EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD MEETING (OPEN SESSION)

12 JULY 2023, 12.30pm

BOARDROOM, TRUST HQ / MS TEAMS

AGENDA

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

OPENING MATTERS				
TB/2023/077	**Chairman's Welcome**	Chairman	v	
TB/2023/078	**Apologies** To note apologies.	Chairman	v	
TB/2023/079	**Declarations of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Chairman	d✓	Information/ Approval
TB/2023/080	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 10 May 2023.	Chairman	d✓	Approval
TB/2023/081	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2023/082	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2023/083	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2023/084	**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/2023/085	**Patient Story** To receive and consider the learning from a patient story.	Chief Nurse	p	Information/ Assurance
TB/2023/086	**Corporate Risk Register and Risk Performance Report** To receive an update on the Corporate Risk Register and approve revisions based on the Executive Risk Assurance Group, Committees' and Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Executive Medical Director	d✓	Information/ Approval
TB/2023/087	**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✓	Information/ Approval

Agenda

TB/2023/088	**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/2023/089	**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 (Executive Medical Director and Chief Nurse) c) Caring (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/2023/090	**Maternity and Neonatal Service Update**	Chief Nurse	d✓	Information/ Assurance
TB/2023/091	**NHS EDI Improvement Plan and Anti-Racism Framework** a) North West BAME Assembly: Anti-Racist Letter b) North West BAME Assembly: Anti-Racist Framework	Executive Director of People and Culture	d✓ d✓ d✓	Information/ Discussion
GOVERNANCE				
TB/2023/092	**Ratification of Board Sub-Committee Terms of Reference** a) Quality Committee	Director of Corporate Governance	d✓	Approval
TB/2023/093	**Finance and Performance Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/094	**Quality Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/095	**Audit Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information

TB/2023/096	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2023/097	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2023/098	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2023/099	**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/2023/100	**Date and Time of Next Meeting** Wednesday 13 September 2023, 12.30pm, Boardroom, Trust HQ / MS Teams	Chairman	v	

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 79

12 July 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.

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

Report linkages

Related Trust Goal	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	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

(79) Declarations of Interests Report

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 31.08.2022)	• 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)	08.03.2023
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 10.02.2023)	• 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)	08.03.2023
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 a paramedic at NWAS • Vice Chair of Governors at St Catherine's RC Primary School, Leyland • Labour Councillor – Clayton West and Cuerden Ward	08.03.2023
Sharon Gilligan Chief Operating Officer Deputy Chief Executive (from 01.01.2023)	• Positive nil declaration	20.02.2023
Jawad Husain Executive Medical Director Deputy Chief Executive (from 10.11.2021)	• Spouse is a GP in Oldham	20.02.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
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
Peter Murphy Chief Nurse	• Spouse works at Liverpool University Foundation Trust.	24.03.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Kate Quinn Executive Director of People and Culture (from 01.01.2023)	• Director at Lancashire Institute of Technology • 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. • Chair of Board of Governors at Bury Grammar School as of 27 March 2023.	20.02.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Shelley Wright Joint Director of Communications and Engagement for East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BFWH) (from 04.01.2021)	• Post held jointly with Blackpool Teaching Hospitals NHS Foundation Trust	20.02.2023

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 82

12 July 2023

Purpose Approval

Title	Minutes of the Previous Meeting

Summary: The minutes of the previous Trust Board meeting held on 10 May 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

(82) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 1.00PM, 10 MAY 2023

MINUTES

PRESENT

Mr S Sarwar	Chairman	Chair
Mr M Hodgson	Chief Executive / Accountable Officer	
Mrs P Anderson	Non-Executive Director	
Mrs K Atkinson	Executive Director of Service Development and Improvement	Non-voting
Professor G Baldwin	Non-Executive Director	
Mr S Barnes	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	
Mr J Husain	Executive Medical Director / Deputy Chief Executive	
Miss N Malik	Non-Executive Director	
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience	Non-voting
Mr P Murphy	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	
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)	Non-voting

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary	
Mrs J Butcher	Staff Guardian	Item: TB/2023/066
Mr D Byrne	Corporate Governance Officer	Minutes
Miss K Ingham	Corporate Governance Manager	
Mr M Maher	Clinical Director, Obstetrics and Gynaecology	Item: TB/2023/068
Mrs R Malin	Programme Director – New Hospitals Programme	Item: TB/2023/067

Mr M Pugh	Corporate Governance Officer	
Miss T Thompson	Head of Midwifery	Item: TB/2023/068

APOLOGIES

Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council

TB/2023/052 CHAIRMAN'S WELCOME

Mr Sarwar welcomed Directors to the meeting. He highlighted that the meeting was Mr Murphy's first in his role as Chief Nurse and would be the last for both Mrs Patel and Dr Dad as members of the Board. Mr Sarwar stated that both Mrs Patel and Dr Dad had provided valuable insight during their tenures and had helped to improve the Trust's ability to deliver safe, personal and effective care. He extended his sincere thanks to both, on behalf of the Board, for their contributions.

TB/2023/053 APOLOGIES

Apologies were received as recorded above.

TB/2023/054 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/2023/055 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 8 March 2023 were approved as a true and accurate record.

TB/2023/056 MATTERS ARISING

There were no matters arising.

TB/2023/057 ACTION MATRIX

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

RESOLVED: Directors noted the position of the action matrix.

TB/2023/058 CHAIRMAN'S REPORT

Mr Sarwar provided a summary of his activities to Directors since the previous meeting. He explained that the majority of the focus at the Trust and system level had been on agreeing the financial arrangements for 2023-24 and advised that this was still an ongoing process. Mr Sarwar added that the main areas of regional focus had been on finances, elective recovery and transformation and productivity. He commented that there would be a strong focus at Integrated Care Board (ICB) level on performance and highlighted that the Trust had delivered strong performance in a significant number of key metrics. Mr Sarwar confirmed that he continued to attend meetings of the Provider Collaboration Board (PCB) and that there was now clear recognition of the need to quantify ongoing corporate and clinical collaboration schemes and how they were expected to shape health and social care across Lancashire and South Cumbria (LSC).

Mr Sarwar went on to highlight several significant developments at Trust level. He informed Directors that the Trust's work on community integrated care services had been recognised as outstanding and had been used as an exemplar by a number of organisations across the country. Directors noted that Mr Sarwar had recently attended the opening of a new infusion suite facility at Burnley General Teaching Hospital (BGTH) alongside Mr Hodgson, as well as another event focused on young people's services at the Trust. Mr Sarwar stated that he had found many of the discussions at the latter event to be particularly relevant to the Trust's services and explained that it would form part of the activities of the Patient Participation Panel (PPP) initiative going forward. Mr Sarwar concluded his update by advising that he had also attended a recent 'Re-Imagining Living Well' event, organised by the local Inspire Motivate Overcome charity, at Ewood Park. He stated that this event had emphasised the crucial role of the local faith and voluntary sectors and that the Trust would need to take every opportunity to utilise these areas as health and social care services continued to develop over the coming years.

RESOLVED: Directors received and noted the update provided.

TB/2022/059 CHIEF EXECUTIVE'S REPORT

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

Mr Hodgson informed Directors that he had recently attended a national leadership event held by the NHS England (NHSE) Executive team and that there had been a significant focus on looking forward to 2023-24, particularly around the 75th anniversary of the NHS. He confirmed that there had also been clear recognition of the scale of the challenges facing Trusts over the coming months, not only in relation to planning and financial asks, but also with regard to the ongoing industrial action. Mr Hodgson reported that a total of 195,000 patient appointments had been cancelled nationally due to the industrial action taken by junior doctors in April 2023, in addition to 175,000 cancelled during the previous strike, and noted that this would have had a clear impact on waiting times and elective activity. Directors noted that NHSE and Health Education England (HEE) had now been formally merged into a new single organisation to lead the NHS and that it would take on all responsibilities regarding planning, recruiting, educating and training the health workforce.

Mr Hodgson informed Directors that several developments had also taken place at a LSC system level, including the most recent meeting of the ICB. He advised that the main part of discussions at the meeting had been in relation to national planning asks and how LSC would address these, as well as the significant financial challenges expected in 2023-24. Mr Hodgson confirmed that all organisations within the ICB had come together to agree a financial plan for 2023-24 and that there was expected to be an increased emphasis on delivering PCB level programmes going forward, including the aforementioned clinical and corporate collaboration schemes.

Mr Hodgson went on to provide a summary of the developments taking place at Trust level. He paid testament to the work done by Executive colleagues, clinical and corporate divisions and all other staff in the organisation towards achieving the Trust's strong end of year position for 2022-23. Directors noted that there had been some significant challenges, such as those related to the 62-day cancer pathways, and that the Trust had responded very quickly to these. Mr Hodgson highlighted that the Trust had achieved a financial break-even position, a very positive staff survey and had received national recognition for the strength of its maternity services, particularly in relation to its response to the Ockenden report. He reiterated that 2023-24 would be a particularly challenging year for the Trust, not only due to the planning

and financial requirements that it would have to meet, but also due to other significant developments, including the implementation of the new Electronic Patient Record (EPR) system. Mr Hodgson stressed that the amount of work being undertaken by colleagues in relation to the latter could not be underestimated and noted that there was a substantial amount still to be done before the planned 'go live' date in June 2023.

Mr Hodgson went on to pay testament to the significant amount of work done by colleagues to minimise disruption and the number of appointment cancellations following the most recent recent industrial action. He added that the Trust would always respect the right of colleagues to strike. Mr Hodgson concluded by highlighting a number of other positive developments across the Trust, including an award given to the district nurse colleagues in Pendle East, a regional award for the Neonatal Intensive Care Unit (NICU), a business award given to the Trust's Charity, ELHT&Me and a National Certificate of Excellence awarded to one of the Trust's Consultant Anaesthetists, Dr Jason Lie, following extensive positive feedback from patients.

Mr Hodgson concluded his update by presenting the latest series of Safe, Personal and Effective Care (SPEC) awards to Directors. He clarified that the areas to be awarded were wards B14, B24, C14b, the Surgical Ambulatory Emergency Care Unit (SAECU) and ophthalmology theatres. Directors confirmed that they were content to approve these recommendations.

Mr Barnes commented that the scale of the challenges facing the Trust in 2023-24 were immense but stated that he was hopeful that it would rise to the challenge. He added that he had full confidence in colleagues to manage the Trust's finances as well as they possibly could and stressed the importance of supporting Executive colleagues to manage the difficult times that lay before the organisation.

Mr Sarwar concurred with Mr Barnes' comments and confirmed that concerns around the financial situation in 2023-24 had been shared with system colleagues.

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

TB/2023/060 **PATIENT STORY**

Mr Murphy explained that the patient story would be presented to the Board in a video format for the first time. He confirmed that this format would be kept for future meetings, adding that he felt it was important to hear from patients and their families directly so they could get their

experiences across properly. Mr Murphy advised that the story being presented was from the point of view of the patient's son and highlighted several concerns around the care provided to his father and the lack of communication provided.


Patient Story - Video.mov

Mr Sarwar commented that the story had been a difficult one to hear and requested that additional context was provided around the patient involved.
Mr Murphy acknowledged that it had clearly been a difficult journey for the patient and that there had been multiple issues around communication with their loved ones. He provided assurances that the issues relating to the retained piece of plastic from the patient's catheter had now been resolved and that it was expected that their condition would start to settle and improve.

Mr Husain explained that although he was not privy to the details of the case in question, it was not unusual for patients with catheters to get infections or to have blockages. He agreed that a lack of communication was clearly an issue and had resulted in a poor patient experience and that lessons would need to be learned to further develop the Trust's systems and processes to avoid placing unnecessary stress on patients in similar situations.

Mr Rehman observed that wider discussions were taking place nationally around the need to avoid admissions to acute settings and enquired when it was expected that this would start to have an effect. He also enquired what effect, if any, the EPR system would have made to the patient's experience, if it had been in place.
Mr Murphy stressed that although it was important to listen to patient stories that were less positive, it was also vital to keep in mind that the vast majority of feedback provided to the Trust around the care it provided was positive. He confirmed that the EPR system would undoubtedly make communication easier, as well as providing several other benefits, and would provide a step change and further opportunities for the Trust to get the types of scenarios described in the patient story right.
Mr Husain confirmed that work was already taking place in the wider system to reduce the numbers of unnecessary hospital admissions but stressed that there was still a substantial

amount of work to do with teams and community colleagues before real benefits would start to be seen.

Mrs Gilligan extended her thanks to Mr Murphy for providing the story. She agreed that it was more powerful hearing directly from patients or their families rather than having their stories read out on their behalf.

Mr McDonald commented that it was clear to him that many of the more negative experiences described in the patient's story could have been avoided. He informed Directors that both he and Mrs Anderson had recently attended an event hosted by Community and Integrated Care colleagues and community partners, including care homes, which had been specifically designed to raise awareness around community services.

Mr Sarwar agreed with many of the points raised, particularly around the need to reduce the numbers of patients coming into acute settings unnecessarily. He urged the need for the Trust to continue to engage with patients and their families, to give them the opportunity to tell their stories and allow the Board to get a better understanding of the realities that they were facing. Mr Sarwar also stated that he would welcome stories from patients from different backgrounds to fully reflect the diversity seen across the Trust's local communities.

Mr Murphy informed Directors that a full redesign of the Trust's Patient Experience Strategy was currently in progress, with input from service users across local communities. He confirmed that this would be presented to the Board at a later date for endorsement.

RESOLVED: **Directors received the Patient Story and noted its content.**
The refreshed Patient Experience Strategy for the Trust will be presented to the Board for endorsement in due course.

TB/2023/061 CORPORATE RISK REGISTER (CRR)

Mr Husain informed Directors that the Trust was currently in the process of reviewing the CRR and updating its format to link it more closely with the revised Board Assurance Framework (BAF) for 2023-24. He also confirmed that the Trust was still on track to move from its current Datix incident reporting system to a new RADAR reporting system later in the year and explained that this would provide a significant amount of additional functionality.

RESOLVED: **Directors received the update and noted the work being undertaken in relation to the CRR.**

TB/2023/062 BOARD ASSURANCE FRAMEWORK

Mrs Bosnjak-Szekeres confirmed that the annual review of the BAF had begun in earnest following a workshop session held with Board members the previous week. She clarified that one of the aims of this process was to interlink the objectives of the Trust more closely to the wider system objectives and strategies. Mrs Bosnjak-Szekeres informed Directors that the revised BAF risks would be presented to the Board's Sub-Committees in June prior to them being presented to the Board for ratification in July.

Mr Sarwar noted that in addition to the Trust recognising its key risks, it would be equally important for it to decide what its appetite and tolerance was in relation to them. He stated that the aforementioned workshop session had been key in starting to shape what the BAF would ultimately look like and confirmed that the Board would revisit it at a later date.

