some Trusts would experience a worsening of their individual position on 78 weeks, however individual Boards were sighted and supportive of this. LTH also had some specific issues in relation to the waiting list initiatives which were under discussion and may need to be escalated to the ICB and regional teams as this presented a further risk to the 78 week target.

Colorectal cancer remained a challenge across most Trusts so proactive mutual aid would remain very important in ensuring that the target was met by the end of March 2023.

In summary, the system was exceptionally challenged due to the combination of winter, covid, flu. Urgent and Emergency pressures, industrial action, and the work on restoration. However, staff were rising to the challenge and L&SC were delivering well compared with other systems with great examples of mutual aid across all areas of work. This provides a strong platform to move into the next phase of restoration.

Trusts were also committed to working towards having a joint Patient Treatment List (PTL) and a paper providing more detail on the specifics of this would come to a future meeting as part of a wider strategy for scheduled care.

System pressures- mental health

The flow of people with Mental Health (MH) needs from Emergency Departments into the Mental Health Urgent Assessment Centres (MHUACs) had worked well over the Christmas period despite the pressures within the system. Acute Trusts had really noticed the difference that the MUACs had made within the last month or so. A report on the MHUACs was due to come back to the PBC in two months.

The phrase mutual aid within an acute setting applies to other providers within a local geographical area, however within MH this means other MH providers. It was important that the ICS and PCB were as sighted on issues relating to the wider MH system as they were on acute pressures. Secure and rehabilitation services nationally were under considerable pressure, with a number of closures of facilities providing these services both within the NHS and the independent sector.

Skylark, an eleven bedded MH facility was due to open on the Royal Preston site which would help reduce the numbers of out of area patients.

LCSFT were committed to tracking the outcomes of the activity they were undertaking and had now joined a group looking at excess mortality rates as part of that process.

Financial pressures

The system's financial position continues to be very challenged with ongoing conversations taking place with the regional and national teams about the likely year end position.

The current operational challenges including the industrial action would inevitably have a detrimental effect on finances. Unfunded beds remained an issue for some trusts due to a lack of out of hospital capacity – some short-term solutions had been found but these were high cost and unsustainable particularly in relation to temporary staffing premiums.

Changes to discount rates were contributing to technical gains and progress continues to be made across all trusts in terms of grip and control – it would be vital to sustain this throughout the remainder of the year.

Any deficit this year would be carried into the following year and was likely to impact on the ability to attract future capital. The next financial year 2023/20024 was set to be even more challenging with much scrutiny around efficiency and restoration of elective activity.

Research and Innovation (R&I)

An update was given on the current state of the National Institute for Health and Care Research (NIHR) Studies in the PCB Trusts, the interactions with local academia and industry, and innovation and the workforce in Research and Innovation (R&I).

A discussion took place on successes to date, opportunities and limitations and recommended ways to move this agenda forward.

Whilst much progress had been made, colleagues across Lancashire and South Cumbria were keen to ensure that they fulfilled their potential in both R&I and Education. In addition to the ongoing work of the networks it was important to develop a unique proposition for L&SC and fully integrated ways of working between different organisations and to focus on some specific areas of research (e.g., deprivation). The ICS were keen to work with the PCB to develop these areas of expertise particularly given the positive effect that involvement in R&I as part of people's job roles had on both recruitment and retention of staff.

Workforce Resilience and Sustainability Project

The Bank and Agency programme had been reset and renamed the Workforce Resilience and Sustainability Programme to reflect the scope of the work required.

A workshop in January including staff side and temporary staffing had been very positive and removed some of the potential barriers to the tender process proceeding at the end of March.

A general communications plan has been prepared and will be disseminated shortly. The Business Case would be coming back to the PCB in March.

Corporate Services Collaboration

Work around the Workforce Resilience and the Sustainability project had been extensive during December. Three workshops had taken place with HR, Finance and Communications with a further workshop to take place in February/March to finalise proposals for the Target Operating Model.

A clear procurement path has been put forward for Bank and Agency and the ELFs Shared Services proposal, and there was good progress on development of a single payroll and other initiatives such as the ledger for finance.

Clarity of leadership, governance and assurance would be essential to the success of the programme and learning had been taken on board from previous programmes to ensure that this was robust.

Work was taking place to align HR policies such as management of change and infrastructure for redeployment, and relevant processes were being put in place in advance of the development of the target operating model.

A forward plan with a clear decision-making timetable would be developed after the next workshop.

Clinical Programme Board

A positive meeting had taken place between the Clinical Services Programme Board and the ICS Medical Director to begin to agree priorities and milestones, particularly for the next year in relation to both the Clinical and Cancer Strategies.

The programme team had done a lot of work with Senior Responsible Officers on the programme plan milestones, decisions, benefit realisation, and the risk register and the forward look for 2023/24 would be firmed up further with the help of the ICS.

Engagement of staff, and interaction with the ICS team would be critical to the success of the clinical programmes– the ICS would be arranging a workshop in March to set out how and when engagement and consultation needed to take place in connection with any proposed service changes. A tool kit had been developed by the ICB and PCB communications and engagement colleagues to make the process as easy as possible and to ensure a consistent methodology.

There was a consensus that delivery of services needed to take place within the existing infrastructure of the ICS and PCB rather than waiting for the New Hospitals Programme (NHP) to come to fruition and that configuration of existing trusts would be a limiting factor that needed to be taken into account. Interdependencies between services would need to be considered when deciding where services should be located. A commissioning view would also be important for many of the projects, for example with regard to the location of regional centres.

Work is progressing in Pennine to review current community services, and this would inform the PCB considerations about the development and delivery of integrated care models. This would need to be closely integrated with the ICS work, as this was a commissioning responsibility.

Cancer Services

The system has experienced challenges in the delivery of some cancer services and some of them were noticeably fragile.

The findings of a deep dive have been reported to the ICS Board. These encompassed a range of issues and a Cancer Plan addressing these will return to IC Board in Q4.

The PCB and ICS now need to work closely with the specialist commissioning to address these challenges. Difficult decisions may need to be made by providers, informed by the PCB in the interest of the public and the best possible outcomes.

The ICS Board would initially be concentrating on a number of key changes within agreed priority specialties – Vascular, Head and Neck and specialist Urology cancer surgery - and NICUs and non-surgical oncology workforce.

Other clinical programmes need to develop robust networks and focus on delivering best practice pathways informed by Get It Right First Time (GIRFT) principles.

Pathology

Presentations have or will shortly be given to individual Trust Boards about the intention for the pathology collaborative to report into the Joint Committee. Meetings had taken place with Divisional Directors within Trusts.

Further discussions had taken place with Browne Jacobson to understand what might be in the Joint Committee Terms of Reference regarding this and the overall direction of travel, with the focus likely to be on ten key areas.

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 been applied to the following documents since the last report to the Board:

- On 24 January 2023 the seal was applied to the deed of variation to the project agreement relating to the removal of security services at Burnley General Teaching Hospital. The document was signed by Mrs Michelle Brown, Executive Director of Finance and Mr Jawad Husain, Executive Medical Director.
- On 24 January 2023 the seal was applied to the deed of variation to the project agreement relating to the removal of security services at Royal Blackburn Teaching Hospital. The document was signed by Mrs Michelle Brown, Executive Director of Finance and Mr Jawad Husain, Executive Medical Director.
- On 25 January 2023 the seal was applied to an underlease relating to part of the Burnley General Teaching Hospital between the Trust and Equans Buildings Ltd for retail space. The document was signed by Mrs Michelle Brown, Executive Director of Finance and Mrs Sharon Gilligan, Chief Operating Officer.
- On 31 January 2023 the seal was applied to a revised letter relating to the above mentioned underlease. The document was signed by Mr Martin Hodgson, Chief Executive and Mrs Michelle Brown, Executive Director of Finance.

Changes to the Trust Board and Executive team

Kate Atkinson has been appointed as Executive Director of Service Development and Improvement at ELHT. Kate, who has worked at the Trust for many years including as interim in the role for the past 12 months, will substantively join the Board and Executive Team. Her appointment follows a robust recruitment process which included a formal interview and two

further stakeholder panels, with a range of colleagues from the Trust, Pennine Lancashire, the Lancashire and South Cumbria system as a whole and partners.

Interim Chief Nurse Julie Molneaux is leaving the Trust Board to retire after almost 40 years as a Registered General Nurse. Julie has worked for the NHS in a number of role during her career including Staff Nurse, Junior Sister, Senior Sister and Clinical Lead Nurse within the specialities of general surgery, complex colorectal, intestinal failure and surgical high dependency. She took up her first senior nurse position in 2002 and joined the Trust in 2014 as Deputy Chief Nurse where she has demonstrated her continuous commitment to high standards of compassionate care, whilst building on and sustaining effective partnership working. The Trust is indebted to Julie for her unwavering hard work and dedication during a long and successful career.

Associate Non-Executive Director Mike Wedgeworth MBE is also leaving the Trust Board. Mike joined the Trust in April 2017 and has been an active and valued member of the team, particularly in relation to his portfolio as 'maternity champion'. Colleagues across the Trust and especially in the Families Division recognise Mike's interest, enthusiasm and support. He is well known in the Trust and will be very much missed. The Trust recognises Mike's contribution to the organisation and wishes him every possible success for the future.

New Chief Information Officer

Daniel Hallen has been appointed as ELHT's Chief Information Officer (CIO), bringing a wealth of digital and programme management experience with him. Daniel succeeds Mark Johnson, a valued and well-respected member of the team, who retired in February after 43 years' service in the NHS. Daniel will lead the Trust's ambition of creating an organisation that is digitally led and digitally skilled. For the next few months, his focus will predominantly be supporting the eLancs Electronic Patient Record (ePR) roll out.

EPR – On Track and Superuser training underway

The Trust continues to focus on delivering of the critical Electronic Patient Record (EPR) project with a 'go live' date for implementation of June 2023. The team continues to work hard to progress and has entered the operational readiness phase.

As part of this the Trust recognises the need to enhance resources across all workstreams and in particularly, engagement and communications support has intensified with colleagues. The Superuser training programme began in February to equip all departments with the knowledge they need to provide support before, during and after go-live.

A central Superuser ‘community’ is in place where colleagues can have conversations, ask questions and share communications materials. Weekly walkarounds at all sites have continued over the past two months to provide demos of the system and to hand out brochures and flyers to display in their departments. The first eLancs Q&A webinar of 2023 took place on 8 February which saw 340 colleagues tune in and over 50 questions asked. This was the highest turnout yet and the team will continue these in the run up to go-live.

Industrial action

Following the 2022/23 pay award for NHS staff, the NHS has experienced a prolonged period of industrial action. At time of writing, there were two trade unions at ELHT who have gained the necessary mandate and either taken, or announced, industrial action:

- Chartered Society of Physiotherapists (CSP) – took action on Thursday 9 February 2023
- Unite (only impacting Pathology Services) – took action on Wednesday 22 February 2023, 7am – 7pm

Sub-cells of the Trust Industrial Action Cell continue to plan around these strikes, to ensure continuity of service and that safety of patients, colleagues and the public are maintained at all times.

The Trust continues to manage the response to industrial action by colleagues at North West Ambulance Service (NWAS), with the following dates currently known for further action:

- Monday 6 March 2023 (GMB and Unite)
- Monday 20 March 2023 (GMB and Unite)

The British Medical Association (BMA) balloted junior doctors around pay and whilst the ballot closed on 20 February the impact on the Trust specifically is not yet known. A sub-cell has been established to plan for this eventuality.

Front Door Therapy Team

The Front Door Therapy team is now working extended hours seven days a week, following a successful trial. They were introduced last year to help with patient flow and discharge by identifying patients in emergency pathways who are well enough to receive care at home. Their services include mobility and social assessments, provision of care, walking aids and equipment, chest physiotherapy and specialist assessment to support with decision making. Their support is saving patients many hours of unnecessary waiting and in many cases avoided the need for hospital admission. They are now available 8.30am until 8pm every day.

Patient champions supporting Emergency Department

To help improve the patient experience in the Emergency Department, Patient Champions have been introduced. They are making cups of tea, distributing sandwiches, providing blankets and speaking with our patients who are perhaps lonely. The champions include non-clinical colleagues who were keen to support patients and the busy Emergency Department, who were facing unprecedented demand.

Flow improvement weeks

A series of five improvement weeks has taken place in ELHT to support patient flow. They looked at all aspects of what we do to see if there is any great practice that could be shared further or any improvements that could be introduced. Departments each took a different theme and tested different ideas to find improved ways of working.

Mass vaccination centres close

The mass COVID-19 vaccination sites in Barbara Castle Way, Blackburn and Charter Walk Shopping Centre, Burnley have now closed. They were the last remaining vaccination centres out of the seven mass sites established across the Lancashire and South Cumbria region during the pandemic. The sites administered over 4.3 million vaccines across Lancashire and South Cumbria including first, second and booster doses with 86% of high-risk and eligible people taking up the offer of their vaccine. The team also administered up to 28,500 vaccines to people in their own homes or via pop-up clinics.

Boost for cancer diagnosis

Cancer screening is being boosted at Burnley through new equipment. Upgrades to x-ray and screening equipment will help speed up diagnosis and treatment of breast cancer. The news came as part of a funding announcement by the Government to increase capacity to make sure people can get the care they need when they need it.

New breast pain clinic

The Lancashire and South Cumbria Integrated Care Board has launched a new breast pain clinic in Burnley to support people in East Lancashire. The specialist service, led by ELHT colleagues, provides a full family history assessment, breast examination and specialist advice to patients suffering from breast pain. The clinic will be based at St Peter's Centre in Burnley and we are encouraging anyone experiencing breast pain to speak to their GP so they can be referred.

Online brain injury and stroke support programme funding boost

An online brain injury support scheme to help brain injury and stroke survivors has been boosted with additional funding. The Lancashire and South Cumbria regional NeuroRehabilitation OnLine

(NROL) programme, which is hosted by ELHT and the University of Central Lancashire (UCLan), uses online video sessions to provide specialist group neurorehabilitation to brain injury and stroke survivors.

The scheme was created in winter 2020/21 because patients were limited in accessing face to face NHS treatment due to COVID restrictions and now over 2,000 patients have been able to access the sessions from the comfort of their own home thanks to funding from the charity SameYou. The additional £169k secured from NHS England's Stroke Quality Improvement Rehabilitation (SQuIRe) catalyst funding process will enable this vital resource to continue for a further 12 months.

Personalised care workshop

More than 25 colleagues from the musculoskeletal (MSK) teams held an insightful workshop on 'Embedding Personalised Care in your Pathways'. Hosted by Kelly Holehouse, Programme Manager for Personalised Care at the Trust, and the ICB Project Support Team, the event encouraged colleagues to look for opportunities to embed personalised care into ELHT's MSK and Orthopaedic pathways to help improve patient experience.

Trainee doctors welcomed

The Trust's has welcomed 45 new trainee doctors from a variety of specialties. An induction was held last month, with talks by key departments and stalls to showcase different services the Trust offers. The trainee doctors are now starting their career journey with the Trust.

Hospital Caterer of the Year

The Trust's Catering Team was a winner at the Vegetarian for Life's national awards. They were named Hospital Caterer of the Year at the Awards for Excellence in Vegetarian and Vegan Care Catering. A total of 14 rising stars in vegetarian and vegan care catering were honoured in a ceremony held in the Houses of Parliament.

"I'm not a Muslim but I will fast for one day" challenge

Colleagues across the Trust will be taking part in an "I'm not a Muslim but I will fast for one day" challenge. The event, on 30 March, is an opportunity for colleagues from all backgrounds to experience fasting, a practice Muslims will be taking part in during the holy month of Ramadan which begins in March. They will all come together at the end of the challenge to break their fast together.

Colleague care month

As part of ongoing support of health and wellbeing, the Trust organised a month long internal campaign to highlight support available. Colleague care month encouraged everyone at the Trust to look after themselves and each other, as well as raising awareness of help provided by the Trust, including helplines, webinars and free physical health checks. There was also a series of virtual support sessions organised offering practice tips and information.

ENDS

Shelley Wright
Joint Director of Communications
March 2023

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

Item 35

8 March 2023

Purpose Information
Action
Monitoring

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

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

Recommendation: 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

- 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	Yes	Confidentiality	No

Previously considered by:

N/A

Executive Summary

1. This report provides 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) There has been no movement or change in risk scores for risks currently held on the CRR, with the total number remaining at 18.
   b) A 48% reduction in numbers of open risks held on the risk register has been achieved since January 2022, along with a 56% reduction in overdue risks for the same period.
   c) Strengthening strategic and operational risks in line with 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) There has been no movement or change in risk scores for risks currently held on the CRR, with the total number remaining at 18. However, there has been a change in the effective of controls, from inadequate to limited, for DATIX ID 9557 *patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provider*

b) Strengthening strategic and operational risks in line with strategy, objectives, targets and board assurance frameworks remains ongoing.

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 1,052 risks at present, a percentage reduction of 48%. For the same period, the total number of closed risks has increased, from 7,100 risks to 8,194 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 are within Diagnostic and Clinical Support (DCS) (28%), followed by Surgical and Anaesthetic Services (SAS) (26%) and Corporate Services (CS) (19%).

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 58% of the total number, followed by health and safety risks with a percentage of 24%.

h) A breakdown of clinical risks shows patient safety risks (31%) 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 targeted for review and is being monitored by the RAM.

j) Work to improve health and safety risk sub type categories and the assimilation of these risks has been completed. This is acting as a benchmark of performance for all other risk types.

k) Work has already commenced with lead specialists or subject matter experts within the fields of finance, fire safety, infection control, information governance, information technology, manual handling, medical devices, medicines management, radiation and security management regarding the identification and assessment of risks, risk profiling and mapping, the monitoring, auditing and review of risks against the systems and or processes they have introduced within their areas of responsibility and control so as to avoid unnecessary duplication, improve standardisation and the quantity and quality of risks held within their areas of work activity.

l) An evaluation 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 at the 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 102 at present, a percentage reduction of 56%. 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) Strengthening the quality of risks held on the corporate risk register and their alignment to the business assurance framework as part of risk management reporting.

b) Continued review of the risk management module of RADAR.

c) Work with services in addressing the 677 foreseeable risks due for review over the next three months.

d) Initial discussions have taken place with members of the Core and Essential Skills Quality Group and Health and Safety Committee to embed risk management (including risk assessment) training as part of the Core and Statutory Training (CAST) or as part of the Management Competency Framework with the focus of risk management training aimed at senior managers, lead specialisms and or subject matter experts responsible for developing, implementing and monitoring systems and processes and will further complimented as part of the delivery of training on RADAR. This action has been delayed due to significant service delivery pressures, many competing priorities and limited resources available. Initial discussions have taken place with the Good Governance Institute to explore ways they can assist with the delivery of this action.

e) Continuation of strengthening the profiling and mapping of strategic and operational risks in line with strategy, objectives, targets and board assurance frameworks remains an ongoing priority action in preparation of the implementation of RADAR.

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

16 February 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 provider	**20**	**Limited**	⟺
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 provider				
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 07/02/2023** 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. A service level agreement with LSCFT is in process, with security management services now being managed in house as of 01/02/2023. Meeting to be held with MEC to discuss registration arrangements. Effectiveness of controls has changed to Limited. **Next Review Date 07/03/2023**		**Date last reviewed**		**07/02/2023**
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
							20	**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 25/01/2023** 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 (from £9.1m to £6.7m) and is still forecasting a breakeven revenue financial plan. Work remains ongoing to close this gap further. **Next Review Date 16/02/2023**		**Date last reviewed**	**25/01/2023**
				Risk by quarter 2022/23	**Q1** 20	**Q2** 20	**Q3** 20	**Q4** 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 16/02/2023** Risk reviewed. No change in risk score. Service continues to see increased waits up to 12 hrs and increased waits to be seen in ED of up to 66 hrs for mental health and up to 30 hrs for physical health. There has been a decrease in 50+ patients over the course of the last month. If this trajectory continues the risk score will be reviewed. **Next Review Date16/03/2023**		**Date last reviewed**	**16/02/2023**	
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
					20	**20**	**20**	**20**
				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 / Daniel Hallam 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 20/01/2023** Due to interface challenges, the EPR system go live date has been extended from November 2022 to Spring 2023. Awaiting outcome of business case and of additional testers required. **Next Review Date 19/02/2023** **A full quality improvement review of this risk is currently being undertaken**		**Date last reviewed**	**20/01/2023**	
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
					20	**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 09/02/2023** Risk reviewed. No change in risk score. Whilst numbers of patients on the holding list remains significant it has reduced across all specialties within the month. The holding list clearance is discussed weekly at divisional PTL with corrective actions and mitigations requested. A process is in place to clinically prioritise patients. Discussions remain ongoing regarding the impact of partial booking on the size of the holding list and teams have been asked for plans to clear the volume of overdue patients as part of the 2023/24 activity planning process. **Next Review Date 08/03/2023** **A full quality improvement review of this risk is currently being undertaken**	**Date last reviewed**	**09/02/2023**			
		Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
			20	**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 04/02/2023** 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 04/03/2023**	**Date last reviewed**	**04/02/2023**		
			Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
					16	**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 27/01/2023** 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 28/02/2023** **A full quality improvement review of this risk is currently being undertaken.**	**Date last reviewed**		**27/01/2023**	
			Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
				16	**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 20/01/2023** 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 19/02/2023** **This risk has been amalgamated with DATIX ID 2636 *inability to maintain establishment of consultant histopathologists* and scored accordingly.**	**Date last reviewed**	**20/01/2023**		
			Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
				16	**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 20/01/2023** 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. Staffing gaps anticipated to be filled in January / February 2023 which should improve capacity **Next Review Date 20/02/2023**	**Date last reviewed**	**20/01/2023**

Risk by quarter 2022/23	Q1	Q2	Q3	Q4
	16	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 23/01/2023** 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 23/02/2023**		**Date last reviewed**	**23/01/2023**	
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
					15	**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 07/02/2023** Risk reviewed. Current score is the same as initial rating as despite the controls, the Division is still not achieving pre-covid performance targets. However significant progress has been made in terms of achieving recovery milestones in terms of 104 and 78 week waiters **Next Review Date 06/03/2023**		**Date last reviewed**	**07/02/2023**	
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
					15	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 31/01/2023** 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 28/02/2023**	**Date last reviewed**	**31/01/2023**

Risk by quarter 2022/23	Q1	Q2	Q3	Q4
	15	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 10/02/2023** 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**	**10/02/2023**	
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**15**	**15**

	Next Review Date 09/03/2023	**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 10/02/2023**		**Date last reviewed**	**10/02/2023**	

	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 09/03/2023**	**Risk by Quarter 2022/23**	**Q1**	**Q2**	**Q3**	**Q4**
			15	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 10/02/2023** 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**	**10/02/2023**			
		Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
			15	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 09/03/2023**		

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 06/02/2023** 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 06/03/2023**		**Date last reviewed**		**06/02/2023**
				Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
					15	**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 26/01/2023** 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 27/02/2023**		**Date last reviewed**	**26/01/2023**	
				Risk by quarter 2022/23	**Q1** 15	**Q2** 15	**Q3** 15	**Q4** 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				
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 07/02/2023** 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 07/03/2023**	**Date last reviewed**	**07/02/2023**		
			Risk by quarter 2022/23	**Q1**	**Q2**	**Q3**	**Q4**
				15	**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		**Item**	**36**
8 March 2023		**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 for review, discussion and recommendation to the Trust Board at the meeting in March 2023. In addition, the Executive Risk Assurance Group, Quality Committee and Finance and Performance Committee have reviewed and discussed the revised document at their meetings in February 2023 and agreed to recommend the revisions to the Board for ratification.

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. There are no proposed changes to risk scores in this round of reviews.

Recommendation: The Board is asked to review, discuss and ratify the revised BAF.

Report linkages

Related Trust Goal	Deliver safe, high-quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on assurance framework	1. The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2. The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter. 3. The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive.

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

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

Previously Considered by:

Executive Directors (February 2023)

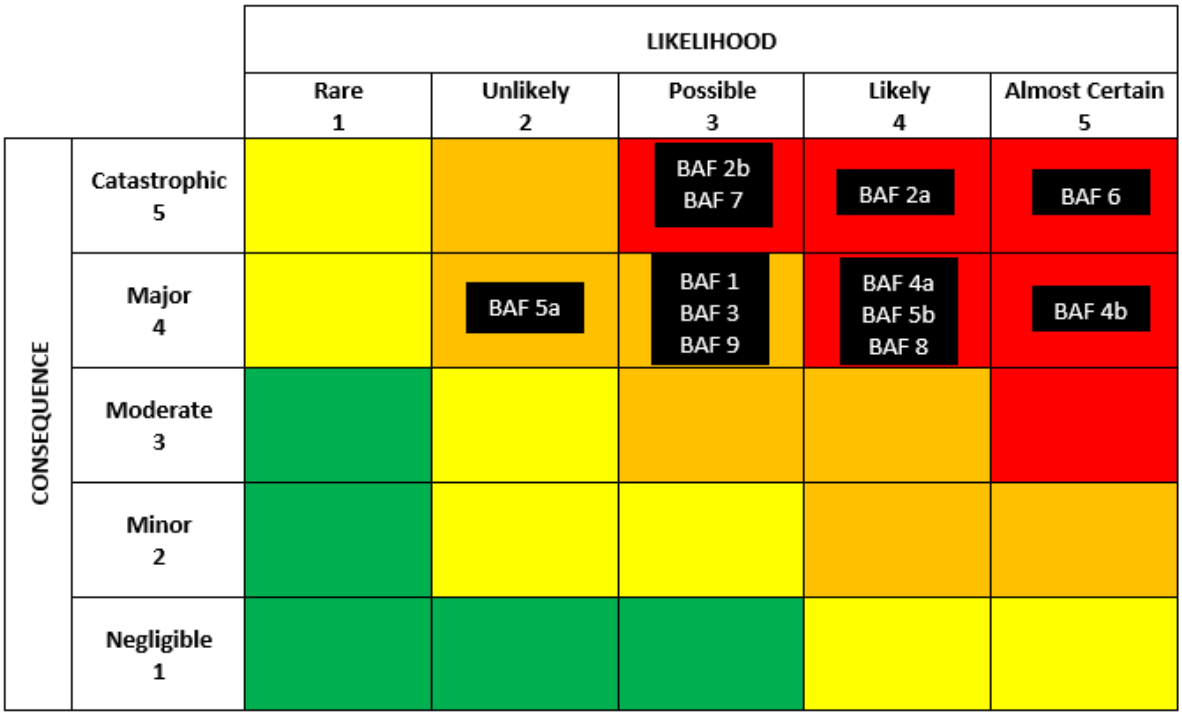
Executive Risk Assurance Group (16 February 2023)

Quality Committee (22 March 2023)

Finance and Performance Committee (27 February 2023)

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 January 2023, including any updates to the actions, assurances and controls.
3. The full BAF will be presented to the Finance and Performance Committee and Quality Committee for completeness before the Board in March 2023. However, the Committees are only asked to discuss the risk scores, mitigations and actions for the risks that are within their remits 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. Following various discussions at the Finance & Performance Committee and at Trust Board about collaborative working within the ICS and PCB, Executive colleagues are working on revising the description of this risk as it is no longer suited to the current circumstances. The review will form part of the annual review of the BAF and Board members will be consulted on the revised risk in relation to system working.

7. **Risk Score:** Remains at 12 (Consequence (C) 4 x Likelihood (L) 3).

8. **Updates to Controls:** There have been four updates to the controls section. Two of the updates relate to place-based working, one being confirmation that the place-based leaders are now in post and are shaping the priorities. The second place-based update relates to the completion of the place boundary review, where a place for Blackburn with Darwen and East Lancashire has been set as part of Lancashire. The

final two controls relate to the confirmation of Provider Collaboration Board (PCB) engagement activities taking place in February 2023 and the review of delivery structures to support the agreed priority workstreams being undertaken.

9. **Updates to Actions:** There have been updates to the majority of the actions. These include:
   a) The addition of place priorities for 2023-24 to action 1 which will feed into Trust level plans once agreed.
   b) The confirmation that place arrangements are complete and new structures are in place, with Directors of Health and Care Integration working with partners to determine place priorities for 2023-24. As a result of this update, action 3 has now been completed and closed.
   c) Additional information added to action 5 relating to the completion of workshops 1 and 2 for frailty/respiratory pathways, action 6 relating to the System Programme Management Office and action 7 relating to ongoing participation by Trust leads in agreed workstreams.

Risk 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.

10. **Risk Score:** Remains at 20 (C5 x L4).
11. **Updates to Controls:** there has been one update to the controls section of this risk. the update being the completion of the investigations that had been identified as part of the Patient Safety Incident Reporting Plan. A thematic review is now being completed to ensure learning across the Trust. New priorities are planned which have been developed via a workshop held in January 2023.
12. **Updates to Assurances:** there have been three updates to the assurances section of this risk, as follows:
   a) The confirmation of the Intensive Home Support Service (IHSS) which complements the Trust's Intermediate Care Allocation Team (ICAT) service weekdays in the Emergency Department (ED).
   b) The Internal Audit Plan for the 2023-24 year is being developed by the Mersey Internal Audit Agency on conjunction with Trust colleagues and will be reported to the Audit Committee in April 2023.

c) The production of Quarterly Guardian of Safe Working reports for junior doctors.

13. **Updates to Actions:** There have been updates to the majority of the actions. These include, but are not limited to:

a) The completion of action 1 to strengthen the patient safety culture. The governance assurance structure review has been completed and a new model, which reflects the insight/involve/improve model has been agreed in principle. A paper will be presented to the Executive Team for agreement prior to adoption of the structure. This action will be moved into the sources of assurance section at the next review.

b) An update has been provided on the ongoing work to register the Trust with CQC for the provision of assessments for patients with mental health needs under section 5.2 of the Mental Health Act. Lancashire and South Cumbria Care NHS Foundation Trust (LSCFT) have agreed in principle to formalise support for the Trust's registration through the management of psychiatric medication, oversight of care plans paperwork and to provide training to Trust staff on mental health and restraint. A Service Level Agreement is being developed and will be shared with the Executive Team once completed. Further work is taking place to develop suitable risk assessments and a mental health strategy for the Trust.

c) The integration of the Patient Safety Incident Response Framework (PSIRF) processes into Trust systems, updates to policies are complete and tier 1 and 2 PSIRF training is to commence on 1 April 2023 in line with the national requirements.

d) The completion date for action 6b has been revised as there is no nationally set date at this time for the Trust's involvement in the COVID-19 inquiry, however preparatory work and evidence gathering has commenced.

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

14. **Risk Score:** Remains at 15 (C5 x L3).

15. **Updates to Assurances:** There have been two new sources of assurance included, they are:

a) The improvement of risk profiles is assisting the movement of risks from high or moderate to low as well as an overall reduction in the number of open and overdue risks on the register.
b) There is a further expectation that the number of open risks held on the system will reduce further as a result of ongoing collaborative working across specialisms.
c) Additional information to an existing source of assurance, which is highlighted in red in the detailed risk sheet. This now reads as follows: "Mersey Internal Audit Agency (MIAA) - work in addressing all actions from the MIAA risk management audit is nearing completion, with one action currently outstanding regarding identified measures to review or develop a risk management training plan, resources and roll out required for delivery. Approval has recently been received by members of the Core and Essential Skills Quality Group to include risk management (including risk assessment training) as part of the management behavioural competency framework. A targeted review of training needs of lead specialisms and or subject matter experts, senior leaders and or managers with strategic and or operational responsibilities have been identified following completion of risk identification, profiling and mapping exercise. A review of risk management training packages used across NHS organisations and the suitability of Health Education England Risk Management Training package and its implementation is being explored. Assurance reporting is being monitored by the Risk Assurance Meeting and Health and Safety Committee."

16. **Updates to Actions:** There have been updates to all but one of the actions, with actions 1a (improvement of senior management awareness of H&S regulation), 1b (senior manager training in H&S), 2a (adoption of a robust H&S framework) and 2b (development of a H&S Strategy) will all be addressed by the newly appointed Health, Safety and Risk Manager by the end of March 2023. In relation to actions 5a and 5b (fire prevention works) the progress of actions have been updated to confirm that support has been identified in the form of the Fire Remediation Programme Team and an update has been included on the progress of fire protection work in non-patient areas and the plan for the recommencement of fire works to be completed in patient areas from April 2023.

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.

17. **Risk Score:** Remains at 12 (C4 x L3).

18. **Updates to Assurances:** there have been three new additions to the assurances, as follows:

    a) The confirmation that the first meetings of the Operational Stakeholder Groups have been undertaken for the maternity and stroke services groups.

    b) The formulation and implementation of the operational plans for CORE20PLUS5 programme.

    c) The commencement in post of a Programme Management support colleague. They are currently undertaking a review of Personalised Care and Health Equity as part of their induction.

19. **Updates to Actions:** there have been updates to the majority of the actions. Action number 6 has been completed and a communications working sub-group is now to be formed across Pennine Lancashire to continue working on health equity. Action 1 (development and approval of a Health Equity Strategy) and action 2 (work with business intelligence leads and clinical staff to develop a screening tool) have had updates to their deadlines for completion (April 2023). Furthermore, action 2 has been updated to reflect the development and demonstration of the new formulary to the Health Equity Alliance and Chief Operating Officer and the development of a project outline for a focus on cancer by the Public Health Registrar and medical students.

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

20. **Risk Score:** Remains at 16 (C4 x L4).

21. **Updates to Controls:** There has been one update to the controls section and one new control added. The new control is the implementation of the Theatre Utilisation Board and its alignment towards delivering 'Getting it Right First Time' (GIRFT) and 85% theatre utilisation. The update relates to the programmed validation of 52-week waiters via the Chatbot system within 12-weeks of the previous validation date.

22. **Updates to Assurance:** There have been two updates to the assurances, they are:

a) The confirmation that all patients who at risk of being 78-week waiters on 31 March 2023 now have a date to be seen.
b) The Trust is demonstrating continued reduction in the backlog of patients who have waited over 62-days on a cancer pathway.

23. **Updates to Actions:** there have been a number of updates to the progress of actions, including, but not limited to:
    a) Action 1 (achievement of 104% trajectory) – work is ongoing with the division to plan for 2023-24 following a comprehensive demand and capacity exercise.
    b) Action 3 (joint improvement work with Cancer Alliance) – the Trust has not appeared in the top 20 Trusts for percentage of backlog over 62-days for three consecutive weeks. As of 2 February 2023, the actual backlog was 232 against the trajectory of 230 patients.
    c) Action 4 (development of outpatient utilisation board) – the draft dashboard is in place with further amendments made to it.
    d) Action 5 (theatre utilisation trajectory) – as of 29 January 2023 theatre utilisation was 82.9%

Risk 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.

24. **Risk Score:** Remains at 20 (C4 x L5).
25. **Updates to Assurances:** there have been three new sources of assurance added to this risk. they are:
    a) The confirmation of the IHSS which complements the Trust's ICAT service weekdays in the ED.
    b) System level plan on demand management in the community for preventing urgent and emergency care (UEC) attendances commenced on 2 December 2022.
    c) The Trust has introduced an extreme escalation policy which is activated when patients have been in the ED for an excessive amount of time.
26. **Updates to Actions:** there have been updates to the progress of a number of the identified actions for this risk, the updates are noted in red in the detailed BAF risk sheet. In addition, there has been one action completed and a further action added.