RESOLVED: **Directors received and noted the update provided in relation to the work being undertaken to review and revise the BAF.**

TB/2023/063 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) ASSURANCE REPORT

Mr Husain requested that the report be taken as read and presented a summary of the salient points to Directors. He stressed that the Trust continued to maintain an open and positive reporting culture, with high numbers of incidents being reported, but with a low incidence of harm rated as moderate or above. Mr Husain highlighted that the numbers of reported pressure ulcer incidents had fallen in March and April following the implementation of a number of quality improvement schemes. He reported that there had been a total of 34 incidents reported under the PSIRF in 2023-24 and confirmed that each had been fully investigated, with relevant learning shared across the Trust and with system colleagues. Directors noted that a total of four Never Events had been declared since January 2023 and that all were being investigated in depth by colleagues with the full involvement of the patients affected and their families.

Mr Husain concluded his update by informing Directors that new patient safety training modules had now been implemented in the Trust, in line with PSIRF requirements. He reported that the uptake for this training was already very encouraging and that the Trust was on track to achieving the final goal of 95% compliance by March 2024.

Mr Hodgson commented that Mr Husain's update, as well as the previous two agenda items, were tangible evidence that the Trust promoted an open and transparent culture.

Mrs Atkinson advised that several focused pieces of improvement work were currently underway and reported that significant improvements had already been made in a range of key areas, including cancer and end of life care.

Mr Sarwar stated that it was important to recognise the amount of time and effort put in by Trust colleagues in achieving its lower than national average levels of harm.

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

TB/2023/064 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Mr Hodgson referred to the previously circulated report and confirmed that it covered the period up to the end of March 2023. He acknowledged that the report provided something of a mixed picture, with positive performance in several areas that was contrasted by significant challenges in others.

b) Safe

Mr Husain referred Directors to the Safe section of the report. He highlighted that there had been no reported cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) in the Trust throughout 2022-23. Mr Husain reported that the Trust had breached its trajectory for clostridium difficile (c.diff) infections and explained that this was due, in large part, to overcrowding within some areas and other elements such as antibiotic usage. He confirmed that teams were working closely with infection prevention and control (IPC) colleagues on how to address this matter. Directors noted that the Trust was still below trajectory for both E. coli bacteraemia and Klebsiella infections. Mr Husain drew attention to the Venous Thromboembolism assessment figures provided in the report and praised the effort of colleagues in reaching 99% in this area, adding that this was above the national requirement of 95%.

Mr Murphy referred to the safer staffing figures provided and confirmed that they had remained relatively stable. He explained that further improvements were expected, as staff would be

moved around to other areas due to estates work being carried out over the coming months. Mr Murphy informed Directors that the Trust had formally moved away from using off-framework agencies earlier in the month and advised that new processes had been developed around staffing across the organisation. He highlighted that further work was taking place with Human Resources colleagues to see what else could be done to address registered nurse vacancies, in addition to the overseas recruitment initiative that was already in place.

Mr Sarwar noted that the Trust currently had around 250 registered nurse vacancies and pointed out that this would continue to place a significant amount of pressure on colleagues if it was not addressed.

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

c) Caring

Mr Murphy referred Directors to the Caring section of the report and drew attention to a number of areas showing positive movement. He acknowledged that there had been significant dips in the patient experience reported through emergency pathways and confirmed that work was already underway to improve this.

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

d) Effective

Mr Husain reported that the Trust's Summary Hospital-level Mortality Indicator (SHMI) performance was within expected levels but advised that its Hospital Standardised Mortality Ratio (HSMR) continued to flag outside expected tolerances. Directors were reminded that a range of factors contributed to this, including ongoing external coding issues with relation to palliative care and co-morbidity. Mr Husain added that the Trust's crude mortality levels were still lower than both regional and national levels.

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

e) Responsive

Mrs Gilligan reported that the Trust had not achieved the 76% Emergency Care 4-hour standard in March, reaching 74.7%, but pointed out that this was a good deal higher than the

national average of 71.5%. She added that 75.3% and 74.9% had been achieved in April and May respectively. Mrs Gilligan also reported that extended wait times in the Trust's Emergency Department (ED) were still being seen but stressed that everything that could be done was being done to address these. She confirmed that the Trust continued to perform well in relation to ambulance handover times, with no breaches of the 60-minute standard in March and had achieved its targets in relation to patients waiting 78 weeks or more for treatment. Directors noted that the Trust was ahead of trajectory for its 65-week targets which was expected to be the next area of national focus. Mrs Gilligan highlighted that the number of patients waiting 62 days or more for cancer treatment had dropped significantly, from 479 in April 2022 to 168 in March 2023, and extended her thanks to the colleagues involved in achieving this.

Mr Sarwar noted that significant additional pressures on urgent and emergency care pathways were already being seen in April and May and that this put an additional onus on the Trust to ensure that patients were discharged as quickly and as safely as possible.

Mrs Anderson commented that it was good to see these positive results considering the very difficult operating context that the Trust was currently working under.

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 informed Directors that work was ongoing to reduce the Trust's overall sickness and absence levels to below the 5% threshold. She advised that other work was taking place across LSC to explore the links between sickness levels and population health which, when complete, would facilitate the development of additional supportive policies going forward. Mrs Quinn went on to highlight the activity taking place at system level to reduce bank and agency spend and the development of a collaborative staff bank and advised that this process was now nearing completion.

Mr Smyth observed that there had been a fall in the number of colleagues completing their mandatory information governance training and requested further information on how this would be managed in the run up to the 'go live' date for the EPR.

Mrs Quinn explained that information governance training compliance was one of the more difficult areas to keep on track. She advised that there had been significant activity around this earlier in the week and confirmed that the situation would be micromanaged in the context of the EPR go live.

Mrs Brown informed Directors that the Trust had achieved its expected financial position for 2022-23, adding that it had ultimately moved to a slight deficit position, related to the recent national NHS pay award for 2023-24. She confirmed that this would help to reduce some of the financial risk to the Trust going into 2023-24 but stressed that it would still have significant financial challenges to manage, with an expected financial gap of around £54,000,000. Mrs Brown explained that work was still ongoing to finalise the Trust's year end financial position and confirmed that this would be brought to the next meeting for sign-off by Board members, alongside the finalised financial recovery plan.

Mr Sarwar commented that there was a clear need for the Trust and other organisations in the area to ensure that they received their fair share of funding for 2023-24. He acknowledged that the scale of the challenges facing the Trust could not be underestimated, but stated that he was confident that it had the appropriate tools in place to meet them.

Mr Hodgson extended his thanks to Mrs Brown, and the rest of the Trust's finance colleagues, for their ongoing efforts in this area. He clarified that some of the Trust's expected financial gap for 2023-24 was dependent on developments in the wider system and the programmes referred to earlier in the meeting.

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

The Trust's finalised year end position and the finalised Financial Recovery Plan will be presented to the Board for approval at its next meeting.

TB/2023/065 NATIONAL STAFF SURVEY REPORT 2022-23

Mrs Quinn referred to the previously circulated report and provided a summary of key highlights to Directors. She explained that a full census of eligible staff had been undertaken and reported that there had been a response rate of 48%. Mrs Quinn noted that this was a reduction of 10% in comparison to the response rates seen in 2021-22 but pointed out that

this had been reflected nationally. She highlighted that the Trust had scored 'above average' in all nine themes in the staff survey and had shown significant improvements in the 'we are safe and healthy' and 'we are always learning' domains. Directors noted that of the 112 questions on the survey, only three had shown any deterioration from the previous year. Mrs Quinn clarified that these questions related to 'satisfaction with levels of pay', 'the organisation acting on concerns raised by patients and service users' and 'if staff would be content with the standard of care provided by the organisation if a friend or relative required treatment'.

Mr Sarwar advised that the Trust was in the process of forming a new People and Culture Committee and that it would play a key role in working through the finer details of these, and future, staff survey results.

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

TB/2023/066 **RAISING CONCERNS REPORT**

Mrs Butcher referred Directors to the previously circulated document and advised that it was the seventh report produced in relation to the Staff Guardian service since its inception. She reported that there had been a total of 1,280 concerns raised over the previous six-year period and that the highest level of concerns between April 2022 and March 2023 had been in relation to perceived bullying by a manager. Mrs Butcher explained that work was already taking place with transformation and organisational development colleagues around this and noted that this coincided with the activity already taking place around the Trust's Behavioural Framework. Mrs Butcher advised that the Mersey Internal Audit Agency (MIAA) had carried out an audit of the service in November 2022 and that the following four recommendations had been made: to present raising concerns reports to the Board twice a year, to mandate Freedom to Speak up Training, for the Board to complete the Freedom to Speak self-assessment tool and for all Board members to complete all three levels of the Freedom to Speak Up training. She confirmed that mandatory training had already been implemented and requested that the Board confirm that they were content to carry out the recommendations relating to completing this and to complete the self-assessment tool.

Mrs Quinn stressed that every effort was being made to maintain an open and transparent culture around the Staff Guardian service and added that work was taking place to better integrate Freedom to Speak Up Champions across the Trust.

Mr Rehman requested additional clarification on whether some staff members had already received Freedom to Speak Up training during their inductions. He also enquired if concerns raised to the service were broken down into categories such as race and how it would be possible to gain a better understanding of how these issues were impacting colleagues.
Mrs Butcher stated that she was unsure what level of Freedom to Speak Up training was provided to colleagues during their inductions but advised that it was provided during any kind of team development exercises. She confirmed that discussions around cases of racial and sexual discrimination did take place but explained that the concerns raised to the service were not currently split along these lines. Mrs Butcher confirmed that she would look into implementing this suggestion going forward.

In response to a query from Mrs Patel regarding the timeframes for dealing with any incidents of a more serious nature, Mrs Butcher explained that direct support was always initially offered to any colleagues requiring it via the Trust's Resolution Policy and that further support was given if the matter then moved into more formal HR processes.

Responding to a query from Miss Wright, Mrs Butcher confirmed that she felt adequately supported by the Trust in managing the issues that were raised to the Staff Guardian service.

Directors confirmed that they were content to accept the recommendations made by the MIAA outlined in the report to approve to note and approve the content of the report, to approve the recommendation from auditors in relation to Freedom to speak up training becoming mandatory and to commit to completion of the Board Freedom to Speak reflection and planning tool along with training for all Board members.

RESOLVED: **Directors received the report, noted its contents and accepted the recommendations set out in the report**

TB/2023/067 **NEW HOSPITALS PROGRAMME (NHP) QUARTER 4 BOARD REPORT**

Mrs Malin referred to the previously circulated report and provided a summary of key points to Directors. She advised that an announcement was still awaited from the Government regarding funding allocations and explained that this would determine the phasing and capital range for the two schemes in place across LSC. Mrs Malin added that no further progress could be made with the programme's business cases until this announcement was made.

Mr Hodgson highlighted that Mrs Malin attended the PCB Clinical Programme Board and noted that the NHP had played a key role in promoting engagement with the work being done.

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

TB/2023/068 **MATERNITY AND NEONATAL SERVICE UPDATE**

Miss Thompson provided a summary of the activities of the Trust's maternity services. She reminded Directors that the Trust had submitted its compliance against nine of the ten safety actions outlined in the Clinical Negligence Scheme for Trusts (CNST) year 4 scheme earlier in the year, with Perinatal Mortality Review Tool (PMRT) reporting being the only action it had fallen short in. Miss Thompson confirmed that the Trust had now achieved 100% compliance in the majority of areas relating to the use of the PMRT and advised that a progress tracker was included in the report to provide more information around each of these standards. She explained that the other major item to note regarding the CNST safety actions was the work taking place in relation to the midwifery workforce, adding that it was planned for a business case to be provided to the Board in Quarter 2.

Miss Thompson went on to inform Directors that the Trust had recently received Local Maternity and Neonatal System (LMNS) insight and regional site visits relating to the Ockenden Review. She explained that a summary of the progress made against the recommendations made during the previous visit from LMNS colleagues in April 2022 was included in the report.

Miss Thompson concluded her update by highlighting that both she and Mr Maher had now completed the first phase of National Quadrumvirate training. She confirmed that the learning form this six-month process would be brought back into the Trust to be shared with colleagues.

Mr Rehman extended his thanks to Miss Thompson and Mr Maher for their warm welcome in his new role as Maternity Champion for the Trust. He noted that a substantial amount of work was taking place in maternity areas and that it was clear that the Trust was held in particularly high regard in this field.

In response to the queries raised by Mrs Patel at the previous meeting regarding the effect of religious and cultural attitudes to expected fetal losses, Miss Thompson confirmed that Mr Maher had looked into this area in detail.

Mr Maher explained that the impact of religious or cultural attitudes on fetal losses was still somewhat unclear, as no national studies had ever taken place to assess whether there was a link between the two areas. He stressed that the Trust had robust pathways in place around this but acknowledged that the situation was a very complex one, with other factors such as complexities of conditions and family circumstances also playing a significant role. Mr Maher added that there was definite need for more focus around the issue nationally to better understand cultural attitudes around terminating pregnancies, or otherwise.

Mr Murphy observed that there was a significant amount of national attention on maternity services and stated that it was positive to see the amount of external validation being given to the Trust in this regard.

Directors confirmed that they were content to approve the Trust's CNST submission and to note the progress made in delivering against the immediate and essential actions outlined in the Ockenden report, whilst also recognising the barriers in place that may impact sustainability.

RESOLVED: **Directors approved the Trust's CNST submission**

TB/2023/069 **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/2023/070 **QUALITY COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

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

TB/2023/071 **TRUST BOARD (CLOSED SESSION) INFORMATION REPORT**

The report was presented to the Board for information.

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

TB2/2023/072 **REMUNERATION COMMITTEE REPORT**

The report was presented to the Board for information.

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

TB/2022/073 ANY OTHER BUSINESS

Mrs Bosnjak-Szekeres informed Directors that recruitment for two new Non-Executive and Associate Non-Executive Directors had commenced and was intended, in part, to function as succession planning to replace colleagues who would be retiring from the Board over the coming months and years.

TB/2023/074 OPEN FORUM

No questions were raised by members of the public prior to the meeting.

TB/2023/075 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.

Mr Hodgson confirmed that he felt that the Board had fulfilled its obligations and that the items discussed had managed to articulate the breadth and depth of the issues that the Trust was currently managing.

Mr Rehman stated that he had been pleased to the see the more challenging patient story presented earlier in the meeting and that he welcomed this approach. He added that he hoped to see similar stories presented in the future to help to provide a clearer picture of the kinds of issues currently facing the Trust's patients.

Mr Sarwar commented that there had been a good balance between recognising the challenges facing the Trust whilst also acknowledging the accomplishments of staff. He also noted the importance of the work being done by Mrs Butcher and the Staff Guardian service in supporting colleagues who were not experiencing the best of the Trust.

Mrs Gilligan agreed that the meeting had been a productive one and that she welcomed the support and challenge provided to the Executive team. She suggested giving consideration to extending the runtime of future meetings to ensure that each agenda item received the appropriate amount of consideration going forward.
Mr Sarwar thanked Mrs Gilligan for her suggestion and confirmed that he would give it more thought for future meetings.