27. The completed action relates to the introduction of a discharge bundle, which was implemented across all wards. This item will move into the sources of assurance section at the next review. The new action relates to ambulance handover times and the work being undertaken with system level partners, including North West Ambulance Service (NWAS) with an aim of reducing the number of patients waiting over 30 minutes for a handover by 50% by the end of March 2023.

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

28. **Risk Score:** remains at 8 (C4 x L2).

29. **Updates to Assurances:** There have been three updates to the sources of assurance relating to service delivery and day to day management of risk control:
    a) The establishment of a Workforce Assurance Group in December 2022.
    b) Further alignment of leadership and Organisational Development activities to the Safe, Personal, Effective Plus Improvement Practice.
    c) A new leadership and management strategy and programme has been accepted and is planned to be rolled out from April 2023.

    Additionally, the following source of assurance has been added regarding specialist support, policy and procedure setting and oversight responsibility:
    d) The participation of the Trust in the development of the ICS Belonging Strategy.

30. **Updates to Actions:** The action in relation to the presentation of the Trust's Leadership Strategy to the Quality Committee in January 2023 has now been closed and completed. A new action has subsequently been added relating to the next steps for the launch of this Leadership Strategy and an accompanying Programme:
    a) Activities for marketing the programme will commence from April 2023 and arrangements for its administration are currently being established. The Quality Committee will continue to receive regular updates on its progress.

    Additional information has also been added to another action:
    b) The action in relation to capacity of staff network members to support the delivery of the inclusion agenda has been updated to reflect the fact that exploration for protected time was included in the People and Culture business case which was refused for progression. External funding is now being explored.

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

31. **Risk Score:** remains at 16 (C4 x L4).
32. **Updates to Assurances:** Three new sources of assurance have been added relating to service delivery and day to day management of risk control, these are:
    a) The establishment of a Workforce, Resilience and Sustainability Programme across the ICB.
    b) The Trust has confirmed support for future cohorts of international nursing colleagues.
    c) The establishment of an Industrial Action Cell within the Trust to plan for and mitigate against of the impact of proposed industrial action.
33. **Updates to Actions:** Updates have been provided for a number of actions, including the revision of timelines in some cases:
    a) The action relating to improving Trust retention levels has been updated to reflect the new timeline for presentation of its new Retention Strategy to the Quality Committee in March 2023.
    b) The actions relating to delivery of an Enhanced Health & Wellbeing offer to the ICS and the establishment of an Industrial Action Cell to ensure planning and business continuity have also both been updated to reflect the new timelines for completion of March 2023. Additional information has also been added to the latter in relation to the work taking place to prepare for potential junior doctor strikes.

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:** Remains at 25 (C5 x L5).
35. **Updates to Controls:** There has been an update to one of the sources of assurance relating to the development of the medium-term Financial Recovery for the 2023-24 financial year.
36. Updates to Assurances: There have been two new sources of assurance added, they are:
    a) The year-end deficit position being agreed in line with the system level position.
    b) The development of the 2023-24 internal audit plan.

37. **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. In addition, there have been progress updates to all of the actions, they include, but are not limited to:
    a) The presentation of the medium-term finance strategy at the Finance and Performance Committee in March 2023.
    b) The agreement of the Trust Accountability Framework and planned issue to the Trust in February 2023. The remainder of the updates are shown in red text in the detailed risk sheet.

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

38. **Risk Score:** Remains 15 (C5 x L3).
39. **Updates to Assurances:** there have been two new sources of assurance included, they are:
    a) The submission of a draft Green Plan video
    b) The annual assessment against the Green Plan is in progress to review against first year targets, data collection for 2021/22 and action plan updates on areas of focus
40. **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.
41. **Gaps in Control:** there have been two new gaps in control, and associated actions added to the risk, they are:
    a) The need for a Green Plan video for the Trust, a draft has been developed and submitted.
    b) The annual assessment of the Trust's Green Plan, the initial draft of which has been completed and submitted.

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.

42. **Risk Score:** Remains at 16 (C4 x L4).
43. **Updates to Controls and Assurances:** The new 'go live' date for the Electronic Patient Records (EPR) system is approved and being communicated to the wider Trust.
44. **Updates to Actions:** There have been some minor updates to two of the actions, they can be seen in red text in the detailed risk sheets.

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.

45. **Risk Score:** Remains at 12 (C4 x L3).
46. **Updates to Assurances:** There have been two new sources of assurance included, they are:
    a) Organisational plans for operational planning have been established and agreed via the planning workshop with Senior Leadership Group, as well as the alignment of planning processes for 2023-24.
    b) Executive Wall updates have been re-established as part of the weekly Executive Team meetings.
47. **Updates to Actions:** There have been updates to the majority of actions which have been highlighted in red text. These include, but are not limited to:
    a) The addition of information regarding workshops 1 and 2 relating to frailty/respiratory pathways.
    b) Addition of information regarding the re-establishment of the Executive wall and its weekly review as part of the Executive team meetings.

Connection with the Corporate Risk Register (CRR)

48. 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. **ID 4932:** Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained.	20 20 20 16 15 15
2b: Health and Safety	**ID 9222:** Failure to implement the NHS Green Plan. **ID 8808:** Burnley General Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke. **ID 7764:** Royal Blackburn Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke. **ID 7165:** Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	16 15 15 15
3: Health Inequalities	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 3.	N/A
4a: Elective Recovery	**ID 8061:** Management of Holding Lists. **ID 8941:** Delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology.	20 16

BAF Risk	Linked CRR Risks	CRR Score
	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.	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
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

49. The ERAG is asked to receive the report, note and discuss the content and recommend it for further discussion at the Board Sub-Committees in advance of it being presented to the Board in March 2023.

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: 14 February 2023

ERAG: 16 February 2023

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

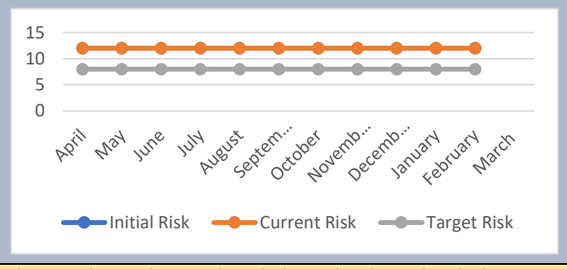
Lead Committee: Finance and Performance Committee

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 have started in post and are beginning to shape their place-based priorities for 2023-24.

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. A Joint Committee has been formed to more effectively enable partnership working for Providers.
- 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 and planned engagement activities are due to commence during February 2023.

Place-Based Partnership (PBP):

- The place boundary review has led to the development of a place for Blackburn with Darwen and East Lancashire as part of Lancashire. Place-based directors are now in post and are beginning to shape their priorities with draft priorities currently being discussed through locality workshops.
- Delivery structures to support agreed priority workstreams currently being reviewed.

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.

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 Programme Board 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. Place priorities being established for 2023-24 which will feed into Trust-level plans once agreed.	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 Programme Board and Directors of Strategy Group to clarify plans for development.	Executive Medical Director/ Interim Director of Service Development and Improvement	End March 2023	PCB Clinical Strategy engagement plans now agreed and underway. Programme Board 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	Review of place arrangements now complete and new structures in place. Directors of Health and Care Integration in post and working with partners to determine place priorities for 2023-24.	B
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.	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. L&SC place teams completed workshop 1 (understand) and 2 (co-design) utilising Engineering Better Care system Improvement Model for frailty/respiratory pathways.	G
6.	Capacity to support all workstreams both for ELHT staff, due to system architecture changes and emerging delivery structures at PCB and ICB.	Continue to review demand and capacity and shape discussions on best way to configure system resources to support delivery	Senior Responsible Officers	March 2023	System Programme Management Office and programme methodology in development. System resource scoping underway to align to Programmes for 2023-24. Programmes to be agreed as part of system planning for 2023-24.	A
7.	PCB Central Services workstreams need clarifying to ensure alignment to wider ICB and organisational strategies.	Work with PCB via Central Services Board to clarify development plans, methodology, consultation and sign off mechanisms.	Senior Responsible Officers	March 2023	Initial stakeholder workshops held to identify opportunities for improvement/collaboration and further workshops planned for early 2023. Ongoing participation by ELHT leads/teams in agreed workstreams with regular updates being provided to Trust Board.	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

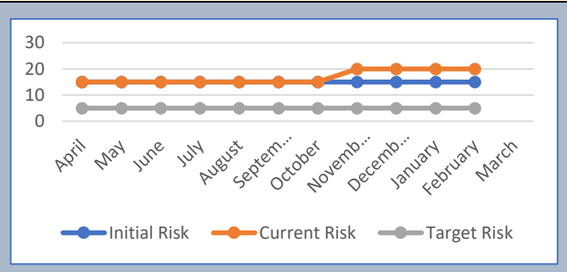
Date of last review: Executive Director: 6 February 2023
ERAG: 16 February 2023

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 have been confirmed, 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 held 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 supporting 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 commenced from mid-December 2022 for patients waiting 52 weeks for treatment. It is being rolled over to specialties to assist in the management and prioritisation of waiting lists.
- Complex Case meeting 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.
- Mobilisation of 24/7 IHSS service complementing the 24/7 Intermediate Care Allocation Team (ICAT) service Monday to Friday between 8am – 4pm for the ED front door team.

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.
- The Internal Audit Plan for 2023-24 is being developed by the Mersey Internal Audit Agency (MIAA) in conjunction with Trust colleagues 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.
- Quarterly Guardian of Safe Working report (GOSW) for junior doctors.

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/ Executive Director of People and Culture	~~November 2022~~ June 2023	This has been partially achieved and the Governance Assurance structure review completed. New model reflecting the Insight/Involve/Improve model – integrating patient and staff safety data (in line with the National Patient Safety Strategy) agreed in principle with the governance team. A business case is being prepared for the Executive team to agree in the new financial year prior to adoption and to link with wider review of reporting structures. Due to this the action due date has been revised to June 2023.	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/ Executive Director of People and Culture	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 Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) and the Trust continues to use external 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

					Histopathology risks combined on the Corporate Risk Register to enable clearer focus on impact and improvements required	
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. IT have suggested a date of the end of July 23 for implementation of Radar.	Radar has completed much of the build across the functions of governance. Twice monthly sponsor meetings and weekly project group continue to meet. Access to the on prem server remains an issue. Which means that staff have still not had the opportunity to test the system. Links were provided last week which did not enable access. Further extension of Datix licence has been necessary which has been funded by the 6 month B7 monies provided as part of the original business plan. IG issues now being raised which will significantly impact on how the Radar system is used. Concerns being discussed around duplication of process, with a requirement for all governance activity to be accessed via Cerner and not permitted to be stored on Radar. Conversations ongoing re understanding the impact of this restriction on governance activity, and additional training required by governance staff to access Cerner for information previously routinely accessed from the incident management system.	R
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 Registration agreed as no earlier than April 2023 to enable supports to be put in place to deliver this care safely.	Lancashire and South Cumbria NHS Foundation Trust (LSCFT) have agreed in principle to formalise support of Mental Health (MH) registration through the management of psychiatric medication, oversight of MH care plans, management of MH Act paperwork for any Section 5(2)s applied within ELHT and to provide training to staff on MH and Restraint. LSCFT have proposed a formal Service Level Agreement (SLA) at cost. Once example SLA received this will be shared with the exec for consideration. Individual patient MH risk assessment and MH strategy shared by LTHT, currently being adapted for adoption at ELHT.	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

BAF Risk 2a

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	Funding to ensure that all Investigators are now permanent agreed and posts recruited to. PSIRF processes and PSIRI panel reviewed in November. Updates integrated into systems and fed back to national team. PSIRF and incident policies have been fully updated in line with final publication documents from NHS England. Final approval scheduled fort PSG in March 2023 Continue to represent ELHT at Northwest PSIRF workshops ELHT incidents team have presented learning at national forum PHSO standards have been built into Radar build Tier 1 and 2 for PSIRF training due to go live on Core Mandatory training on 1st April 2023. In line with national requirements	G
		b) COVID-19 Independent Inquiry will require significant resource to co-ordinate.	Executive Director of Nursing/ Executive Medical Director/ Executive Director of Integrated Care, Partnerships and Resilience	No date announced nationally	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/Governance teams No target date yet – preparation started at Trust level.	G
		c) Introduction of Liberty Protection Safeguards. (LPS)	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. No change not off target	G
7	Need to increase patient/public engagement and influence	Introduction of Patient Safety Partners (PSP).	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.	A

				We are attempting to offer this PSP role as an opportunity to volunteers who are already engaged with the organisation.	Project Lead and the Trust's Communications Team have created a draft website in respect of communication package 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. No change	
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

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: 6 February 2023
ERAG: 16 February 2023

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.
- 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 45% reduction in the number of open risks held on the risk register as a result of work to improve the quality of risks held. For the same period, there has been a 42% reduction in numbers of live overdue risks, with less than 1% of tolerated risks surpassing their review date.
- Further significant reductions in numbers of open risks held is expected as a result of working collaboratively with lead specialisms and or subject matter experts within the fields of medical devices, infection control, medication, information governance, finance, radiation, security management etc. to improve the quality of strategic and operational risks within their areas of responsibility and control.
- 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 risks.
- 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 (MIAA) - work in addressing all actions from the MIAA risk management audit is nearing completion, with one action currently outstanding regarding identified measures to review or develop a risk management training plan, resources and roll out required for delivery. Approval has recently been received by members of the Core and Essential Skills Quality Group to include risk management (including risk assessment training) as part of the management behavioural competency framework. A targeted review of training needs of lead specialisms and or subject matter experts, senior leaders and or managers with strategic and or operational responsibilities have been identified following completion of risk identification, profiling and mapping exercise. A review of risk management training packages used across NHS organisations and the suitability of Health Education England Risk Management Training package and its implementation is being explored. Assurance reporting is being monitored by the Risk Assurance Meeting and Health and Safety Committee.
- 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	March 2023	Plan underway to agree actions and timescales This will be covered under the framework referenced in action 2. New Health, Safety and Risk manager will be leading on this work.	G
		b) Develop strong senior management health and safety leadership competencies through completion of externally accredited ½ day IOSH ‘leading safely’ qualification.		March 2023	Plan underway to identify external training course provider This will be covered under the framework referenced in action 2. New Health, Safety and Risk manager will be leading on this work.	G
2	There is no overarching framework or strategy in place for the effective management of health and safety.	a) Adopt a more robust, integrated framework and service delivery model that creates a more unified organisational approach to managing health, safety and risk. b) Develop a health and safety strategy that is aligned to the quality strategy, new patient safety strategy, organisational strategic aims and objectives, values, quality improvement programmes and the human resources behavioural framework.	Executive Director of Integrated Care, Partnerships and Resilience	March 2023	a) Framework agreed and development of strategy underway. Will go to H&S Committee before April 2023 for approval. New Health, Safety and Risk manager will be leading on this work. b) Framework agreed and development of strategy underway. Will go to H&S Committee before April 2023 for approval. New Health, Safety and Risk manager will be leading on this work.	G 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.	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.	Executive Director of Integrated Care, Partnerships and Resilience	March 2023	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. Next Health and Safety Committee will take place on 15 February and will review progress.	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: • Burnley General Hospital – Renal Suite • Burnley General Hospital – Phase 5 • 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. Identified support is now in place with a dedicated fire remediation programme team.	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. Passive fire protection work has continued throughout Winter, focussing on non-inpatient settings. From April 2023, work will recommence on inpatient settings at RBH and this will require the provision of a decant ward. Plans are in place to mobilise the decant ward to support this improvement activity. In addition, following the development of a fire and remediation plan at BGH, this will also require a decant ward to be mobilised. Plans are also in place to secure a decant ward from April 2023.	A

BAF Risk 3

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

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

Strategy: Clinical Strategy

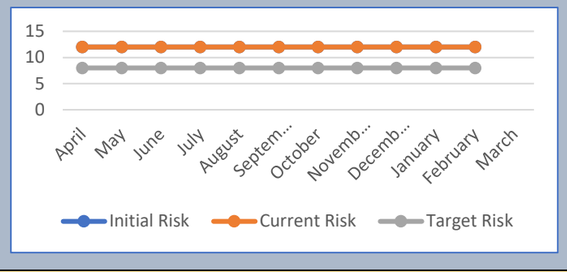
Date of last review: Executive Director: 6 February 2023
ERAG: 16 February 2023

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
- The Operational Stakeholder Groups have been identified and preliminary meetings have been undertaken for Respiratory Services, and Mental Health presentations in ED. Further meetings have also been ~~set up for~~ **undertaken with** Maternity and Stroke services.
- Operational plans for Core20PLUS5 have been formulated and are in place.
- A Programme Management support colleague has started in post and is undertaking a review of the Personalised Care and Health Equity agenda as part of their induction.

<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.

BAF Risk 3

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 Partnerships and Resilience	April 2023	Strategy is currently in its development stage. An outline of the proposed strategy was presented at the Health Equity Alliance meeting in September, with consensus 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. This item was presented to the Trust Board in January 2023 and it was agreed that a development date would be presented later in the year.	G
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	April 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. The new formulary for assessing health inequalities has been developed and demonstrated to the Health Equity Alliance and Chief Operating Officer. The referral to treatment list (RTT) was used as a sample to test the analytics. This has also been shared with Business Intelligence Leads, who will seek to reproduce the outputs for the integrated care report (IPR). Next stages involve agreeing the structure and formatting onto the IPR. Additionally, senior medical students are focussing on health inequalities with the Public Health Registrar, with a specific focus on the cancer pathways. A project outline has been completed	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. This project is on track to be completed as planned.	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	Action complete with a Comms working subgroup will be formed across Pennine Lancs that continues working on the health equity agenda.	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

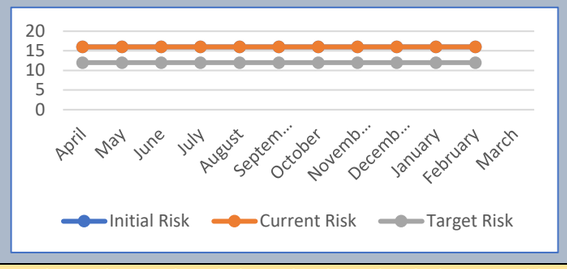
Date of last review: Executive Director: 2 February 2023
ERAG: 16 February 2023

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. Programmed validation in place via chatbot to meet >52 weeks waits within 12 weeks of previous validation date.

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 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:

- The Trust is on trajectory to achieve the target in relation to 78-week waiters by 31 March 2023 and all patients at risk of being 78 week waiters on 31 March 2023 have a date to be seen.
- 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 demonstrating continued reduction in the backlog of patients who have waited more than 62 days on a cancer pathway.

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.
- 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.
- Theatre Utilisation Improvement Board in place and aligned towards planning to deliver GIRFT requirements, including 85% utilisation.
- Governance processes have been reviewed around theatre utilisation and introduced support and challenge sessions with the Chief Operating Officer and Deputy Medical Director for Performance for any specialties that do not achieve trajectory.

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 02.02.2023: Work is ongoing with division to plan for 2023-24 following comprehensive capacity and demand exercise.	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 2023	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 2023 in line with the final trajectory. Update as at 02.02.2023: trajectory for end of January 2023 was 230 actual backlog 232 and the Trust has not appeared in the top 20 Trusts for percentage of backlog over 62 days for three consecutive weeks.	A
5	Improved performance data to support the outpatient transformation programme	Developing an outpatient utilisation dashboard	Chief Operating Officer	March 2023	In process of developing the dashboard, anticipated to be in place by March 2023. Draft dashboard in place with further amendments made. On track.	G
6	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	Chief Operating Officer	March 2023	The position was (until 29 January 2023, was 82.9%)	A

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

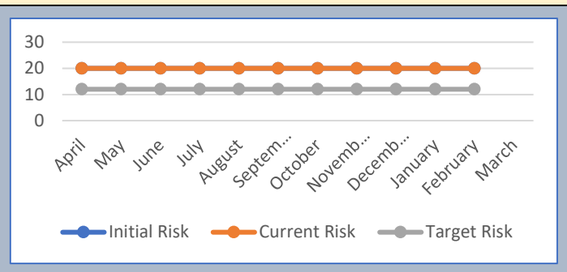
Date of last review: Executive Director: 6 February 2023
ERAG: 16 February 2023

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).
- Mobilisation of 24/7 IHSS service complementing the 24/7 ICAT service and Monday to Friday between 8am – 4pm for the ED front door team.

<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
- System level plan on demand management in the community for preventing UEC attendances was rolled out on 2 December 2022.
- Introduced an extreme escalation policy which is activated when patients have been in the emergency department for an excessive amount of time (initially 18 hours, now 12 hours).

<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.

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	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	LSCFT have reviewed their mental health urgent assessment centre (MHUAC) pathway and have introduced a revised operating model to support timely mental health assessment treatment and/or intervention.	~~R~~ G
2	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 March 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 12 hours (this was 18 hours till 24th Jan 23) for a bed are moved to the AMU and patients from AMUs moved as +1 patient per ward (Boarding). In place and being reviewed.	A
3	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	Action complete, the discharge bundle has been introduced across all wards. This item will move to sources of assurance at the next review.	B
4	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. Bed modelling is now complete, which shows that there is a deficit in acute medical beds for the current volume of patients	G
5	Winter planning including allocation of the national discharge fund	Deployment of a winter plan and the national discharge fund scheme received on the 25th Jan 23 (until March 23)	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. The winter plan is developed and deployed however risks remain given the challenges outlined in this BAF. A further allocation of £683K was allocated on the 25th Jan 23 for discharge schemes (till March 23).	G
6	Ambulance handover times	As part of an LSC collaboration the Trust is working with NWAS colleagues to improve ambulance handover times.	Chief Operating Officer	End March 2023	The aim is to reduce by 50% the number of patients who take more than 30 minutes for handover.	G

BAF Risk 5a

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

Executive Director Lead: Executive Director of HR and OD, Operational Director of HR and OD

Strategy: People/Workforce Strategy

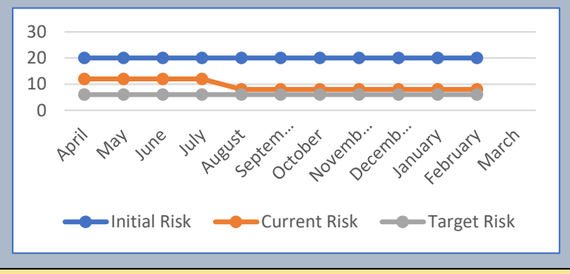
Date of last review: Executive Director: 13 February 2023
ERAG: 16 February 2023

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 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 installations 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.
- Workforce Assurance Group established and held inaugural meeting in December 2022. This is a monthly meeting and reports into the Quality Committee.
- Further alignment of leadership and Organisational Development (OD) activities to the Safe, Personal, Effective Plus (SPE+) Improvement Practice as part of Trust Improvement Continuum has been scoped and built into Improvement Practice Development Plan.
- A new leadership and management strategy and programme has been accepted and is planned to be rolled out from April 2023.

BAF Risk 5a

	Specialist support, policy and procedure setting, oversight responsibility: • Director of HR and OD is involved in a national staff experience forum. • Integrated Care System (ICS) Equality, Diversity and Inclusion (EDI) collaborative is in place to support the development and sharing of best practice. • NED EDI lead is a member of the regional BAME Assembly. • We are participating in a new national rainbow badge programme which will enable us to develop a robust action plan and achieve accreditation as a Trust. • The Trust has a Partnership Officer (link between the Unions and Trust) who works with the Director of HR and OD to ensure that employee relations between the Trust and Trade Unions colleagues is effective. • Connections made and introductory meetings held with the ICB EDI lead. • The Trust is participating in developing the ICS Belonging Strategy. Independent challenge on levels of assurance, risk and control: • WRES and Workforce Disability Equality Standard (WDES) standards are monitored nationally and reported to the Trust Board on an annual basis. • National Staff Survey reports and benchmarks the Trust's performance against other organisations at a national and regional level. • Required to work within the national FTSU framework and are accountable to the National Guardian for delivery. • 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.	Executive Director of People and Culture	January 2023	Completed - The Strategy has been to Executive Team, Senior Leadership Group and Quality Committee and is now approved. Please refer to action 2 for the next steps.	B
2	The need to embed the Leadership Strategy	The Trust will launch the Leadership Strategy and Programme in April 2023 following presentation to the Quality Committee in January.	Executive Director of People and Culture	July 2023	Activities for marketing the programme will commence from April 2023. Arrangements for the administration of the programme are being established. Regular reporting to the Quality Committee will take place.	A
3	Full roll out of the behaviour framework	Additional communications and OD support with individual teams.	Executive Director of People and Culture	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.	Executive Director of People and Culture	July 2023	A paper has been developed to provide a rationale for supporting the networks with protected time and a small budget. This was included in the People & Culture business case which has been refused for progression. The recommendation to seek external funding will now be explored, however there is a risk to this work progressing at the scale and pace required without this. Due to this development, it has been necessary to review the completion date.	A

BAF Risk 5b

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

Executive Director Lead: Executive Director of Human Resources and Organisational Development

Strategy: Workforce / People Strategy

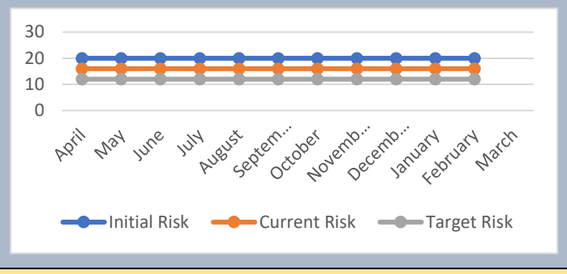
Date of last review: Executive Director: 13 February 2023
ERAG: 16 February 2023

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.
- Workforce, Resilience and Sustainability Programme established across the PCB.
- Trust has supported the future cohort of international nurses.
- Industrial action cell established within the Trust to plan for and mitigate against the impact of proposed industrial action.
- A wellbeing website has been delivered providing consistency across the ICS. – this will move to sources of assurance
- Programme of Winter Wellbeing in place to support staff
- 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

<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.

Independent challenge on levels of assurance, risk and control:

- Workforce Plan submission – there is an annual workforce plan submission to the national regulator which is triangulated internally with finance and activity data and aligned to our clinical strategy. This is monitored through the Integrated Care Board (ICB).
- Workforce Race Equality Standard (WRES) and Workforce Diversity Equality Standard (WDES) action plans with timelines in place. Regular reporting to the Board on progress. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust staff networks.
- 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	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.	Executive Director of People and Culture	March 2023	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. 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. 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. As at the beginning of 2023/24, the vacancy gap for Registered Nurses will be around 253 WTE. A future cohort of 240 has been supported by the Trust for 2023/24 which, alongside expected recruitment of newly qualified RNs, is expected to close the vacancy gap entirely by the end of the year (even when taking into account attrition). These actions are included in the Quarterly Workforce Report	G

					for Finance & Performance Committee at the February meeting.	
2	Improve Trust retention levels / Develop Retention Strategy	Implementation of targeted plan to deliver the national People Promise of Flexible Working and development of a Trust Retention Strategy. The first milestone is to agree the strategy.	Executive Director of People and Culture	March 2023	Delivered flexible working manifesto and are working with teams to deliver flexible working pilots. Pilots in CIC have 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 March 2023. Whilst the flexible working strategy has been agreed and is due to go to Quality Committee in February, the wider retention strategy requires further development and will be taken through Execs and Quality committee in March. A new approach to exit interviews called 'Moving On Conversations' has been rolled out and this will inform the retention strategy. The Workforce Innovation Team have been undertaking engagement with newly qualified nurses and those nurses nearing retirement age to gain insight into what would help to retain them. There is no further update to provide on this action.	G
3	Regional/national shortage of roles	Explore opportunities for collaborative working/system-wide roles through Lancashire and South Cumbria ICS e.g. Diagnostic Network	Executive Director of People and Culture	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. This plan will be routed through PCB and ICB People Board as part of the governance for the Workforce Resilience and Sustainability Programme.	A
4	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.	Executive Director of People and Culture	March 2023	A programme of work has been developed and was presented to the LSC Growing Occupational Health and Wellbeing Together Collaborative Workshop on 14 December 2022. 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 timescales are very dependent on the operating model as part of the central services work. The OD and Well team are continuing to explore how staff can be further supported during this period of unprecedented demand.	G
5	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	March 2023	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 are co-ordinating a system wide response to any industrial action.	G

BAF Risk 5b

					The Deputy Director of People and Culture is working with colleagues from across the PCB to co-ordinate information and response on behalf of providers. The Director of People and Culture is meeting regularly with Staff Side colleagues to ensure good working relationships throughout any industrial action. Of industrial action so far, the Trust response and impact has been manageable, however plans are now underway to prepare for junior doctor strikes which will present significantly greater challenges to service delivery, including the effect on resource, staff burnout, morale, patient experience and potential harm. The timeline for action has been moved because the industrial action is ongoing with no known date for resolution at this stage.	

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: 6 February 2023

ERAG: 16 February 2023

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)

Organisation

- Financial Recovery plan (short term) in place including additional controls
- Medium term Financial Recovery plan in development for the 2023-24 financial year
- 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 February 2023, further update to go to Audit Committee in April 2023.
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Waste reduction programme are reported and scrutinised through the monthly Finance Assurance Board with Executive and cross-Divisional team representation, Capital Planning Board chaired by the Director of Finance, and Finance and Performance Committee, sub-committee of the Board.

System

- System finances monitored through System Finance Group (includes representation of all providers and Integrated Care Board (ICB)) to facilitate understanding and actions associated with the overall system financial position.
- System Corporate Collaboration group oversees potential savings and other benefits of corporate collaboration opportunities including strengthening fragile services.
- System improvement Value Stream Analysis (VSA) on bank and agency undertaken in September 2022, identifying further potential savings. Governance structure in place to review progress.

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

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

- 2021-22 financial targets achieved in accordance with agreed plan.
- The Financial Plans for 2022-23 were presented to the Board at their meeting in May 2022 and approved.
- The financial plan for 2023-24 and associated financial recovery plan in development – due end March 2023
- 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 10 reported due to system planning gap. Planning gap with providers to address. Remaining gap of £5.1m for ELHT. Assumed system support/working for gap not materialised.
- 2022-23 financial targets – year end deficit agreed in line with system position.
- Additional financial controls are in place to reduce spend.
- Benefits Realisation team established, recruited to and some staff have commenced in post.

Specialist support, policy and procedure setting, oversight responsibility:

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

Independent challenge on levels of assurance, risk and control:

- Internal and external audit – agreed internal audit plan for 2022-23, clean Head of Internal audit opinion received, clean external audit of annual accounts for 2021-22 received, counter fraud workplan for 2022-23 agreed.
- Mersey Internal Audit Agency (MIAA) audit of Care Quality Commission (CQC) Well-led evidence underway.
- Re-accreditation at Finance Staff Development (FSD) level 3 (the highest level) for financial management within the finance team and supporting the wider organisation. High level of qualified staff in department (53%) with a further 35% in training.
- 2023-24 internal audit plan in development

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

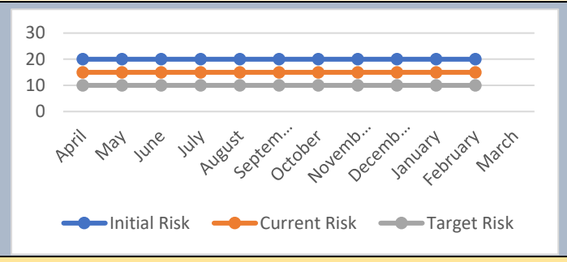
No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Medium term financial strategy to be developed (financial recovery)	Finalise and sign-off through Finance and Performance Committee	Executive Director of Finance	Q3 2022-23	Draft strategy currently in development This will be presented to the F&P Committee in March with the financial plan for 2023/24	A
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. Although savings achieved due to the target being increased, the gap remained the same.	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	February 2023	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. Finance structure now agreed, however identified gap around not having a Financial Recovery Board	G
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	February 2023	Presented to SLG December 2022. Meeting structure to be put in place. Document agreed but yet to be formally issued	G
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. Providers have agreed to work to an agreed £30m deficit. Forecast outturn suggests the system is approximately £4m from target.	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 All costs have been reviewed and are either in the plan or will form part of the financial gap for 2023/24.	G

<table>
<tr><td colspan="2">Risk Description: The Trust fails to deliver the strategic objectives set out in its NHS Green Plan</td><td colspan="2">Executive Director Lead: Executive Director of Finance</td></tr>
<tr><td colspan="2">Strategy: Wider sustainability (NHS Green Plan)</td><td colspan="2">Date of last review: Executive Director: 10 February 2023
ERAG: 16 February 2023</td></tr>
<tr><td colspan="2">Links to Key Delivery Programmes: Waste Reduction Programme / Sustainability</td><td colspan="2">Lead Committee: Audit Committee</td></tr>
<tr><td colspan="2">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

 
</td><td>Effectiveness of controls and assurances:

<table><tr><td></td><td>Effective</td></tr><tr><td>X</td><td>Partially Effective</td></tr><tr><td></td><td>Insufficient</td></tr></table></td><td>Risk Appetite: Cautious / Moderate</td></tr>
<tr><td colspan="2">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 is 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 Board (ICB) oversight arrangements in place via ICB 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.</td><td colspan="2">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
• Green Plan submission to ICB achieved in accordance with agreed timescales
• Divisional Waste Reduction Programmes in development
• Regional feedback received on NHS Green Plan – positive with some recommendations (already covered in local action plan)
• Draft Green Plan video submitted
• Annual assessment in progress to review against first year targets, data collection for 2021/22 and Action Plan updates on areas of focus

<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 ICB – 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</td></tr>
<tr><td colspan="4">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.</td></tr>
</table>

BAF Risk 7

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. This is important to support ownership of the areas of focus in the Green Plan and will support the annual updates.	Executive Director of Finance	Q1 2023-24	Governance in place – first year system audit underway Delayed to Q1 due to operational pressures	A
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	Q1 2023/24	In process of being pulled together. Will be included in presentation to Execs/SLG Delayed to Q1 2023/24 due to operational pressures	A
4	Trust wide sustainability group paused through covid	To be re-established	Executive Director of Finance	Q1 2023/24	Revised TORs in development – Inaugural meeting September/early October Delayed to Q1 2023/24 due to operational pressures	A
5	Trust Green Plan Video	Executive Team and Board to approve and then make the video available on the Trust website to supplement the Trust Green Plan	Executive Director of Finance	Q1 2023/24	Draft video completed	A
6	Annual Assessment of the Trust Green Plan	To agree update with the Trust Executive Team and Board approval. Then to replace the current Plan on the website with the updated version	Executive Director of Finance	Q1 2023/24	Draft update completed	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

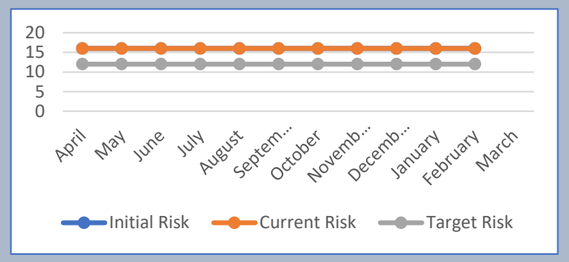
Date of last review: Executive Director: 10 February 2023
ERAG: 16 February 2023

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 30 January 2023.