Mr Sarwar concluded by noting the importance of stakeholders working with the Trust in developing commissioning frameworks going forward. He suggested that the Board may want to consider inviting partners to attend future meetings to get their views on this as system working continued to develop.

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

TB/2023/076 **DATE AND TIME OF NEXT MEETING**

Mr Sarwar informed Directors that the next Trust Board meeting would be taking place on Wednesday, 10 May 2023 at 13:00.

Mr D Byrne, Corporate Governance Officer

TRUST BOARD REPORT

Item 82

12 July 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	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 strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2. The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3. A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4. The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5. The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

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	September 2023	Agenda Item: September 2023.
TB/2023/040: Maternity and Neonatal Service Update	A full business case regarding the additional funding required to satisfy the Birth Rate+ nursing and midwifery staffing recommendations will be developed and presented to the Board for approval at a later date.	Head of Midwifery	September 2023	Update: The business cases presentation has been deferred to the July Quality Committee meeting and will now be presented to the Board in September 2023.
TB/2023/041: Staff Health and Wellbeing Report	A further update on the Trust's Health and Wellbeing Plan will be provided to the Board in six months' time.	Executive Director of People and Culture	September 2023	Agenda Item: September 2023
TB/2023/060: Patient Story	The refreshed Patient Experience Strategy for the Trust will be presented to the Board for endorsement in due course.	Chief Nurse	November 2023	Agenda Item: November 2023

Item Number	Action	Assigned To	Deadline	Status
TB/2023/064: Integrated Performance Report – Well-led	The Trust's year end position and the finalised Financial Recovery Plan will be presented to the Board for approval at its next meeting.	Executive Director of Finance	July 2023	A further update will be provided under the Well-led section of the Integrated Performance Report in July 2023.

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

12 July 2023

Item 84

Purpose Information

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

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

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

Report linkages

Related Trust Goal	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 strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2. The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3. A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4. The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5. The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by:

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

NHS England publishes 15-year workforce plan

NHS England has published its Long-Term Workforce Plan which sets out how the NHS will address existing and future workforce challenges by recruiting and retaining thousands more staff and working in new ways to improve the experience of staff and patients. Commissioned and accepted by the government, the plan provides a costed approach on developing the current NHS workforce to meet current and future demand and challenges and to support the health and wellbeing of the population. Over £2.4 billion has been committed on top of existing funding commitments to fund additional education and training places over the next five years. The three areas that NHS England have focussed on in the plan are:

- Train: Substantially growing the number of doctors, nurses, allied health professionals and support staff. This is underpinned by a £2.4 billion funding commitment.
- Retain: A renewed focus and major drive on retention, with better opportunities for career development and improved flexible working options. This comes alongside reforms to the pension scheme, with an aim to retain 130,000 staff working in the NHS for longer.
- Reform: Working differently and delivering training in new ways. Advances in technology and treatments will be explored and implemented to help the NHS modernise and meet future requirements.

Equality, diversity and inclusion plan launched

The NHS aims to enhance patient experience and support colleagues through its first equality improvement plan. Trusts will be asked to develop talent management strategies to reduce turnover, improve recruitment, and foster diversity in leadership roles.

By June 2024, measures such as mentoring, development opportunities, apprenticeship programmes, and graduate management training schemes should be implemented. The plan

addresses gender inequality and aims to provide psychological support for those who have experienced bullying, harassment, discrimination, or violence.

The equality, diversity and inclusion improvement plan sets six actions to enhance workforce and financial performance, including the establishment of internal targets to combat bullying, harassment, discrimination, and violence by March next year.

High-res skin imaging to speed up cancer diagnoses

Thousands of patients are set to benefit from faster diagnosis and treatment for skin cancer, thanks to the accelerated NHS implementation of 'teledermatology'. This innovative approach involves capturing high-quality images of skin spots, moles, or lesions using a compact lens, roughly the size of a 50p coin, that can be attached to a smartphone camera. Referred to as a dermatoscope, this simple technology enables specialised dermatologists to double their patient review capacity in a single day.

Currently used by approximately 15% of healthcare Trusts that offer dermatology services, teledermatology is scheduled to be rolled out across the entire country by July of this year. The use of dermatoscopes to take photos is also being expanded across GP practices, which can support people living in more in rural communities to get a faster diagnosis without having to travel for a specialist appointment or avoid the requirement to attend a specialist.

NHS measures to improve eye care and cut waiting times

New clinical guidance to reduce eye care waiting times in England has been published. The wide-ranging evidence-based interventions are designed to provide advanced diagnostic imaging before consultant referrals. This reduces patient anxiety, eases pressure on ophthalmology services, and saves money. Ophthalmology is currently the busiest outpatient speciality in secondary care and makes up almost 10% of the entire waiting list.

World-first NHS test for thousands with inherited blood disorders

The NHS is to introduce a ground-breaking genetic blood-matching test for thousands of people living with sickle-cell disease or thalassemia, lessening the painful side effects of transfusion treatments. The NHS will be the first healthcare system globally to offer blood group genotyping, which involves a thorough DNA analysis of each patient's blood group. This innovative program, a collaboration between NHS England and NHS Blood and Transplant (NHSBT), ensures more accurate matching of transfusion recipients with donated blood, enhancing treatment outcomes and reducing the risk of adverse reactions and the formation of antibodies that target donor blood cells.

NHS England publishes data on junior doctor industrial action in June

Data has been published which represents the impact of industrial action conducted by members of the British Medical Association (BMA), Hospital Consultants and Specialists Association (HCSA) and British Dental Association (BDA) on 14 to 17 June.

During the course of the four-day strike action there were 69,473 staff not at work, with 106,120 cancellations, a reduction in comparison with the previous strike action in April (195,000).

Changes in NHS England's Executive team

Sara Hurley, the Chief Dental Officer for England is standing down after eight years in the position to focus on new roles as a Non-Executive Director at Surrey Heartlands ICB and as an independent director at the University of Suffolk.

Kate Brintworth has been appointed to the role of Chief Midwifery Officer for England. Kate will pioneer the team in delivering the Three year delivery plan for maternity and neonatal services working alongside Matthew Jolly, National Clinical Director for Women's Health, and Duncan Burton, Deputy Chief Nursing Officer for England – Delivery and Transformation Programme.

John Quinn has been appointed as Chief Information Officer, with key responsibilities of running and evolving the NHS's critical technical infrastructure and managing cyber security for national services. John has been filling the role on a temporary basis since February and was previously the Executive Director of IT Operations and Enterprise Services at NHS Digital.

3. Regional Updates

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

Members of the Lancashire and South Cumbria ICB met on 3 May 2023. A recording of the meeting is available to watch online here: LSC Integrated Care Board :: 3 May 2023 Board Meeting (icb.nhs.uk)

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.

Feedback on 2023-24 planning submission to ICS

The ICB has received formal feedback from the NW Regional Team on the key points to address in the 2023-24 Planning submission. These are line with national expectations, for example Emergency Care and System Resilience, Elective and Cancer Care, Mental Health, Learning Disability and Autism, Workforce and Finance. As discussed at the May Board the financial challenge for the Lancashire and South Cumbria is significant, with the system submitting an overall deficit plan. This has resulted in the ICS being required to implement some additional controls with associated reporting, oversight and assurance arrangements. In response the ICS, in dialogue with the Provider Collaboration Board, is developing a system recovery and transformation architecture. This may result in additional controls being applied to individual organisations within the system.

Board to Board with Lancashire and South Cumbria Integrated Care Board

Colleagues from the Trust Board met with counterparts at the Lancashire and South Cumbria Integrated Care Board for a joint session at Fusion House on May 18, 2023. During this event, a presentation providing an overview of the Trust's success during 2022-23, as well as challenges and opportunities for enhanced collaboration was provided, with the aim of highlighting where improvements could be made. ICB colleagues, led by Non Executive Directors, were able to ask questions and further discuss issues. Feedback from the session was very positive from both organisations and further events will be scheduled.

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

PCB meeting – 16 March 2023

The PCB membership comprises the Chief Executives and Chairs of the five provider trusts in Lancashire and South Cumbria and meets monthly. It is Chaired by Mike Thomas, also Chair of University Hospitals of Morecambe Bay NHS Trust and the lead Chief Executive is Kevin McGee CEO of Lancashire Teaching Hospitals.

The Board receives updates on a number of standing items and strategic items and a Joint Committee has been established to give the PCB a mechanism via which to make decisions on a number of key programmes of work as agreed with Trust Boards.

An overview of the March meeting is included at the end of the report as Appendix 1. This includes progress made on plans to develop a central approach to corporate services and bank and agency management across the system.

Provider Collaborative colleague briefing

A colleague briefing took place on 31 May to update people on work by the local NHS Trusts to improve health and care across Lancashire and South Cumbria.

The event was led by Chief Executives from across the system included ELHT CEO Martin Hodgson and provided updates on our collaboration, working together through significant challenges, our clinical strategy, central services collaboration, and our people strategy.

The dates of next briefings are:

- **4 September 2023** (13.00pm –14.00pm)
- **8 December 2023** (11.30am – 12.30pm)
- **5 March 2024** (12.30am – 13.30pm)

New Hospitals Programme update

Funding of more than £20billion was announced by the Government for the next phase of the national New Hospital Programme. This includes two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary as part of a rolling programme of national investment in capital infrastructure beyond 2030. This will also include investment in improvements to Furness General Hospital.

Further detailed work is underway to assess the viability of potential locations for new hospital builds for both Royal Preston Hospital and Royal Lancaster Infirmary and to develop the required business cases. There is still further work to be completed in this area and additional sites may emerge over the coming period. Further information will be shared in due course. Find out more about the funding announcement on the New Hospitals Programme website here.

NHS chief pharmacist visits Barrow to see impact of work to tackle opioids problem

England's chief pharmaceutical officer, David Webb, visited Barrow to find out how local NHS colleagues are working together to improve medicine safety. The area has previously been under the spotlight for having one of the highest drug death figures in the North West, but over the past

five years pharmacy professionals have been working collaboratively in multi-disciplinary teams to help tackle the issue. Partnership working across different organisations has reduced the number of people in the town using opioids.

GPs and practice colleagues explained how they were able to halve the number of opioid prescriptions and improve outcomes for their patients, and the Morecambe Bay Medicines Optimisation Team discussed quality and safety initiatives in primary care.

New AI powered technology to help prevent vulnerable people falling

New artificial intelligence (AI) technology, in the form of a ceiling light, is being piloted in a care home to help prevent residents from falling. The pilot at Hartland House, a residential care home in Milnthorpe, is being funded by NHS Lancashire and South Cumbria Integrated Care Board (ICB) and involves the installation of AI-powered Nobi smart lamps in residents' bedrooms which monitor their behaviour and movement 24/7.

Around a third of people aged 65 and over, and around half of all people aged 80 and over, fall at least once a year.

The Nobi smart lamps have the ability to identify when a fall has occurred, ensuring the person is attended to swiftly. If a resident falls, the lamp detects this immediately and speaks to the resident, asking if they are okay. In the event of no response or a call for help, the intelligent lamp is pre-programmed to send a message to the care team plus an image to show where and how the fall has occurred; ensuring a rapid response and extra information about the fall, helping to prevent a future fall.

New dads can download DadPad for advice and support

Dads-to-be in Lancashire and South Cumbria are set to benefit from the DadPad app - an easy-to-use resource, developed with the NHS to provide support and guidance.

The DadPad app is a useful resource before baby arrives and after baby is born, and is designed to be used as a quick, on-the-go reference tool, allowing new dads to enjoy their babies and feel more confident about fatherhood.

Written by health professionals, DadPad is already up and running in other areas of the UK, and each area has content edited and amended to be bespoke to local needs, including details of nearby support groups and services. The app covers topics such as feeding, holding, changing and cleaning your baby, surviving without sleep and coping with crying and home safety and first aid.

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

There have been no applications of the Trust Seal since the previous meeting.

Industrial action

The Trust is managing the ongoing uncertainty of potential industrial action by professional groups and trade unions over a pay dispute with the Government. This has led to multiple periods of industrial action, requiring careful planning to minimise the impact on patients, families, and colleagues.

Most recently, British Medical Association (BMA) members including junior doctors (also known as post graduate doctors and clinical fellows) took part in industrial action at NHS organisations across England, including the Trust, from 7am on Wednesday 14 June to 6.59am on Saturday 17 June 2023. To ensure service continuity and safety, the Trust's senior leadership took significant steps, including establishing an incident room and holding daily meetings both in the run up to, during and after the industrial action took place.

The Trust keeps colleagues informed through regular updates and directs them to important information, such as patient flow and timely discharge. Externally, the Trust collaborated with the wider healthcare system to provide consistent messaging, encouraging people to attend appointments unless informed otherwise. This communication aims to reduce disruptions and maintain quality care during these challenging times.

Further industrial action by junior doctors is expected on Thursday 13-18 July, followed by two days of consultants strikes on Thursday 20 and 21 July, which will be the first time in nearly 50 years. More than 24,000 consultants in England voted in the BMA’s ballot (a turnout of 71%), with 20,741 (86%) voting for industrial action.

The Royal College of Nursing (RCN) confirmed that the recent ballot for Industrial action did not reach the legal threshold. The RCN reported approximately 140,000 ballot papers needed to be returned in the post to meet the threshold and only 122,000 were received by the closing date of Friday June 23.

Agenda for Change pay award

On 2 May the NHS Staff Council endorsed the pay offer that was made by the government for colleagues employed on Agenda for Change (AfC) terms and conditions of service. Eligible colleagues received payment in their June pay. Full details of the pay deal can be found on the NHS Employers website here, along with details of the new pay scales.

The NHS Staff Council has provided a joint statement as to how this decision was reached, which can be found here. This agreement impacts colleagues on Agenda for Change pay scales only, so does not include medical and dental colleagues.

EPR Update

The Trust successfully went live with its new Electronic Patient Record (EPR) on the weekend of 16 June 2023. The Emergency Department was the first area to be declared live on Saturday, 17 June at 6.29am. All remaining wards and areas followed in a planned and methodical order over the weekend, before concluding with Outpatients and Theatres on Monday 19 June.

Ninety percent of end-users had been trained on the system at the point of go-live and more than 1,000 Superusers and Floor Walkers were recruited and specially trained to support colleagues with the roll out. Three briefings were held each day between the Superusers, Floor Walkers, Gold Command and Oracle Cerner experts as a way to connect, escalate issues and answer questions whilst being deployed to specific areas to help. These support networks continue to grow and are being utilised by colleagues right across the Trust to resolve problems and share ideas.

Whilst the EPR is live across all Trust sites, this is just the beginning of the digital journey and the Trust now needs to stabilise the system whilst colleagues get used to a new way of working. Throughout July, the eLancs team will work on bringing online additional elements to enhance the EPR further.

Health and wellbeing support

Our colleagues have demonstrated exceptional dedication and focus in implementing the new Electronic Patient Record (EPR) system, as well as managing very high demand for services across all settings.

To support the health and well-being of our colleagues, a comprehensive package of support remains in place. This includes provisions such as food, drinks, and mini therapy sessions like massages, allowing individuals to recharge and enjoy some much-needed downtime.

With the assistance of ELHT&Me and funding from the Staff Lottery, the Well Team organised a delightful surprise for our colleagues in the hot weather — a visit from ice cream vans. This treat offered our hardworking colleagues the opportunity to enjoy in a free ice cream, further boosting morale and showing appreciation for their efforts.

Patient waiting times reduced through collaboration

Patient waiting times for some diagnostic tests have improved because imaging services are being delivered as a collaborative network across the four hospital Trusts in Lancashire and South Cumbria.

During the COVID-19 pandemic in April 2020, 47% of patients were waiting over six weeks for their CT scans. This has now reduced to below 1% because the trusts are working extremely hard to ensure patients have better access to diagnostics no matter where they live.

Part of this involves offering patients whose nearest hospital has longer waits access to a scan more quickly at a hospital with a smaller waiting list. This means some patients are travelling further to be seen more quickly.

The Diagnostic Imaging Network, made up of the four acute hospital trusts (Blackpool Teaching Hospitals, East Lancashire Hospitals, Lancashire Teaching Hospitals and University Hospitals of Morecambe Bay), provides the following imaging scans: CT, MRI, X-Ray, DEXA, radionuclide and non-obstetric ultrasound.

By working together, elective imaging activity across the network has increased. As of 31 March 2023 our Network is delivering 150% CT and 137% MRI scanning activity compared to pre-COVID levels in 2019/20.

New network for colleagues

A new network has been set up for international and overseas colleagues. The first meeting took place in May. The group is part of the Trust's ongoing support for colleagues and a chance for international and overseas colleagues to meet and share experiences.

The peer support group will be able help influence and improve the work environment – including recruitment, access to training and development, career progression, coaching and mentoring, and wellbeing.

Launch of the SPE+ Leadership Core Pathway

The Trust's Organisational Development Team welcomed the first cohort of leaders to the SPE+ Leadership Core Pathway. Over the coming months the cohort will complete several leadership modules and undertake a quality improvement project.

The Executive team attended the event to welcome the group to their leadership journey and share their thoughts on the importance of leadership within the Trust.

This is the first of several elements of the Trusts SPE+ Leadership and Management Strategy. There are many more exciting things to come, including leadership and management development modules, an ELHT Leadership Forum and an SPE+ Core Management Pathway.

Birthing centre praise in high profile podcast

Trust's birthing centre has been praised in a national podcast. Davina McCall called Blackburn Birth Centre "the place to go" in the latest episode of Making the Cut, a wellness podcast with Michael Douglas. The namecheck came after Great Harwood-based yoga teacher Tessa Clemson gave birth to her second baby at the birth centre last week and shared her birth story with Davina.

BBC's Morning Live

The Trust was approached by BBC's Morning Live programme after a patient's relative requested a shout-out from Dr Xand for a young patient who was nervous about getting hearing aids. The production company suggested that Dr Xand meet the patient during her hearing aid fitting and he agreed with her family's permission.

Dr Xand also met with Andrea Curran, Lead for Paediatric Audiology, at BGTH, to discuss child hearing loss and stigma surrounding hearing aids. This collaboration aims to raise awareness and support Ruby while highlighting the importance of addressing hearing loss in children. The programme was due to air the week commencing 3 July 2023.

ELHT&Me in the news

The hospital charity continues to go from strength to strength and is becoming a focus for media interest, particularly around the ongoing progress of our therapy dog Alfie who is now one-years-old. ITV Granada spent time on site with the team for a feature on Alfie's work as ELHT 'Head of Happiness' and the benefits of investing in the service, including interviews with the Chief Executive and Head of Charity which was widely sharing on social media after broadcast with lots of good feedback.

Supporting patients in their own home

Over 14,000 East Lancashire residents have now been supported to return home from hospital at the earliest opportunity through the Home First team at the Trust and Lancashire County Council. The team meet patients who are ready for discharge but may have aftercare needs, to see how they can be helped to remain at home safely.

They visit them at home, put in place equipment and organise support, working closely with a range of other community services including Supporting Together (home care), Age UK, Carers Link, hospice services and a range of community health services. This has reduced unnecessary delays in hospital when individuals are well enough to leave.

Trust hosts General Medical Council visit

Charlie Massey, the Chief Executive of the General Medical Council (GMC) paid a visit to Royal Blackburn Teaching Hospital in May. The visit provided an excellent opportunity for Mr Massey to witness first-hand the exceptional standards of patient care and professionalism that East Lancashire Hospitals Trust consistently upholds.

As the leading regulatory body for doctors in the UK, the General Medical Council plays a crucial role in ensuring the highest standards of medical practice and patient safety.

Mr Massey spent a significant portion of the visit speaking with doctors and support colleagues, gaining insights into the challenges and triumphs they experience in their daily duties. The visit aimed to strengthen the relationship between the GMC and the Trust, while fostering a deeper understanding of local healthcare needs, both within the local communities and across the integrated healthcare system.

Sir Julian Harley approves of our improvement

Chief Executive for NHS Providers, Sir Julian Hartley's visit to ELHT left him thoroughly impressed with the Trust's improvement programme. He observed a strong and effective connection between the executives and frontline teams, emphasising the importance of collaboration and communication in achieving their goals. Additionally, he noted the close integration between acute and community services, as well as their seamless coordination with system partners.

This integrated approach ensures comprehensive and holistic care for patients throughout their healthcare journey. Most notably, Sir Julian was struck by the evident pride exhibited by ELHT's colleagues, a testament to their dedication and commitment to delivering high-quality healthcare services.

NHS CONFED 2023

The annual NHS confederation Expo took place at Manchester Central conference centre on June 14 and 15, 2023, which co-incided with a period of industrial action at the Trust. For this reason, attendance was limited to the Chief Executive, who was present on the first day alongside a number of other health and care leaders and their teams at what is considered to be one of the biggest health and care conferences in the world. Sessions included some high profile speakers

including the Chief Executive of NHS England Amanda Pritchard, show Health Secretary Wes Streeting and Mathew Taylor, the Chief Executive of NHS Confed.

£2m research project

The Trust will be leading a major UK research project after securing £2million of funding. The National Institute for Health Research approved the grant following a bid by a national team of clinicians, academics and patients, led by Mr Panos Kyzas, a Consultant Surgeon at ELHT.

The research will look into the use of antibiotics following surgery for mandible fractures, something that impacts over 6,000 people every year. Mandible fractures are the most common facial fractures and often need surgery, which comes with a risk of infection afterwards. Antibiotics are often prescribed to reduce that risk. The trial will take place at various hospitals across the country, looking at different antibiotic approaches following the surgery.

SMOCH team's national recognition continues

Colleagues from our Specialist Medicines Optimisation Care Home (SMOCH) team were invited to speak at the annual British Geriatrics Society conference to present their anticholinergic project and provide further information on guidance and patient outcomes.

The event follows the team's recent positive work within the community, which includes supporting local nurses and carers to improve the quality of life of older residents through medicines optimisation. Jane Shanahan and Alison Marshall, Senior Pharmacy Technicians from the SMOCH team, showcased their work and shared best practice, before taking part in a question and answer session from the audience.

Colleagues join King's Coronation celebrations

Two ELHT colleagues became a part of history as they joined NHS colleagues in a prime seat outside Buckingham Palace to watch the ceremonial procession on Saturday.

Shafiq Sadiq, Armed Forces Veteran Advocate Support Officer and Tehseen Ganchi, Diagnostic Radiographer, both based at Royal Blackburn Teaching Hospital, were part of 200 NHS colleagues and volunteers all seated in a purpose-built grandstand with a unique and memorable view of the ceremonial processions up and down The Mall. Colleagues were invited by NHS England to put their name into a draw to win a pair of tickets.

Also at the Coronation was Sue Chapman, Deputy Divisional Director for Estates and Facilities who was watching from the Abbey after being invited because she has been awarded a British Empire Medal.

SPEC Success

The Gynaecology and Breast Care ward at BGTH has been recognised for delivering outstanding care for a fifth time in a row.

Colleagues on the unit were presented with the gold SPEC award, by Chief Nurse Peter Murphy, given after a team receives five consecutive green Nursing Assessment and Performance Framework (NAPF) assessments – the first time this accolade has been awarded to a ward at the Trust.

SPEC awards are presented to departments that have three or five 'Green' ratings on their unannounced Nursing Assessment and Performance Framework (NAPF) inspections.

A number of teams have all achieved a further green NAPF outcome and presented at the SPEC panel, making them eligible for Silver or Gold status. Colleagues described quality improvement initiatives that have been undertaken and how they will showcase this to the rest of the organisation.

The panel agreed that the wards/ areas should be recommended for this prestigious status following the review.

Following approval from the Trust Board, the Children's Medical Unit, side A, and High Dependency Unit, Lancashire Women's and Newborn Centre Theatre and the Coronary Care Unit will receive a Silver award and Ward 15 and C10 will join our elite Gold status, delivering safe, personal and effective care at all times.

Mayor's chosen charity

ELHT&Me has been named as one of the chosen charities of Councilllor Parwaiz Akhtar, Blackburn with Darwen Borough Council's newly appointed Mayor for 2023-24. He will be a familiar face to many at ELHT, as he is a Health Care Assistant on Critical care at the Trust.

Our fundraising is looking forward to being part of bringing our community together throughout his Mayoral year to raise funds that benefit us all - our colleagues, patients and visitors throughout every area of care.

NHS anniversary

Celebrating 75 years of the NHS

A number of planned key activities will mark the week of the anniversary. Colleagues have also been encouraged to arrange their own ways to mark the anniversary and share their celebrations.

Completed Activity

- **NHS 75 Conversation**

  On behalf of NHS Assembly, the Trust held a special Teams Brief which has had 231 views. A set of questions were used to guide the conversations. Responses and views were collated and shared with the NHS Assembly, who will provide a summary to NHS England on the key learning from the many conversations taking place across the NHS.

- **NHS 75th Toolkit**

  A toolkit was issued which incorporates Teams backgrounds, comment cards (memorable person, best day in the NHS, ect) for people to create their own NHS 75 ward boards.

Celebration Week Activity

- **Hospital environments**

  The main entrances of the hospital sites will be dressed to celebrate and welcome in the anniversary week. Additional decorations for the RBTH and BGTH entrances are being provided from Equans. The reception back lights at RBTH will also be turned blue on Monday 3 July for the week of the celebration.

  Anniversary flower planters have been created and located outside the main entrance to complement the main entrance and walkway to the car park which are also illuminated blue.

- **NHS75 stories**

  A number of national media outlets have confirmed coverage of a selection of the NHS stories. These include stories about premature twins who were treated in NICU and an ELHT colleague who was the recipient of a double lung transplant.

- **Raising a cuppa for the NHS**

  Tea party kits have been produced to encourage colleagues to raise a cuppa to toast the NHS. It includes printable materials, including invitations, cake toppers, paper coasters and decorations, including NHS 75 bunting. Anyone organising a tea party will be encouraged to share photos so the activity can be highlighted around the Trust.

  During the anniversary week, Executive Directors have been invited to visit sites to express their gratitude and thanks. Providing an opportunity to take time to sit down and raise a cuppa

for the NHS with colleagues creating an environment for open conversations about experiences and memories of the NHS and ELHT.

- **Anniversary benches**
  Equans very generously donated two benches with 'Happy 75th Birthday' plaques. The benches will be presented to CEO Martin Hodgson on Wednesday 5 July to be placed on the RBTH and BGTH sites.

- **NHS 75 Special Teams Brief**
  Team Brief on Tuesday 4 July will be an NHS 75 Special, again providing an opportunity for colleagues from across the Trust to come together at 12noon to raise a cuppa and share some of the NHS 75 stories. During the event, Executive Directors will announce their chosen winner of the NHS 75 Tea Parties.

  Our Star Awards will be launched as part of the live event. This year they will have a special NHS 75 theme, with new categories, including a special award in memory of Jasper, the Trust's therapy dog. Awards winners will receive a special trophy and there will also be themed party packs for all the nominees.

- **Mayors Tea Party**
  The Mayor will be hosting a tea party on 4 July to celebrate the personal and professional achievements of special group of people. These include colleagues from ELHT and Blackburn with Darwen council.

- **Parliamentary Awards**
  Vicki Stevenson-Hornby, Pancreas Specialist Nurse, has been shortlisted for the national awards in the category 'The Nursing and Midwifery Award'. Vicki has been instrumental in helping reduce waiting times for patients between referral and confirmed diagnosis.

  The national awards ceremony will take place on Wednesday 5 July, at the Queen Elizabeth II Centre in London. The MP who submitted the nomination has also been invited.

- **NHS 75 Give Aways**
  Nominations for teams or individuals who deserve a special 75th celebration surprise will be encouraged through our closed Facebook group, OLI and bulletins. Winners will be chosen at random to receive one of 65 bundles of celebration cakes to enjoy while raising a cuppa for the NHS.

- **NHS 75 menu**
  A special celebration menu will be available in our restaurants during the week of the anniversary.

- **NHS75 birthday on Radio Lancashire**
  Radio Lancashire's Graham Liver will be interviewing Martin Hodgson for the Breakfast Show on Tuesday 4 July.

  On Wednesday 5 July, Radio Lancashire will be live from different locations on the RBTH and BGTH sites, interviewing colleague during the course of the day.

- **Lighting up blue**
  The lighting of the Wainwright Bridge has been confirmed and will the first time the bridge has been illuminated. RBTH entrance and walkway and BGTH phase 5 entrance and Fairhurst building will also be lit up blue.

- **NHS 75 Magazine**
  The 75 stories will be collated and formed into a highly attractive magazine to share all the amazing stories in one place. This will be published on our website as a flip-book on Friday 7 July and shared widely both internally and externally.

- **Charity Activity**
  ELHT&Me, the hospitals charity, has arranged a wide range of ways people can get involved in the NHS 75th birthday celebrations and raise vital funds at the same time. These include:
  - NHS Big Tea Party
    The charity will be at Morrisons' championing the Big Tea Party on 4 July in Nelson and 14 July in Great Harwood.
  - Big NHS 75 Raffle
    The NHS 75 raffle will be drawn on Wednesday 5 July, with prizes of £1,000, £500 and £250. All prize funds have been generously donated by Consort, Equans, Walter Carefoot and Sons and O'Neil and Partners.
  - Blackburn 10K
    Organised by RunThrough and hosted by Blackburn with Darwen Borough Council, the Blackburn 10k will open for entries on 4 July in aid of ELHT&Me. The race will take place on 10th December 2023 starting and finishing inside Ewood Park.
  - Manchester to Blackpool bike ride - Sunday 9 July
    A popular event with four different grades, to suit every ability from fun cyclist to

serious competitor. Riders have the option of taking on the journey either as a group or individually. This year CEO Martin Hodgson has signed up to ride for ELHT&Me.