<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.
- 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

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~~30 January 2023.
- 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.

sets out a common set of principles for future digital services. The corporate collaboration approach is now actively being considered across the ICS and alignment to that strategy is part of day-to-day delivery. • 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. Additional review undertaken by TSSM (NHS England).	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 submitted and working through process with NHSE Formalisation of the Northern Star approach is being undertaken with action plans being drawn up to begin 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: 14 February 2023

ERAG: 16 February 2023

Links to Key Delivery Programmes: Overarching all Key Delivery Programmes

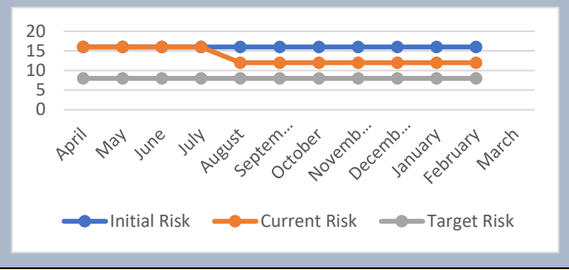
Lead Committee: Finance and Performance Committee

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

Current Risk Rating: **C4 x L3 = 12**

Initial Risk Rating: C4 x L4 = 16

Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

Improvement Practice:

- Established and evidence-based Improvement Methodology and Practice (Improving Safe, Personal and Effective Care (SPE+)), led by ~~Interim~~ Director of Service Development and Improvement to ensure delivery of more reliable improvements and outcomes.
- Development of Lancashire and South Cumbria (LSC) system-level method of improvement and agreed testing on one system priority during 2022-23 to support single approach to system improvement work.
- Established Improvement Hub team to support delivery of Improvement priorities within Key Delivery Programmes 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, 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.
- Organisational plans for operational planning have been established and agreed via the planning workshop with Senior Leadership Group, as well as the alignment of planning processes for 2023-24.
- Executive Wall updates have been re-established as part of the weekly Executive Team meetings.

Specialist support, policy and procedure setting, oversight responsibility:

- Key Delivery and Improvement Programmes monitored at Senior Leadership Group and relevant Trust Board sub-committees
- PCB/Integrated Care Board (ICB) Programme Boards report through relevant Pennine Lancashire, PCB/ICB governance structures

Independent challenge on levels of assurance, risk and control:

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

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

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

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

BAF Risk 9

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	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 as part of sign off of Trust Strategic Framework for 2023-24.	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	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. Over 500 staff trained in 2022-23.	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.	Director of Service Development and Improvement	Autumn 2023	L&SC place teams completed workshop 1 (understand) and 2 (co-design) utilising Engineering Better Care system Improvement Model for frailty/respiratory pathways.	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.	Director of Service Development and Improvement	April 2023	Work actively underway to 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. New place arrangements currently being reviewed and priorities identified to enable agreement/sign off of Improvement Priorities for 2023/24.	G
6	Executive Wall and Visual Management	Development of executive leadership wall to enable oversight of all key delivery programmes	Director of Service Development and Improvement	March 2023	Executive wall now established and reviewed weekly as part of the Executive Team meeting to give oversight of all 11 key delivery programmes.	G

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **37**

8 March 2022 **Purpose** Information / Approval

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) and decision-making process for the level of incident reviews. This report includes information on maternity specific serious incidents reporting as required by Ockenden recommendations.

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

Report linkages

Related Trust Goal	Deliver safe, high quality care 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 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. 3. 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.

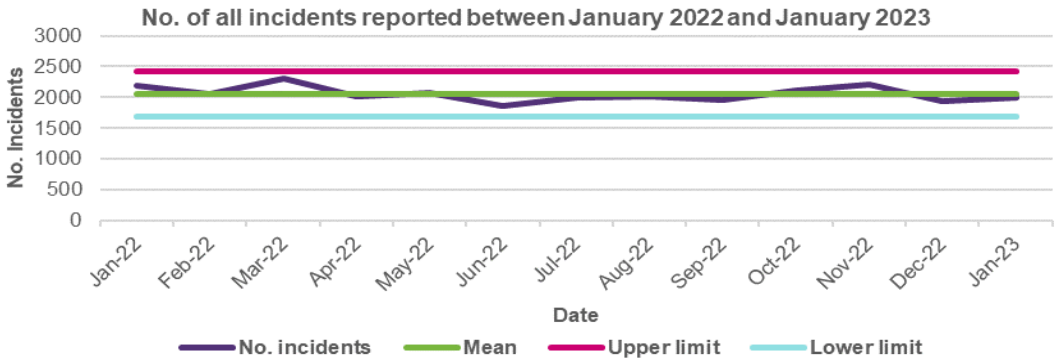
Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

1. Incident Reporting

1.1 Over the last year, reporting of incidents has remained within control limits, as seen in graph 1. However, there is some variation around the mean, which can be expected with incident reporting and can be subject to natural variation.

Graph 1: Incidents reported over last 12 months



1.2 The Trust has a positive incident reporting culture with high numbers of incidents being reported, but with a low incidence of moderate or above harm. A breakdown of incidents reported by percentage of harm level over the last 12 months compared to the National average is provided in appendix A. There was an increase in the number of low harm incidents in December 2022 with a slight reduction in January 2023. This trend will be monitored to determine if it is a consistent increase and then ascertain the factors affecting the change.

1.3 There continues to be an increase in the number of pressure ulcers incidents reported caused by multiple factors. (See section 7 Themes and Trends for further information and actions taken).

1.4 All incidents are reviewed / triaged by the Incident and Policy Team in line with the new Patient Safety Incident Reporting Framework. The Trust has a decision-making process to identify the required level of incident review each incident requires. (See appendix B: Level of incident reviews and appendix C: Decision marking flowchart for further information). If an incident meets National / Local priority or highlights key issues not linked to quality improvement or known risks these are added to a PSIRF tracker and discussed at the weekly complex case meeting to agree level of review.

2. Duty of Candour

2.1 There have been 20 reported incidents of moderate and above harm in January 2023, of which Duty of Candour applies, as set out in CQC Regulation 20. None have resulted in a breach of candour.

3. Patient Safety Incident Investigations (National and Local Priorities)

3.1 In December 2021 the Trust started reporting and managing incidents under the National Patient Safety Incident Response Framework (PSIRF). The Trust is required to report incidents that meet either the National priorities and/or Local Priorities identified in the Trusts Patient Safety Incident Response Plan (PSIRP). Grid 1 provides a breakdown of all incidents the Trust has reported and status of investigation. All PSII reports and safety improvement plans are presented at the Trusts Patient Safety Incidents Requiring Investigation (PSIRI) Panel for Trust approval and signoff. Safety Improvement Plans are monitored at the Lessons Learnt Group.

Grid 1: National and Local incidents reported by categories by fiscal year

Category	Priority	2021/22 (Dec/Mar)	2022/23 (Apr/Mar)	Total
Local	ED Transfer/Handover	0	2 (6%)	2 (4%)
Local	Fall Fracture Neck of Femur	1 (7%)	2 (6%)	3 (7%)
Local	NBM+5 days Vulnerable Adult	1 (7%)	3 (9%)	4 (9%)
Local	104-day cancer breach	0	1 (3%)	1 (2%)
Local	DNACPR	1 (7%)	1 (3%)	2 (4%)
National	Death	8* (57%)	11 (35%)	19 (41%)
National	Never Event	1 (7%)	2 (6%)	3 (7%)
National	Screening Incident	0	1 (3%)	1 (2%)
National	HISB Investigation - Maternity	2 (14%)	6 (20%)	8 (17%)
National	Neonatal Death	0	2 (6%)	2 (4%)
National	Safeguarding	0	1 (3%)	1(2%)
Total reported		14	32	46
Current Status				
Total closed		10 (71%)	5 (16%)	15 (33%)
De-escalated		2 (14%)	4 (12%)	6 (13%)

Awaiting closure		2 (14%)	2 (6%)	4 (8%)
Open		0	21 (66%)	21(46%)

**Two National reported Deaths involved patient falls and have been included as part of the Local Priority for falls learning*

3.2 Of the 46 reported PSIIs:

- 15 have been fully investigated, approved by PSIRI panel and agreed for closure on StEIS.
- 6 have been de-escalated as there was no issues highlighted with care or treatment (1 x DNACPR, 1 x Fall and 4 x Deaths).
- 4 investigations are either awaiting PSIRI approval or completion of safety improvement actions.
- Of the 21 incidents currently under investigation
  - The ELHT Patient Safety Incident Investigation Team are currently completing 17 investigations.
  - A further 4 Incidents are currently being investigated by the Healthcare Investigation Branch (HSIB) on average these take 6 months before the Trust receive the final report

4. Never Events (reporting period April 2022 to March 2023)

4.1 From 1st April 2022 to date the Trust has reported 2 Never Events, first reported in April 2022 retained foreign object (no harm) and second wrong site surgery - nerve block (low harm) recently reported in February 2023, further information is provided in grid 2 below.

Grid 2: Never Events Overview

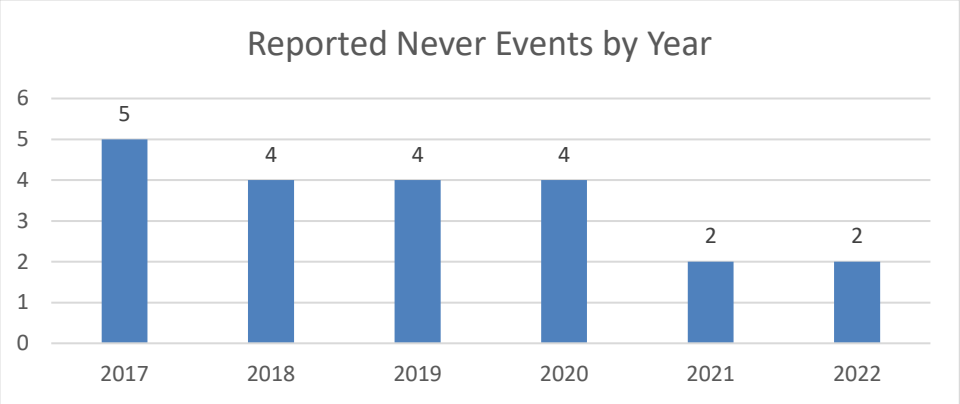
Incident type	Reported	Division	Status	Comments	Action Plan
Guidewire left in situ No Harm	April 2022	MEC	Approved for closure	ELHT Patient Safety Alert 2022/001 (LocSSIPs) published to highlight learning and actions across the Trust.	Completed incident closed.
Wrong site surgery	February 2023	SAS	Under investigation	The incident has been reported in StEIS as a Never Event. Round table meeting completed, and immediate learning	Investigation ongoing

(Nerve block) Low Harm				identified regarding 'stop before you block'. PSII investigator appointed working with Division.	

4.2 The Trust is awaiting MIAA audit results for LocSSIPs implementation and management. Results of the audit will enable the Trust to identify if any further improvement work is required. A new NatSSIPs 2 National Guidance was published early this year which is currently being reviewed in line with Trust NatSSIPs policy by Deputy Medical Director for Quality and Safety.

4.3 The number of Never Events reported by the Trust over the last 6 years is shown is graph 2. In the last two years (2021 and 2022) the Trust has seen a 50% decrease in the number of Never Events to the previous three years.

Graph 2: Number of reported Never Events 2017 to 2022



5. Patient Safety Responses (PSR)

5.1 All incidents that are of moderate or above harm and/or have key safety issues identified, and do not meet the national or local reporting priorities for a PSII are required to have a Patient Safety Response (PSR) completed and are managed within division. Appendix D provides a breakdown of the types of PSR investigations and numbers undertaken as of 16th February 2023.

5.2 Of the 1323 PSRs requested, 746 (56%) are for pressure ulcers. (See section 7 Themes and Trends for further information and actions taken)

5.3 Learning from PSRs are shared at the Divisional Patient Safety Incidents Requiring Investigation (DPSIRI) Panels and though divisional and directorate Patient Safety Groups. Any Divisional safety issues identified are either incorporated into divisional quality improvements, identified on the risk register for management or developed as safety improvement actions. Each division provides a bi-monthly report to the Lessons Learnt Group which highlights trends/themes from PSRs, safety improvements completed or currently being implemented to support the improvement in patient/staff safety.

5.4 The Trust is currently investing in a new governance management system 'RADAR'. The system should allow for better tracking of PSR investigations and safety improvements from a divisional and corporate level.

6. PSIRI Panel Approval and Learning from Reports

6.1 During January 2023 a total of 4 PSII reports were presented and approved at the Trusts PSIRI panel. 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.

6.1.1 Incident resulting in death: (eIR1233300) – the report raised issues with regards to communication and use of SBAR which has been escalated as a QI project trust wide, appropriate knowledge and understanding of staff of patients with signs of upper gastrointestinal bleeds and a review of medical input into Pendle View.

6.1.2 Inpatient Fall leading to fractured neck of femur (eIR12333152) - the report raised some policy discrepancies, and a need to look at the safe transfer of care proforma in terms of does it adequately highlight safeguarding risks. It was agreed that the safe transfer of care work needs to be undertaken across all divisions with the input of QI.

6.1.3 HSIB report of a maternal death (eIR1222352) – all antenatal and obstetric care was given in line with national guidance, HSIB have made safety recommendations, however these are related to NWAS. (Reported has been shared with NWAS for learning)

6.1.4 HSIB report of Hypoxic ischaemic encephalopathy (eIR1230184) – all correct guidance was followed; new triage system has been suggested nationally but it was confirmed that the decision making would have remained the same in this case. Division is looking to strengthen their process.

7. Themes and Trends

7.1 Increase in Pressure Ulcer reporting, lapses in care are being identified however, the increase is related to high complexity and acuity of patients as well as an increase demand on the service. All divisions have robust pressure ulcer prevention action plans in place to aid in the reduction of occurrence and harm, action plans are being monitored by the Pressure Ulcer Steering Group. It has been highlighted that a refresh of the educational programme is required, this is planned to be discussed at the next Pressure Ulcer Steering Group with a plan to change the training from a 3-year cycle.

7.2 Emerging theme were unmet patient communication needs and lack of involvement of advocates for vulnerable patients which contributed to undesirable care and treatment or were a factor within an incident. These were highlighted at the Patient Safety Group and agreed action to discuss at the PSRIF Local Priorities Workshop and to raise with Quality Improvement.

7.3 Patient Safety is currently working closely with Quality Improvement to identify and triangulate themes from Incidents, complaints, Inquests, and other data sources to support identification of possible new Local priorities for investigation under PSIRF for the next 12 months. A data pack is currently being developed will be shared with all attendees and discussed at the PSIRF workshop to help inform new priorities.

8. Local Priorities Learning and Quality Improvement Update

8.1 Reducing 104-day cancer breaches – due to the way in which patient harm is currently recorded, it has been extremely difficult to identify incidences leading to patient moderate harm and above. Therefore, the PSII Team are currently undertaking a cluster review of 6 individual cases picked at random. Appendix E provides an overview of existing QI work.

8.2 Nil by mouth (NBM) in vulnerable adults – one investigation completed and three investigations currently on going or waiting approval by Divisions and PSIRI panel. Findings highlighted that the communication care plan did not indicate the patients' individual needs or how staff were supporting the patient to communicate their needs. Lack of understanding and knowledge of staff with patients with Learning Disabilities. Staff must initiate a plan for nutritional intake for patients who are nil by mouth at the earliest opportunity and number of days. NMB should be added to ward round documentation. Appendix E provides an overview of existing QI work.

8.3 DNACPR – one investigation has been completed. These have been difficult to identify form incident reporting, areas of learning have been highlighted in a recent audit which data is being used to support QI work. Investigation highlighted the need to review the guidance and process for management of the red bag system to ensure that staff are aware of their roles and responsibilities in relation to the information contained within them. Poor communication with families/carers. Appendix E provides an overview of the QI project from learning and existing QI work.

8.4 Falls, fractured neck of femurs (#NOF) - one investigation completed and one investigation on-going. There are another 3 cases reported under Death, which involve falls. These take the total number to 5 x falls. Themes / Learning highlighted regarding lack of medical completion of post falls checklist. Training compliance, level of observation the patient receives is determined and documented in line with the Enhanced Care Risk Assessment. Appendix E provides an overview of the QI project from learning and existing QI work.

8.5 ED, Inappropriate transfers / handovers to internal wards/teams across all acute and peripheral sites - two investigations completed and one investigation on-going. One transfer and handover, also involves a patient fall as part of the investigation. These have highlighted poor verbal and written communication on handover/transfer. Appendix E provides an overview of the QI project from learning and existing QI work.

9. Maternity specific serious incident reporting in line with Ockenden recommendations

9.1 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 49 maternity related incidents have been reported on StEIS of which:

- 23 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.
- 7 are currently being investigated by HSIB
- 1 are awaiting feedback from division following queries from the ICB
- 3 are currently under investigation by the Trust

9.2 The Family care divisional PMRT update will continue to be presented at ELHT Trust Board each quarter detailing any deaths that have occurred and cases that have been reviewed with any learning or issues identified. This is a specific ask of CNST safety action one. Prior to trust board submission these cases will be reflected through the divisional mortality report with any exceptions to be reported at trust wide patient safety group aligned with CNST submissions. In addition, specific details for CNST Year four, safety action 1 and the required standards aligned with the Perinatal mortality review process is reflected in the maternity and neonatology update being presented to trust board on the 8th of March 2023.

9.3 Compliance with Safety Action 1; October – December 2022 – New cases

Month	a) i 1	a) i 2	a) ii	b	c	d
Oct; 4 new cases	75%	75%	100 %	100% 2 N/A	75%	100%
November; 5 new cases	100%	100%	100%	100% 2 N/A	100%	100%
December; 4 new cases	100%	100%	100%	N/A	100%	100%

Standard a) i1 pertains to starting MBRRACE cases within 7 days of the death and Standard a) i2 pertains to completing the surveillance form within 1 month of the death; 1 case was not reported or completed within this timeframe due to error.

Standard C: 1 of the families was not informed of the process as they left the UK before the baby had died and left no contact details.

9.4 October- December 2022 – Completed cases; 1 HSIB case and 1 outside of CNST timeframe

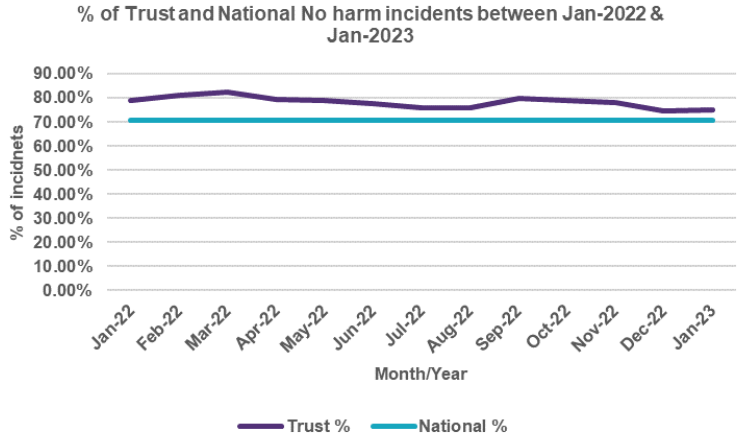
Month case reviewed	a) i 1	a) i 2	a) ii	b	c	d
October - 0	N/A	N/A	N/A	N/A	N/A	N/A
November - 8	100% 2 exempts	66% 2 exempts	100% 2 exempts	12.5% 1 exempt	100%	100%
December -1	100%	0%	100%	100%	100%	100%

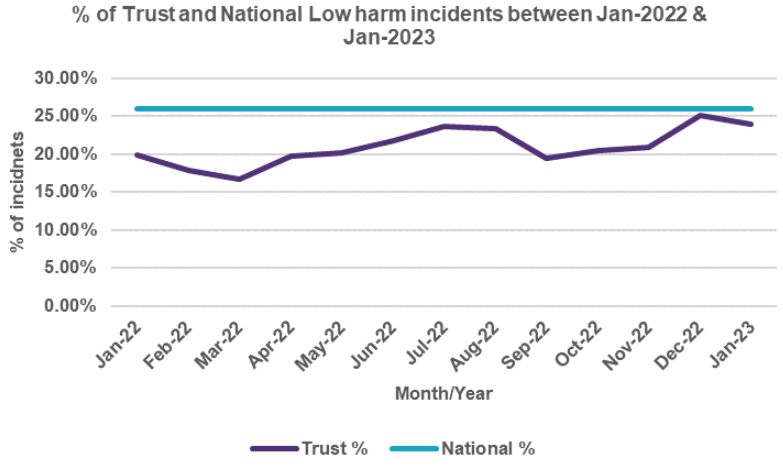
9.5 Identified learning following the quarterly PMRT review investigations

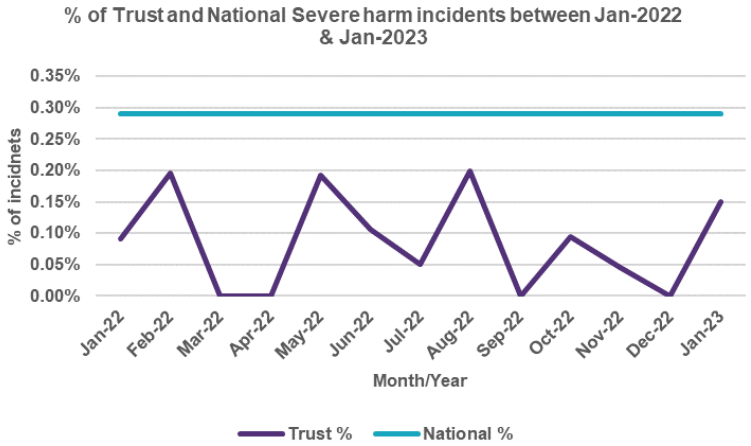
8 cases had no learning identified from review process.
1 case identified an area for learning and implementation

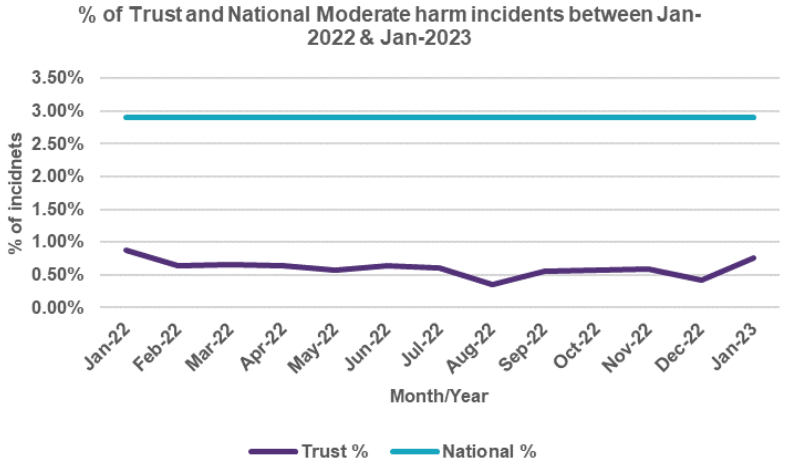
Case #	Issue	Action	Progress/ By whom
79405	This was a complex pregnancy. These were not acknowledged as part of the patient journey to be reflected in the personalised individual care planning or plan. (PCP) Gaps were noted or not documented within the PCP	1)Lengthy discussions with the multidisciplinary (MDT) team regarding this review and findings at the maternity/ Neonatology weekly quality and safety forum 2)Appropriate counselling and documentation of suspected large for gestational age (LGA) babies to be evidenced and included in the PCP. 3) Process reviewed using the LGA proforma and scan onto the electronic patient record (EPR) until a template is devised within badger net 4) Prospective audit regarding LGA counselling, documentation, and outcomes to be added to the Ante natal clinic planner – three months following the revised process	Due for completion 28/03/23 Antenatal clinic leads- Lorraine Bray – ANC manger Helen Collier – ANC Consultant lead

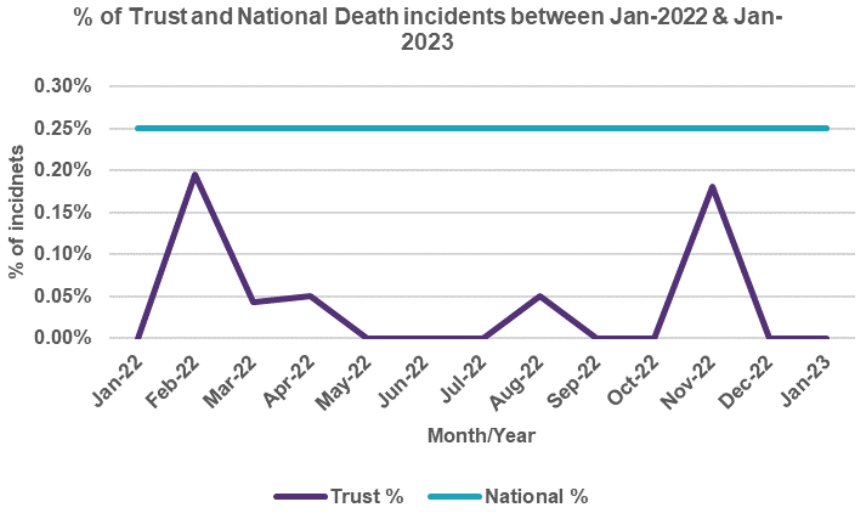
Appendix A: ELHT Incidents by Level or harm Vs National Average



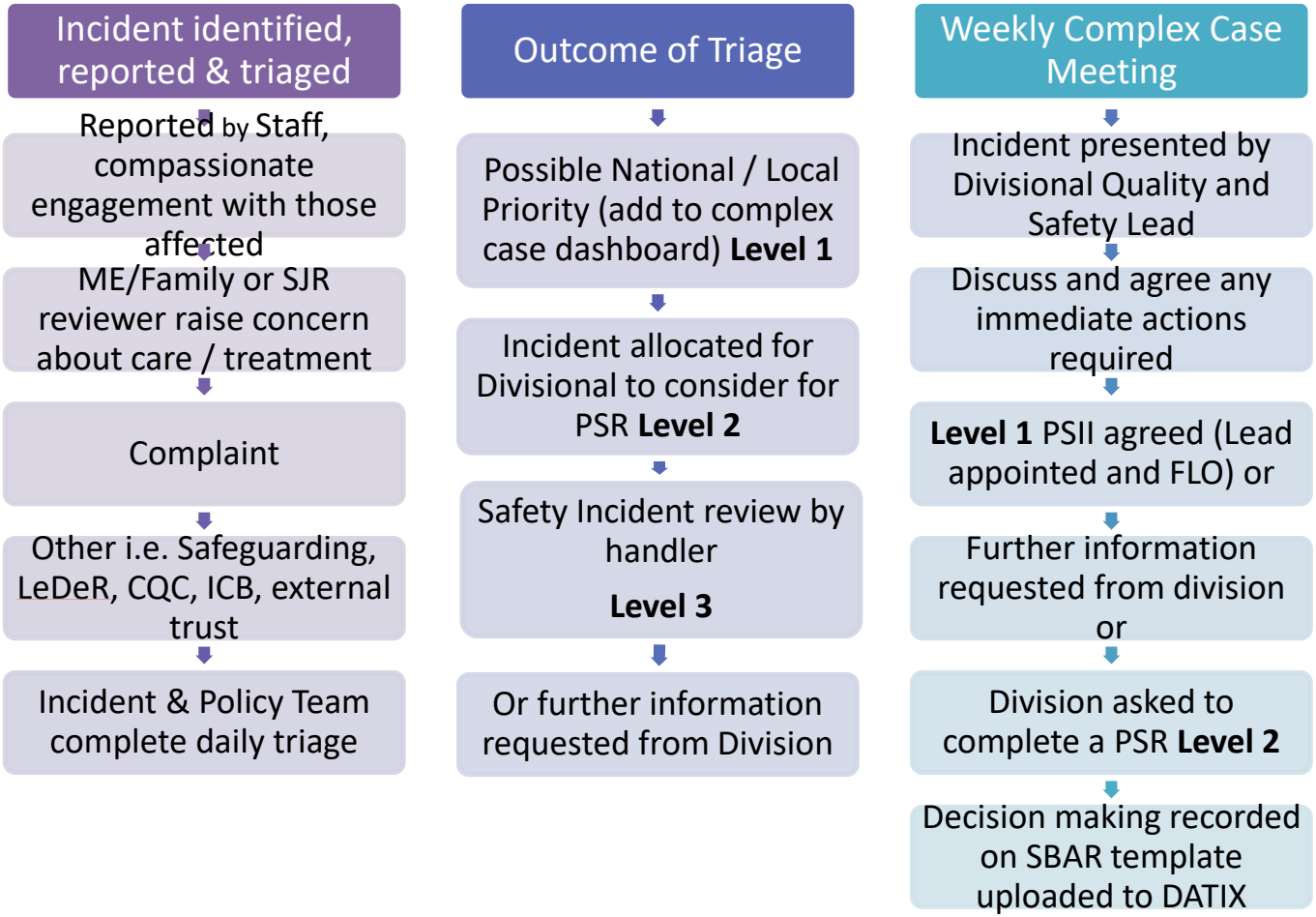



% of Trust and National Severe harm incidents between Jan-2022 & Jan-2023
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
% of incidnets
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Month/Year
Trust %
National %


% of Trust and National Moderate harm incidents between Jan-2022 & Jan-2023
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
% of incidnets
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Month/Year
Trust %
National %


% of Trust and National Death incidents between Jan-2022 & Jan-2023
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
% of incidnets
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Month/Year
Trust %
National %

Appendix B: PSIRP Decision Marking Process



Appendix C: Level of Incident Review

Level 1 – Patient Safety Incident Investigation

- Meets National priority or PRSIP local priority
- PSII Team nominated Lead
- SEIPS Methodology / National report template
- Full involvement of Patient/Family
- Informs new and ongoing Safety Quality Improvement

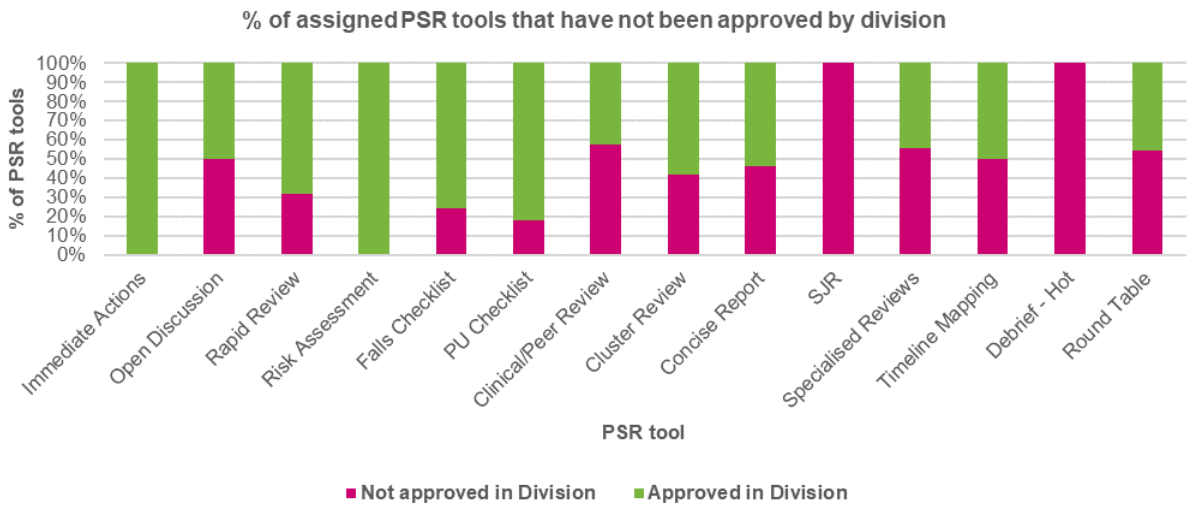
Level 2 – Patient Safety Response (Learning)

- Incidents where contributory factors not fully understood
- Limited improvement activity
- Concerns raised by Patient, Family, other
- Areas of increase reporting / concern
- PSR tool/template
- Lead appointed by Division
- Informs Safety Quality Improvements

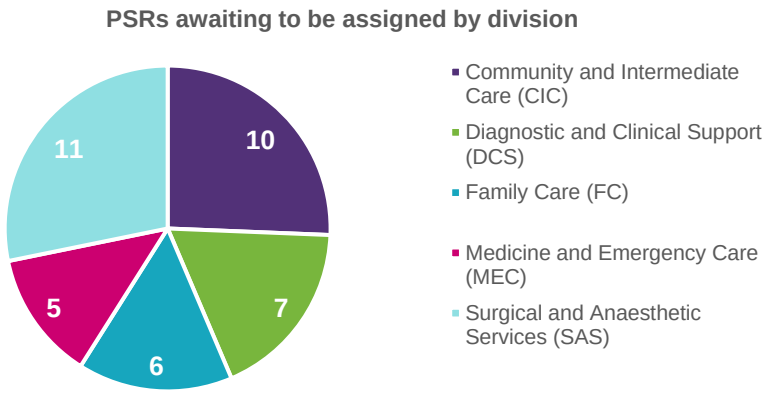
Level 3 – Service Incident Review (Improvement)

- No Harm / Low Harm incidents not identified as Local Priority, limited concerns
- Moderate/Severe harm Incidents where contributory factors are fully understood and linked to Quality Improvement work
- Incident Handler to have oversight / review

Appendix D: Patient Safety Response Overview



No. of PSRs	
Investigation tool	**No.**
Immediate actions	1
Open discussion	6
Rapid review	195
Risk assessment	1
Falls checklist	33
Pressure checklist	725
Clinical/Peer review	59
Cluster review	12
Concise report	91
SJR	1
Specialised reviews	86
Timeline mapping	18
Debrief - Hot	1
Round table	22
Awaiting to be assigned	39
Total	1290



Of the 1290 PSRs requested, 725 (56%) are for Pressure Ulcers

Appendix E: Overview of Local Priorities 1 to 5 Quality Improvement Programmes

Local Priority 1: Reducing 104 Day Cancer Breaches

Existing Quality Improvement Work: 2439: Histopathology Processing and Reporting Turnaround Times

Aim**:** To decrease the turnaround for processing and reporting of histopathology specimens.

Improvement Phase: Embed - numerous changes made related to process; communication; and environment

Impact:

- Turnaround time overall average: Baseline (January 22) = 31 days; Current (October 22) = 17 days
- 2WR specimen turnaround time: Baseline (January 22) = 22 days; Current (October 22) = 17 days
- Urgent specimen turnaround time: Baseline (January 22) = 21 days; Current (September 22) = 16 days
- Routine specimen turnaround time: Baseline (January 22) = 38 days; Current (September 22) = 18 days
- note: data provided by histopathology can sometimes change due to quality checks in the department but as of the end of October 2022, these were the figures).

Education and Training**:** 2 x Kata Learners in Department (one focusing on appraisals; one focusing on a specimen booking in process) and 3 x SSC4 Medical Students working on three separate tests of change

Other information**:** Backlog of specimen awaiting to be processed reduced to 0 at the end of October 2022; Number of specimens requiring escalation reduced (as per Histopathology Manager - now collecting specific numbers for this).