- NHS 75 badge
  A limited edition pin badge in celebration of the NHS 75 anniversary is available in the Charity Hub or from their online store.
- Wear it Blue
  A great opportunity for the local community, businesses, schools and social groups to sport something blue for the day and raise funds for ELHT&Me.
- Briercliffe Festival
  ELHT&Me will be attending the gala to promote the charity and encourage sign up of the activities planned.
- The big NHS Tee off
  A charity golf day is to be held at Clitheroe Golf Club on Friday 18 August. The event includes an 18 hole, four-ball Stableford competition, a two-course meal, evening presentation with entertainment and prizes for the top three finishing teams.

- **NHS England Activity**
  There are a wide range of ways patients, colleagues and the public can get involved with the NHS's 75th birthday celebrations. The Trust has been sharing these events to amplify the message. These include 30 Days Wild, photography competition in partnership with Fujifilm, NHS Ambassador programme visiting schools to inspire children and young people to consider a career in the NHS, and NHS England has teamed up with ParkRun to host ParkRun for the NHS on Saturday 8 and Sunday 9 July.

Armed Forces Day

As part of ongoing support for veterans, the Trust commemorated Armed Forces Day with a community event at Royal Blackburn Teaching Hospital.

The Armed Forces Veterans team took over the main entrance with stalls from Royal British Legion, Blackburn Rovers Football Club, 207 Squadron, 206 Field Hospital Reserves, 4 Lancashire Reserves and Healthier Heroes, as well as a display of military vehicles.

The event was open to patients, colleagues and members of the public, as part of the Trust's support of the Armed Forces community.

As well as Armed Forces Day, the Trust has celebrated a range of awareness days over the last two months, shining a light on the work of a variety of colleagues and services.

These have included:

- Dying Matters week
- Men's' Health week
- Legs Matter week
- Learning Difficulties week
- Continence week
- Pathology week
- Breastfeeding Celebration week
- National Healthcare Estates and Facilities day
- What Matters to You day

Awards

Regional success in NHS Parliamentary Awards

Vicki Stevenson-Hornby, a pancreas specialist nurse at the Trust has been crowned the regional winner of the Nursing and Midwifery category at the NHS Parliamentary Awards – and will now go on to compete for the national prize.

She has been instrumental in supporting the development of the Trust's diagnostic pathway, helping reduce the time patients wait between referral and confirmed diagnosis.

Her work was put forward for the NHS Parliamentary Awards by local MPs Sir Jake Berry, Nigel Evans, Antony Higginbotham and Andrew Stephenson.

Veteran team shortlisted for Services award

The Veterans team at ELHT, who have so far supported more than 1,300 veterans since it was set up last year, are nominated in the Most Outstanding NHS/Healthcare category of the Services Awards.

The Awards celebrate the very best of the Armed Forces and Emergency Services. Winners will be announced at a glittering black-tie event on Wednesday, 28 June at the Stadium of Light, Sunderland.

Trust shortlisted for HSJ Patient Safety Awards

Teams from across ELHT have been shortlisted for major awards recognising safety, culture and experience in patient care. The HSJ Patient Safety Awards has the ambition of helping 'drive improvements in culture and quality across the NHS.' The annual awards recognise and reward the hard-working teams and individuals who strive to deliver improved patient care. In total, the Trust has been shortlisted for three awards:

Improving Care for Older People Initiative of the Year

- **East Lancashire Hospitals Trust** - Intensive Home support Service and Emergency department collaboration

Patient Safety Team of the Year

- **East Lancashire Hospitals Trust** - Improvements in outcomes for patients undergoing ablative oncological head and neck surgery, and reconstruction

Staff Wellbeing Initiative of the Year

- **East Lancashire Trust** - Workforce Wellbeing

Shortlist success for HR team

The Trust been named a finalist for the Best Human Resources/Learning and Development and Organisational Development Team of the Year in the Chartered Institute of Personnel Development People Management Awards for Lead Employer Mass Vacinations.

The awards recognise the talent and outstanding performance across the professions commending success across all sectors and within businesses of all sizes. Winners will be announced on Thursday 21 September at a ceremony in London.

Hyndburn Rural District Nurses presented with Cavell Trust award

An inspiring national awards programme, Cavell Star Awards are given to nurses, midwives, nursing associates and healthcare assistants who shine bright and show exceptional care to one of three groups of people: their colleagues, their patients or their patients' families.

The Hyndburn Rural District Nurses received a Cavell Trust award for providing exceptional patient care to the community.

Apprenticeship awards

A number of colleagues were shortlisted at this year's Lancashire and South Cumbria NHS Health and Social Care Apprenticeship Awards 2023.

Mia Louise Holden, based at BGTH's Booking Centre, won non-clinical apprentice of the year and Emma Gudgeon, Heather Thompson and Maria Nowell were highly commended in their categories.

Nominees must be working towards, or have completed in the last 12 months, an apprenticeship at an NHS health and social care organisation. The awards celebrated the very best apprentices and took place in May.

ELHT&Me are Creating Better Futures

The Trust's charity ELHT&Me attended the first in person Creating Better Futures. The awards are designed to recognise excellence and drive more activity across our portfolio in initiatives that represent four sustainability priorities: Climate, Environment, Communities and People.

ELHT&Me were awarded the Gold Standard Communities and People award for the creation and delivery of the Charity hub at the main entrance of RBTH.

Nursing Times Awards 2023

The Trust has been informed that our entry for Improvements in the provision of end-of-life care has been shortlisted in the Nursing in the Community category.

The awards bring together the nursing community to shine a light on the brightest talent in the profession and recognise those of making nursing innovative, patient-focused and inclusive. It has never been more important to recognise the incredible contributions of the nursing profession.

Winners will be announced at a celebration event on Wednesday 25 October.

Emma Cooke
Joint Deputy Director of Communications
June 29, 2023

Appendix 1

Provider Collaboration Board – 21 June 2023

- The Provider Collaboration Board (PCB) met on 21 June 2023. It received updates on the following standing items: system pressures and performance updates within urgent/emergency care and elective care; mental health and learning disabilities, and finances.

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

- The Joint Committee has been established to give the PCB a mechanism via which to make decisions on key programmes of work as agreed with Trust Boards. Updates on central services, the Lancashire and South Cumbria (LSC) collaborative bank development and the pathology network were discussed under Joint Committee working items.

1. System pressures – acute

- Average daily attendances across May were at a record high: around one per cent higher than the previous peak level in December 2022. Despite three bank holidays and school half term within the month, the number of people visiting LSC hospitals increased sharply from April. However, most of the increase was of low acuity and so emergency admissions via ED remained relatively stable.

- Despite the increase in activity, the Trusts' four-hour performance was up slightly in May compared with March/April and back above the 76% target.

- There had been an increase of 64 people waiting over 78-weeks for treatment at the end of April; this was a direct consequence of strike action. NHS England expects that all systems will eliminate 78-week waits by the end of June, including patients waiting due to capacity and patient choice. There have, however, been many highlights across the Elective Recovery Programme, with specialist advice overperforming against the 2023/24 national standard of 21% (at 26%) and theatre utilisation remaining in the second top quartile having been the fourth highest ICB in the country at the end of February.

2. System pressures – mental health and learning disabilities

- Pressures within the mental health urgent care pathway are being primarily driven by bed capacity which is around 30% below the national average, and the subsequent result of very high / 100% occupancy and the inability to admit in a timely manner.

- Capacity pressures are exacerbated by reduced flow out of acute mental health beds. Two factors were noted: lack of available specialist placements (clinically ready for discharge) and inpatient processes, including clarity of pathways. The latter are a particular focus for Trust improvement while system partners are supporting the former. While demand within mental health urgent care is moving back towards pre-Covid levels, measures to further reduce this pressure will be beneficial.

- An improvement management group has been put in place to address issues of increased demand and recruitment challenges across children and young people's mental health services, with mutual aid continuing to be offered from system partners. There is still a high demand and waiting time for ADHD patients and there is currently an exploration of private providers to support with this.

3. Central Services Transformation Update

- A paper for decision was brought to the meeting about central services' transformation phasing and next steps in moving to our ONE LSC model, including proposed governance, leadership and communication arrangements.

- The programme will transform the way we deliver non-clinical services to remove duplication and improve efficiency and effectiveness to better support patient care and offer colleagues a great place to work.

- The Joint Committee agreed that transactional operational central services will be brought together into one 'umbrella' service hosted by one of our NHS Trusts. This is known as a 'Host Trust Model'. The identity for the services that will be within our new target operating model was agreed as 'ONE LSC', which stands for 'ONE Lancashire and South Cumbria'.

- Services will begin new ways of working from September 2023. In practice this means teams actively working together within a system-wide leadership arrangement to agree the right approach for their services.

- The Joint Committee stressed that the planning for new service operating models should be inclusive, with teams engaged from across the system in considering the right approaches for their services.

- Updated governance arrangements were discussed. The Joint Committee also acknowledged the importance of ensuring Trust Boards are fully engaged in helping to support key changes and have the ability to influence the decision-making processes of the PCB.

- The operational leadership structure will start being put in place before September 2023. Clear and transparent appointment processes will take place to ensure equity of opportunity for recruitment to any roles within the new arrangements.

- Included in the paper was a communications plan. This is a live document developed through a process of engagement with colleagues; suggestions to further improve and develop our collective approach to communications and engagement continue to be very welcome.

- These proposals were agreed by all Chief Executives and Chairs who form the Joint Committee, allowing us to move to the next stage in our journey.

4. Collaborative Bank Development

- The development of a system-wide collaborative bank is one of a range of programmes ongoing through the Workforce Resilience and Sustainability Programme, which forms part of the Central Services Portfolio. This includes an underpinning strategy to develop a workforce for the future.

- The aim of the collaborative bank is to improve patient experience, boost our temporary workforce and reduce agency spend.

- The Joint Committee endorsed the recommended solution, the result of a six-month market engagement process to determine the best option to help us establish and administer our collaborative bank.

- We are now entering a commercial phase of the process to make sure we can achieve best value for money in our transitional arrangements, therefore details of the preferred solution are currently confidential.

- The Joint Committee acknowledged the incredibly hard work of all of those involved in the project to date.

5. Pathology Service – Collaboration agreement

- The Joint Committee approved the Collaboration Agreement which defines the legal and contractual relationship between the four acute Trusts regarding the Lancashire and South Cumbria Pathology Service. Among other things it includes the nature of the services covered by the collaboration and the terms of reference for the new Pathology Network Board.

- The Pathology Network Board is a sub-committee of the PCB, with certain strategic matters relating to the pathology service delegated to the Joint Committee for decision making.

- The work of Prof Anthony Rowbottom and Tim Bennet in developing the network approach to pathology delivery was commended by the PCB.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

12 July 2023

Item 86

Purpose Information
Action
Monitoring

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

Summary: This report provides an overview of risks held on the Corporate Risk Register and live risks held on the Trust Risk Register

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

Report linkages

Related Trust Goal

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

Related to key risks identified on assurance framework

1. The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
2. The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
3. A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
4. The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
5. The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by:

N/A

Executive Summary

1. 18 risks are currently held on the Corporate Risk Register (CRR)
2. 36 risks scoring 15 + are held on the Risk Register requiring presentation at the Risk Assurance Meeting (RAM)
3. Since the completion of the Mersey Internal Audit Agency Risk Management Audit (Jan 22) open risks have reduced by 45% from 1,709 to 931 risks
4. Mersey Internal Audit Agency has recently completed a further review of the Trust's Risk Management Framework (April 23); a final report is awaited
5. The profiling and mapping of strategic and operational risks has been completed

Risk management and the impact of taking / not taking action

6. Risk management is the process of identifying, assessing, managing, controlling and reviewing risks in order to minimise harm.
7. It is a key health and safety legislative requirement and a key line of enquiry of inspection used by the Care Quality Commission (CQC) when monitoring healthcare service provision.

Corporate Risk Register (CRR) Performance Activity

8. A total of 18 risks are currently held on the CRR.
9. 1 risk has been removed from the CRR since the last meeting:
   a) Risk ID 8960 – 'Risk of undetected foetal growth restriction and preventable stillbirth and compliance with pulsatility index ultrasound guidance' – risk score reduced to 3
10. 1 risk has been removed and replaced since the last meeting:
    a) Risk ID 9439 – 'Failure to meet internal and external financial targets for the 2022-23 financial year' – closed and replaced with Risk ID 9771 'Failure to meet internal & external financial targets for 2023-24 Financial year'
11. 1 risk detail has been amended:
    a) Risk ID 8126 'Potential to compromise patient care due to lack of Trust-wide advanced Electronic Patient Record (EPR) System'. ePR has been implemented, however, factors remain around the implementation; these are continuously being monitored and evaluated.

Risk Management Performance Activity (Trust Wide)

12. Key points of note since the last meeting.

a) Open risks have reduced by 45% from 1,709 (Q4 2021 – 22) to 937.

b) Open risks deemed 'significant' or 'moderate' have reduced by 42% from 1,368 (Q4 2021 – 22) to 789.

c) There are currently 608 risks over 3 years old; of these, 449 are live risks and 147 are tolerated risks.

d) Overdue risks have increased, from 230 (Q4 2021-22) to 256, an 11% increase

e) Tolerated risks exceeding their 'review date' continue to remain below 5%.

f) Clinical risks account for 59% (n = 602) of the total number of open risks, followed by health and safety risks, 23% (n = 231). Numbers of open risks for the remaining risk types are, in comparison, much lower.

g) Patient safety risks remain the highest clinical risk sub-type, accounting for 34%, followed by the management of medical devices (16%), workforce staffing (13%), 'other' (13%), medication (9%), sub optimal care (7%), missed diagnosis (3%), infection control (3%) and delayed transfers (2%).

h) Manual handling risks remain the highest health and safety risk sub-type, (32%) followed by radiation (13%), fire safety (11%), violence and aggression (11%), environmental (8%), Sharps (7%), equipment management (6%), occupational driving (3%), waste management (4%), 'other' (2%), control of substances hazardous to health (COSHH) (1%) and the management of contractors (1%).

i) Highest numbers of open risks are held within Diagnostics and Clinical Services (DCS) (29%) followed by Surgical and Anaesthetic Services (SAS) (25%) and Corporate Services (19%).

Mitigations for risks and timelines

6. Work to improve the health and safety risk sub type categories has been completed; this will act as a benchmark for all other risk types.

7. The risk sub type category of 'other' does not add value to the risk identification or management process. It is anticipated that this category will be removed following the introduction of RADAR.