Local Priority 2: Vulnerable Adults Nil by Mouth (NBM)

Existing Quality Improvement Work: 2508: Discussion of Nutrition & Hydration on Ward Round

Aim: To improve the frequency and quality of the discussion of a patient's nutrition and hydration status on Ward Round

Improvement Phase: Test & Adapt

Impact: Not yet known
Education and Training: 3 x SSC4 Medical Students working on establishing a new baseline, collecting staff feedback and to undertake a test of change.

Other information: Been awaiting approval of the Nutritional Support Team Business Case, this has now been approved (January 2023).

Local Priority 3: DNACPR – Communication with Patients, Relatives and GP colleagues in Primary Care

To be registered:

Aim: To improve the frequency and quality of communication of DNACPR with Patients, Relatives and GP Colleagues in Primary Care by March 2024.

- To increase the number of patients who are informed that they have an DNACPR in place by X% by 31st May 2023.

Improvement Phase: Understand

Impact: Not yet known

Education and Training: 2 x SSC4 Medical Students working on understanding the current state from both a patient/relative and primary care colleague perspective.

Existing Quality Improvement Work: 2118: End of Life and Bereavement Care Improvement Project

Aim: Improve NACEL metrics (improving inpatient care when a patient is in the last days of life).
Latest: 5 x priorities:

- 7-day SPC and Bereavement Business Case
- Triangulating EoL and Bereavement data
- Recognition of Dying – see below
- Advanced Care Planning Education
- Embedding the ELHT CARE Bereavement Model

Improvement Phase: Embed / Test & Adapt

Impact:

- NACEL 2022 provisional results show no significant change (casenotes audit from April and May 2022); Biggest improvement is related to preferred place of death (meeting patient wishes) - 2019 = 5%; 2022 = 38%
- Bereavement Survey results as of January 2023 - positive responses 58%; Mixed responses 14%; Negative responses 26%

Education and Training: No update

Other information: HSJ Award shortlisting, unfortunately didn't win but being shortlisted was well ahead of the expected trajectory.

Sub A3 part of EoL and Bereavement Care: Improving Recognition of Dying

Aim: To increase time between recognition of dying and the patient dying.

Background: Identified through 2022 NACEL results that ELHT are well below the National average.

Benefits: Timely manner leads to right care at the right time by the right people; More chance to achieve patient end of life wishes; improved advanced care planning.

Latest: Task and finish group is every growing (21 members) with more members of staff wanting to be involved; 2 x working groups working on tests of change related to process and information and people and culture.

Impact: Increased discussion leading to more awareness and engagement in the project. Tests of change will start to be implemented March 2023.

Local Priority 4: Falls – Fractured Neck of Femurs (#NOF) resulting from a slip, trip or fall

To be registered:

Aim**:** To improve the compliance with the Post Falls Checklist by X% by May 2023.

Improvement Phase: Understand

Impact: Spot-check Audit undertaken by Falls Steering Group Chair in July/August 2022, this highlighted poor compliance with the Post Falls Checklist across all the Divisions.

Education and Training: 5 x SSC4 Medical Students working on understanding the current state from both a Medical and Nursing perspective.

Existing Quality Improvement work: 2676: Management of Fractured Neck of Femurs

Aim: To reduce the number of falls with Severe harm and above by X% by March 2024.

- To be ≥ the national average in all 8 x NHFD KPI's, with a particular focus on: Prompt Surgery, Bone Medication and Admission to Specialist Ward

Improvement Phase: Understand

Impact: Not achieving Best Practice Tariff

Education and Training: 3 x SSC4 Medical Students working on understanding the current state around the 3 areas of particular focus.

Other information: Improvement Programme Lead currently pulling together all #NOF improvement work undertaken/registered and any learning from 2018 to date, together into one project.

Local Priority 5: ED – Inappropriate transfers and handovers to internal wards/teams across all acute and peripheral sites

Registered 2156: The Safe Transfer of Patients - ED Transfers

Aim: To reduce the waiting time from the point of the bed turning green to the patient arriving on the ward by X by April 2023.

Improvement Phase: Understand

Impact: Delays in care, poor patient experience, quality of care given, overcrowding, patient flow

Education and Training: 1 x SSC4 Medical Student working on understanding the current state within the RBH Emergency Department.

Other information: The focus into the safe transfer of patients from the Emergency Department, has been incorporated as part of the Spread of the Trust-wide QIP 2156: The Safe Transfer of Patients

To be registered: e-SBAR

Aim: To have one standardised process across all the Divisions for the handover of a patients clinical and personal care by June 2023.

Improvement Phase: Understand

Impact: Increased incidents, impact on patient flow

Education and Training: Member of the Clinical Skills Team part of the Project Group. To engage with our Foundation Years 1 & 2 Doctors.

Other information: Two meetings have now taken place with representatives from across the Divisions (SAS, MEC and CIC), with both Nursing and Clinical input. A Trust-wide spot-check audit has been agreed and will take place across the Trust, on one day during March 2023 – date to be agreed.

Existing Quality Improvement Work: 2156: The Safe Transfer of Patients

Aim**:** 80% of patients to be transferred in accordance with the Trust guidance for the Safe Transfer of Patients by July 2022.

Improvement Phase: Embed / Spread

Impact: 100% of staff reported that they used the trial ELHT Patient Decision Matrix for the Safe Transfer of patients document, 88% of staff found the trial document easy to use, 96% of staff referred to/used the Patient Transfer Decision Matrix overleaf, 72% of staff reported that they would recommend that the trial document replaces the current Transfer of care documents

Education and Training**:** Spot-check audit undertaken in July 2022, results to be collated and compared. As part of monitoring the sustainability of this QIP, a spot-check audit will be undertaken in Summer 2023.

Other information: Improvement Programme Lead currently incorporating the ED improvement work and any learning together into the Trust-wide Safer Transfer QIP.

Existing Quality Improvement Work: 2645: Improving Clinical Observations at ELHT

Aim: To ensure that all patients identified as requiring clinical observations have these taken on time (or within the 30min window either side) by March 2024.

Improvement Phase: Test & Adapt

Impact: Between October 2021 and September 2022, an average of 114, 806 clinical observations have been taken per month, however on average per month: 1554 - were not taken**,** 59.96% - were Taken on Time**,** 18.12% - Obs were Missed **,** 5.87% - were Taken Late**,** 16.05% - had Extra Obs taken**,** 5307 - Obs are Edited

Education and Training: 5 x SSC4 Medical Students working on understanding the current state across all Divisions (SAS, MEC and CIC) and the Emergency Department. The SSC4 Medical Students will then support the implementation and testing of the chosen change ideas.

Other information: 3 x Trustwide Clinical Observations Workshops have now been undertaken with representation from across the Divisions and MDT. Collaboratively, this group have worked together to Understand the current state and identify opportunities for improvement, Co-design change ideas and have now agreed 2 x change ideas to Test – 1. Myth Busting and 2. Creating a standardised Observations Station.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

Item 38

8 March 2023

Purpose Information Assurance

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

Summary: This paper presents the corporate performance data for December 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, maternity and community although have deteriorated from baseline levels.
- There were 55 operations cancelled on the day (non-clinical). This continues to be below baseline.
- There were no STEIS reportable incidents during January
- The emergency readmission rate is showing an improvement on baseline.
- There were 0 P.aeruginosa detected in month.

Areas of Challenge

- There were 7 healthcare associated clostridium difficile infections, 9 post 2 day E.coli bacteraemia and 3 Klebsiellas detected in month.
- Friends & family scores in A&E are below threshold.
- The Hospital Standardised Mortality Ratio (HSMR) remains 'above expected levels'.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) was not achieved in January at 74.0%.
- There were 648 breaches of the 12 hour trolley wait standard (32 mental health and 616 physical health).
- There were 368 ambulance handovers > 30 minutes and 31 > 60 minutes. Following validation, 9 of the 31 were actual ELHT breaches and 22 were due to non-compliance with the handover screen.
- Performance against the cancer 62 day standard remains below threshold in December at 64.0%.
- The 28 day faster diagnosis standard was not met in December at 72.2% and is still showing significant deterioration from normal variation.
- There were 14.0 breaches of the 104 day cancer wait standard.

- The 6wk diagnostic target was not met at 12.8% in January.
- In January, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 48,189, and the number over 40 weeks has increased to 3,872.
- In January, there were 1047 breaches of the RTT >52 weeks standard.
- There were 18 RTT pathways >78wks which is above trajectory due to acceptance of Preston patients via mutual aid.
- In January, there was 1 breach of the 28 day standard for operations cancelled on the day.
- Length of stay - non-elective continues to be above baseline, however is in in quartile 2 (lowest 50%) nationally (Model Health data)
- Sickness rates are above threshold at 6.3% (January).
- The Trust vacancy rate is above threshold at 6.9%
- 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 90%.
- Temporary costs as % of total pay bill remains above threshold at 13%.
- The Trust is reporting a year-to-date adjusted deficit of £4.7m in month 10. Through the work to close the system planning gap, the Trust gap has moved from a forecast £6.7m gap to a £5.1m gap. NHSE has accepted that L&SC ICS can submit a £30m deficit as this is offset by historic CCG surpluses, meaning the £30m is not repayable in 2023-24 but there will be zero surplus available for transformation going forward.

No Change

- The Summary Hospital-level Mortality Indicator (SHMI) has remained as expected at 1.05.
- The complaints rate remains below threshold, and is showing no significant variation.
- The trust turnover rate is at 7.1% in December and remains below threshold.
- 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 January 2023 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	7		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	55		
M65	MRSA	0	0		
M124	E-Coli (HOHA)	n/a	5		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	0		
M157	Klebsiella species bacteraemia (HOHA)	n/a	0		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	22.9		
M69	Serious Incidents (Steis)	No Threshold Set	0		
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	36%		
C40	Maternity Friends and Family - % who would recommend	90%	92%		
C42	A&E Friends and Family - % who would recommend	90%	78%		
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%	96%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	94%		
C15	Complaints – rate per 1000 contacts	0.40	0.18		
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.05		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at Oct-22)	Within Expected Levels	112.4		
M74	Hospital Standardised Mortality Ratio - Weekday (as at Oct-22)	Within Expected Levels	109.0		
M75	Hospital Standardised Mortality Ratio - Weekend (as at Oct-22)	Within Expected Levels	122.2		
M73	Deaths in Low Risk Conditions (as at Oct-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

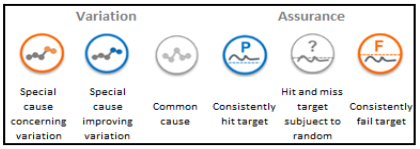
	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95.0%	74.0%		F
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95.0%	75.3%		F
M62	12 hour trolley waits in A&E	0	648		F
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	368		F
M84	Handovers > 60 mins (Arrival to handover)	0	31		F
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	41.6%		
C3	Referral to Treatment (RTT) non admitted pathways: percentage within 18 weeks	No Threshold Set	67.1%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	42222	48,189		
C4.2	Referral to Treatment (RTT) waiting times Incomplete pathways -over 40 wks	No Threshold Set	3872		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	480	1047		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1.0%	12.8%		?
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	64.0%		?
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	69.0%		?
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	93.3%		?
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	94.8%		P
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	84.5%		?
C36	Cancer 62 Day Consultant Upgrade	85.0%	75.9%		?
C25.1	Cancer - Patients treated > day 104	0	14.0		?
C47	Cancer - % Waiting over 62 day (Urgent GP Referral)	N/A	13.06%		
C46	Cancer - 28 Day faster diagnosis standard	75.0%	72.2%		?
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	55		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re admissions within 30 days	No Threshold Set	11.8%		
M90	Average length of stay elective (excl daycase)	No Threshold Set	3.7		
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%	7.1%		
M78	Trust level total sickness rate	4.5%	6.3%		
M79	Total Trust vacancy rate	5.0%	6.9%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	78.0%		
M80.35	Appraisal (Consultant)	90.0%	97.0%		
M80.4	Appraisal (Other Medical)	90.0%	99.0%		
M80.2	Safeguarding Children	90.0%	94.0%		
M80.21	Information Governance Toolkit Compliance	95.0%	90.0%		
F8	Temporary costs as % of total paybill	4%	13.0%		
F9	Overtime as % of total paybill	0%	0%		
F1	Variance to H1 financial performance surplus / (deficit) (£m)	£0.0	-£4.9		
F2	Variance to H1 Waste Reduction Programme (WRP) achieved (£m)	£0.0	£0.0		
F3	Liquidity days	-12.4	-14.20		
F4	Capital spend v plan	85.0%	59.0%		
F18a	Capital service capacity	1.4	1.2		
F19a	H1 Income & Expenditure margin	0.0%	-0.8%		
F21b	Variance to agency ceiling (in millions) *	£0.0	-£6.2		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	93.2%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	97.0%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	96.9%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	99.0%		

NB: Finance Metrics are reported year to date.

KEY

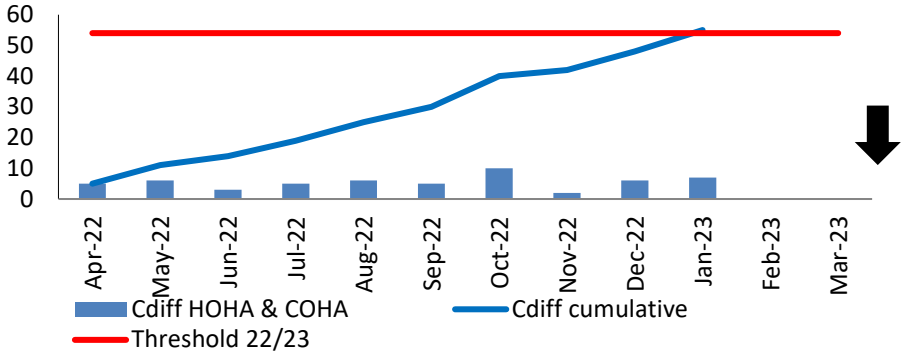


SPC Control Limits

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

SAFE

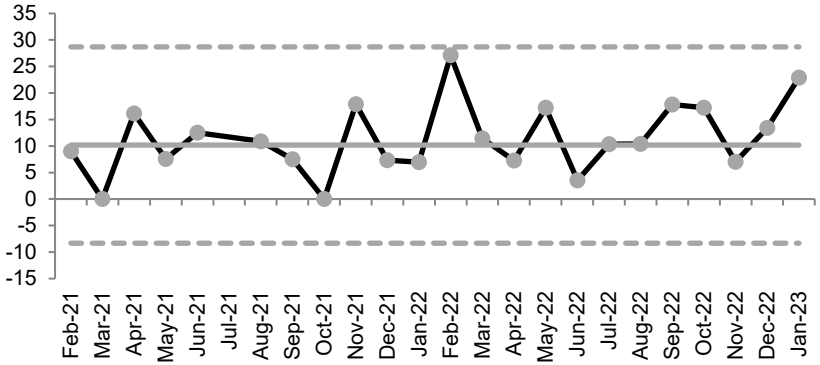
C Difficile (HOHA &



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

The Clostridium difficile 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.

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



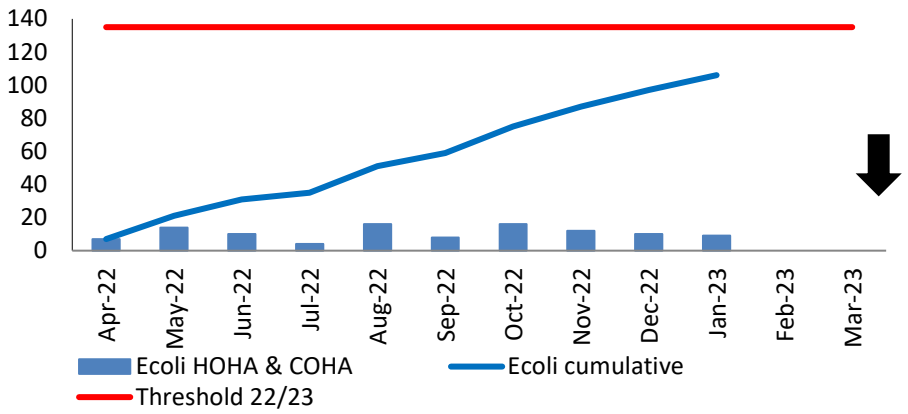
There were 7 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in January. All 7 were were HOHA.

The year to date cumulative figure is 55 (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 January.

SAFE

E. Coli (HOHA & COHA)

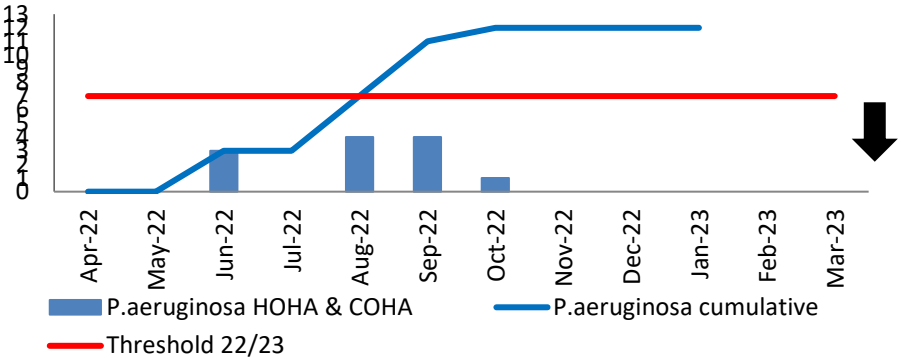


The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

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

There were 9 reportable cases of E.coli bacteraemia identified in January. 5 of which were HOHA and 4 were COHA.

P.aeruginosa

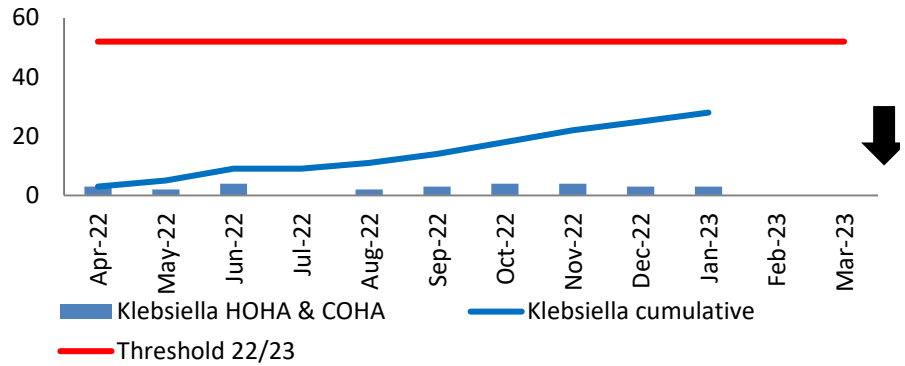


From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England.

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

There were 0 reportable cases of Pseudomonas identified in January.

Klebsiella



There were 3 reportable cases of Klebsiella identified in January. All of which were COHA.

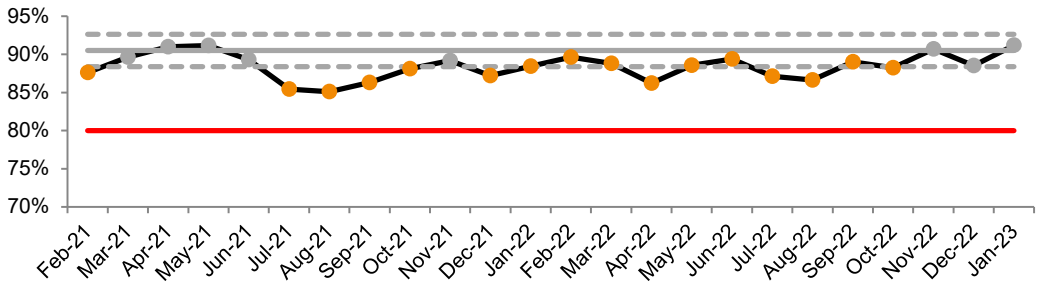
Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

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

SAFE

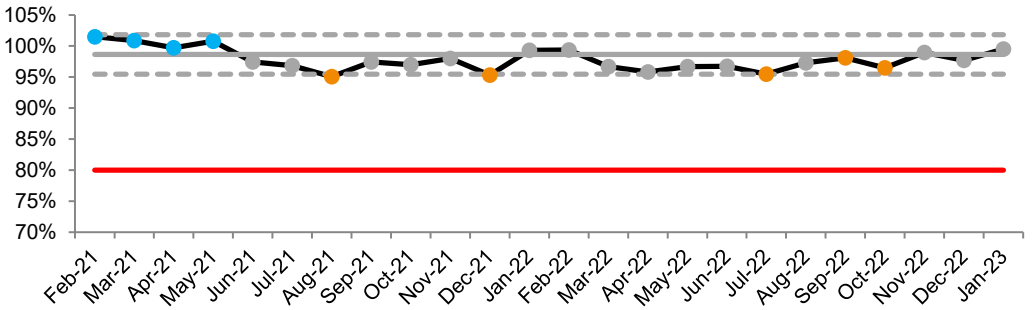
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



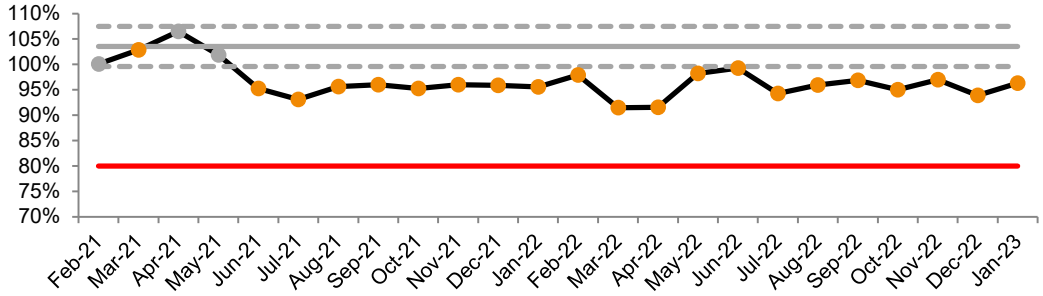
The average fill rate for registered nurses/ midwives during the day has returned to previous levels and based on current variation will consistently be above threshold.

Registered Nurses/ Midwives - Night



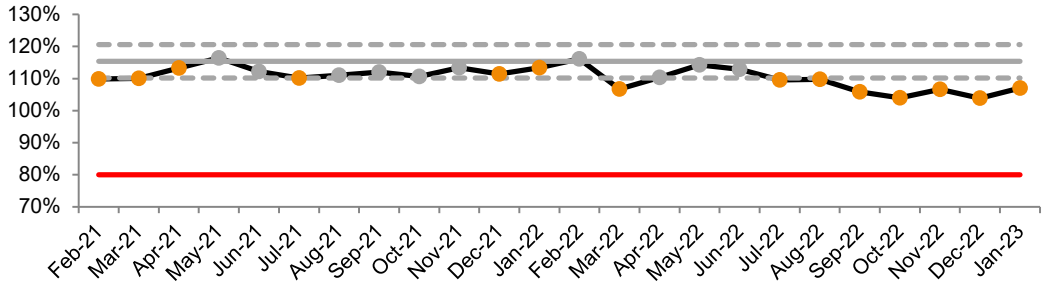
The average fill rate for registered nurses/ midwives at night is showing a return to previous levels, however based on current variation will consistently be above threshold.

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 remains above threshold, however is showing a reduction on previous levels. Based on current variation will consistently be above threshold.

SAFE

Staffing in January 2023 has remained a challenge, Covid and influenza is 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 January 2023, 1 area fell below the 80% for Registered Nurses/Midwives for the day shifts. This is 3 less than the previous month. There is still the on-going impact of maternity leave, sickness and vacancies. Bank and agency fill is slightly better than December but remains challenging, with high numbers of last-minute cancellations or no shows.

MEC

• **Ward C5 -** 76.3 % 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
Jan-23	97.1%	136.0%	100.0%	102.2%	30,546	8.49	1	0	0	0

SAFE

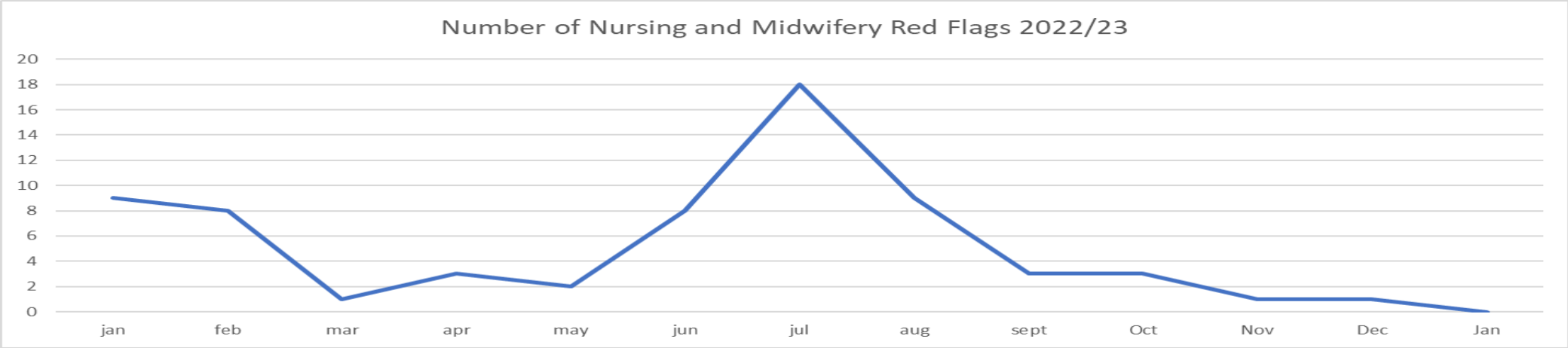
Monthly Trend

	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 (%)
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
Dec-22	88.5%	93.9%	97.7%	103.9%	29,786	8.44	4	5	0	0
Jan-23	97.1%	136.0%	100.0%	102.2%	30,546	8.49	1	0	0	0

SAFE

National Nursing Red Flags
On reviewing Datix in January 2023 there were 0 red flags reported. This is one less than last month.

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.

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

- £50k funded NHSE project to support HCSW retention has been agreed and can commence

- 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.

SAFE

- Nursing Recruitment Strategy Workshop planned for March 2023

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

- A review of the Nursing Associate workforce has commenced, this will include competencies and development and will highlight opportunities to develop the NA workforce.

- International midwifery recruitment in progress with plan to employ a minimum of 2 overseas midwives in early 2023. The first midwife has passed their OSCE and has commenced in post.

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

- For Apr 2022 – Dec 2022 the target of recuiting 71 nurses was achieved.

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

A 2023 ELHT strategy to recruit 244 (20 per month) International Nurses over 12 months commencing in April has been agreed.

SAFE

Family Care Staffing Summary – January 2023

On reviewing Datix in January 2023 there were no National Midwifery Red Flags reported

Maternity (Midwife to Birth Ratio)

Month	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Staffed to full Establishment	01:27	01:28	01:27	01:27	01:27	01:28	01:27	01:28	01:28	01:27	01:27
Excluding mat leave	01:27	01:29	01:29	01:28	01:27	01:28	01:27	01:29	01:27	01:27	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	18.76	14.79	15.8	14.87	23.9	16.10	20.75	30.56	21.74	17.99	25.73

Maternity- January 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.

SAFE

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.

Recruitment drive continues aligned with DSO report and plan, accuracies with PWR data reviewed. Second international recruitment midwife has now commenced in post and in supernumerary period.

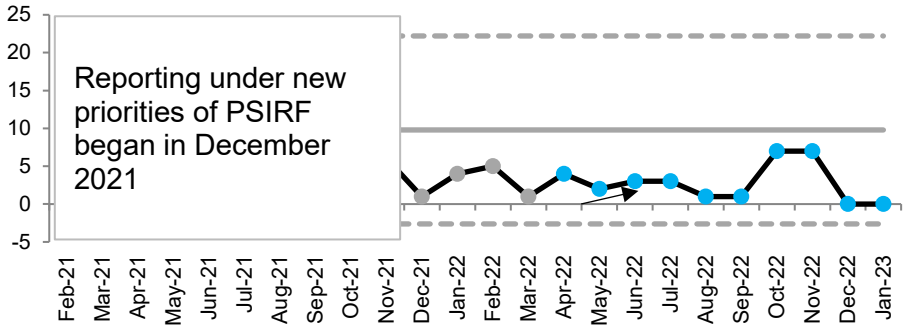
Neonatology – No exceptions/staffing reviews continue to be part of the daily maternity safety huddles. Bank and agency covered although minimal agency cover is required due to bank uptake with enhanced rates. Enhanced bank rate to continue until March. No closures.

Paediatrics- To follow up on the x1 nursing red flag incident to understand learning and if any other mitigation could have been considered from an escalation perspective

Gynaecology – No exceptions

SAFE

Serious Incidents



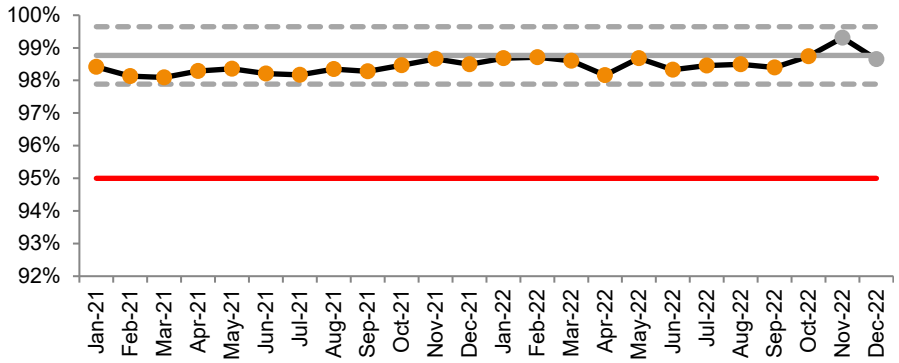
PSIRF Category	No. Incidents
	0

There were no never events reported in January.

No incidents meeting a national or local priority and whereby a patient safety incident investigation (PSII) is underway, have been reported onto STEIS in January.The Trust started reporting under these priorities on 1st December 2021.

A detailed report providing assurance on the management of each of the STEIS reported incidents is submitted monthly to the Trust Board and Quality Committee.

VTE assessment



The Venous Thromboembolism (VTE) assessment trend has returned to baseline levels, however is still above the threshold.

Pressure Ulcers

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

Category of pressure ulcer	Total Number		
	2019/2020	2021/2022	2022/2023 (Apr - Jan)
2	14	44	54
3	3	14	3
4	0	3	8
Deep Tissue Damage	23	53	66

Multiple factors continue to contribute to both pressure damage incidents occurring and lapses in care being determined which include the increased complexity and acuity of patients and increased pressure on services.
There are currently 83 investigations ongoing which will affect the final number on lapses in care on the chart below.

All Divisions remain committed to preventing avoidable harms, all have robust pressure ulcer prevention action plans and continue to hold weekly Pressure Ulcer Review Panels where practice is discussed.

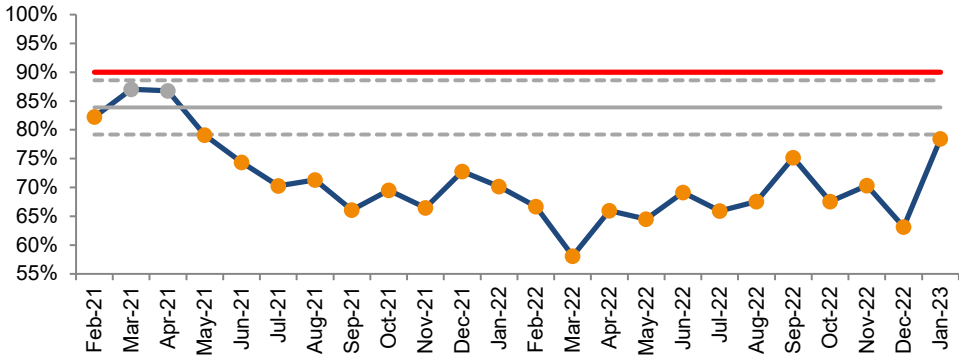
It has also been highlighted that a refresh of the educational programme is required which will be discussed at the next Pressure Ulcer Steering Group with a view to changing the training from 3 yearly

CARING

The Friends & Family Test (FFT) question – “Overall how was your experience of our service” is being used to collect feedback via SMS texting and online via links on the Trust’s website.

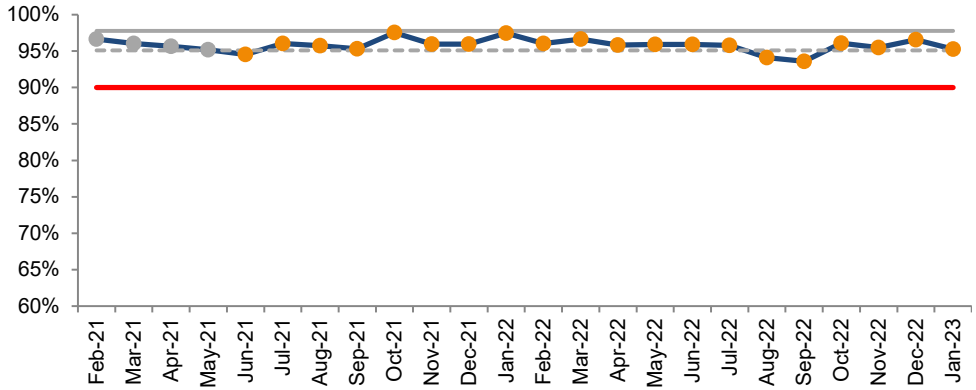
Baseline period for SPC comparison is Apr 18 - Mar 20

Friends & Family A&E



A&E scores are showing a significant deterioration from the baseline (Apr 18 - Mar 20) Based on current variation this indicator is not capable of hitting the target routinely.

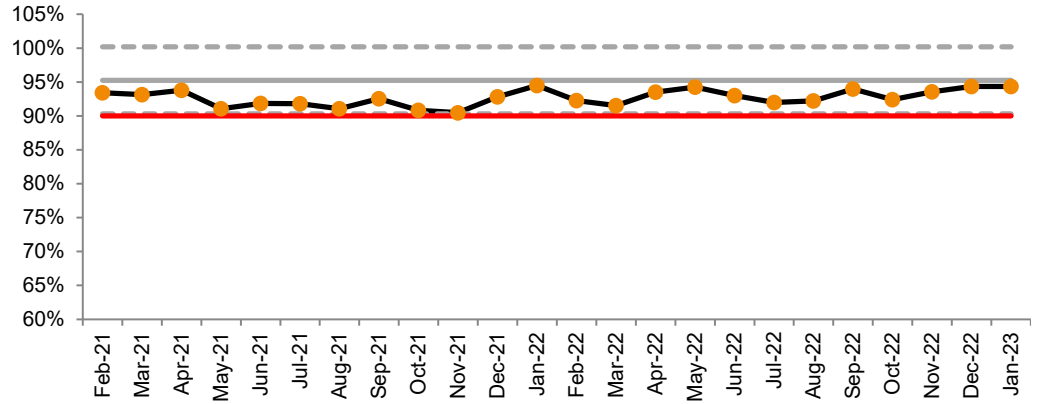
Friends & Family Inpatient



Current performance is above target but is showing significant deterioration from the pre-covid baseline, however based on recent performance will consistently be above threshold.

CARING

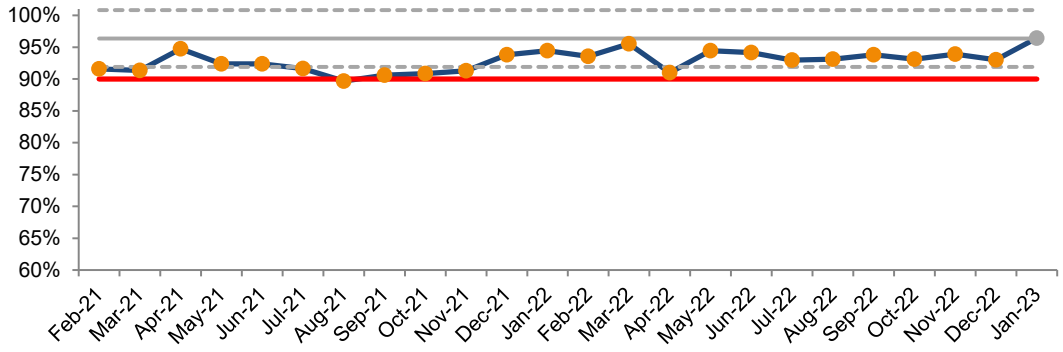
Friends & Family Outpatients



Outpatient scores continue to be above target, however remain below the pre-covid baseline.

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

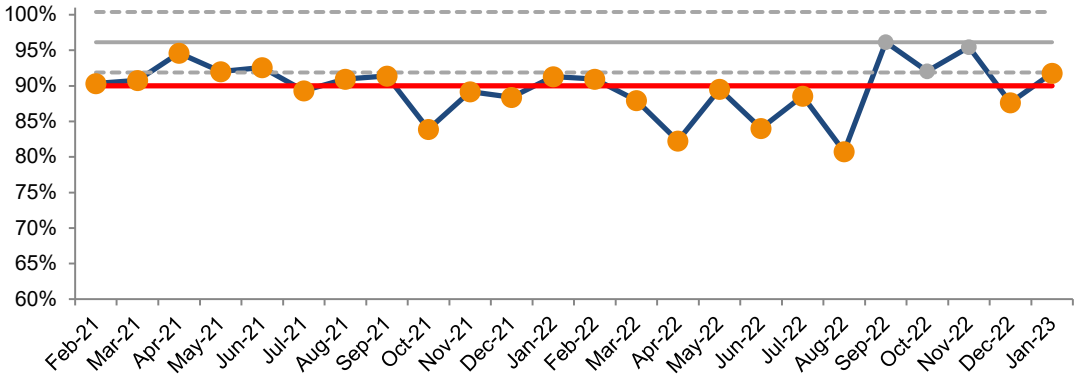
Friends & Family Community



Community scores are above target this month and are within the normal range when compared with pre-covid levels.

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

Friends & Family Maternity

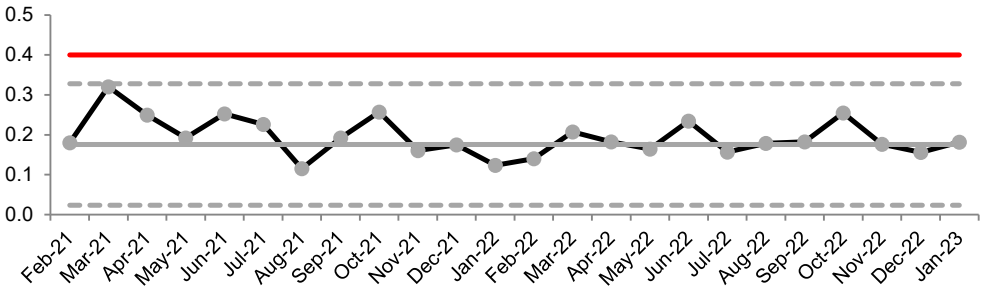


Maternity scores are above target this month however are showing deterioration compared to the pre-covid baseline.

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

CARING

Complaints per 1000 contacts



The Trust opened 23 new formal complaints in January.

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 January the number of complaints received was 0.18 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	75	88.89	95.31	92.74
Community	Community and Intermediate Care Services	91.71	91.67	89.67	94.65	91.55
Community	Diagnostic and Clinical Support	100	92.86	100	100	95.91
Community	Family Care	93.75	-	-	100	98.53
Community	Surgery	99.86	98.24	-	-	98.7
ED_UC	Medicine and Emergency Care	75	61	55.56	72.92	62.92
Inpatients	Community and Intermediate Care Services	91.44	85.75	89.96	90.5	89.38
Inpatients	Diagnostic and Clinical Support	99.38	96.9	92.34	95.09	95.76
Inpatients	Family Care	95.09	90.91	94.41	92.31	93.49
Inpatients	Medicine and Emergency Care	90.8	81.85	84.34	86.79	85.47
Inpatients	Surgery	93.79	85.96	89.9	90.43	89.92
OPD	Diagnostic and Clinical Support	99.61	97.84	97.35	97.76	98.37
OPD	Family Care	99.35	96.43	97.5	97.25	97.76
OPD	Medicine and Emergency Care	100	99.57	100	98.64	99.47
OPD	Surgery	98.91	94.12	97.25	98.56	97.18
Other	Surgery	100	100	100	100	100
Postnatal	Family Care	94.74	97.14	100	92.98	95.31
PostnatComm	Family Care	100	75	100	100	92.31
SDCU	Family Care	89.81	91.67	91.18	92.19	91.09
	Total	**95.48**	**91.66**	**90.6**	**93.44**	**92.61**

The table demonstrates divisional performance from the range of patient experience surveys in January 2023.

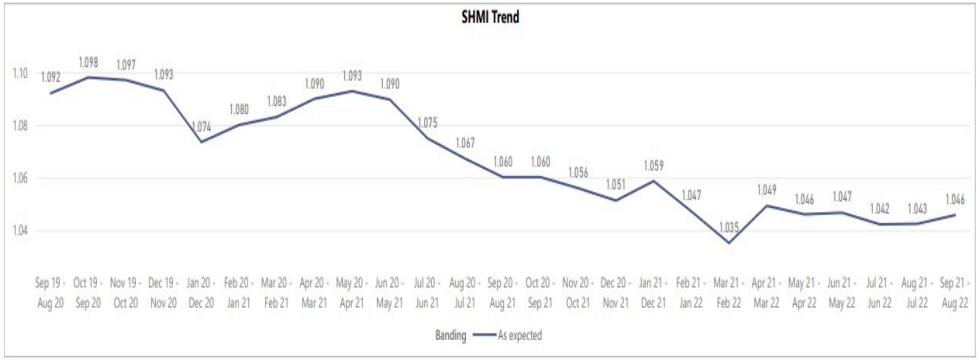
The threshold is a positive score of 90% or above for each of the 4 competencies.

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

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

EFFECTIVE

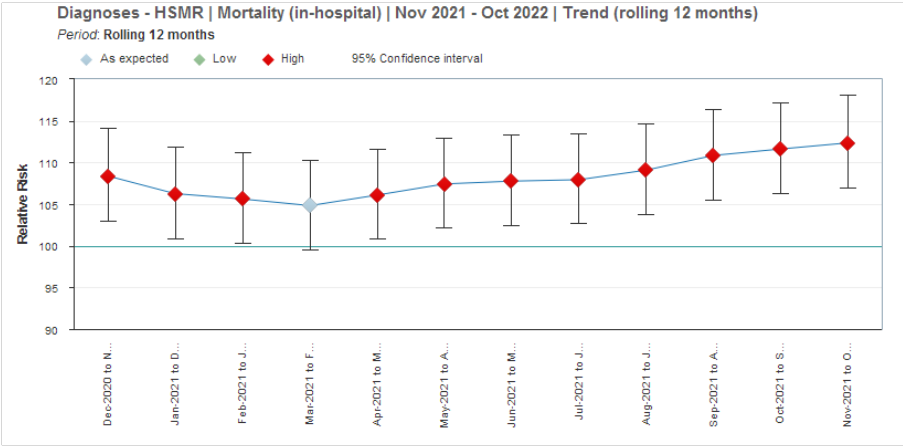
SHMI Published Trend



Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month Nov 21 – Oct 22
	ALL
TOTAL	112.35
Weekday	109.0
Weekend	122.2
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 Sep 21 to Aug 22 has remained within expected levels at 1.05, as published in January 23.

The latest indicative 12 month rolling Hospital Standardised Mortality Ratio (HSMR), (Nov 21 – Oct 22) has increased from last month and is 'above expected levels' at 112.4 against the monthly rebased risk model.

The benchmark model has been adjusted this month to account for data up to July 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: Septicemia (except in labour), Pneumonia , Congestive heart failure nonhypertensive, COPD and Malignant neoplasm without specification of site.

Septicemia (except in labour) and Secondary Malignancies are also currently 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	Dec-22	Jan-23	TOTAL
Deaths requiring SJR (Stage 1)	46	212	250	263	214	163	14	10	13	14	20	13	29	22	17	13	165
Allocated for review	46	212	250	262	214	163	14	10	13	14	20	13	28	19	15	13	159
SJR Complete	46	212	250	262	214	161	14	10	13	14	19	11	22	9	3	0	115
1 - Very Poor Care	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0
2 - Poor Care	8	19	22	34	35	22	4	1	2	3	3	2	8	2	0	0	25
3 - Adequate Care	14	68	70	70	65	48	3	4	3	6	9	3	7	2	0	0	37
4 - Good Care	20	106	133	129	103	78	6	5	7	5	6	6	7	5	3	0	50
5 - Excellent Care	3	18	25	29	10	12	1	0	1	0	1	0	0	0	0	0	3
Stage 2																	
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	4	1	2	3	3	2	8	2	0	0	25
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	0	0	0	0	0	0	0	0	0	0	0
Allocated for review	6	18	21	30	35	22	4	1	2	3	3	2	8	2	0	0	25
SJR-2 Complete	6	18	21	30	35	22	4	1	2	3	3	2	5	2	0	0	22
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0	0	0	0	0	0	0	1
2 - Poor Care	3	6	7	13	13	10	2	1	1	2	1	1	4	2	0	0	14
3 - Adequate Care	2	10	13	13	21	10	1	0	0	1	2	1	1	0	0	0	6
4 - Good Care	0	1	0	2	1	1	0	0	1	0	0	0	0	0	0	0	1
5 - Excellent Care	0	0	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	Dec-22	Jan-23	Total
stage 1 requiring allocation	0	0	0	1	0	0	0	0	0	0	0	0	1	3	2	0	6
stage 1 requiring completion	0	0	0	0	0	2	0	0	0	0	1	2	6	10	12	13	44
Stage 1 Backlog	0	0	0	1	0	2	0	0	0	0	1	2	7	13	14	13	50
stage 2 requiring allocation	0	0	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	0	0	0	0	0	0	1	2	3
Stage 2 Backlog	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	3

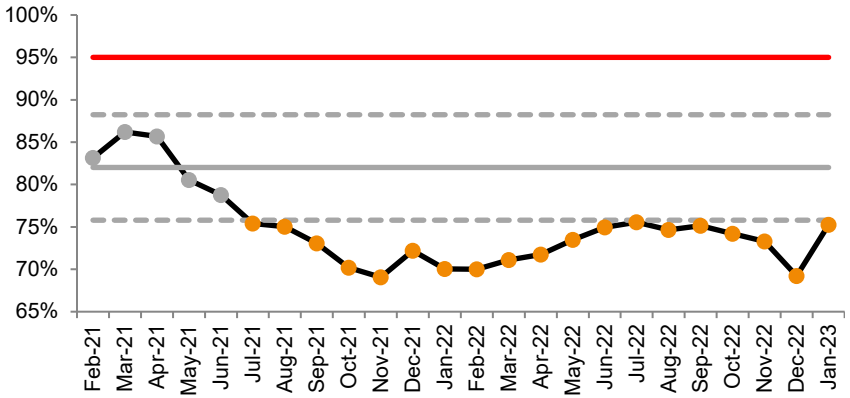
EFFECTIVE

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

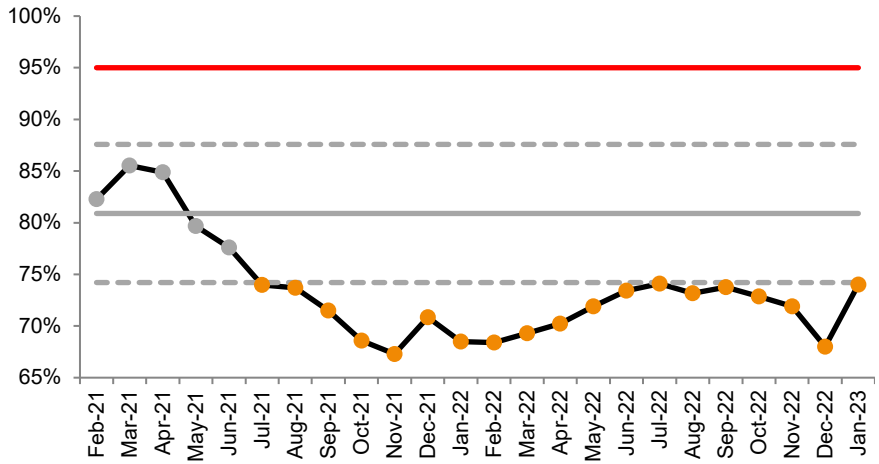
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 75.27% in January, 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.

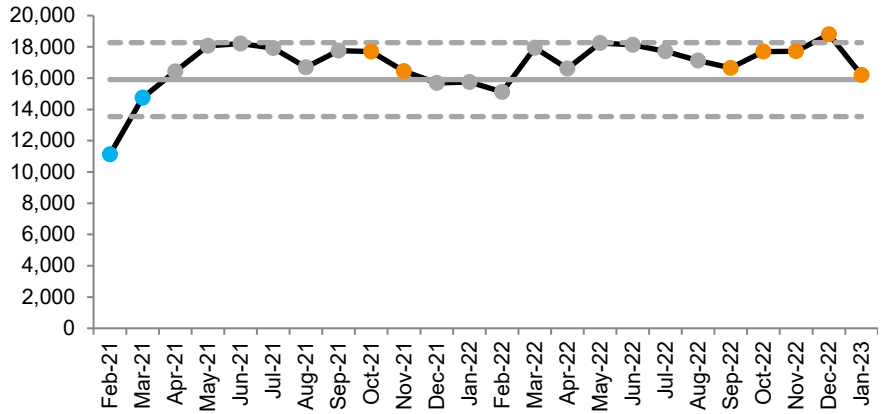
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 74.01% in January.

The national performance was 72.4% in January (All types) with 0 of the 110 reporting trusts with type 1 departments achieving the 95% standard.

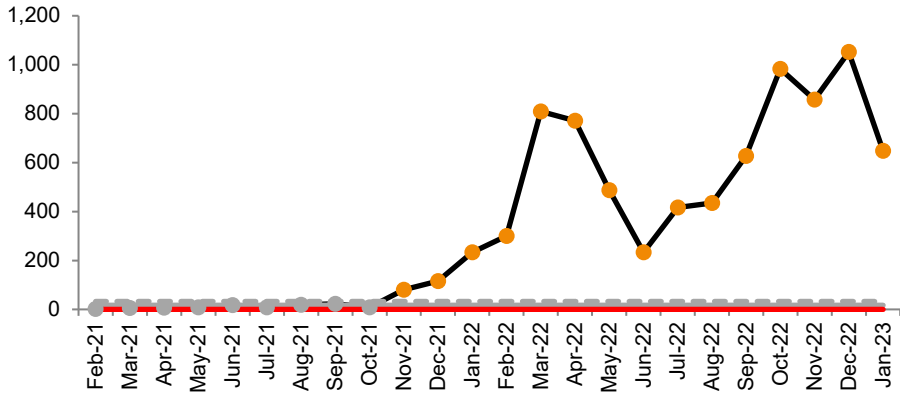
A&E Attendances - Trust



The number of attendances during January was 16,196, which remains significantly higher than baseline levels.

RESPONSIVE

12 Hr Trolley Waits

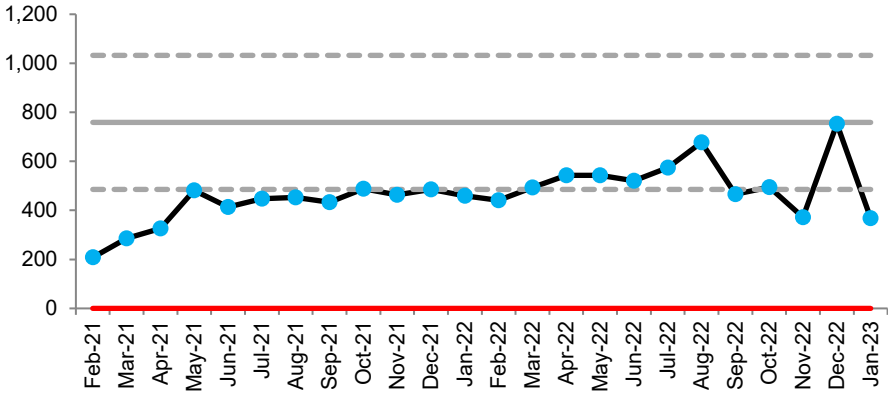


There were 648 reported breaches of the 12 hour trolley wait standard from decision to admit during January, which is higher than the normal range. 32 were mental health breaches and 616 were physical health.

Rapid review timelines are completed in accordance with the NHS England Framework for all breaches and a root cause analysis will be undertaken.

	Mental Health	Physical Health
No. 12 Hr Trolley Waits	32	616
Average Wait from Decision to Admit	39hr 20 min	18hr 08 min
Longest Wait from Decision to Admit	95hr 24 min	43hr 54 min

Ambulance Handovers - >30Minutes

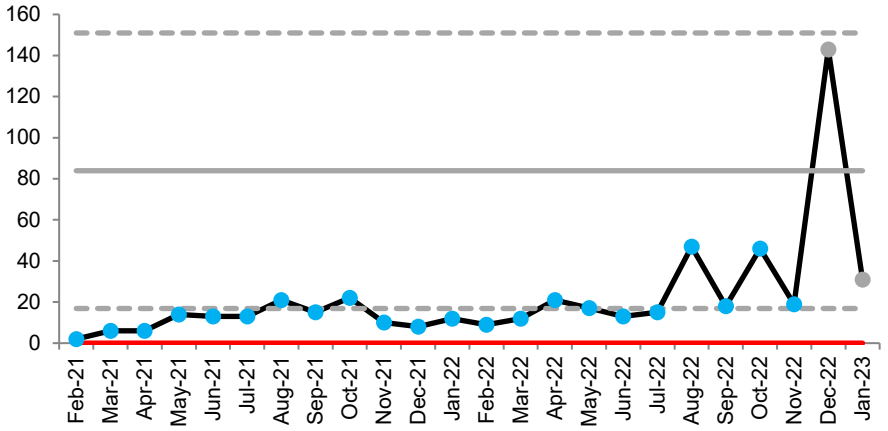


There were 368 ambulance handovers > 30 minutes in January. The trend is still showing significant improvement from previous levels, but based on current variation is not capable of hitting the target routinely.

There were 31 ambulance handovers > 60 minutes in January, which continues to demonstrate a signifcant improvement. Following validation, 9 of the 31 were actual ELHT breaches and 22 were due to non-compliance with the handover screen.

The average handover time was 22 minutes in January and the longest handover was 2hr 18 minutes.

Ambulance Handovers - >60 Minutes



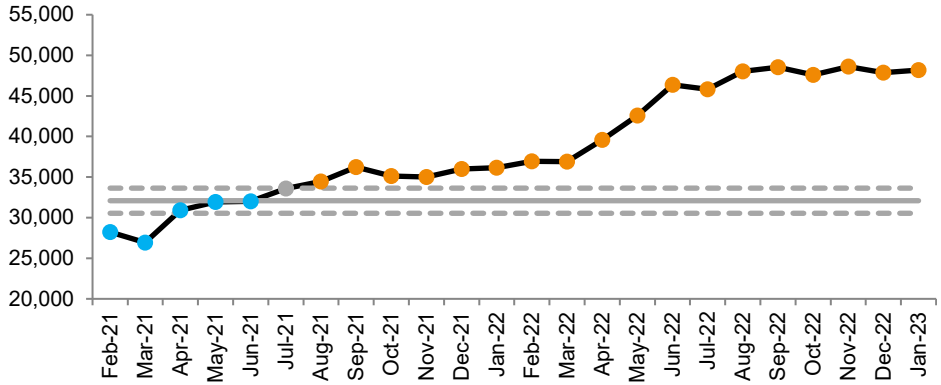
RESPONSIVE

At the end of January, there were 48,189 ongoing pathways, which has increased on last month and is above pre-COVID levels.

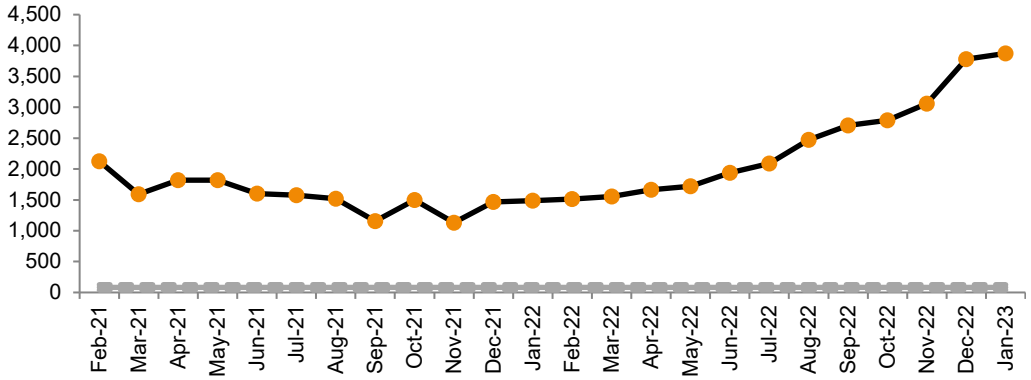
The number of pathways over 40wks increased in January with 3872 patients waiting over 40 wks at month end.
There were 1047 patients waiting over 52 weeks at the end of January which has increased on last month and is above trajectory.
There were 18 patients waiting over 78 weeks which was above trajectory. This is mostly due to the acceptance of mutual aid patients from Preston.

No patients were waiting over 104 weeks.

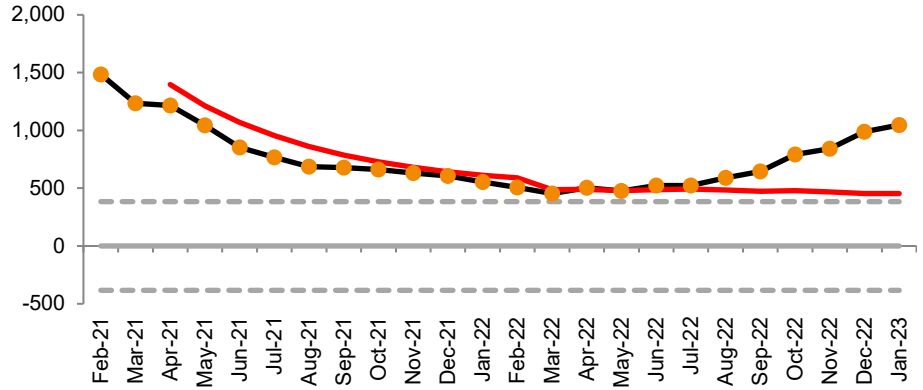
Referral to Treatment (RTT) Total Ongoing



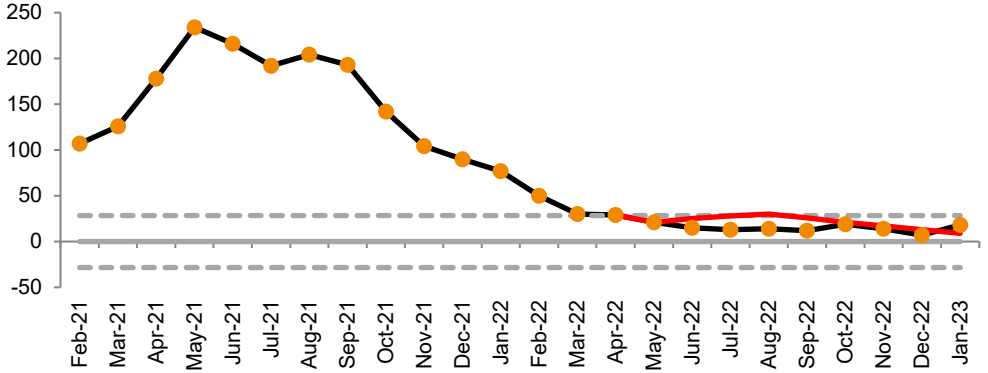
RTT Total Over 40 wks



RTT Total Over 52 wks



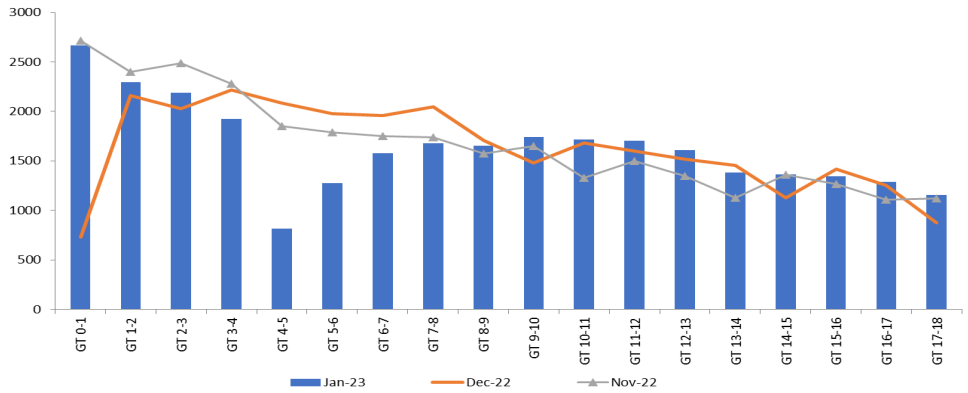
RTT Total Over 78 wks



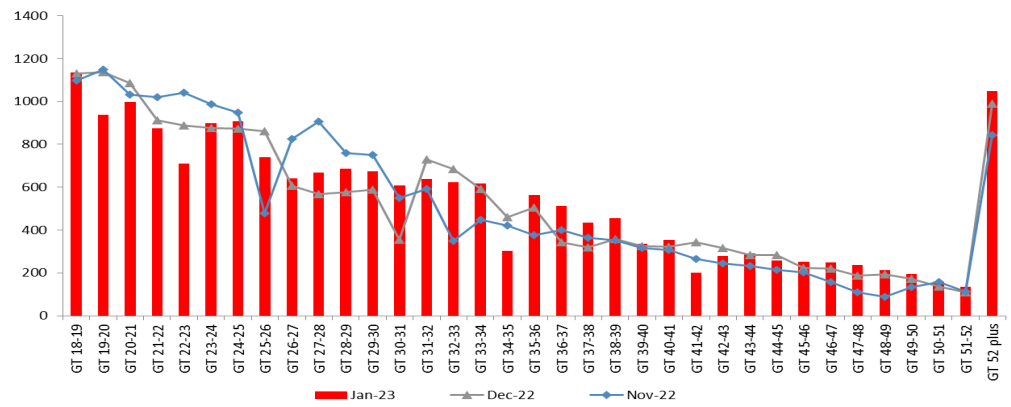
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

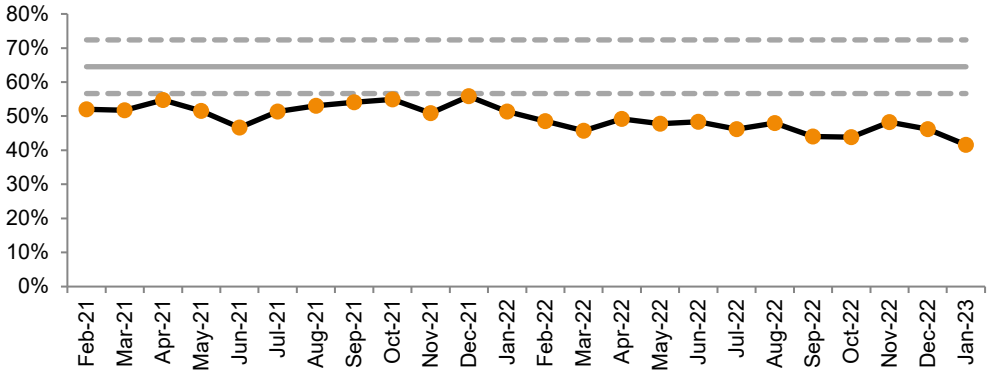


RTT Over 18 weeks

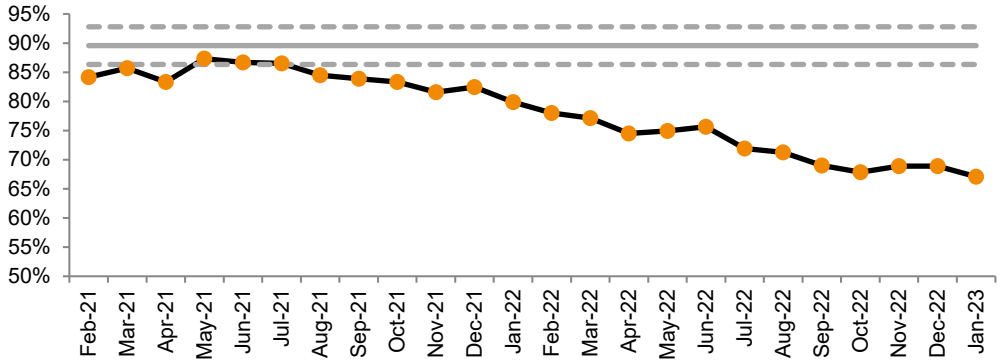


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted

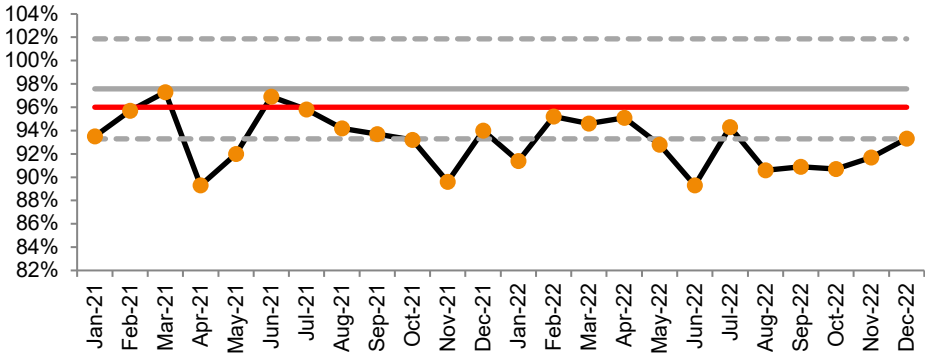


RTT Non-Admitted



RESPONSIVE

Cancer 31 day



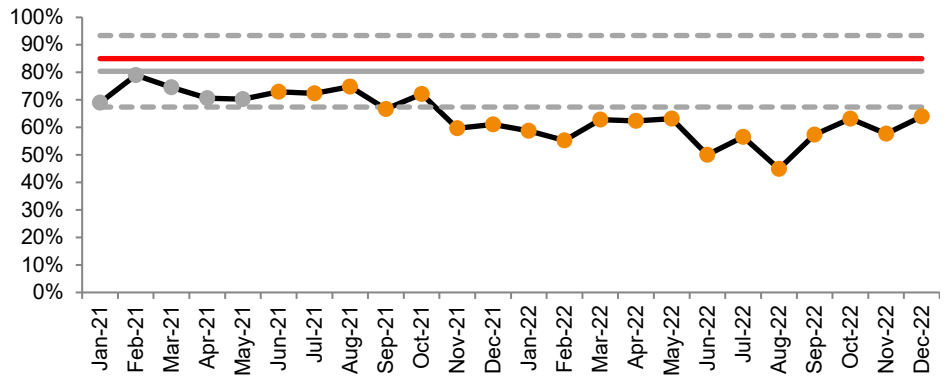
The 31 day standard was not achieved in December at 93.3%, below the 96% threshold.

National position - 92.7%

Q3 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



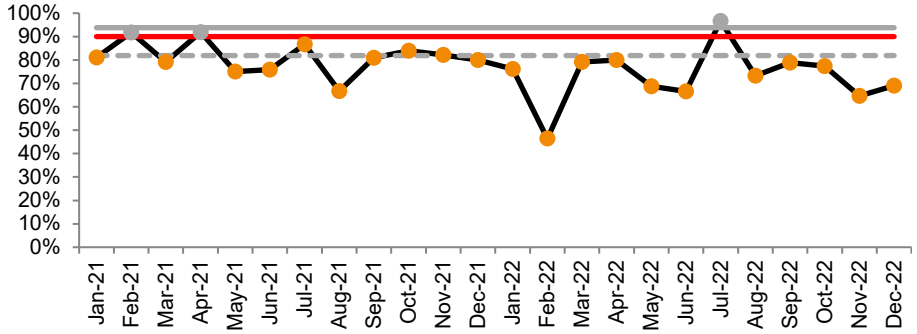
The 62 day cancer standard was not achieved in December at 64.0% below the 85% threshold.

National position - 61.7%

Q3 was not achieved at 65.4%

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

Cancer 62 Day Screening



The 62 day screening standard was not achieved in December at 69.0%, below the 90% threshold.