8. For open risks where the current risk score has met its target score, and the control measures employed are well managed, sustained or mitigated against, the risk can be closed or tolerated.
9. Improving the standardisation of risks associated with delayed transfers, missed diagnosis and the provision of sub-optimal care are being reviewed by divisions.
10. The number of open risks are expected to decrease with better utilisation of lead specialists and subject matter experts.
11. A targeted review of risk management performance in Estates and Facilities, Family Care, Radiology and Security management has been completed.
12. The risk management framework and escalation process has been reaffirmed to all risk handlers and/or leads.

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

13. Leaders and managers have oversight of the strategic and operational risks / threats to enable appropriate and effective action to remove, reduce or control them.
14. The profiling and mapping of strategic and operational risks and its links to the Board Assurance Framework remains crucial to its success. A risk profiling and mapping exercise has been completed, awaiting approval.
15. A proforma has been developed and agreed by the Senior Executive Team for use within future senior management risk management reports. It is anticipated that this will improve the quality of risk information held on the CRR. This new proforma is to be extended for use for all risks scoring 15 or above for presentation at RAM.

Resource implications and how they will be met

16. The Health, Safety and Risk Management team continue to operate with very limited resource and capacity.

Conclusion of Report

17. Effective risk management performance supports the Trust in achieving its strategic and operational objectives.
18. Improving the quality of risk information held and better utilisation of lead specialisms and or subject matter experts remains a key focus area.

19. Limited resource to support the risk management framework is impacting on the quality of risks held. In addition, the supporting of colleagues in effectively managing their risks.

Next Actions

20. A summary of key focused activity.
    a) The continuation of cosmetic improvement works regarding the quantity and quality of risks held on the risk register.
    b) Strengthening links between the Board Assurance Framework and the profiling and mapping of strategic and operational risks and improving corporate governance arrangements.
    c) Targeted review of all risks held across DCS and security management.
    d) Continuation of targeted work with lead specialisms and or subject matter experts.
    e) Embedding risk management, including risk assessment training, as part of the management competency framework, with support from the Good Governance Institute in its delivery.

How the decision will be communicated internally and externally

21. Decisions regarding the validity of risks and any subsequent risk scores are made through Divisional Quality and Safety meetings, Committees and or Groups with the process of escalation through approved governance frameworks.

How progress will be monitored

22. Progress in monitoring the quality and integrity of open risks held on the risk register, in particular, those with a current risk score of fifteen or above, is undertaken at the monthly Risk Assurance Meeting (RAM) and Executive Risk Assurance Group (ERAG) meetings.

23. Senior Executive Leads are nominated by the ERAG to monitor and review risks scoring fifteen or above that are approved onto the corporate risk register and ensure they are being well managed or mitigated in accordance with the risk management framework.

24. Mersey Internal Audit Agency (MIAA) were commissioned by the Trust in 2021 – 22 to audit its risk management framework. MIAA concluded that the Trust had an adequate system of internal control, however, identified some areas of weakness in design and / or inconsistent application of controls. A second audit has since been completed (April 2023); the overall objective of the audit was to ensure that core risk management controls have been established and maintained. A final reported is awaited.

Appendices

Summary of the CRR

Detailed CRR

J Houlihan, Assistant Director of Health, Safety and Risk

R Derbyshire, Health, Safety and Risk Manager

03 July 2023

Summary of the CRR

Corporate Risk Register						
No	ID	Where is the risk being managed	Title	Risk Score (current)	Effectiveness of Controls (taken from Datix)	Changes since last report
1	9771	Trust Wide	Failure to meet internal and external financial targets for the 2023-24 financial year	25	Adequate	↑
2	9557	Trust Wide	Patient, staff and reputational harm as a result of the Trust not being registered for mental health provision	20	Limited	↔
3	9336	MEC	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery	20	Limited	↔
4	8126	Corporate	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	DCS	Potential delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology	16	Limited	↔
9	8033	Trust Wide	Complexity of patients impacting on ability to meet nutritional and hydration needs	16	Limited	↔
10	7165	Corporate	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	16	Limited	↔
11	6190	SAS	Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales	16	Limited	↔
12	8839	SAS	Failure to achieve performance targets	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	8257	DCS	Loss of transfusion service	15	Limited	↔
15	7764	Corporate	RBH - breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke	15	Adequate	↔
16	7008	Trust Wide	Failure to comply with 62-day cancer waiting time target	15	Limited	↔
17	5791	Corporate	Failure to recruit to substantive nursing and midwifery posts may impact on patient care and finance	15	Adequate	↔
18	4932	Trust Wide	Patients who lack capacity to consent to placements in hospital may be being unlawfully detained	15	Limited	↔

Risks removed from the CRR since the last meeting

No	ID	Where is the risk being managed	Title	Risk Score (current)	Effectiveness of Controls (taken from Datix)	Changes since last report
1	9439	Trust Wide	Failure to meet internal and external financial targets for the 2022-23 financial year			Closed
2	8960	Family Care	Risk of undetected foetal growth restriction and preventable stillbirth and compliance with pulsatility index ultrasound guidance	3	Adequate	↓

Corporate Risk Register Detailed Information

No	ID	Title				
1	9771	**Failure to meet internal and external financial targets for the 2023-24 financial year**				
Lead		Risk Lead: Charlotte Henson Exec Lead: Michelle Brown	**Current score**	**25**	**Score Movement**	New risk
Description		Failure to meet the Trusts financial plan and obligations together with the failure to meet the wider Lancashire and South Cumbria ICB system financial plan. Failure to meet the plan and obligations is likely to lead to the imposition of special measures and limit the ability of the Trust to invest in the services that it provides. The financial risk is made up of the - lack of control as in the current wider NHS system financial regime, the funds are allocated to the ICB to agree how they are allocated our across the partner organisations - A 7.4% efficiency target of £54.6million for the Trust, a level that has never been achieved previously - a system financial gap of £12m within ELHTs financial plan that is within the 7.4% - A system financial deficit that still needs closing -unknown additional consequences of the impact of the ePR -unknown extent of inflation rates -unknown impact of the pay awards -unknown impact of industrial action				
Controls and Assurances in place		Controls 1. Robust financial planning arrangements to ensure financial targets are achievable within the Trust 2. Accurate financial forecasts 3. Financial performance reports distributed across the Trust to allow service managers and senior managers to monitor financial performance 4. Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made within delegated limits Assurances 1. Frequent, accurate and robust financial reporting and challenge by the way of:- • Trust Board Report • Finance and Performance Committee Finance Report • Audit Committee Reports • Integrated Performance reporting • Divisional and Directorate Finance reports • Budget Statements • Staff in Posts Lists • Financial risks and • External Reporting and Challenge		**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. A high efficiency target than has ever been achieved in the past, to ensure the full Trust is engaged and playing their part in reducing efficiencies and the cost base 2. The financial regime is managed at a system level rather than at a Trust level 3. The financial gap is across the system gap not just the Trust Gaps / weaknesses in assurance 4. Poor monitoring of the system risk 5. Lack of understanding of the full system risks 6. Lack of airtime for discussion of the full system financial risks	
Update since the last report		**Update 22/06/2023** Risk reviewed. At M2 the Trust is reporting a £9.3m deficit against a plan of £6.1m, £3.2m of plan. The variance to plan is due to unidentified WRP and additional staffing costs related to industrial action. Work is ongoing at Trust and System level to enable identified schemes, both in year and recurrently, **Next Review Date 14/07/2023**		**Date last reviewed**	**22/06/2023**	
				Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					25			
				8-week score projection	**25**			
				Current issues	System wide external influences			

No	ID	Title				
2	9557	Aggregated risk – patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provision				
Lead		Risk Lead: Lyndsay Parsons Exec Lead: Peter Murphy	**Current score**	**20**	**Score Movement**	⟷
Description		Increase in patients requiring psychiatric assessment or suitably detained under the Mental Health Act (MHA) often experience delayed assessment of their needs or delayed transfer due to limited availability of specialist beds. East Lancashire Hospitals NHS Trust (ELHT) is not currently registered or resourced to provide the specialist care that is required.		**Gaps and potential actions to further mitigate risk**		7. ELHT requires suitable resources, infrastructure and capital funding to fully and safely enable detention of patients under the MHA. 8. A more formal service level agreement with LSCFT detailing support of staff, escalation pathways, management of psychiatric medication, mental health care plans and training requires approval. 9. Mental Health Liaison Nurse support to wider clinical areas remains unclear. 10. Assessment process for the management of patients is at the consultation stage. 11. Ongoing inquests contain issues relating to this risk. Inquest closure forms are retrospective. 12. Assessments regarding the management of ligatures are only completed within high-risk clinical areas. 13. A staff safety dashboard is currently in primary stages of development. 14. A policy for de-escalation is being developed and requires ratification and roll out. 15. Management of challenging behaviours training is available but is not mandatory. 16. Medical staff require relevant training and supervision to enable them to effectively utilise s5.2 of the MHA 17. Additional and significant training requirements needed in relation to the care of patients with mental health and learning disabilities to develop staff competencies and confidence 18. External training provider identified and training of security staff remains on target for completion end June 2023. 19. Governance arrangements regarding the monitoring and review of episodes of patient self-harm require review. 20. A recent review of case law highlights prosecution of NHS organisations regarding the management of ligatures and absconding patients due to inadequate service provision and severity of harm.
Controls and Assurances in place		<u>Controls</u> 5. A functioning Mental Health Unit Assessment Centre (MHUAC) is in place. 6. Mental Health Liaison Nurse support based within the Emergency Department (ED). 7. Pathway for the management of mental health patients is within ED. 8. Enhanced care assessments undertaken. 9. Transfer of security management service provision from external provider now inhouse. 10. Security staff on site to support clinical management of patients 11. Protocols in place for more challenging patients. 12. Assessments for the management of ligature risks completed by services with support from the health and safety team where required. <u>Assurances</u> 2. Collaborative working arrangements in place between ELHT and Lancashire and South Cumbria NHS Foundation Trust (LSCFT). 3. Gold calls escalate concerning cases at system level. 4. Monitoring and review of environmental incidents and episodes of self-harm currently being undertaken by the Health and Safety Team. 5. Visibility of inquest closure forms at Trust Wide Quality Governance meetings and within fortnightly Quality and Safety Exec Slide Pack. 6. The Safeguarding Team are available for advice regarding the management of at risk patients. 7. The Care Quality Commission (CQC) and Integrated Care Board (ICB) are supporting ELHT regarding registration.				
Update since the last report		**Update 16/06/2023** Risk reviewed. No change in risk score. Effectiveness of controls have improved from inadequate to limited. Application for registration as a service provider submitted to the CQC and is awaiting the outcome of review. **Next Review Date 14/07/2023**		**Date last reviewed**		**16/06/2023**
				Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					20			
				8-week score projection	**20**			
				Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

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

<table>
<tr><td></td><td></td><td></td><td>on demand vs capacity so complaints continue to increase yearly despite interventions being put in place.
25. Friends and family results highlighting increasing concerns of waiting times
26. System partners ability to flex and meet demands of local health population compounded with offer of mutual aid, with support with hospital diverts increasing risk.</td></tr>
<tr><td rowspan="4">Update since the last report</td><td rowspan="4">Update 12/06/2023
Risk reviewed. No change in risk score. Multiple long waits are still being experienced in particular patients ‘not for corridor’. A Nursing Assessment and Performance Framework (NAPF) inspection has highlighted ED as remaining red.

Next Review Date 12/07/2023</td><td>Date last reviewed</td><td colspan="4">12/06/2023</td></tr>
<tr><td>Risk by quarter 2023-24</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>8 week score projection</td><td colspan="4">20</td></tr>
<tr><td>Current Issues</td><td colspan="4">Recovery and restoration pressures, recruitment and retention</td></tr>
<tr><td></td><td></td><td>20</td><td></td><td></td><td></td></tr>
</table>

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: Daniel Hallen Exec Lead: Michelle Brown	Current score	20	Score Movement	⟷

Description	The absence of a Trust wide electronic patient 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. ePR Go live commenced on 18 June 2023 following extensive roll-out of training and support. However, IT issues and resource to support the effective implementation process remain that might affect patient safety. Management support and monitoring are in place to ensure delivery of ePR across the Trust	**Gaps and Potential actions to further mitigate risk**	1. Implementation issues remain; however, these appear to be understood and managed. 2. IT Network stability improvements made and being monitored. 3. Staff familiarisation improving as process becomes 'business as usual' 4.
Controls and Assurances in place	Controls 1. Extra-med patient flow software which includes capture of nursing documentation. 2. Use of Integrated Clinical Environment (ICE) and EMIS Group Healthcare Software Systems and Information Technology. 3. Use of Winscribe Digital Dictation System allowing clinicians to quickly streamline and automate dictation and transcription workflow. 4. WinDIP Electronic Document Management System assists with the digitalisation of paper records 5. ORION Health and Social Care Clinical Portal provides a single view of patient information across different IT systems. 6. Paper contingencies in place for data capture. 7. Register of non-core systems capturing patient information (feral systems) in place. 8. ePR system monitored following implementation. Management walk around - Trust execs remain informed and aware of incidents. Incidents logged on Datix to ensure resource targeted to resolving issues. Gold command on stand-by to advise and direct. 2 x daily Incident Management Team meetings Assurances 1. All critical systems managed by Informatics or services with direct links to Informatics. 2. Improved infrastructure (including storage) to maintain and manage existing systems. 3. Consistent monitoring of current clinical systems and support via Helpdesks and Informatics Services. 4. Significant amount of business intelligence systems data quality and usage reports. 5. 24/7 system support services. 6. Additional administrative staff in support. 7. Close monitoring of issues and incidents as system went live 8. Trust Exec oversight around reported incidents and feedback from senior management following daily walk-rounds		
Update since the last report	**Update 29/06/2023** Risk Reviewed. No change in risk score. Extensive training and roll-out support and comms. Senior management receive daily updates on delivery concerns to enable an effective response. 8-week projection score forecast to reduce as issues resolved and ePR becomes 'business as usual' **Next Review Date 29/07/2023**	**Date last reviewed**	**29/06/2023**
		Risk by quarter 2023-24	Q1: 20; Q2: ; Q3: ; Q4:
		8 week score projection	**12**
		Current issues	Management and resolution of issues as they develop following the introduction of Cerner.

Note: This risk remains under review following the implementation of ePR.