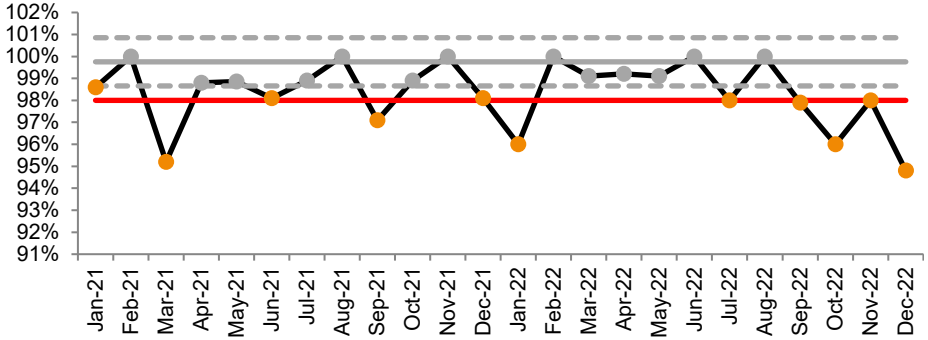
National position - 73.0%

Q3 was not achieved at 72.4%

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)



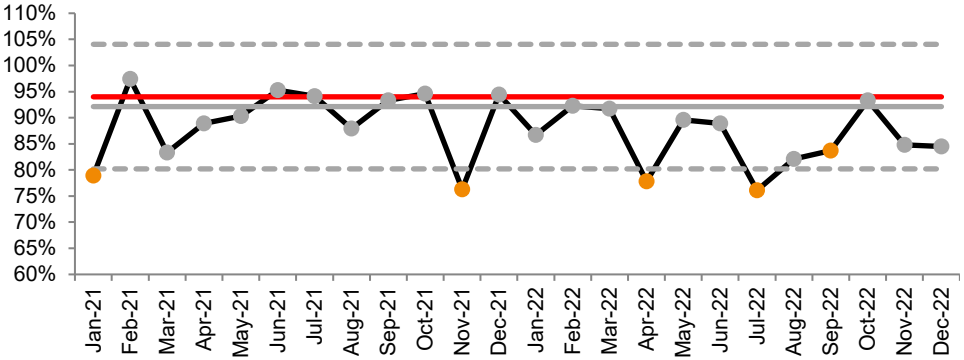
The subsequent treatment - drug standard was on target in December at 94.8%

Q3 was not achieved at 96.3%

* 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)

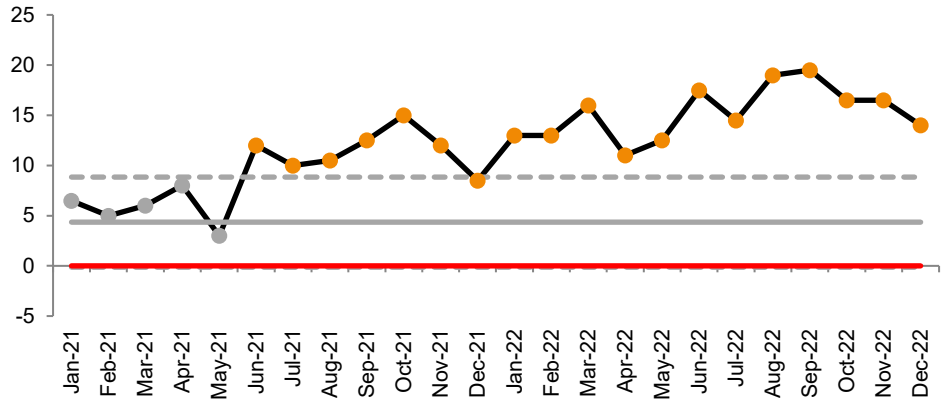


The subsequent treatment - surgery standard was not met in December at 84.5%, below the 94% standard.

Q3 was not achieved at 86.8%

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

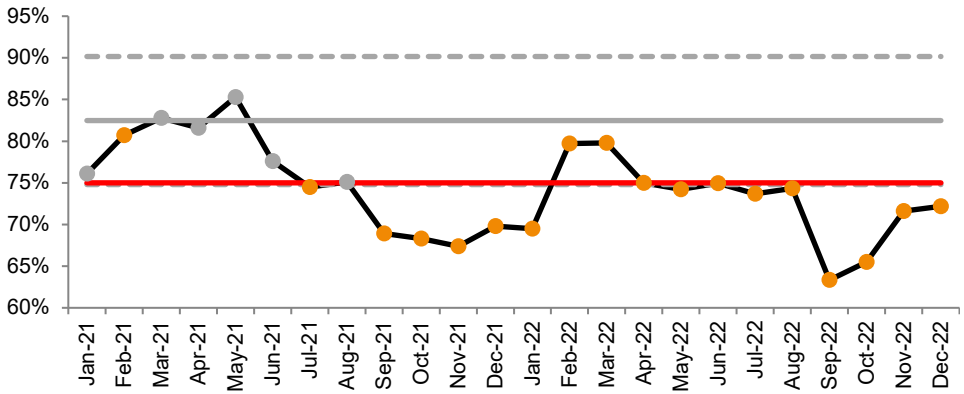


There were 14.0 breaches allocated to the Trust, treated after day 104 in December and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the consultants involved in the pathway as required.

The trend is showing a significant increase on the baseline.

RESPONSIVE

Cancer 28 Day faster diagnosis



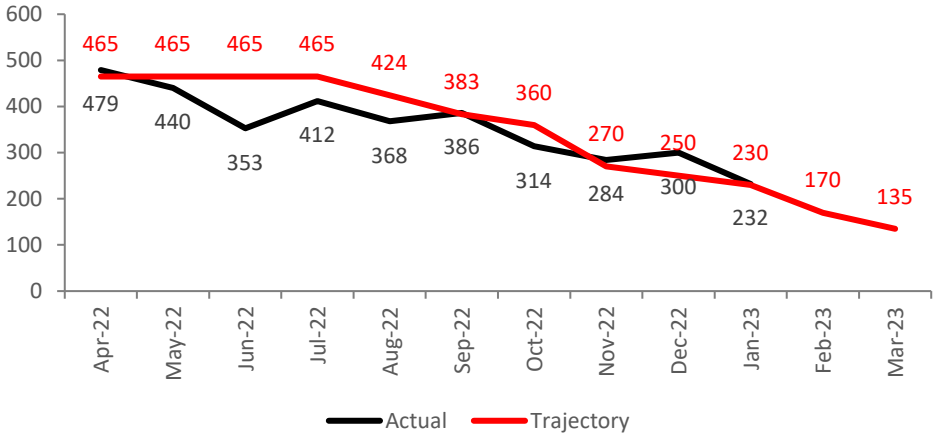
The 28 day faster diagnosis standard did not acheive the target in December at 72.2%

National position - 69.7%

Q3 was not achieved at 69.5%

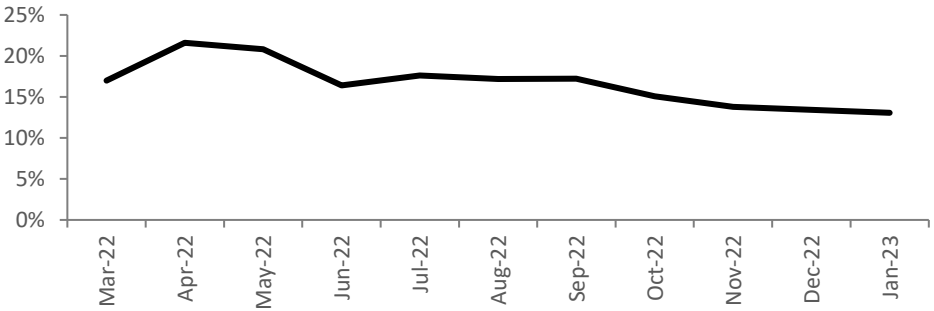
The trend is showing significant deterioration over the last 12 months.

Cancer >62 day vs trajectory



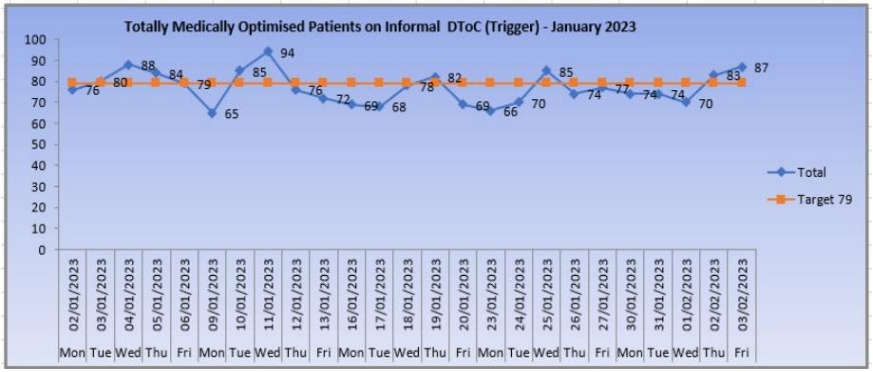
At the end of January the number of patients >62 days was 232 vs 230 trajectory. This was 13.0% of the total wait list.

Cancer % Waiting >62days (Urgent GP Referral)



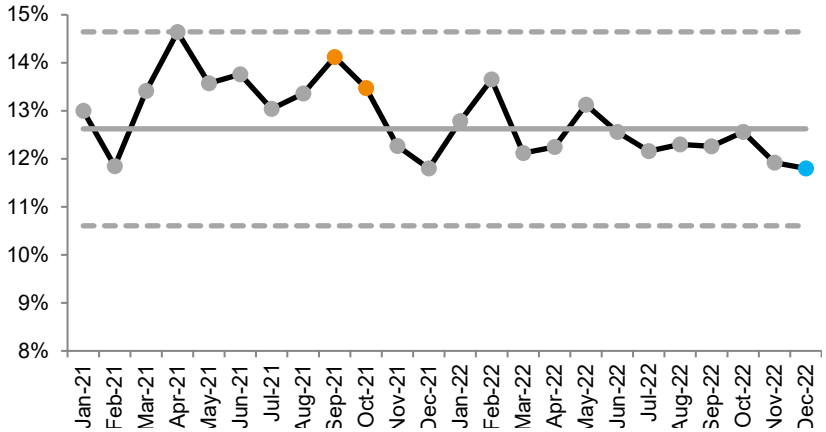
RESPONSIVE

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.

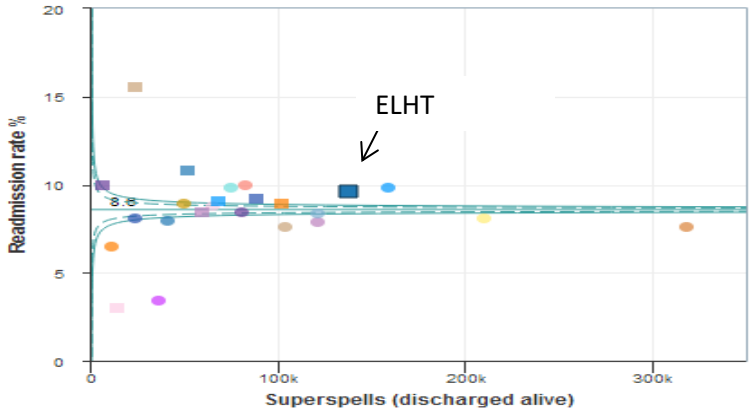
Emergency Readmissions



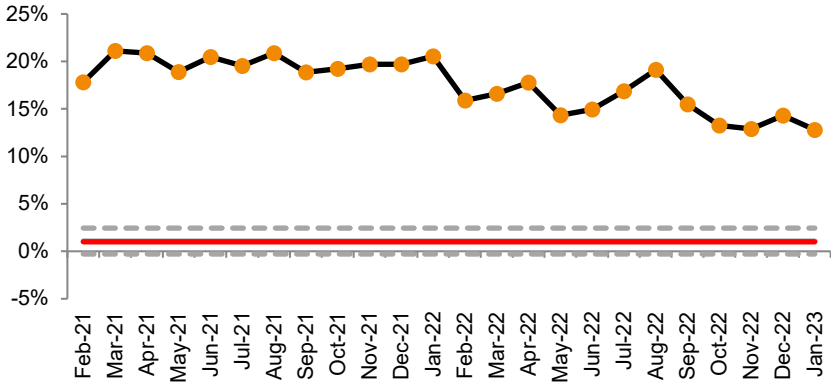
The emergency readmission rate trend has improved significantly on the baseline.

Dr Foster benchmarking shows the ELHT readmission rate is higher than the North West average.

Readmissions within 30 days vs North West - Dr Foster
August 2021 - July 2022



Diagnostic Waits



In January, 12.8% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is above the 1% threshold.

The trend remains significantly higher than baseline and based on current variation this indicator is at risk of failing the target.

Nationally, the performance is failing the 1% target at 31.3% in December (reported 1 month behind).

RESPONSIVE

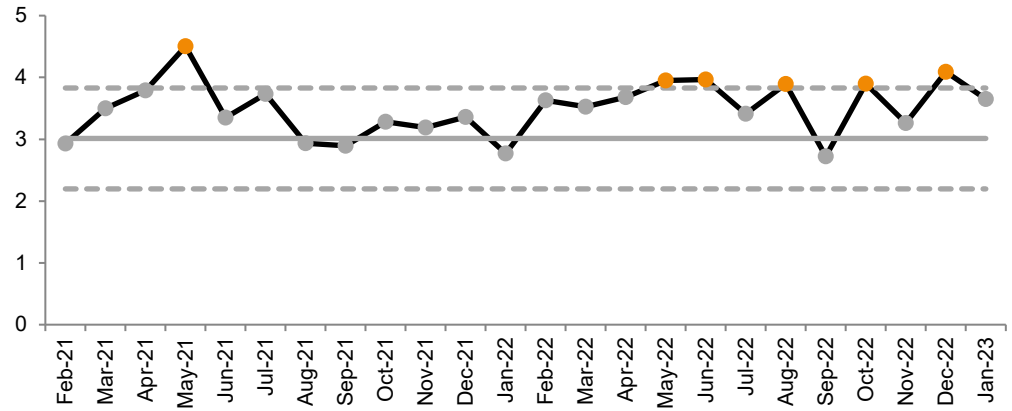
Average length of stay benchmarking

Dr Foster Benchmarking Nov 21 - Oct 22

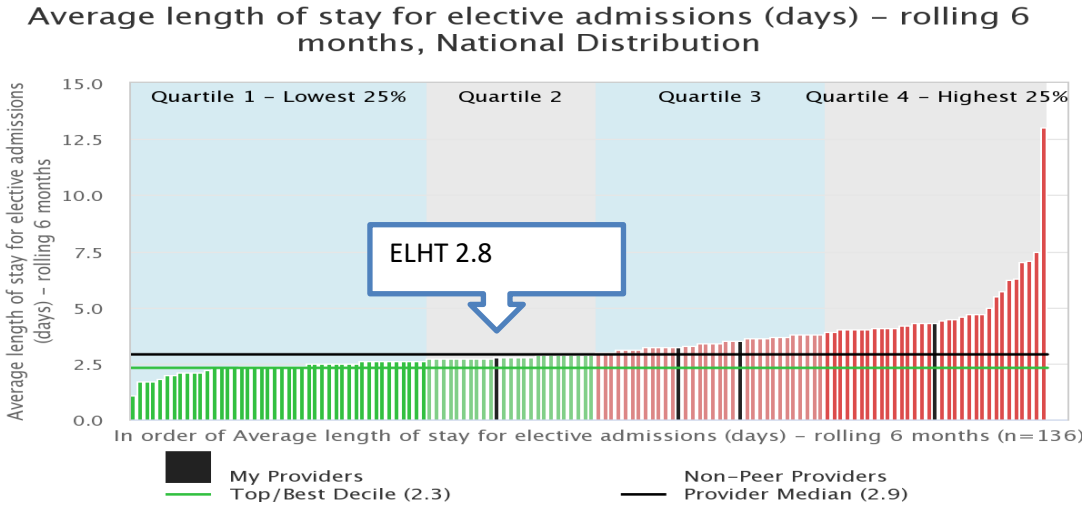
	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	61,006	10,194	50,812	3.3	2.6	-0.7
Emergency	62,587	62,587	0	4.0	4.4	0.4
Maternity/ Birth	13,022	13,022	0	2.3	2.2	-0.1
Transfer	208	208	0	8.2	23.5	15.4

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.

Average length of stay - elective

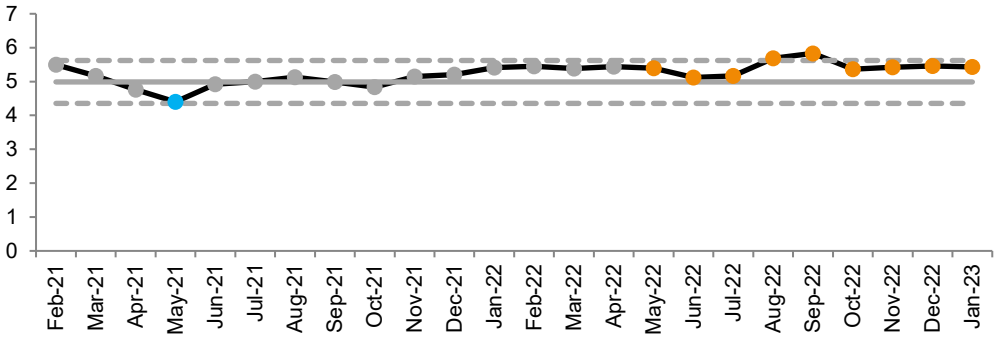


The Trust elective average length of stay is within normal range this month.



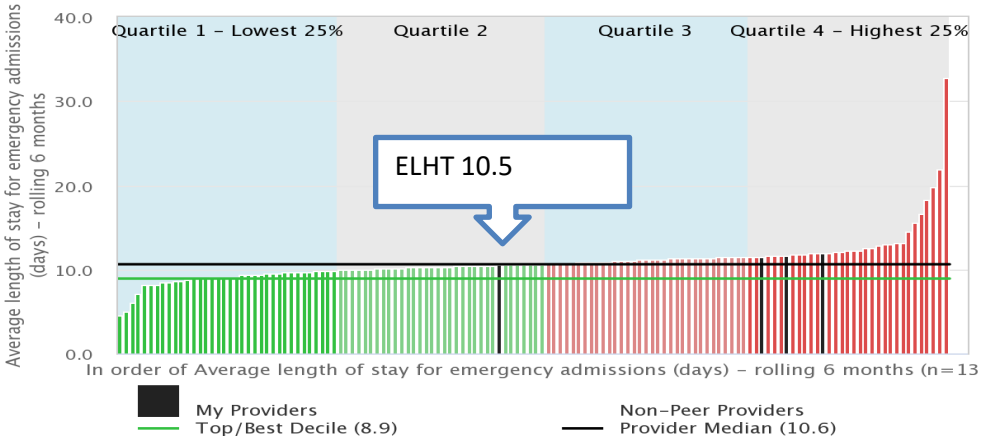
Data up to Oct 22 from the model health system shows ELHT in the second quartile for elective length of stay. Excludes day case.

Average length of stay - non elective



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

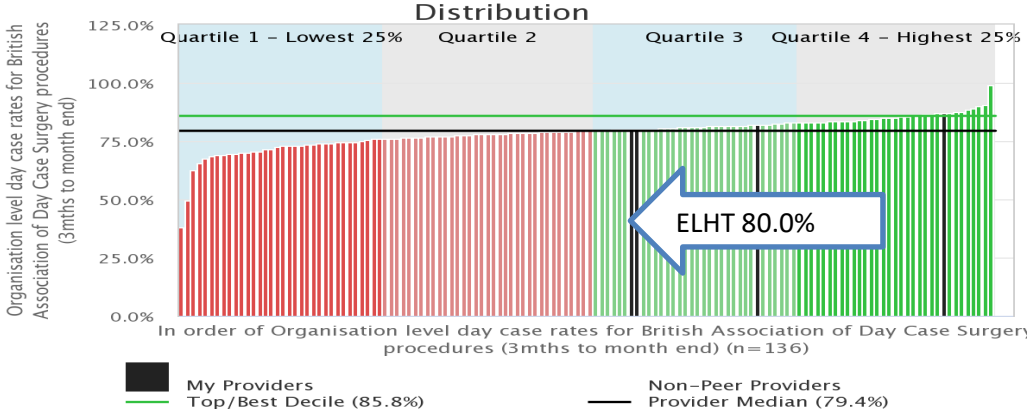
Average length of stay for emergency admissions (days) – rolling 6 months, National Distribution



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

Daycase Rate

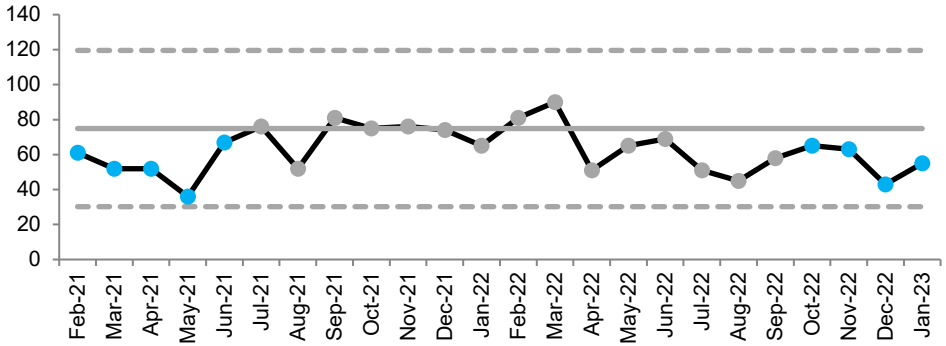
Organisation level day case rates for British Association of Day Case Surgery procedures (3mths to month end), National Distribution



Model health system data based on latest 3 months up to Oct 22, shows ELHT in the third quartile for daycase rates at 80.0%. Data is for adults only

RESPONSIVE

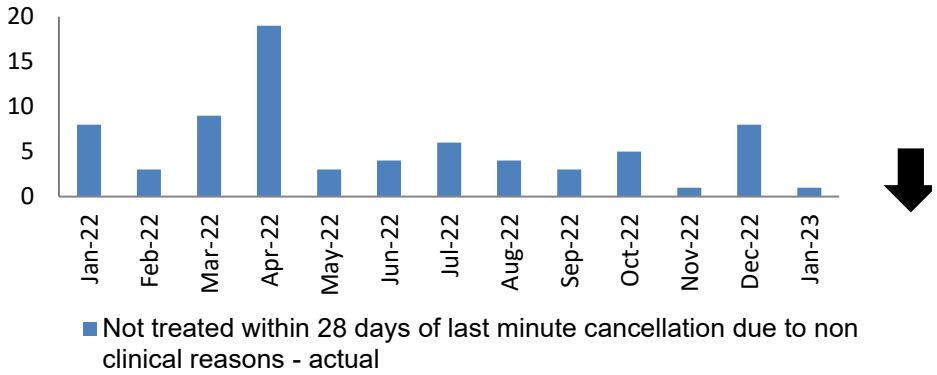
Operations cancelled on day



There were 55 operations cancelled on the day of operation - non clinical reasons, in January.

The trend is showing a reduction on baseline levels.

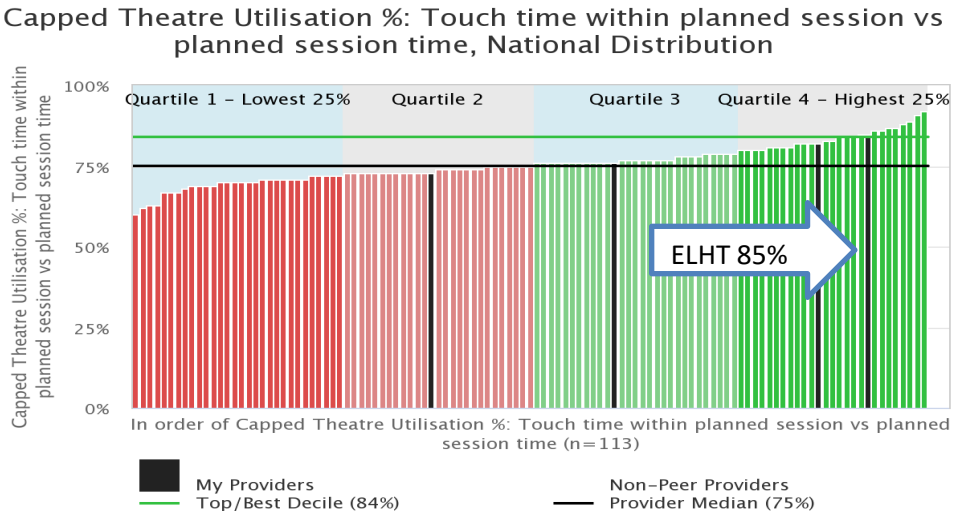
Operations cancelled on day - breaches of 28 day



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

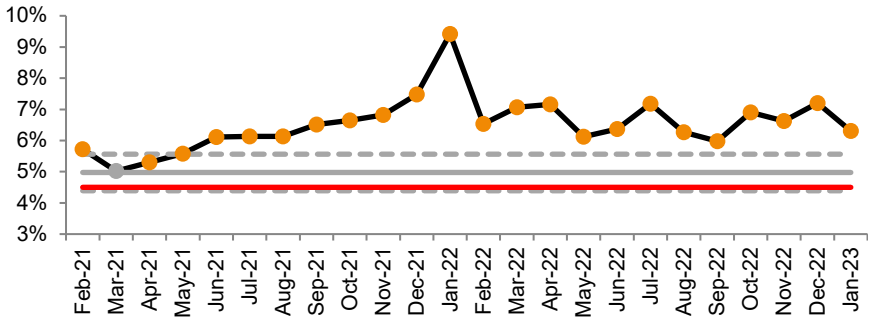
Theatre Utilisation



Data taken from 'The model hospital' shows capped theatre utilisation at 85% for the latest period to 29th January 23. This is in the fourth quartile nationally, with 4 being the highest and 1 the lowest.

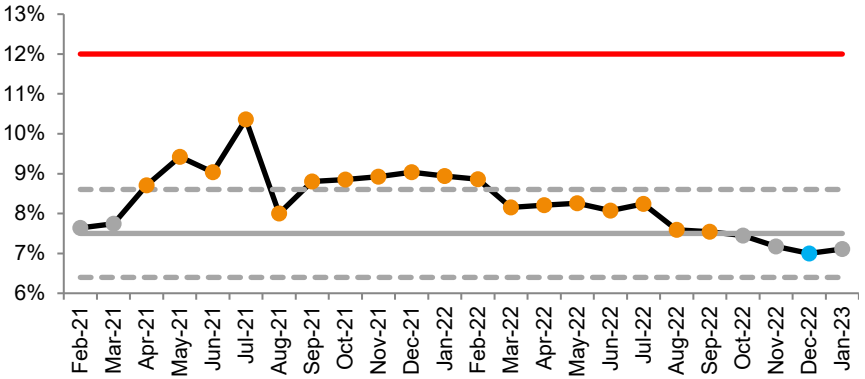
WELL LED

Sickness



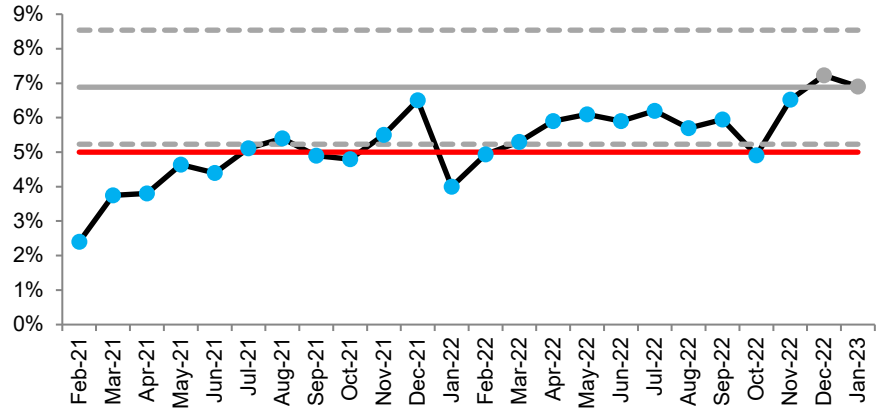
The sickness absence rate was 6.3% for January which is above the threshold of 4.5%. The trend is showing a significant increase and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 7.1% in January and remains below threshold. This is within the normal range when compared with baseline. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



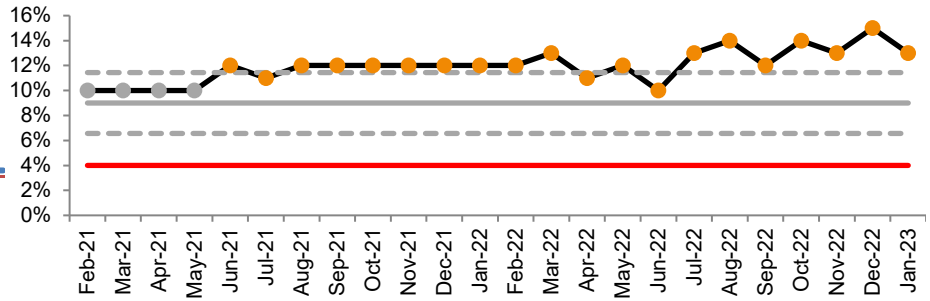
The vacancy rate is 6.9% for January which is above the 5% threshold.

The trend is showing 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.

WELL LED

Temporary costs and overtime as % total pay bill

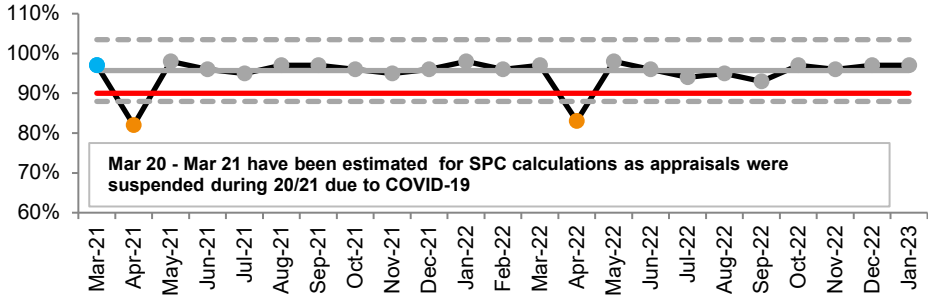


In January 2023 £5.1 million was spent on temporary staff, consisting of £1.9 million on agency staff and £3.2 million on bank staff

WTE staff worked (9,652 WTE) was 69 WTE less than is funded substantively (9,721 WTE).

Pay costs are £0.9m more than budgeted establishment in January.

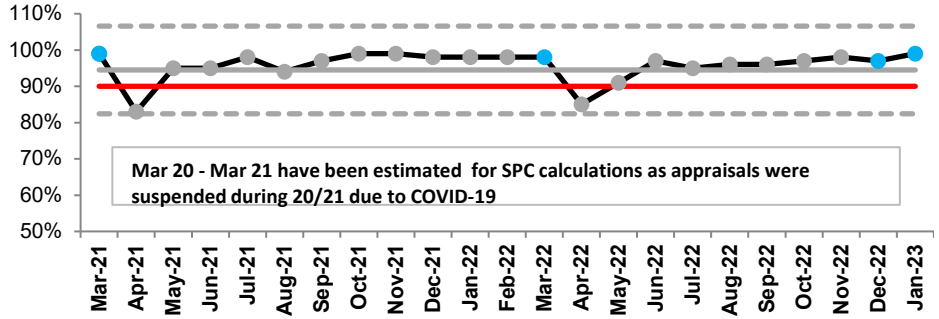
Appraisals, Consultant



At the end of January 23 there were 647 vacancies

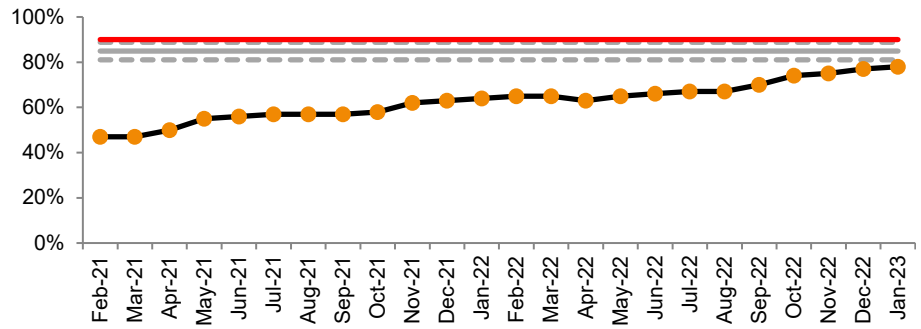
The temporary staffing cost trend shows a significant increase and is not capable of hitting the target.

Appraisals, Other Medical



The appraisal rates for consultants and career grade doctors are reported cumulative year to date to January 23 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.

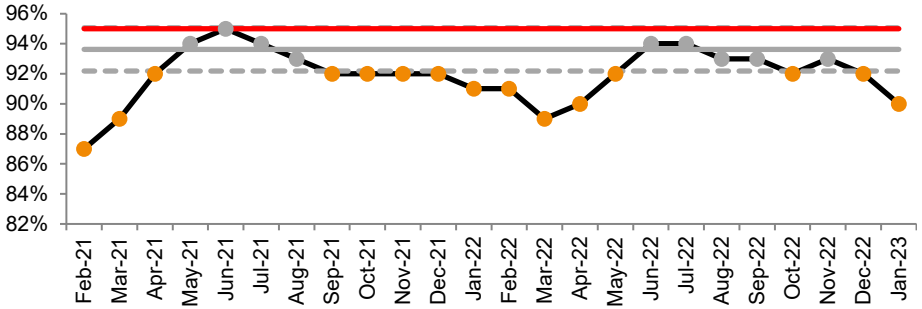
WELL LED

Job Plans

Stage	Consultant	SAS Doctor
Not Published	0	0
Draft	6	6
In discussion with 1st stage manager	163	30
Mediation	0	0
Appeal	0	0
1st stage sign off by consultant	35	1
1st stage sign off by manager	41	7
2nd stage sign off	23	1
3rd stage sign off	47	10
Signed off	44	32
Locked Down	1	0

As at January 2023, there were 360 Consultants and 87 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 90% in January which is below the 95% threshold. The trend is showing deterioration this month and is at risk of not meeting the target.

Core Skills Training % Compliance

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

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%

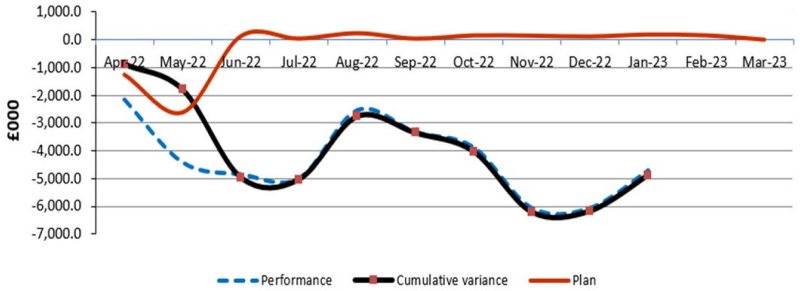
Information Governance and Fire Safety are currently below threshold at 90% and 94% respectively.

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

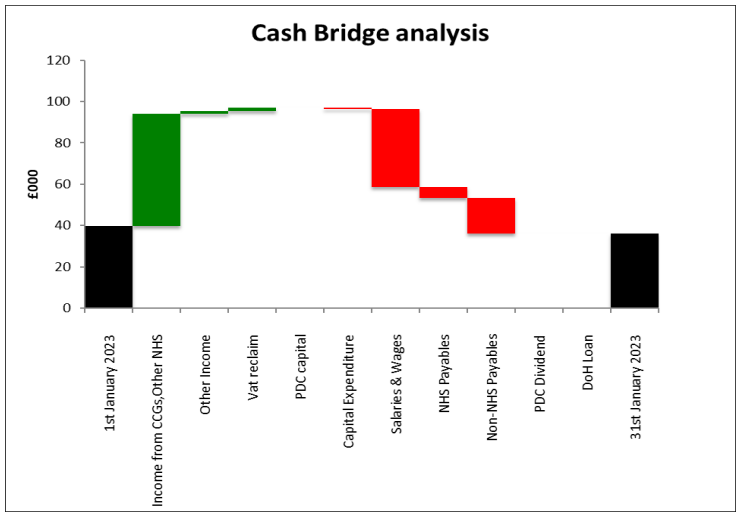
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



The Trust's financial performance is showing a £6.3 million deficit performance year to date against a breakeven financial plan.

Cash



The Trust's cash balance is £36.1 million as at 31st January 2023.

NHSE has accepted that L&SC ICS can submit a £(30)m deficit as this is offset by historic CCG surpluses, meaning the £30m is not repayable in 2023-24 but there will be zero surplus available for transformation going forward.