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

Lead	Risk Lead: Leah Pickering 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.	**Gaps and Potential actions to further mitigate risk**	1. Holding list remains high due to backlog from COVID-19. 2. Patients currently booked into appointments not RAG rated will drop onto the holding list if appointments are cancelled and do not have a RAG rating identified. 3. Patients added to the holding list from other sources such as theatres, wards etc. will not have a RAG identified. 4. Specialities continue to review patients waiting over 6 months and those rated as red to ensure they are prioritised appointments. 5. General lack of capacity across many specialities impacting on reducing holding list numbers. 6. Not all staff follow the standard operating procedures for RAG rating of patients leaving some patients without a rating.
Controls and Assurances in place	Controls 1. Red, Amber, Green (RAG) ratings included on all outcome sheets in outpatient clinic. 2. Restoration plan in place to restore activity to pre-covid levels. 3. RAG status for each patient to be added to the comments field on the patient record in Outpatient Welcome Liaison Service (OWLS) to capture current RAG status. This will allow future automated reports to be produced. 4. All patients where harm is indicated or flagged as a red rating to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers. 5. A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at the time of putting them on the holding list. Process has been rolled out and is monitored daily. 6. 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. 7. Administrator appointed to review all unknown and uncoded patients requesting clinical input and micromanagement of red patients in chronological order to find available slots. Assurances 1. Updates provided at weekly Patient Transfer List (PTL) meetings. 2. Daily holding list report circulated to all Divisions to show the current and future size of the holding list. 3. Meetings held between Divisional and Ophthalmology Triads to discuss current risk and agree next steps. 4. Requests 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. 5. Meetings held with Directorate Managers from all Divisions to understand position of all holding lists. 6. Individual specialities undertaking their own review of the holding list to identify if patients can be managed in alternative ways. 7. Updates provided weekly to Executive Team.		
Update since the last report	**Update 04/05/2023** Risk reviewed. No change in risk score. The size of the holding list continues to remain a challenge with significant numbers of patients still overdue an appointment – May 3,207 within ophthalmology, 1,139 in urology, 857 in ear, nose and throat services, 1,215 in general surgery 1,164 in oral and maxillofacial surgery. **15 June Update** 2,606 Ophthalmology 1050 Urology 763 ENT 1148 General Surgery 1065 Max Facs **Next Review Date 15/07/2023**	**Date last reviewed**	**15/06/2023**
		Risk by quarter 2023-24	Q1: 20; Q2: ; Q3: ; Q4:
		8 week score projection	**20**
		Current issues	Recovery and restoration pressures, recruitment and retention

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.	**Gaps and Potential actions to further mitigate risk**	1. Urgent requests are being treated as routine as referral cannot be to agreed turnaround times. 2. 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. 3. 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		Controls 1. Certain non-urgent tests referred out due to reagent shortages. Assurances 1. Senior members of staff chasing reagents daily via email and phone. 2. Monitoring via operations and department. 3. Monitoring by Divisional Quality and Safety meetings				
Update since the last report		**Update 19/06/23** The outstanding issue impacting on this risk relates to our current supplier (and nationally) having low stocks of reagents. **This risk has been reduced to the lowest possible score within our control. This risk will be recommended to move to tolerated risk register following discussion at ERAG re any potential further internal action.** **Next Review Date 19/07/2023**	**Date last reviewed**	**19/06/2023**		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
				16			
			8 week score projection	**16**			
			Current issues	External influences regarding mitigation of risk beyond the control of the Trust. 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.	**Gaps and Potential actions to further mitigate risk**	1. Buildings will need resources to bring them up to standard e.g., insulated walls and adequate windows etc. 2. Long term target of reaching carbon neutral will require significant investment to make all buildings compliant with minimum standards under BREEAM. 3. A review of utilising staff resources, numbers and competency / skills sets of staff to be able to deliver actions required is needed. 4. A review of energy efficiency equipment e.g. gas boilers before 2032, heating and ventilation units etc. is required. 5. Funds for capital projects and increased costs of materials and services required to meet NHS sustainability strategy needs. 6. Budget commitments to deliver net zero carbon plan is significant but will need to be factored into wider plans. 7. Lack of full carbon emissions monitoring. 8. Lack of compliance with Greenhouse Gas Emissions Trading Scheme Order 2020.		
Controls and Assurances in place		Controls 1. Development of new Green Plan which sets out nine priority areas of focus that appraise and set actions to be achieved within the next three years centred on workforce and systems leadership, sustainable models of care, digital transformation, travel and transport, estates and facilities, medicines, supply chain and procurement, food and nutrition and adaptation. 2. Building works undertaken to Building Research Establishments Environmental Assessment Method (BREEAM) standards. 3. Purchase of EV fleet vehicles where possible. 4. Review of energy and waste processes for reduction / greener strategies. Assurances 1. Full review of legislative requirements, organisational arrangements, processes, equipment, and competencies required completed. 2. Local leadership, raised awareness of requirements, actions, understanding. 3. Collaborative working with neighbouring NHS organisations to identify improvement and compliance strategies.				
Update since the last report		**Update 19/06/2023** Green Plan now in place and submitted to ICB. Updates included routinely on the Executive Improvement Wall. **Risk score will be reviewed at next ERAG**. **Next Review Date 19/07/2023**	**Date last reviewed**	**19/06/2023**		
			Risk by quarter 2023-24	**Q1**: 16	**Q2**:	**Q3**:	**Q4**:
			8 week score projection	**16**		
			Current issues	Commitment of adequate resources required 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: Dayle Squires 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.	**Gaps and Potential actions to further mitigate risk**	1. A 5 year workforce plan in place to support recruitment and retention. 2. Increased focus on backlog reduction to support performance recovery showing signs of improvement. 3. Lack of equipment partially addressed by capital funds. 4. Process of recruiting to a clinical director histopathology role is underway, with recruitment to additional substantive and locum posts remaining ongoing. 5. Some breaches in compliance fall outside the control of the Trust e.g. patients breaching targets due to complexities in pathways, comorbidities or patient choice.
Controls and Assurances in place	Controls 1. Sample tracking software now installed. 2. Locum laboratory biomedical staff and consultants now recruited into post. 3. Triaging of cases by consultants to maximise resources based on clinical urgency. 4. >50% of work sent to external reporting services. 5. Escalation process for priority cases is well established. Assurances 1. Monitoring at Directorate and Departmental meetings. 2. Monthly monitoring of turnaround times (TAT's) against targets. 3. Attendance at weekly cancer performance meetings. 4. Collaborative working established with Lancashire and South Cumbria Foundation Trust (LSCFT) to implement digital pathology to aid recruitment and retention. 5. Multiple external reporting services being used to help mitigate the risk. 6. Annual assessment of pathology performance undertaken by the UK Accreditation Service (UKAS), the accrediting body.		
Update since the last report	**Update 19/06/2023** . Histopathology consultants recruited earlier this year. Trust have been stepped down from Tier 2 concern re Cancer diagnosis. **Score will be recommended for reduction and likely removal from CRR at next ERAG.** **Next Review Date 19/07/2023**	**Date last reviewed**	**19/06/2023**

	Q1	Q2	Q3	Q4
Risk by quarter 2023-24	**16**			
8 week score projection	**16**			
Current issues	External influences regarding mitigation of risk beyond the control of the Trust. There continues to be a national shortage of histopathologists.			

o	ID	Title
9	8033	**Complexity of patients impacting on ability to meet nutritional and hydration needs**

Lead	Risk Lead: Tracey Hugill Exec Lead: Peter Murphy	Current score	16	Score Movement	⟺

Description	Failure to meet nutrition and hydration needs of patients as set out within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which sets out the requirements for healthcare providers to ensure persons have enough to eat and drink to meet nutrition and hydration needs and receive support in doing so.	**Gaps and Potential actions to further mitigate risk**	1. Nutrition and hydration are not consistently reviewed at ward rounds along with a lack of timely best interest decisions. Above bed management boards to include nutrition and hydration risk at a glance. 2. Not all patients are weighed. There is an over reliance on estimation of weight, not actual. Weaknesses identified in accurate assessment and recording of malnutrition risk and compliance with policy and procedural controls. 3. Current MUST toolkit insufficiently used to gather compliance reports and prevents healthcare assistants from inputting weights. The use of CERNER is expected to improve collective recording and retrieval of data. 4. The timely review of blood test results relating to parenteral feeding. 5. Limited staffing capacity of Speech and Language Therapists, Dietetics, Endoscopy and Nursing delaying assessments and impacting on feeding routes. 6. No process in place for the recording and review of compliance with non-mandatory training. 7. Training gap identified regarding nutrition and hydration within doctor curriculum. 8. Access to advice via Nutrition Support Team is limited and instigated by dieticians or nutrition nurses rather than referral from ward due to lack of capacity. 9. There is no medical representation at the Nutrition and Hydration Steering Group.
Controls and Assurances in place	Controls 1. Regulatory requirements and guidance written into nutrition and hydration provision to inpatients, parental nutrition, enteral feeding, refeeding, mental capacity and safeguarding adults policies and procedures. 2. Standard operating procedures and tools in place i.e. ward swallow screen, electronic malnutrition screening tool, food record charts and fluid balance, nasogastric tube care bundle, food for fingers and snack menus. 3. Training provided to staff that includes malnutrition screening, nasogastric tube replacement, nasogastric x-ray interpretation and nasogastric bridle, mouthcare, malnutrition identification and management, fluid balance, Percutaneous Endoscopic Gastronomy (PEG) management and food hygiene. Assurances 1. Nutrition and hydration prompt on ward round sheets 2. Inclusion within ward manager audits. 3. Monitoring of incidents and levels of harm, complaints, patient experience outcomes etc. as part of divisional reports. 4. Outcome results form part of the work plan of the Nutrition and Hydration Steering Group. 5. Inclusion via Nursing Assessment and Performance Framework (NAPF).		
Update since the last report	Update 19/06/2023 No change in risk score. Business case approved and ongoing recruitment in Q2 2023-24 period. Work on going in raising awareness with clinical team. It continues to be a part of Quality strategy for the year 23-24 **Next Review Date 19/07/2023**	**Date last reviewed**	**19/06/2023**

Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	16			
8 week score projection	16			
Current issues	Recruitment and retention ongoing			

o	ID	Title
10	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	16	Score Movement	⟷

Description	Failure to provide quality assurance of legislative compliance regarding the reporting of certain types of injuries, diseases and dangerous occurrences to the Health and Safety Executive (HSE) within set regulatory timescales	**Gaps and Potential actions to further mitigate risk**	1. RIDDOR performance increasingly attracting the interest of the Care Quality Commission. 2. Revisit and deliver RIDDOR awareness training to occupational health team. 3. Ensure occupational disease is more explicitly included as part of RIDDOR performance reporting. 4. Include RIDDOR performance as part of Divisional Quality and Safety Lead KPI's. 5. Review of incident reporting process to improve quality and quantity of incidents being reported. 6. Review of investigation process to utilise lead specialisms and subject matter experts more effectively when reviewing and investigating incidents within their areas of responsibility and control and of determining external reporting requirements of RIDDOR when undertaking investigations. 7. The Health and Safety Team are currently reviewing and investigating c30% of all incidents reported in DATIX and is not sustainable. 8. Review of triage process to avoid multiple reviews of incidents and duplication. 9. Review of Health and Safety Team resources pending outcome of review of incident management process. 10. Impact assessment of RIDDOR on the new Patient Safety Incident Response Framework being reviewed. 11. Replacement of DATIX with the new Total Quality Management System (RADAR) may lead to loss of organisational memory and delay incident investigations and subsequent impact on external regulatory reporting requirements. 12. Investigations to determine RIDDOR reportable incidents highlighting gaps in quality management systems or processes and of existing policy, procedural and risk assessment processes not being followed by managers and staff 13. There is no standardised quality management system for capturing total numbers of days lost off work and as a result of a workplace accident or injury. 14. Threshold target of 95% compliance with RIDDOR timescales continues to not be achieved or consistently maintained.
Controls and Assurances in place	<u>Controls</u> 1. RIDDOR reporting requirements contained within scope of incident management policy and procedures. 2. Responsibilities of staff to report any health concerns embedded within the health and safety at work policy. 3. Improved data capture and utilisation of incident management module of DATIX. 4. A centralised process is firmly established for the health and safety team to review and submit RIDDOR reportable incidents externally to the HSE. 5. Increased management and staff awareness and understanding of RIDDOR i.e. what is and what is not reportable, consequences and timescales involved, relevant work examples and the issue of guidance. 6. RIDDOR awareness training developed by health and safety team and rolled out to targeted staff groups i.e. members of the health and safety committee, lead specialisms and subject matter experts, occupational health, legal services, divisional quality and safety leads and teams, patient safety investigation leads, with further ad hoc training across divisional groups available, where necessary. 7. Increased senior management awareness of RIDDOR to help drive and reinforce the importance of ensuring legislative compliance. <u>Assurances</u> 1. Specialist advice, support, and guidance readily available from the Health and Safety Team. 2. Full review of legal requirements and of measuring and reviewing performance completed and remains ongoing. 3. Continuous monitoring and review of all accidents and incidents to staff, patients, contractors, and members of public reported in DATIX undertaken by the Health and Safety Team. 4. Thematic review of RIDDOR performance against legislative requirements included as a standalone agenda item of the Health and Safety Committee, with escalation by exception 5. Collaborative working partnerships strengthened with clinical and non-clinical service specialisms and safety critical roles e.g., matrons, ward managers, patient safety lead investigators, incident and triage team, infection control, occupational health, estates and facilities, human resources, legal services, falls lead, manual handling lead, security management etc. should any significant trends be identified. 6. Days lost off work as a result of absence or injury captured as part of HR return to work processes. 7. Continuous reduction in numbers of RIDDOR reportable incidents from 54 in 2020-21, 45 in 2021-22 to 35 in 2022-23 with this reduction expected to continue. 8. Work to increase compliance continues to improve from 15% in 2021-22, 54% in 2022-23 to 57% in 2023-24 to date.		