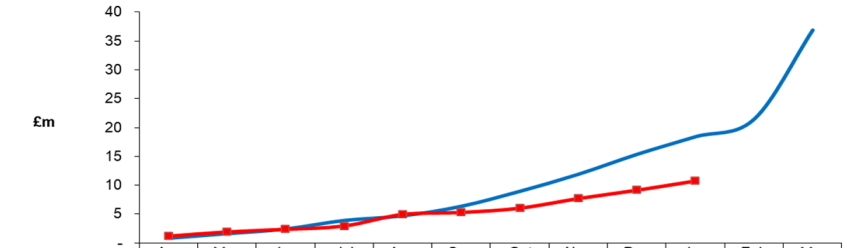
This transpires to a forecast outturn position of a £(5.1)m deficit fro ELHT, an improvement of £1.6m change from the reported forecast outturn for month 9 of £(6.7)m.

The 2022-23 capital programme continues to carry risk, but plans are in place to meet the planned Capital limits.

WELL LED

Capital expenditure

Capital expenditure profile



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	0.81	1.61	2.42	3.89	4.70	6.35	8.94	11.90	15.35	18.41	21.46	36.89
Actual	1.22	1.97	2.41	2.98	4.98	5.33	6.07	7.73	9.18	10.77		

The cash balance on 31st January 2023 was £36.1m, £3.6m lower than the previous month.

The WRP target at month 10 was £24.0m. WRP achievement is £24.0m at month 10, in line with plan. It has been necessary to non-recurrently support this position by £14.1m.

The Trust is £7.6m behind its planned capital spend as at 31st January 2023.

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	477	403	0	746	134	**880**	3,290
Community & Intermediate Care	930	0	903	876	957	**1,832**	1,129
Surgical & Anaes Services	3,519	138	0	1,131	2,526	**3,657**	3,677
Family Care	610	137	0	404	343	**747**	1,882
Primary Care	0	0	0	0	0	**0**	75
Diagnostic & Clinical Support	1,118	597	35	1,008	742	**1,750**	2,785
Estates & Facilities	1,009	0	0	531	478	**1,009**	1,564
Corporate Services	3,066	703	377	3,205	941	**4,146**	1,050
Education, Research & Innov'N	255	0	0	12	243	**255**	270
Further 2% Non Recurrent Savings	14,144	1,450	(1,072)	5,261	9,261	**14,523**	13,078
Total	25,128	3,429	243	13,174	15,626	**28,800**	28,800

Schemes to the value of £28.8 million have been identified, of which £25.1 million has been transacted to date.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

Item 39

8 March 2023

Purpose Information

Title	New Hospitals Programme Quarter 3 Board Report
Executive sponsor	Mrs K Atkinson, Executive Director of Service Development and Improvement

Summary: The purpose of this report is to provide an update on the Lancashire and South Cumbria New Hospitals Programme for the Quarter 3 period: October to December 2022.

This quarterly report is presented to the following Boards:
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Provider Collaborative

The report includes the progress against plan for October to December 2022, in particular providing an update on the technical analysis of the shortlisted options and the viability of potential new sites in terms of equality impact and travel and transport analysis.

In addition, the feedback from stakeholders on the recommended options reported to Trust Boards in September and October 2022.

It outlines next steps with the national New Hospital Programme business case and capital funding allocation.

Recommendation: It is recommended the Board:

- Note the progress undertaken in Quarter 3.
- Note the activities planned for the next period.

Report linkages

Related Trust Goal	Deliver safe, high quality care Improve health and tackle inequalities in our community 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.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

NEW HOSPITALS PROGRAMME Q3 BOARD REPORT

1. Introduction

1.1 This report is the 2022/23 Quarter 3 update from the Lancashire and South Cumbria (L&SC) New Hospitals Programme.

2 Background

2.1 Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) are working with local NHS partners to develop a case for investment in local hospital facilities. The programme is part of Cohort 4 of the Government's commitment to build 40 new hospitals by 2030. Together with eight existing schemes, this will mean 48 hospitals built in England over the next decade, the biggest building programme in a generation. Further information can be found on the 'Improving NHS infrastructure' website.

2.2 The L&SC New Hospitals Programme (NHP) offers a once-in-a-generation opportunity to transform the region's ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare.

3 National New Hospital Programme

3.1 **Programme business case and early / enabling works** – the national programme business case has been presented to HM Treasury in December 2022. The outcome of this will determine the capital allocation and phasing for the L&SC NHP. The team are expecting confirmation of the outcome in Q4 and will then plan accordingly. The outcome of the national business case will also include the status of the L&SC bid for early works / investment at Furness General Hospital to improve the Critical Care Unit and Emergency Department.

3.2 **National guidance** – as part of cohort 4, L&SC NHP is expected to fully adopt the national NHP guidance including standard hospital design (Hospital 2.0), digital, demand and capacity modelling and the associated underpinning assumptions. Members of the NHP team and wider system colleagues have been proactively supporting the national team on developing some key components of this guidance. A briefing from the national team on the status and next steps is anticipated in Q4.

4 Progress against plan (for the period October to December 2022)

4.1 **Shortlist of options** – the focus of Quarter 3 has been on potential new site options for both Royal Lancaster Infirmary (RLI) and Royal Preston Hospital (RPH), which the Trust Boards of Directors approved at their meetings in September (UHMBT) and October (LTHTr) 2022.

4.2 The programme has made positive steps in understanding further technical and design details on potential new sites. Such analysis has included a review of the traffic impact in / around each new site, geographical surveys, and discussions with local authority planning and highways teams. All of this provides input to the deliverability of each site i.e., could a new hospital facility be accommodated on the site with sufficient supporting infrastructure.

4.3 Subsequently, the team continues to appraise potential sites against the agreed technical criteria as further details emerge. This will continue up to a future shortlisting of sites ahead of any business case submission and public consultation (if required).

4.4 In addition, several new sites have been identified to the team throughout Q3, these have been appraised against the pass / fail criteria and reported to the Strategic Oversight Group (SOG) in December 2022.

4.5 **Equality impact –** significant work has been undertaken to ensure equality, diversity and integration are at the heart of each option. During Quarter 3, the Communications and Engagement Oversight Group received a demographic insight report, outlining an overview of the demographics of L&SC and intelligence relating to protected characteristic groups, health inclusion groups and groups who may be more likely to experience health inequalities. Work has started on the equality and health inequalities impact of the communications and engagement strategy, model of care, digital strategy, and site selection and appraisal. This important work will continue throughout the process to enable the Programme to consider the likely impact of new hospital facilities on different groups of people.

4.6 **Travel and transport analysis for potential new sites –** another really important component part of any future business case has been completed this quarter. The travel and transport analysis seeks to understand travel through an equality-related lens and explores potential considerations for the Programme. The report considers accessibility to the potential new sites for patients, staff and the public. An update has been provided to the SOG in December 2022 and this work will feed into the future shortlisting of sites.

5 Public, patient and workforce communications and engagement

5.1 At the end of Quarter 2, the team launched a milestone update announcing recommendations for preferred options and alternative options for Royal Lancaster Infirmary and Royal Preston Hospital. Subsequently, a new open-access online survey was issued, which captured 604 views on the proposals and on what was most important to people from new hospital facilities. The feedback positively supported the recommended options and explored the acceptable proximity to existing sites. Participants reported in even stronger proportions than at the shortlist survey that the key challenges they face in accessing existing hospital facilities revolve around the location of hospital sites, public transport links and parking. As in the shortlist survey, respondents felt that the most important considerations to ensure that future hospital facilities meet their needs were hospital sites being in accessible locations, futureproofing to meet future (not just current) healthcare needs and adequate car parking.

5.2 Several new blogs have been published on the New Hospitals Programme website during Quarter 3 and shared through NHP and partner external and internal communications channels. This includes two blogs by the ICB director of strategic estates, infrastructure and sustainability. The first blog focuses on the improvements needed at RLI and RPH, exploring the condition of the existing estate, associated backlog maintenance, the impact on the availability and suitability of space for clinical and operational activity. The second blog explores the requirement for the NHS to achieve carbon neutrality by 2040 and the targets set for hospitals.

5.3 The Medical Director at UHMBT has contributed a blog regarding future plans for Westmorland General Hospital.

5.4 The NHP Operational Lead for LTHTr has issued a blog discussing the major benefits that new hospital facilities will bring to the care of patients, such as co-locating clinical services next to each other in the most productive way, improved infrastructure around the hospitals, including car parking and access routes, the latest technology and equipment, and right environment for caring for patients.

6 Stakeholder management

6.1 Stakeholder engagement has continued, including webinar sessions for NHS staff during October and November 2022. The team hosted six sessions and key topics of discussion were the provision of car parking, the impact on Chorley and South Ribble Hospital, the impact on Westmorland General Hospital and engagement with stakeholders. Drop-in engagement sessions have also been held at Royal Preston Hospital and Chorley and South Ribble Hospital, following on from engagement at UHMBT sites earlier in the year.

6.2 Meetings have been held with a number of local MPs during Q3: Mark Menzies MP, Cat Smith MP and David Morris MP, as part of a rolling programme of engagement.

6.3 Furthermore, the team have continued their collaboration with Lancaster University to co-produce a report on the engagement of underrepresented people; identifying good practice, developing a framework for future engagement and providing evidence to inform the NHP's engagement practice. The findings of this will be reported in Q4 and will benefit not only the NHP but many other engagement initiatives across L&SC.

7 Programme governance and risk

7.1 During Quarter 3, the Programme has strengthen the approach to risk, aligning with the programme objectives and revising the risk appetite, as well as continuing to manage dependencies within the integrated care system and national team.

8 Next period – Q4 2022/23

8.1 Further work will be undertaken in Quarter 4 to continue to review and strengthen all aspects of the options pending the outcome of the national Programme Business Case. Upon this announcement the team will work with the national team to

understand the outcome of the business case and what this means for new hospital facilities in L&SC.

9 Conclusion

9.1 This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 3 2022/23.

10 Recommendations

10.1 The Board is requested to:

- Note the progress undertaken in Quarter 3.
- Note the activities planned for the next period.

Rebecca Malin
Programme Director
January 2023

Jerry Hawker
Programme Senior Responsible Officer

TRUST BOARD REPORT | **Item** | **40**

8 March 2023 | **Purpose** | Information / Action / Monitoring

Title	Maternity and Neonatal Service Update
Executive sponsor	Mrs J Molyneaux, Executive Director of Nursing.

Summary: The purpose of this report is to provide:

1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Maternity Safety Ambition, specifically relating to the ten CNST maternity safety actions included in year four of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. (Appendix 1 -CNST year 4 criteria)

2. Updates regarding ELHT maternity services response to the NHS England/Improvement (NHS E/I) – Ockenden review of maternity services

Recommendation: The Board of Directors are asked to.

- Approve the CNST submission, update report and recommendations.
- Review progress against the plan to deliver the Ockenden immediate and essential actions.
- Note the maternity workforce planning position.
- Have oversight through direct reporting to trust board any barriers that may impact the sustainability plans for delivery aligned with the maternity and neonatology safety ambition.

Report linkages

Related Trust Goal	Deliver safe, high-quality care Improve health and tackle inequalities in our community
Related to key risks identified on assurance framework	1. The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive. 2. The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.

3. Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce.
4. Recruitment, retention, and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy).
5. The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
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

1. INTRODUCTION

The purpose of this report is to provide:

1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Maternity Safety Ambition, and the Secretary of State's ambition to halve the number of stillbirths, neonatal and maternal deaths, and brain injuries by 2025. This will include reduction of the pre-term birth rate from 8%-6% by 2025.

2. An overview specifically relating to the ten CNST maternity safety actions included in year four of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. (Appendix 1 CNST criteria)

3. Updates regarding ELHT maternity services response to the NHS England/Improvement (NHS E/I) – Ockenden review of maternity services

4. Pending single point delivery plan due early 2023, as directed from the East Kent report in October 2022.

A bi-monthly assurance report will be provided to ELHT Board of Directors for ongoing oversight and monitoring of maternity and neonatal services. This will also include bi-monthly floor-to-board Maternity and Neonatology report for interim discussions at Trust Wide Quality Committee.

2. MATERNITY INCENTIVE SCHEME

A summary of progress to date with regard to the attainment of all ten safety actions is detailed in the progress tracker below. The detail of each of the safety actions included in the year four scheme is detailed in Appendix 1 for reference if needed.

2.1 Update as of March 2023

As of March 2023, the CNST – MIS for Year 4 has been submitted on the 2nd of February 2023 with 9/10 Safety Actions submitted as Passed.

Table 1 – CNST – MIS Progress Tracker

Safety Action	Progress/ Status	Areas of Concern / Ongoing Actions
1. Perinatal Mortality Review Tool (PMRT)	Failed	Missed timeframes for reporting to MBRRACE at 7 and 28 days, with missed timeframes for publishing PMRT report as draft by 4 months. Full process mapping of the PMRT process complete January 2023 with identified immediate improvements in place -
2. Maternity Services Data Det (MSDS)	Passed	None

3. Avoiding Term Admissions to NICU (ATAIN)	Passed	Ongoing resource to be confirmed for quarterly TC audit.
4. Clinical Workforce	Passed	Ongoing action plan for nursing workforce against BAPM requirements
5. Midwifery Workforce	Passed	Ongoing action plan for achieving appropriate uplift in funded establishment as per Birth-rate+ Report
6. Saving Babies Lives v2 Care Bundle (SBLv2)	Passed	None
7. Maternity Voice Partnership	Passed	None
8. Training	Passed	None
9. Board Assurance	Passed	Ongoing improvements to the process for triangulation of incidents, complaints, and claims data – RADAR system.
10. NHS Resolution	Passed	None

2.2 Safety Actions at Risk

Narrative relating to the safety actions at risk is provided. As CNST Year 4 has been submitted as of 2nd February 2023, and CNST Year 5 has not yet been received, detail of the failed safety action with planned improvements and actions is below.

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

As of the 2 February 2023 twenty-two eligible cases met the defined threshold for reporting and requirements for surveillance information where required to be completed within one month of the death the Perinatal Mortality Tool (PMRT) in the year 4 reporting period.

Within the year 4 timeframe there were a total of nine neonatal deaths and thirteen stillbirths that were eligible for CNST targets, therefore the issues leading to non-compliance affect both stillbirth and neonatal deaths proportionately.

A process mapping exercise with obstetric, neonatal, bereavement midwife and governance colleagues has taken place facilitated by the divisional project manager **(Appendix 2).**
Errors have been detected in cases during the failsafe process relating to the inputting of surveillance data that has impacted upon the compliance rate attained. A failsafe process is now in place with oversight for the maternity safety champions and governance team to negate this risk for further surveillance submissions. Training for relevant staff members has been scheduled for early February 2022. The PMRT consultant lead has enhanced the database for all dates to be reviewed as a flagship approach together with the governance team.
The PMRT point prevalent data base position will be presented at the monthly maternity Governance board meeting.

Table 2 Perinatal Mortality Review Tool progress tracker

Please see below a progress tracker for Trust Board reflecting PMRT compliance against the CNST standards, this will be commenced alongside CNST Year 5.

Safety Action 1 (Standard A)	Compliance	Rag
I. All perinatal deaths eligible to be notified to MBRRACE-UK from 1 September 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.	**TBC**	
ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death	**TBC**	
Safety Action 1 (Standard B)	**Compliance**	**Rag**
i. At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, three cases reviewed to date within deadline Not applicable as four five including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death	**TBC**	
Safety Action 1 (Standard C)	**Compliance**	**Rag**
i.For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought.	**TBC**	
Safety Action 1 (Standard D)	**Compliance**	**Rag**
Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**TBC**	

2.3 MIS - Items to note

Safety Action 2 – MSDS

Please note ELHT Maternity Services have an up-to-date Digital Strategy aligned to the Wider Trust digital strategy and the seven measure of success within the What Good Looks Like Framework **(appendix 3)**

Safety Action 4 – Clinical Workforce

An ongoing monthly audit is in place to monitor attendance at the defined clinical scenarios in accordance with the recommendation of the CNST year 4 programme to ensure ongoing monitoring and attainment of the RCOG workforce standards.

Safety Action 5 – Midwifery Workforce

A systematic evidence-based process to calculate midwifery establishment is completed. Trust board to evidence midwifery staffing budget reflects establishment as calculated form the findings in the birth rate plus workforce report completed in September 2022. Where trusts are not complaint with a funded establishment based on birth rate pus findings or equivalent calculations, Trust board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls

Agreed plan for discussion with Trust board (Appendix 4)

Safety Action 9 – Board Assurance

A Maternity and Neonatal Safety Champions newsletter is being devised which will include feedback from monthly walk rounds, both staff and service user feedback and key service / transformation programme updates. The first iteration is in draft currently to be finalised by April 2023.

3. MATERNITY CQC SURVEY

The National maternity CQC survey which took place between 1- 28 February 2022. Feedback reflected at national level was that people's experiences of care had reflected a deterioration in the last five years. All CQC surveys are available to review on the CQC website.

ELHT survey results are attached in (**Appendix 5).** In general, the feedback was overall positive with some areas identified for improvements this has been presented to us by IQVIA colleagues at January Obstetrics/ Gynaecology speciality board. Out of the 17 Trusts in the Northwest ELHT was rated as number one as part of this survey reflecting a position of being in the top ten in England. We feel extremely proud of these results as a maternity team.

Safety Champions across Maternity and Neonatology will continue to drive improvements within the individual areas across the services for the areas of improvement and sustainability plans for the areas we are delivering a high standard of care with support of the multi-disciplinary team. The divisional project manager will oversee and aligned the area improvement plans into a full Maternity and Neonatal response.

4. OCKENDEN UPDATE

Full presentation update given to January 2023 Public Trust Board (Appendix 6) A regional site visit is taking place Thursday 16th March and a LMNS Insight Visit on Tuesday 28th April.

ELHT Maternity service will provide a response to the initial Insight Visit recommendations (April 2022) and the points to consider, as below. This response will be part of Trust Board May 2023 paper.

1. Compensatory rest arrangements for consultants following on call.

2. Consider how patients who have a cognitive impairment, visual impairment or English is not their first language have equal access and input into their records

3. The Trust has employed a PMO to coordinate the maternity transformation programme, the regional maternity team consider this best practice. Consider how it shares best practice models with other trusts and the LMS

4. Ensure that the service user voice is representative of the population served

5. Ensure that all staff regardless of grade can inform and participate in QI initiatives to ensure QI capacity and capability building

6. Undertake a capacity and demand exercise and consider re-establishing a 5 day per week service for elective caesarean sections

5. INCIDENTS AND REPORTING: HEALTH EQUALITIES

Report covers period 1st January 2022 – 1st January 2023

Over the last 5 years there has been a steady decline in stillbirth numbers in ELHT. In the period covered by this report there were:

- Twenty-six stillbirths (5 of which were not eligible for investigation via PMRT process)
- Twenty-seven neonatal deaths (2 of which were not eligible for investigation via PMRT process)
- Four cases were investigated by HSIB (Health Service Investigation Branch)
- Nine cases were “expected” deaths, most often in the context of a confirmed lethal congenital abnormality
- There were **no** cases where any issues with care would have changed the outcome

Ethnicity

Ethnicity	Number *
White British	17
White European	4
Asian	26
*Cases eligible for PMRT investigation (n=46)	

Deprivation

Factor	Number
History of mental health issues	12
Substance misuse	1
Smoking	8
Social services involvement	4
Domestic abuse	1
Language barrier	3
Learning difficulties	3

9 (17%) cases occurred in couples who were first (n=6) or second (n=3) cousins.

5 (9%) mothers had multiple (≥2) deprivation factors.

Comparison to national themes

Ethnicity

The 2020 MBRRACE report into perinatal mortality showed a disparity in stillbirth rates between different ethnic groups (for example 2.78/1000 for White British mothers compared to 3/1000 for Pakistani mothers). This would agree with local data which show that 56% of mother suffering a perinatal loss were of an Asian ethnicity (Pakistani, Indian or Bangladeshi).

It is worth noting that of the nine “expected” fetal losses or neonatal deaths (usually due to severe or multiple congenital abnormalities), over half (56%) were to mothers of Asian ethnicity. This may reflect religious and cultural attitudes towards termination of pregnancy and end-of-life care following birth but is difficult to further elucidate based on the small numbers involved.

Mental health

Mental health was highlighted as major factor in *maternal* mortality in the latest MBRRACE report in 2022. We can see in our local data that maternal mental health is also over-represented in the perinatal population, with 23% of mothers having a mental health problem during pregnancy.

Deprivation

As is demonstrated by the figures above, there is a considerable burden of deprivation on our local population. When deprivation exists within higher-risk ethnic populations there is a known impact on perinatal outcomes as well as maternal mortality [MBRRACE 2022].

Key issues

- Provision of aspirin prescriptions to women at substantial risk of pre-eclampsia or fetal growth restriction
- Screening for mental health concerns at antenatal contacts

- Dynamic risk assessments throughout pregnancy (i.e., for aspirin prescription or blood-thinning medications)

Actions

- Scoping work for the development of a Patient Group Directive to allow midwives to prescribe aspirin.
- ELHT Patient Safety Alert (PSA) with 100% compliance target to ensure mental health is assessed at each antenatal contact – in process currently and to be reported back to ELHT Patient Safety Group on 28th March.
- Appointment of new lead obstetrician for perinatal service (commenced November '22).
- Commenced a perinatal mental health collaborative with wider Trust colleagues including ED in January 2023.
- Addition of perinatal mental health services to weekly governance meeting agenda, to ensure maximum visibility of caseload and any immediate issues arising from poor outcomes.
- Co-production with MVP groups; sure start, IMO, health visitors, for service user feedback and part of CNST Safety Action 7.

6. MATERNITY AND NEONATAL DASHBOARD INDICATORS

To include CNST, Ockenden overview of safety and quality programmes of work within Maternity and Neonatal services, to be devised, discussed, and shared at ELHT Trust Boards as from May 2023 reporting.

7. CONCLUSION

On Behalf of ELHT maternity and neonatology services this bimonthly assurance report to trust board will provide progress updates of the ten CNST maternity safety actions, implementation of the immediate and essential actions outlined within the full Ockenden report soon to be interwoven into the single point delivery plan as recommended from the East Kent report findings due for publication in March 2023.

Appendix 1 – CNST Criteria for the year four scheme

MIS-year-4-relaunch-October-2022-v5-Fin

Appendix 2 – PMRT Process Map

PMRT Process Map .xlsm

Appendix 3 – Maternity Services Digital Strategy

ELHT Maternity Digital Strategy (1).pp

Appendix 4 – Midwifery Workforce – Birth-rate+ Action Plan

Birthrate + Action Tracker PDF (1).pdf

Appendix 5 – IQVIA CQC Survey

East Lancashire Hospitals NHS Trust S

Appendix 6 – Ockenden Progress Update to Board January 2023

ELHT Ockenden Update - for LMNS Ja

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **41**

8 March 2023 **Purpose** Information
Monitoring

Title	Staff Health and Wellbeing Update Report
Executive sponsor	Mrs K Quinn, Executive Director of People and Culture

Summary: The NHS People Plan and People Promise set out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care. The actions are organised around four pillars:

- Looking after our people- with quality health and wellbeing support for everyone.
- Belonging in the NHS- with a particular focus on tackling the discrimination that some staff face.
- New ways of working and delivering care- making effective use of the full range of our people's skills and experience.
- Growing for the future- how we recruit and keep our people, and welcome back colleagues who want to return.

This update provides the Board with an overview of the work being carried out across the Trust in relation to staff health and wellbeing

Recommendation: Board members are asked to:

- Review the proposed methodology and actions and advise on if there are any omissions.
- Support the ELHT wellbeing programme and ethos.
- Agree to and commit the organisation to this programme of actions within the outlined timescales.
- Individually commit to participate in the programme by role modelling healthy leadership behaviours and demonstrating that an enhanced staff health and wellbeing lens is applied to all decisions.
- Discuss and approve the action plan for deployment throughout 2023.
- Review the progress of the action plan in 6 months' time at Trust Board.

Report linkages

Related Trust Goal	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. Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce. 2. Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy).

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Our Staff Health &
Wellbeing Strategic Action Plan
2023 – 2024

well
Staff Wellbeing and Engagement

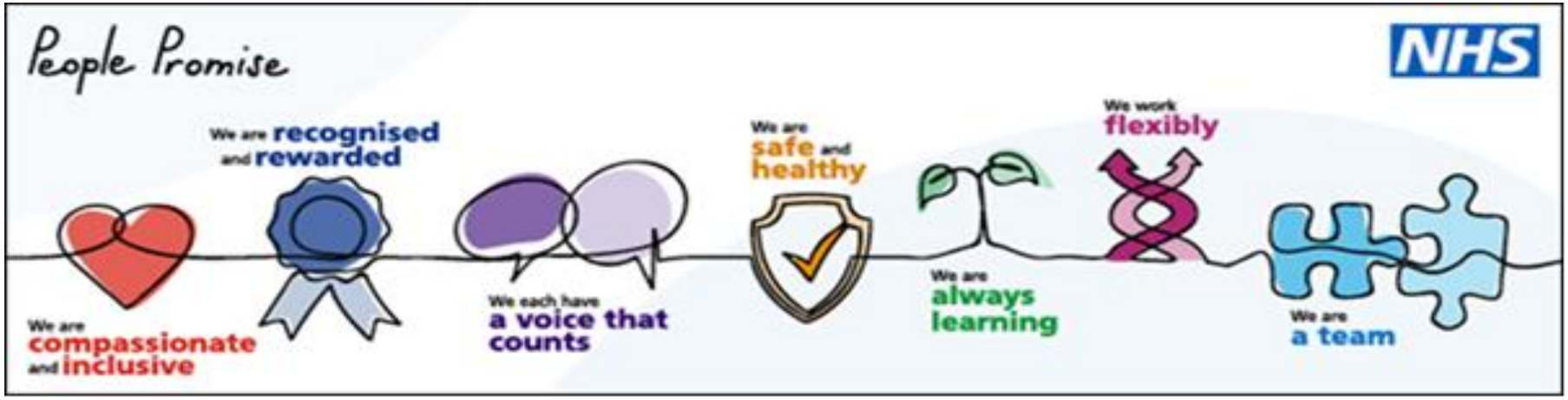
1. Introduction

1.1 The NHS People Plan and People Promise set out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care. The actions are organised around four pillars:

- Looking after our people- with quality health and wellbeing support for everyone.
- Belonging in the NHS- with a particular focus on tackling the discrimination that some staff face.
- New ways of working and delivering care- making effective use of the full range of our people's skills and experience.
- Growing for the future- how we recruit and keep our people, and welcome back colleagues who want to return.

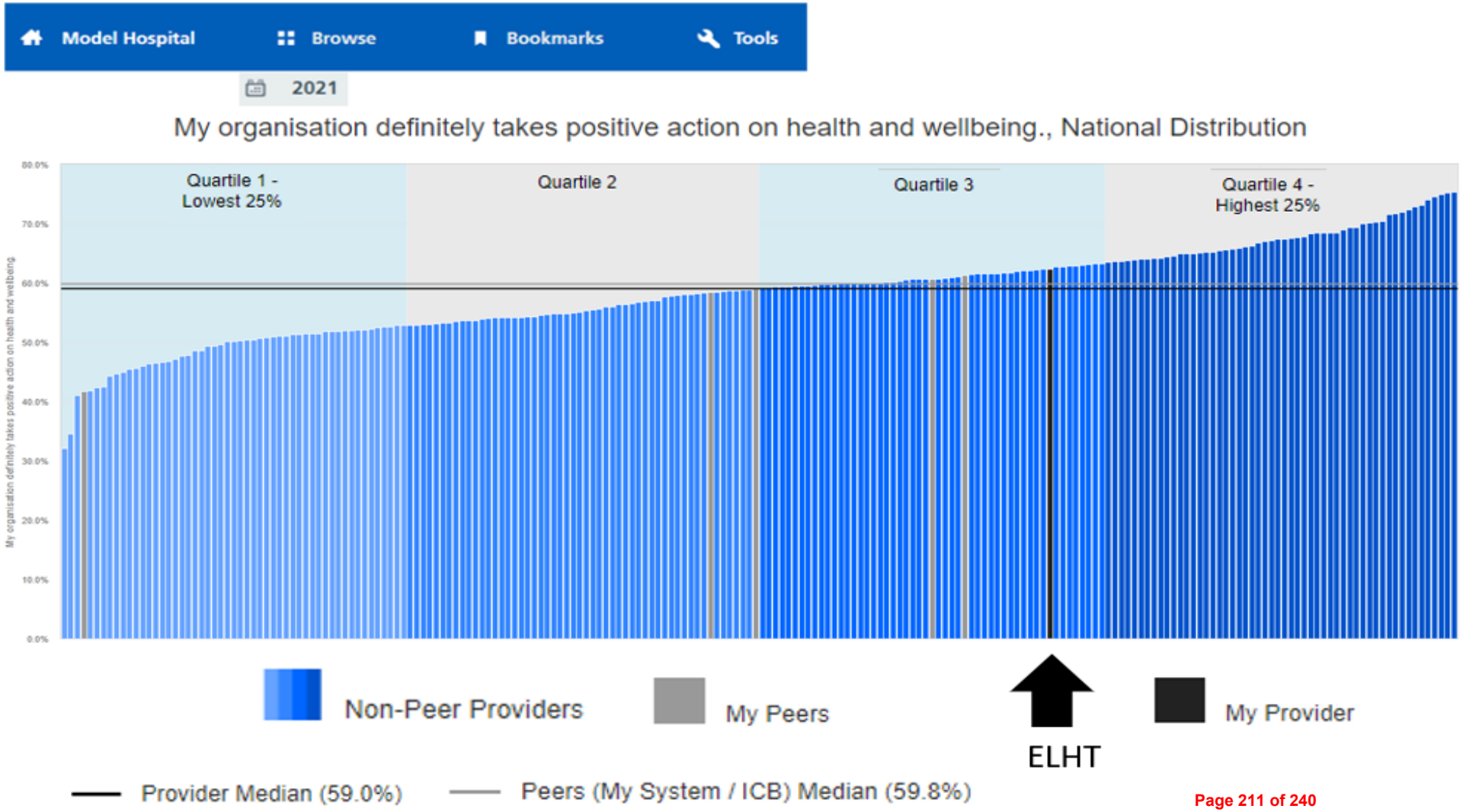
1.2 The NHS People Promise has come from those who work in the NHS. People in different healthcare roles and organisations have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace.

1.3 ELHT has progressed our approach to staff health and wellbeing over the last 12 months and seen significant improvements in our 2022 national staff survey results as a result of our evidence based proactive and preventative and reactive and responsive approach. Whilst we have made progress, there is still much more to do to further support colleagues working in a very challenged environment to best support their health and wellbeing across 2023. Our staff health and wellbeing strategic action plan will enable and support the People Promise indicators depicted in the infographic below:



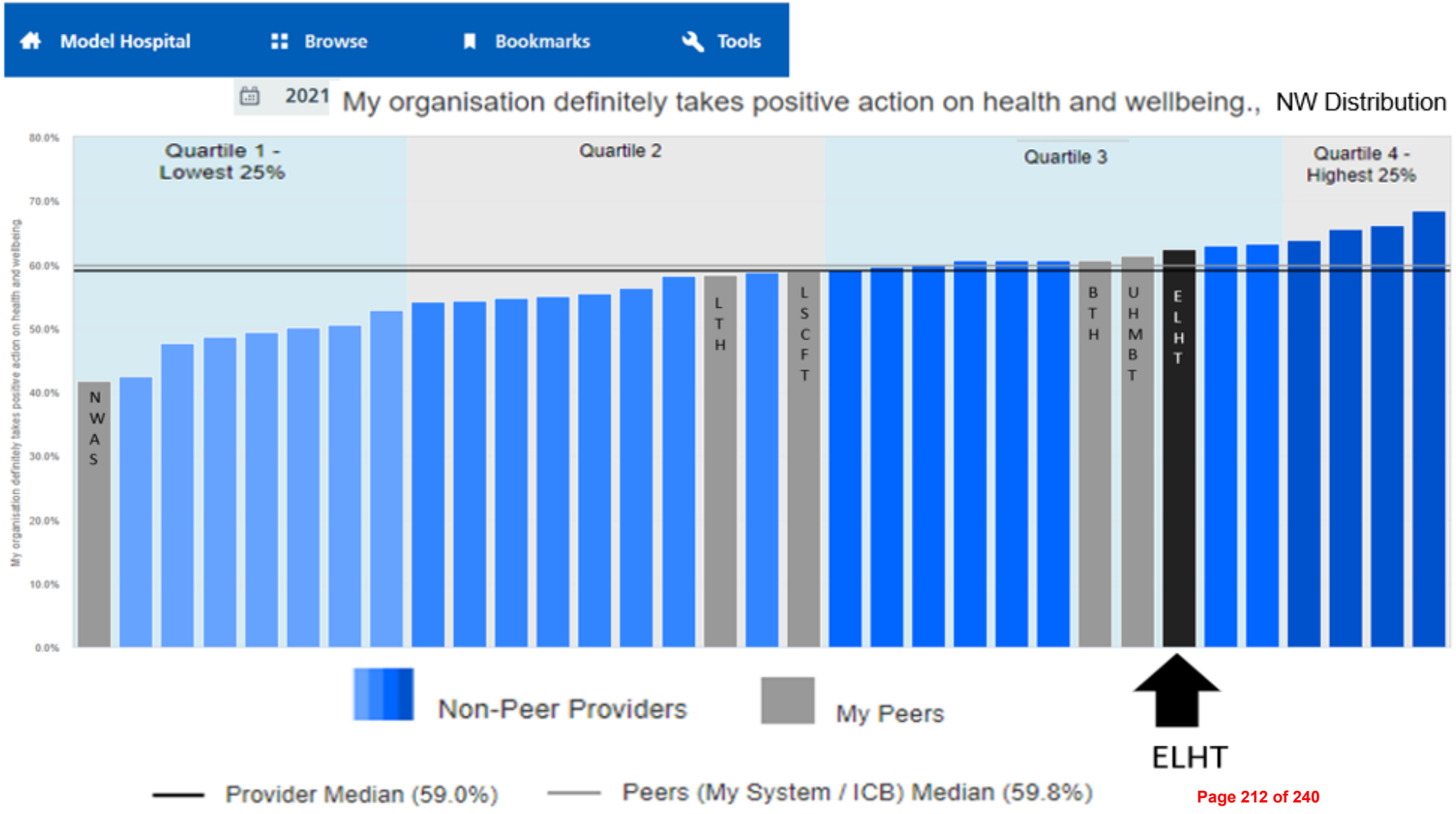
1. Introduction

1.4 The model hospital staff health and wellbeing metrics sourced via the national staff survey (2021) help us to measure progress. The measure below allows us to understand how staff members feel about their health and wellbeing in comparison to 214 organisations. A higher proportion indicates that a higher degree of staff members feel their employer helps improve health and wellbeing. We intend to apply this years staff health and wellbeing strategic action plan to progress to Quartile 4- the highest 25% by April 2024.



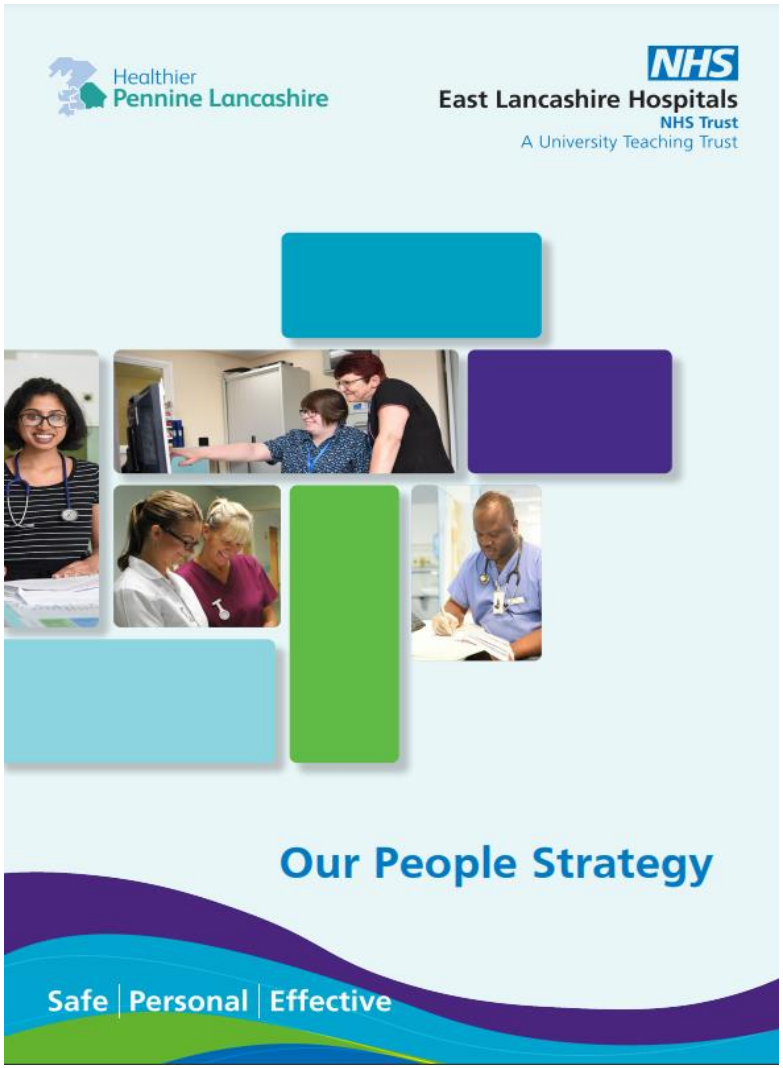
1. Introduction

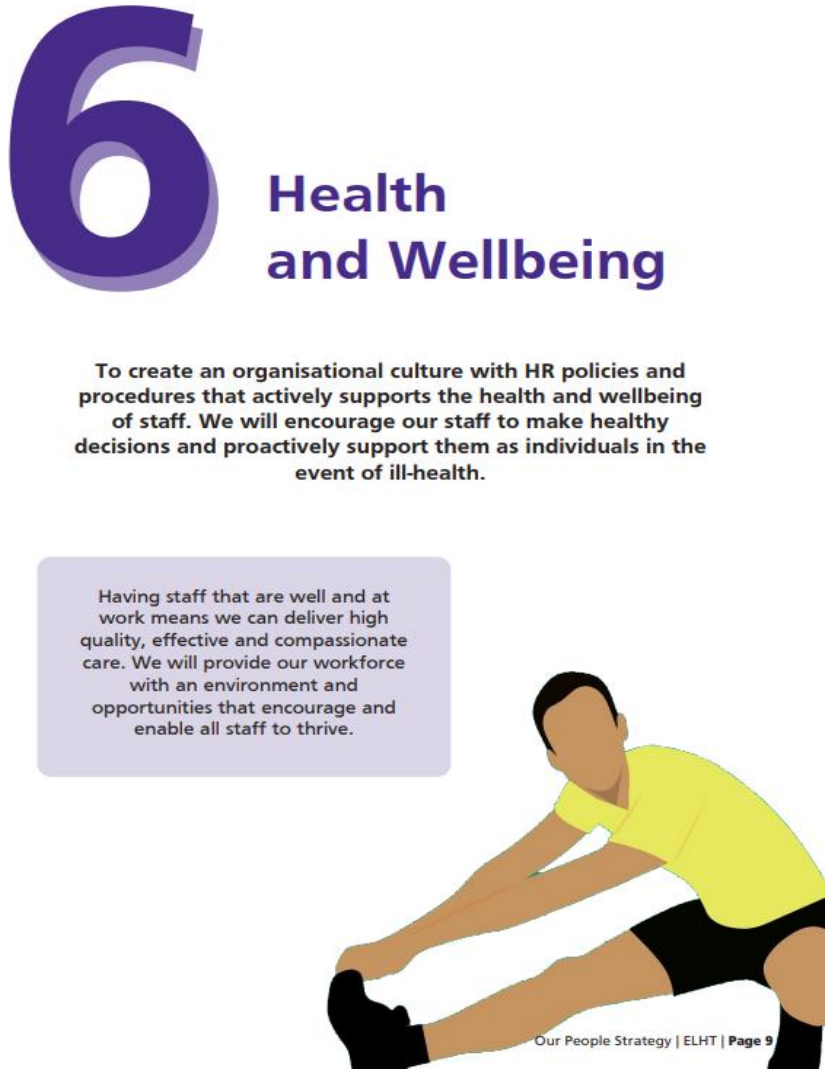
1.5 Drilling down further to the North West distribution we can better understand the Lancashire and South Cumbria (LSC) and wider North West system picture for staff health and wellbeing. It can be seen that ELHT ranks 1st across the LSC Provider Collaborative partners. We intend to apply this years strategic action plan to support the Provider Collaborative to progress staff health and wellbeing across the LSC system along with delivering our organisational ambition to progress to Quartile 4- the highest 25% by April 2024.



2. Alignment to Vision, Values and Strategic Framework

2.1 The 2023 staff health and wellbeing strategic action plan is underpinned by our vision, values, strategic aims and objectives. Deployment of this plan will specifically focus on enabling Staff Health and Wellbeing- priority 6 from our ELHT People Strategy.





3. How has our new staff health and wellbeing strategic action plan been devised?

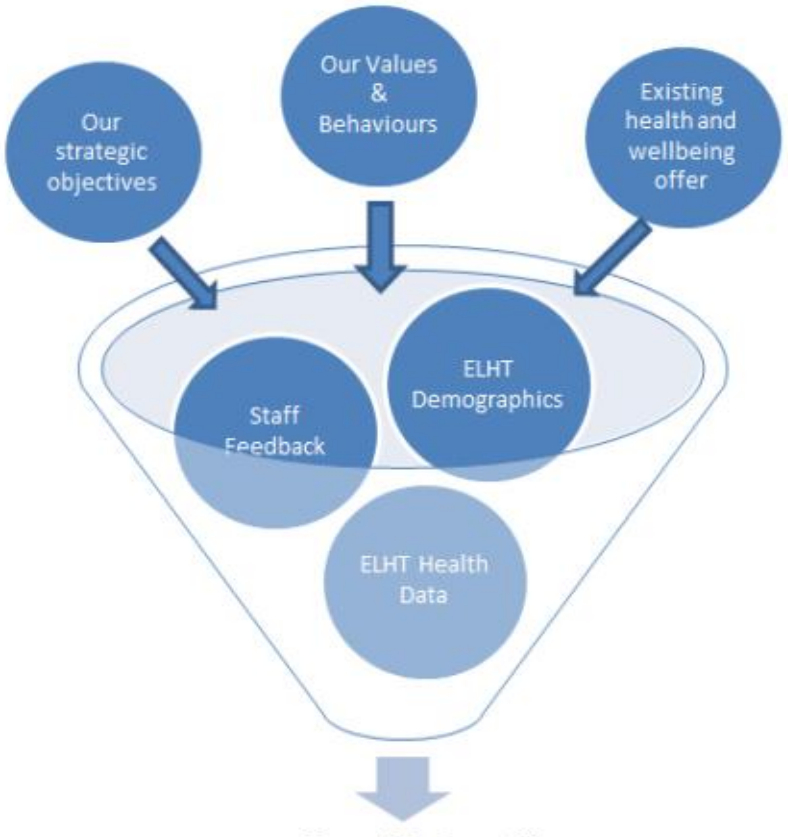
3.1 In order to ensure our plan is relevant and has an impact that is clear and visible to staff and meaningful for the organisation, we have considered multiple sources of information and undertaken a number of diagnostic activities to inform the plan. These include review and analysis of:

- The NHS Staff Health and Wellbeing Framework diagnostic tool.
- Sickness absence data and specific reasons for absence.
- Occupational health usage trends and themes.
- The ELHT Health and Wellbeing Needs assessment survey responses.
- National Staff Survey responses and themes.
- Workforce demographics.
- Feedback from key stakeholders across the organisation

Personal wellbeing is more than a sickness absence metric

More emphasis needs to be placed on preventative interventions rather than discrete reactive support

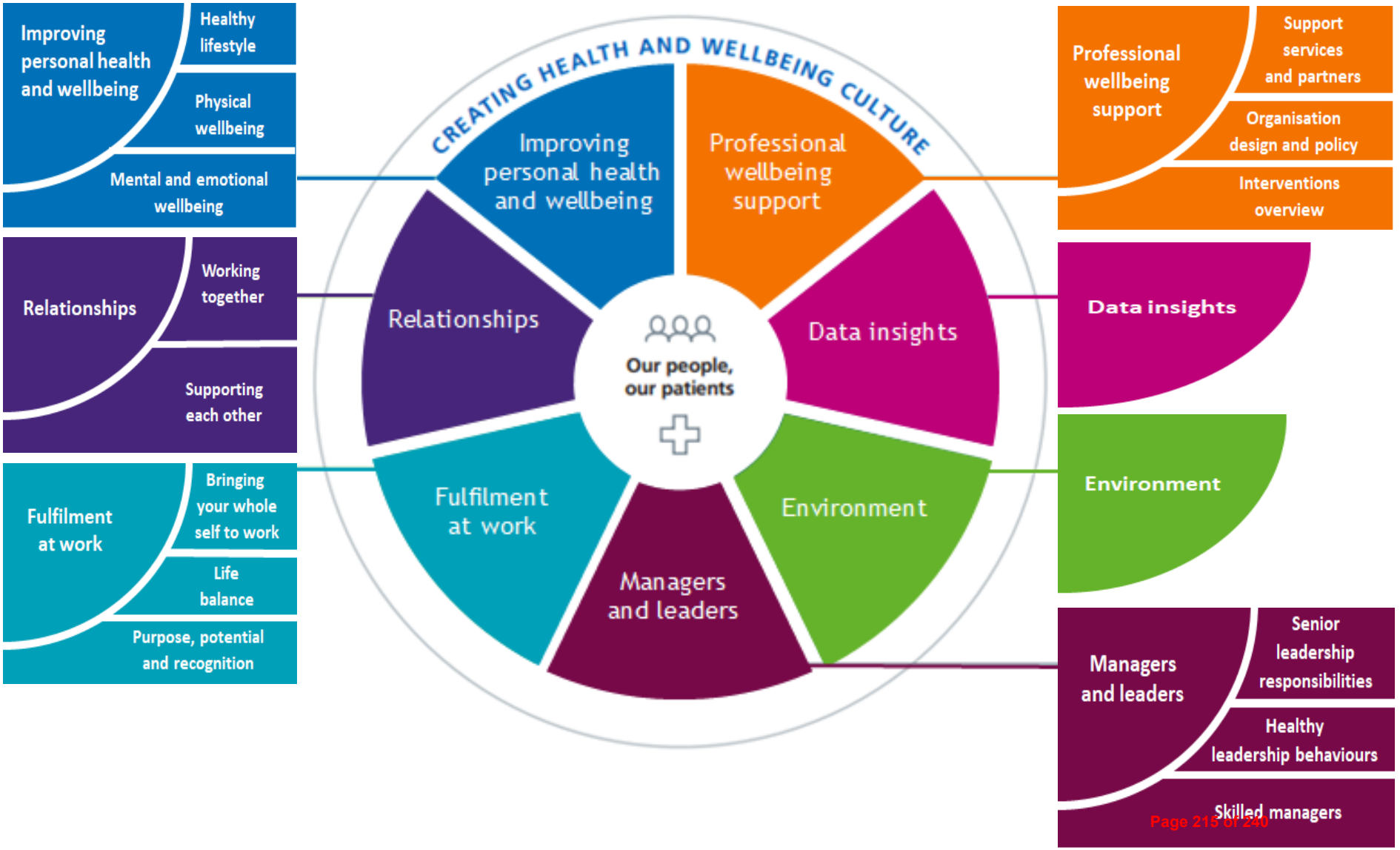
Mental and physical wellbeing needs to be viewed more broadly, such as the inclusion of financial wellbeing and menopause support



Our Staff Health & Wellbeing Strategic Action Plan 2023-2024

4. Utilising best practice and the NHS Staff Health and Wellbeing Framework

4.1 The NHS Staff Health and Wellbeing Framework developed by NHSE/I and NHS Employers sets out the standards for what NHS organisations should focus on based on the evidence base to support staff feeling well, healthy and happy at work. We will use this model to organise our plan into 7 key themes for action throughout 2023.

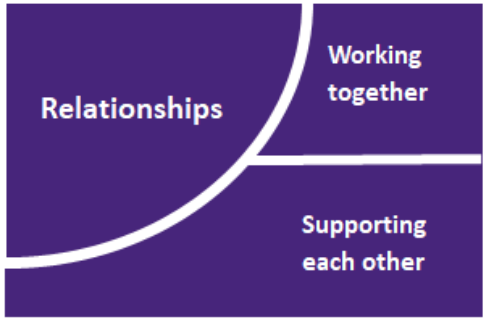


5. Key high impact Actions for 2023

East Lancashire Hospitals NHS Trust
A University Teaching Trust

5.1 Improving Personal Health & Wellbeing Actions

- Review and further develop our mental health pathway and interventions utilising internal and external services, expertise and resources by April 2024.
- Evaluate our Early Access to Support for Employees- EASE Service day 1 sickness absence support for MSK & MH by April 2024.
- Offer more physical & virtual drop in sessions to support self care, resilience and healthy lifestyle activities, e.g. weight management, smoking cessation, posture throughout 2023.
- Become an accredited menopause friendly workplace by April 2024.
- Broaden our financial wellbeing support via our Cost of Living Steering Group throughout 2023.
- Introduce more free on-site massage therapy & wider complementary therapies for teams by April 2024.
- Roll out monthly wellbeing challenges for sleep, hydration, digital detox, healthy eating throughout 2023.
- Offer monthly virtual health and wellbeing bite-sized training to support self-care throughout 2023.
- Further embed the Staff Wellbeing Portal as the first point of reference for all things wellbeing & staff benefits to ensure we have an accessible holistic & inclusive offer throughout 2023.
- Offer freely available on site health checks for all staff throughout 2023.
- Offer discounted gym memberships via salary sacrifice and promote onsite facilities throughout 2023.

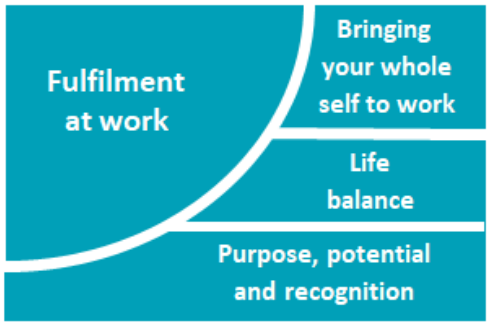


5. Key high impact Actions for 2023

East Lancashire Hospitals NHS Trust
A University Teaching Trust

5.2 Relationships Actions

- Recruit & train a further 100 active Wellbeing & Engagement Champions to support a team wellbeing culture by April 2024.
- Further promote the ELHT Mediation Service and approach to Early Resolution throughout 2023.
- Evaluate the buddy system for new starters by April 2024.
- Offer coaching & mentoring for all staff and make the offer highly visible and easily accessible throughout 2023.
- Launch a civility & respect toolkit and training to support psychological safety & team working by April 2024.
- Encourage speaking up & “if you see something say something” via staff stories throughout 2023.
- Promote and further embed the ELHT Vision, Values and Behavioural Framework across teams and departments throughout 2023.
- Build relationships with wider system partners to support the Growing Occupational Health and Wellbeing Services Together programme across LSC throughout 2023 to enable the Provider Collaborative Corporate Services Review and future delivery model.



5. Key high impact Actions for 2023

East Lancashire Hospitals NHS Trust
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5.3 Fulfilment At Work Actions

- Dedicate a month of the year to focus specifically on Colleague Care to support self care, colleague care and organisational care to promote prioritising wellbeing by April 2024.
- Further embed staff networks for BAME, Mental Health, Disability, LGBTQ+, Women and consider networks for Carers, & International staff throughout 2023.
- Host our annual Festival of wellbeing & inclusion by Dec 2023.
- Devise & roll out a staff passport, incorporating carers, disability, health & wellbeing by April 2024.
- Promote the teams & services that feel overlooked or less visible e.g. #Proud2BeCommunity, #Proud2BeE&F throughout 2023.
- Ensure every member of staff has the opportunity for a regular wellbeing conversation with their line manager throughout 2023.
- Review and amend the attendance policy through a compassionate wellbeing lens by April 2024 aligned to the regional wellbeing programme.
- Continue to promote Employee /Team of the Month throughout 2023.
- Re-evaluate and refresh our approach to employee reward and recognition and roll out and embed interventions to support recognition, gratitude and appreciation throughout 2023.

5. Key high impact Actions for 2023

East Lancashire Hospitals NHS Trust
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5.4 Managers and Leaders Actions

- Further embed the role of the Wellbeing Guardian so that staff understand the role & how they can access the Guardian throughout 2023.
- Schedule monthly Back to the Floors by Executives and Non-Executives throughout 2023.
- Senior managers to role model healthy leadership behaviours, e.g. not working excessive hours, being clear that staff should not be accessible out-side of working hours, not holding virtual meetings for longer than 1 hour without a break from the screen, etc.. throughout 2023.
- Offer training to all line managers to understand the Occupational Health and Wellbeing offer and how/when to signpost and refer staff for support throughout 2023.
- Launch a manager wellbeing peer support network aligned to #ProjectM by April 2024.
- Create wellbeing training & development opportunities for ICS shared learning spaces for colleagues and managers throughout 2023.
- Pilot the Team Engagement Diagnostic (TED) to support managers understanding their teams dynamics & needs throughout 2023.
- Review and relaunch manager and leadership development training programmes to ensure training for managers/leaders is people focused rather than policy focused throughout 2023.

5. Key high impact Actions for 2023

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5.5 Professional Wellbeing Support Actions

- Acknowledge the continuing impact of COVID 19 on the workforce & the cumulative effect of working through the pandemic & build this into our thinking around modelling for support services to aid restoration & recovery throughout 2023.
- Further establish collaborative relationships with external partners, e.g. Resilience Hub, LSC Growing Occupational Health and Wellbeing Together Programme, regional & national pathway providers throughout 2023.
- Simplify pathways to appropriate internal and external support services to enable staff to find the best wellbeing support options based on their needs & choices throughout 2023.
- Review the Occupational Health Service & offer & unify working practices & standards across the ICS as part of the “LSC Growing OHWB services Together Programme” by April 2024.
- Further develop & embed structures to support communication & collaboration between internal support services e.g. Well Team, OH, Psychology, Chaplaincy & Spiritual care, bereavement team, Staff Side etc.. throughout 2023.
- Ensure all people policies & processes are evaluated & deployed through a wellbeing lens throughout 2023.
- Ensure our interventions are both proactive & preventative as well as reactive & restorative throughout 2023.

5. Key high impact Actions for 2022

5.6 Environment Actions

- Input into the development of the Green Plan throughout 2023.
- Create access to hydration stations across the sites & encourage regular hydration throughout 2023.
- Create more staff spaces for rest breaks & well spaces both indoors & outdoors throughout 2023.
- Refresh our environment within the Occupational Health and Wellbeing Services Department to make it feel less clinical and more inviting for colleagues accessing services.
- Ensure there are adequate changing & showering facilities across the sites to support active travel & dignity & respect for staff throughout 2023.
- Review the accessible & affordable healthy food provision for staff working 24/7 across the organisation, e.g. access to food for night staff by June 2023.
- Promote the salary sacrifice cycle scheme & green & active travel throughout 2023.
- Sign and action the NHS smoke-free pledges and refocus our efforts on the smoke-Free environment & tackling smoking on site premises throughout 2023.
- Create walking routes around Trust sites to encourage outdoor activity by Apr 2023.
- Progress with the staff safety group to support violence reduction across the Trust to reduce/eliminate incidents and improve staff safety from aggression and violence throughout 2023.

5. Key high impact Actions for 2023

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Different people need different things at different times

"By using data, organisations can make more evidence based decisions to improve health and wellbeing. Reviewing detailed and accurate absence data allows interventions to be more targeted, so that they can better help to reduce unplanned absences"

5.7 Data Insights Actions

- Contribute to creating a system wide Wellbeing dashboard and scorecard which measures & monitors both output & outcome metrics for staff health and wellbeing by April 2024.
- Scope, implement, roll-out and evaluate Britain's Healthiest Workplace Survey in 2023.
- Continue with the quarterly Employee Engagement Sponsor Group to review data insights & monitor the progress of the staff health & wellbeing strategic action plan throughout 2023.
- Continue to implement the quarterly staff pulse survey outside of the national staff survey window, i.e. completed in Q1,2,4 throughout 2023.
- Robustly capture information from exit interviews throughout 2023.
- Use triangulated data to target areas of greatest need of intervention applying an evidence based approach throughout 2023.

6. Conclusion

6.1 ELHT has made progress with our staff health and wellbeing indicator and has started to shift the focus to a holistic evidence based health and wellbeing approach. Further organisational commitment and support aligned to our staff health and wellbeing programme will help ELHT to continue our improvement journey and ambition to meet the people promise for all of our staff.

7. Recommendations

7.1 It is recommended that the Trust-Board:

- review the proposed methodology and actions and advise on if there are any omissions.
- support the ELHT wellbeing programme and ethos.
- agree to and commit the organisation to this programme of actions within the outlined timescales.
- individually commit to participate in the programme by role modelling healthy leadership behaviours and demonstrating that an enhancing staff health and well-being lens is applied to all decisions.
- discuss and approve this action plan for deployment throughout 2023.
- review the progress of the action plan in 6 months time.

Lee Barnes Associate Director Staff Wellbeing & Engagement 21.02.2023

TRUST BOARD REPORT **Item** **42**

8 March 2023 **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 February 2023.

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

Trust Charitable Funds Committee Update

At the meeting of the Trust Charitable Funds Committee held on 1 February 2023 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 31 December 2022 stood at £596,000 and that total expenditure amounted to £624,000. The Charity's overall accumulated fund balance was noted to be £1,784,000. Members noted that the Trust's investment portfolio demonstrated a net loss of £145,000 during the same period.
2. The Committee received an update on the fundraising activity that had taken place since the previous meeting. Members noted that a new online platform was being developed which would enable better coordination of fundraising events and centralise advertising to drive further custom to the Charity Hub and Retail Outlet. Members were also informed that staff lottery activity was ramping up following the appointment of a new fundraising assistant. It was confirmed that following the discussions at the previous meeting, £60,000 of charitable funds had been used to gift £5 vouchers to all Trust colleagues over the Christmas period and that a significant proportion had elected to donate this back to the Charity.
3. An update on the Charity Hub and Retail Outlet was also provided to members. It was confirmed that the Outlet was performing well and had significantly increased the visibility of ELHT&me in the Trust.
4. The Committee was informed that a final iteration of a new strategy to promote further donations from the Charity's corporate partners would be provided at a future meeting for approval.

Dan Byrne, Corporate Governance Officer, 23 February 2023.

Lancashire and South Cumbria Provider Collaborative

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TRUST BOARD REPORT		**Item**	**43**
8 March 2023		**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 30 January and 27 February 2023.

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:

(43) Finance and Performance Committee Information Report

Finance and Performance Committee Update

At the meeting of the Finance and Performance Committee held on 30 January 2023, members considered the following matters:

1. Members received an update on the system financial performance, noting that the national team had agreed a £30 million deficit control total. Members noted the original system deficit was £120 million and significant work had taken place to reduce this to the current level. Members were informed that the Trust share of the system deficit had reduced from £19.9 million to £6.7 million. Members were updated on financial risks, including non-pay inflation, the 5% efficiency requirement and the impact from strike action. Members were informed about the Trust financial position, noting this was £6.2 million behind plan. It was noted that the Trust's capital programme was reporting an in-year pressure of £1.4 million and that the performance against the Better Payment Practice Code was well above the 95% requirement on three targets.
2. Members received a presentation regarding the National Planning Guidance, noting that key guidance was still to be received, however the Trust had received the main aspects and the technical guidance. Members noted that speciality detail would be released from the Integrated Care Board (ICB) and at present, the Trust was not in a position where the initial contract offer had been received for the new financial year.
3. The Committee received a proposal for a core Electronic Patient Record (EPR) system across the acute Trusts within Lancashire & South Cumbria. Members were advised that this would be strategically in line with the national requirements for the inter-operability between Trusts, the ICB digital strategy and the Provider Collaboration Board (PCB) digital strategy. Members provided approval for the proposal to be investigated further.
4. Members received an improvement presentation on Elective Improvement. Members received the UEC improvement plan on a page, noting the commitments, aims and objectives for inflow, flow and out of flow streams. Members noted the 95% target for patients to be seen within 4 hours of arriving at the Emergency Department (ED), along with the focus on bed occupancy and to provide a standardised specialist service response to prevent admission or enable the safe discharge of patients into the community.
5. The Committee received the Integrated Performance Report, noting that there had been significant performance improvement across the Trust, including a reduction of 12 hour waits within the Emergency Department. Members noted that work was

taking place to reduce the waiting times for referral to treatment (RTT), however the focus remained on reducing waiting lists. Members were updated on theatre utilisation and the work taking place to hit 85% usage, noting that the Trust had reached 83% usage the previous week and that there had been a positive visit from the national Get It Right First Team (GIRFT) team. The Committee noted that staff sickness level had stabilised around 5.3%.

6. 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. It was noted that fire safety training compliance remained strong and would continue to be monitored through the Senior Leadership Group meetings.
7. The Committee received a presentation from the Directorate of Education, Research and Innovation covering the directorate's work over the past 6 months, including the directorate's strategy and plans. Members noted that the strategy established the ambitions for the Trust and was underpinned by three plans covering education, research and innovation. Furthermore, the plans set out measurable objectives and key performance indicators.

At the meeting of the Finance and Performance Committee held on 27 February 2023 members considered the following matters:

1. Finance Reporting
2. National Planning Guidance
3. Improvement Update
4. Integrated Performance Report
5. COVID-19 & Restoration Update
6. Quarterly Workforce Update
7. PLICS and Model Hospital Update
8. Private Finance Initiative Update
9. Corporate Risk Register
10. 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, 08 March 2023

Lancashire and South Cumbria Provider Collaborative

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TRUST BOARD REPORT		**Item**	**44**
8 March 2023		**Purpose**	Information
Title	Quality Committee Information Report		
Executive sponsor	Miss N Malik, Committee Chair		

Summary: The report sets out the summary of the papers considered, and discussions held at the Quality Committee meetings held on 25 January 2023 and 22 February 2023.

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:

(44) Quality Committee Information Report

Quality Committee Update

At the meeting of the Quality Committee held on 25 January 2023 members considered the following matters:

1. Members were informed that the pressures seen in the Trust's urgent and emergency care pathways had started to ease since their peak in December 2022. It was noted that the impact of these pressures on staff had been significant and that the long waits seen in the Trust's emergency department had resulted in a very poor experience for a significant number of patients. The Committee was also informed that there had been heightened levels of aggression being directed towards staff, both in acute settings and in the wider community. It was requested that a more detailed update on staff safety and welfare was provided to members at a future meeting.
2. An update was provided to the Committee on the Getting It Right First Time (GIRFT) process and the increased importance of reducing inefficiencies and increasing productivity in light of the wider financial challenges currently facing the NHS. It was confirmed that significantly more engagement around GIRFT was taking place at a system level.
3. A new Leadership and Management Strategy 2022-25 was presented to the Committee for ratification. Members noted that the Strategy had been developed following extensive engagement with colleagues from across the Trust via a dedicated steering group and was based on a number of drivers, including the NHS People Plan and several of the Trust's own policies. The Committee was advised that the Strategy would be launched in stages, starting with a Core Leadership Programme in spring 2023.
4. An update was provided to members on the development of the Trust's flexible working offer following the implementation of its flexible working manifesto in 2021. It was noted that the implementation of the Leadership and Management Strategy would help to further embed flexible working within the Trust and that the next step would be further developing flexible contracts. In response to queries raised, it was also confirmed that the Trust was committed to extending this offer to clinical and nursing colleagues.
5. Members received an update on the work taking place in the Trust to comply with the NHS Complaint Standards scheme implemented in April 2022 by the Parliamentary and Health Service Ombudsman. The Committee noted that there had been a

number of significant challenges to overcome, particularly around staff availability, but that good progress had been made in several areas.

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. No items were raised for escalation to the Audit Committee or to Trust Board.

At the meeting of the Quality Committee held on 22 February 2023 members considered the following matters, a full summary of the discussions that took place will be provided at the next meeting:

1. Risk Reporting: Corporate Risk Register
2. Risk Reporting: Risk Assurance Meeting Update
3. Integrated Performance Report
4. Patient Safety Incident Response Framework Report
5. Infection Prevention and Control Report
6. Clinical Harms Review Management (Holding Lists) Update
7. Quarterly Report on Safe Working Hours: Doctors and Dentists in Training
8. CQC Update (System Review and Well-led Preparations)
9. Trust Wide Quality Group Update

Dan Byrne, Corporate Governance Officer, 23 February 2023.

Lancashire and South Cumbria Provider Collaborative

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TRUST BOARD REPORT

8 March 2023

Item **45**

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 16 January 2023.

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

(45) Audit Committee Information Report

Audit Committee Update

At the meeting of the Audit Committee held on 16 January 2023, members considered the following matters:

1. Members were updated on the Management Response to Internal Audit on Catering Services, noting that following the review, a number of recommendations had been raised for action. Members were informed that these were now all complete and that additional mitigations had been introduced, including the all catering staff being retrained in cash handling and the development of enhanced standard operating procedures. Members noted that following the release of the updated NHS Food Standards in 2022, all catering policies and procedures over the past 5 years would be reviewed during 2023.
2. Members received a progress update on the actions following the internal audit on risk management. Members noted that of the six actions listed in the review, the only area that remained outstanding was training. Members were advised that it had been agreed that risk management training was to be added to the mandatory training requirement for all staff, and that the Trust Board would receive training at a future development day. Members noted there had been a reduction in the number of open risks by 32% on the Corporate Risk Register (CRR). Furthermore, there had been an 81% reduction in overdue risks and 539 risks had been removed from the live risk register, compared with over 1700 at the time of the audit.
3. Members discussed the Trust's Current Financial Position, noting that the Trust deficit had reduced to £6.7 million, and that the national team had confirmed they would accept a system wide deficit of £30 million for Lancashire and South Cumbria. Members were informed that a significant proportion of non-recurrent savings was within the Trust position, alongside a reduction in expenditure. Members were advised about the Trust's indicative starting position for the 2023/24 financial year, however the final guidance was still to be received from the Department of Health and Social Care in order to determine the actual position.
4. The Committee received an update on consultant job planning, noting that the percentage of approved eased from 8% to 21%, and that a number of job plan panels were planned over the coming months. Members noted that key areas for consideration included making sure that on-call commitments and supporting professional activities were uniform across the directorate, along with educational commitments being shared out.

5. The Committee were updated on the Trust's commitment towards the NHS Green Plan, noting that the Green Plan assessment and data submission had now been completed and the response was yet to be received. Members noted that the findings would be presented back to the Committee once received.
6. Members received the Internal Audit Progress report, noting that the Fit and Proper Persons Test audit had received limited assurance and that 3 high priority recommendations had been made. Members noted that the Healthcare Financial Management Association Financial Sustainability checklist had been reviewed and adequate evidence was available to support the score for 11 of the 12 areas. The Committee received a proposal to defer the data quality review to the 2023/24 financial year with the rationale to look at data quality once the new Electronic Patient Record system had been implemented. Members approved the proposal.
7. The Committee received an update on the work undertaken by the External Auditors, noting that all work for the 2021/22 audit had now been completed and that work would now commence for the 2022/23 audit year. Members were advised that the audit plan would be brought to the next meeting and that work would be completed ahead of the June 2023 deadline.
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 a copy of the CRR, noting that work continued to standardise and amalgamate risks were possible, and that the CRR would be updated to replicate the style of the Board Assurance Framework (BAF) by moving potential actions to a separate action plan.
10. Committee members were presented with a copy of the BAF.
11. Members were provided with a copy of the Waivers Report, nothing that there had been two waivers in the period between 1 October 2022 to 30 November 2022.
12. 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.
13. Members were updated on current work taking place within the system, noting that the Integrated Care Board had been in operation since 1 July 2022 and that consideration needed to be given for the levels of corporate collaboration taking place and ensuring oversight of work was taking place.
14. The Committee were informed that both the Standing Orders and Standing Financial Instructions policies were being reviewed and that a session would be held with the

Audit Committee and any interested Non-Executive Directors to review the changes prior to presentation to the Trust Board.

15. Members were presented with the draft 2022/23 annual report and accounts timetable. It was noted that the full timetable had not yet been released from the Department of Health and Social Care, however the current timetable was inline with previous years submissions.
16. Members were informed that the template for the review of accounting policies had not yet been received and that the draft accounting policies would be brought to the April Audit Committee meeting.

Mr M Pugh, Acting Corporate Governance Team Leader, 8 March 2023

TRUST BOARD REPORT

Item 46

8 March 2023

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 11 January 2023.

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 11 January 2023, the following matters were discussed in private:
   a) Round Table Discussion: Site Operational Pressures
   b) Round Table Discussion: Fire Safety
   c) National Planning Guidance 2023-24
   d) Financial Recovery Plan Update
   e) Service Development Update: Community Services
   f) Fire Safety
   g) Electronic Patient Record Progress Update
   h) Nosocomial Infections Update
   i) Pathology Update
   j) Industrial Action Update
   k) Any Other Business: Endoscopy Workforce Investment Business Case
   l) Any Other Business: Pathology Digital Business Case
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, 23 February 2023.

Lancashire and South Cumbria Provider Collaborative

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TRUST BOARD REPORT		**Item**	**47**
8 March 2023		**Purpose**	Information
Title	Remuneration Committee Information Report		
Executive sponsor	Mr S Sarwar, Chairman		

Summary: The list of matters discussed at the Remuneration Committee meetings held on 11 January 2023 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

(47) Remuneration Committee Information Report

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 11 January 2023 members considered the following matters:
   a) Deputy Chief Executive Appointment and Remuneration
   b) Executive Director of Strategy and Improvement Remuneration
   c) Revised Car Allowance amount for Chief Nursing Officer

Mr D Byrne, Corporate Governance Officer, 23 February 2023.