Update since the last report	**Update 13/06/2023** Risk reviewed. No change in risk scoring as requirement re RIDDOR reporting is reliant on single member of staff. Work to improve compliance is heavily reliant on changes required to the incident management process and of capacity and resources within the Health and Safety team. Next Review Date 12/07/2023	**Date last reviewed**	**13/06/2023**		
		Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
			16			
		8 week score projection	**16**			
		Current issues	Deficiencies in the incident management framework and limited resources within health and safety team delaying progress			

No	ID	Title
11	6190	**Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale**

Lead	Risk Lead: Sara Bates Exec Lead: Sharon Gilligan	**Current score**	**16**	**Score Movement**	⟷

Description	Insufficient clinic capacity for patients to be seen in outpatient clinics resulting in un-booked new patients and a very large holding list of overdue patients. In some cases, there is significant delay and therefore a risk to patients. Demand far outweighs capacity, and this has been exacerbated since the COVID-19 pandemic. All patients are risk stratified (red, amber, green) but still cannot be seen within timescales with additional risk that amber patients could be become red over time etc.	**Gaps and Potential actions to further mitigate risk**	1. Insufficient staff numbers to provide capacity. 2. Insufficient estates capacity and outpatient space to provide required clinics 3. Ability to flex theatres to outpatient departments and vice versa but opportunities are limited. 4. Funding and difficulties recruiting additional medical staff and equipment so as to be able to increase activity e.g., medical, nursing, admin etc. 5. The use of locums is a short-term fix. Patients tend to be brought back for further review impacting long term on holding list. 6. Getting It Right First Time (GIRFT) report not yet created for patient waiting times above 25% within recommended timescales for review. Focus on use of patient initiated follow up (PIFU) to help manage back log
Controls and Assurances in place	Controls 1. Integrated Eye Care Service in place for specific pathways, keeping relevant patients out of hospital eye services where possible. 2. Use of clinical virtual pathways where appropriate. 3. Action plan and ongoing service improvements identified to reduce demand. 4. Failsafe Officer in place to validate the holding list and focus on appointing red rated patients and those longest waiting. 5. Expanded non-medical roles e.g. orthoptists, optometrists, specialised nurses etc Assurances 1. Capacity sessions held where doctors are willing and available. 2. Increased flexibility of staff and constant review and micro-management of each subspecialty. 3. All holding list patients reviewed weekly by administrative staff with patients highlighted where required to clinical teams. 4. Weekly operational meetings challenge outpatient activity and recovery.		
Update since the last report	**Update 15/05/2023** Risk Reviewed. No change in risk scoring. A new glaucoma virtual monitoring service is in place to manage reviews. Whilst this has supported the service, numbers of urgent glaucoma patients are still being received. The triage process is being reviewed and improved. The holding list remains a major concern with similar numbers awaiting review of appointments which are unable to be accommodated. Awaiting recruitment to support capacity. **Next Review Date 25/07/2023**	**Date last reviewed**	**25/06/2023**

	Q1	Q2	Q3	Q4
Risk by quarter 2023-24	**16**			
8 week score projection	**16**			
Current Issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
12	8839	**Failure to meet performance targets (SAS)**				
Lead		Risk Lead: Leah Pickering 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. As a result of the COVID-19 pandemic, all surgical specialities are currently significantly challenged for meeting Referral to Treatment (RTT). The failure of this standard means that individual patient care is impacted as patients will have to wait an extended length of time for treatment which will further impact on patient experience and treatment plans. Patients may also deteriorate waiting for treatment for extended lengths of time. As this standard is externally monitored failure may lead to organisational reputational damage and patients choosing not to be treated by the Trust.	**Gaps and Potential actions to further mitigate risk**	1. Next recovery milestone is the eradication of all patients waiting >65 weeks by end March 2024. Target plans are in place to achieve this by end of Dec 2023. 2. Gaps between demand and capacity still remain within surgical specialties. 3. Balancing cancer performance targets and achievement of referral to treatment performance remains challenging. 4. Pension rules and workforce challenges have reduced consultant numbers offering additional capacity sessions to manage demand. 5. Inability to recruit to some specialities is still impacting on performance targets.
Controls and Assurances in place	Controls 1. Micromanagement of all 65 and 52 week breaches continues as business as usual at weekly patient treatment list (PTL) meetings. Patients continue to be seen in order of clinical priority. 2. Revised clinical harms process has been implemented to ensure patient safety. 3. Addition of priority code monitoring to enable all clinically urgent patients to be tracked for dates. 4. Outpatient Transformation Group tracking outpatient redesign. 5. Recovery plans updated weekly by Directorate Managers. 6. Additional waiting list initiatives for theatres and clinical to close gaps and maximise capacity. Assurances 1. Attendance of Divisional Information Manager (DIM) at Directorate meetings to provide updates on current position. 2. Exception reports provided by DIM where standards are not being met. 3. Weekly PTL meetings held within division of awareness of current position and ensure suitable controls remain in place to focus on achievement of the standard. 4. Bi-weekly meetings held with Directorate Managers led by the Director of Operations to monitor and review performance and trajectories. 5. Regular performance monitoring and challenge at Divisional Management Board (DMB) and Senior Management Team. 6. Monthly meetings held with commissioning teams to work on demand management and explore options for mutual aid and outsourcing		
Update since the last report	**Update 04/05/2023** Risk reviewed. No change in risk scoring. Division achieved the elective recovery milestone in terms of eradication of patients waiting >78 weeks by the end of March 2023. **Update 15/06/2023** Overall RTT performance Trust achieved the 65 weeks trajectory in April. In May there were 4 more patients waiting than planned. Risk areas include gastro/digestive disease services due to greater demand than capacity – impacted by Junior Dr strikes. Referral Assessment Triage Service introduced to assist in ensuring patients are managed on the right pathway **Next Review Date 15/07/2023**	**Date last reviewed**	**15/06/2023**

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

No	ID	Title
13	8808	**Burnley General Teaching Hospital (BGTH) Phase 5 - 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 faster spread of smoke or fire between compartments within a timescale <1 hr or 30 mins that compartments and doors are designed to provide.	**Gaps and Potential actions to further mitigate risk**	1. Assurances required regarding integrity of fire doors and surrounds. 2. Fire door programme agreed and in place and replacement work undertaken.
Controls and Assurances in place	Controls 1. Contractual arrangements in place between the Trust and its PFI partners in establishing duty holder responsibilities of building controls, servicing of systems and planned preventative maintenance programme. 2. Suitable building fire detection systems in place to provide early warning of fire. 3. Fire safety awareness training forms part of core and statutory training requirements for all staff. 4. All relevant staff trained in awareness of alarm and evacuation methods. 5. Emergency evacuation procedures and business continuity plans in place across services. 6. Project team established to manage passive fire protection remedial works. 7. Random sampling and audit of project works being undertaken for phases 1 to 5. 8. Find and fix process in place for fire remedials. Assurances 1. Weekly IMT meetings and Fire Safety Committee led by Executive Leads set up to seek assurances and monitor progress with project. 2. Fire safety management performance forms part of standing agenda item of Health and Safety Committee. 3. Collaborative working in place between the Trust, Consort Healthcare and third parties to identify and prioritise higher risk areas, address remedial works and the correction of defects to fire doors and frame sealings. 4. All before and after photographic evidence of remedial works recorded and appropriately shared. 5. Arrangements and responsibilities of managers and staff contained within fire safety policy. 6. Staff fire wardens positioned in most areas and additional fire wardens provided by Consort Healthcare to maintain extra vigilance, patrol common areas across hospital sites and undertake fire safety checks. 7. Provision of on site fire safety team response. 8. Total Fire Safety Ltd have commenced programme of work across phases 1 to 4. Balfour Beatty undertaking programme of work across phase 5. 9. External monitoring, servicing and maintenance of fire safety alert system and suitable fire safety signage in place. 10. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England. 11. Independent consultant employed to review and oversee project management.		
Update since the last report	**Update 13/06/2023** No change to risk scoring. LFRS have issued enforcement action. Improvement works being monitored and reviewed at the fortnightly Fire Safety Meetings and Fire Safety Committee. **Next Review Date 12/07/2023**	**Date last reviewed**	**13/06/2023**
		Risk by quarter 2023-24	Q1: 15 / Q2 / Q3 / Q4
		8 week score projection	**15**
		Current issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title
14	8257	**Loss of Transfusion Service**

Lead	Risk Handler: Dayle Squires 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.	**Gaps and Potential actions to further mitigate risk**	1. No fire safety incidents have been reported since 2019 to date. 2. Assurances required regarding the robustness of service fire safety risk assessment and business continuity plans to help mitigate this risk. 3. Options appraisal carried out regarding purchase of a single unit under bench blood fridge within a remote site to reduce risk however this would present greater risks regarding monitoring and maintenance of blood stock levels, increased time and resources, limited number of units stored or available for transfusions weighted against delivery timescales, units needing to be 0+ and 0- and track and traceability of bloods. 4. Despite purchase of blood tracking system being complete, it requires a program of installation and validation testing which can take up to 12 months to complete.
Controls and Assurances in place	<u>Controls</u> 1. Emergency bloods can be stored in temporary insulated boxes for a period of time. 2. Should Level 0 be out of bounds, clinical flow room would be the point of contact for all skilled staff. 3. Fridge now in place on Burnley General Hospital site. 4. Label print runs have been successfully carried out. 5. Bio Medical Scientist to station themselves outside laboratory entrance and issue emergency units out. <u>Assurances</u> 1. Regular meetings held regarding systems set up and testing. 2. Numbers of fire safety incidents, in particular, regarding activation of alarms are being closely monitored. 3. As system validation testing is rolled out changes to IT processes will occur to meet plans for electronic release of blood from remote fridges. 4. Medicines and Healthcare Products Regulatory Agency inspection recently carried out to review compliance with Blood Safety and Quality Regulations 2005 and Good Practice Guidelines for Blood Establishment.		
Update since the last report	**Update 19/06/2023** Risk reviewed. Equipment now in place and validation ongoing. MHRA visit reported positive management systems in place. **Risk is now recommended to move to be reviewed and transferred to directorate for monitoring. Decision at the next ERAG to recommend it as a tolerated risk.** **Next Review Date 19/07/2023**	**Date last reviewed**	**19/06/2023**

Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	15			

8 week score projection	15
Current issues	System requires installation and validation which can take up to 12 months

No	ID	Title
15	7764	**Royal Blackburn Teaching Hospital (RBTH) Phases 1-5 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 faster spread of smoke or fire between compartments within a timescale <1 hr or 30 mins that compartments and doors are designed to provide.	**Gaps and Potential actions to further mitigate risk**	1. Assurances required regarding integrity of fire doors and surrounds. 2. Fire door programme agreed and in place and replacement work undertaken.
Controls and Assurances in place	Controls 1. Contractual arrangements in place between the Trust and its PFI partners in establishing duty holder responsibilities of building controls, servicing of systems and planned preventative maintenance programme. 2. Suitable building fire detection systems in place to provide early warning of fire. 3. Fire safety awareness training forms part of core and statutory training requirements for all staff. 4. All relevant staff trained in awareness of alarm and evacuation methods. 5. Emergency evacuation procedures and business continuity plans in place across services. 6. Project team established to manage passive fire protection remedial works. 7. Random sampling and audit of project works being undertaken for phases 1 to 5. 8. Find and fix process in place for fire remedials. Assurances 1. Weekly IMT meetings and Fire Safety Committee led by Executive Leads set up to seek assurances and monitor progress with project. 2. Fire safety management performance forms part of standing agenda item of Health and Safety Committee. 3. Collaborative working in place between the Trust, Consort Healthcare and third parties to identify and prioritise higher risk areas, address remedial works and the correction of defects to fire doors and frame sealings. 4. All before and after photographic evidence of remedial works recorded and appropriately shared. 5. Arrangements and responsibilities of managers and staff contained within fire safety policy. 6. Staff fire wardens positioned in most areas and additional fire wardens provided by Consort Healthcare to maintain extra vigilance, patrol common areas across hospital sites and undertake fire safety checks. 7. Provision of on-site fire safety team response. 8. Total Fire Safety Ltd have commenced programme of work across phases 1 to 4. Balfour Beatty undertaking programme of work across phase 5. 9. External monitoring, servicing and maintenance of fire safety alert system and suitable fire safety signage in place. 10. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England. 11. Independent consultant employed to review and oversee project management.		
Update since the last report	**Update 13/06/2023** No change to risk scoring. LFRS have issued enforcement action. Improvement works being monitored and reviewed at the fortnightly Fire Safety Meetings and Fire safety Committee. **Next Review Date 12/07/2023**	**Date last reviewed**	**13/06/2023**

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

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.	**Gaps and Potential actions to further mitigate risk**	1. Excessive waiting times within many clinical areas due to recruitment difficulties into key posts as a result of national shortages. 2. A 5-year workforce plan in place to support recruitment and retention. 3. Some breaches in compliance with national standards are outside the control of the Trust e.g. complexity of care pathways, comorbidities or patient choice.
Controls and Assurances in place	Controls 1. Cancer Action Plan in place to improve quality and performance, patient care and experience which is monitored as part of cancer performance meetings. 2. Cancer performance pack issued to all key stakeholders along with additional reports. 3. Breach analysis process in place whereby all breaches or near misses of national standards are mapped out along with identified delays which are reviewed by responsible directorates. Any areas of learning and improvement are fed into action plans. Assurances 1. The Lancashire and South Cumbria Integrated Care Board, Pennine Lancashire Cancer Tactical Group, Lancashire and South Cumbria Cancer Alliance Rapid Recovery Team and other key stakeholders regularly discuss and review performance, progress, and ideas for improvement. 2. Cancer performance meetings review all patients at risk of breaching national cancer waiting times treatment standards. 3. A tumour site patient treatment list meeting is regularly held with key individuals in attendance to review lists patient by patient and priority actions identified. 4. A hot list representing all patients at risk of breaching standards is distributed twice weekly and a detailed review is held at cancer performance meetings. 5. NHS England and the Lancashire and South Cumbria Cancer Alliance provide investment and funding into problematic areas 6. There are regular meetings and escalation between Cancer Services and the Directorates, with close Executive oversight, minimum of 3 times a week to discuss actions related to cancer improvement and escalating individual patient pathways.		
Update since the last report	**Update 19/06/2023** 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. Actions taken include expansion of capacity and services, long-term recruitment and retention plans with short-term locum and insourcing support to prop up capacity, pathway redesign, improving processes, and investment of cancer alliance transformation funding. Impact of actions reported bimonthly to ICB and data will be included in July update at which point the risk score will be reviewed. **Next review date 19/07/2023**	**Date last reviewed**	**19/06/2023**
		Risk by quarter 2023-24	Q1: 15; Q2: ; Q3: ; Q4:
		8 week score projection	**15**
		Current issues	Recovery and restoration pressures, recruitment and retention

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: Peter Murphy	**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.	**Gaps and Potential actions to further mitigate risk**	1. Progression of next cohort of international nurses to support recruitment and selection. 2. Progression on recruitment of 2 x Band 6 part time staff to aid newly registered staff 3. A 5-year workforce plan in place to support recruitment and retention
Controls and Assurances in place	Controls 1. Use of e-rostering, both actual and planned, staffing numbers recorded daily and reported monthly as part of quality assurance processes. 2. 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. 3. 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. 4. Review of business continuity plans remains in place. Assurances 1. Daily staffing teleconference held with Director of Nursing and repeated as required 2. Monitoring of red flags, incident reporting, complaints and patient experience data. 3. Monthly financial reporting and non-medical agency group review of spending. 4. Regular performance reporting of actual and planned staffing levels at Quality Committee and Trust Board meetings. 5. Appointment of Lead Recruitment Nurse with focus on ongoing local, national and international recruitment of registered nurses and healthcare support workers. 6. Formal review and exercising of professional judgement to allocate or reallocate staff appropriately and address deficits in skills shortages and or numbers.		
Update since the last report	**Update 19/06/2023** Risk reviewed. No change in risk score. Nurse staffing levels continue to remain challenging. International recruitment, skill mix review and new career pathways supported by the People Strategy have enabled the Trust to demonstrate that it has reduced this risk to as low as is reasonably practicable, within the Trusts ability. **This risk will be recommended for consideration to move to tolerated risk register following discussion at ERAG re any potential further internal action**. **Next review date 19/07/2023**	**Date last reviewed**	**19/06/2023**
		Risk by quarter 2023-24	Q1: **15** | Q2: | Q3: | Q4:
		8 week score projection	**15**
		Current issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title				
18	4932	**Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained.**				
Lead		Risk Lead: Lyndsay Parsons Exec Lead: Peter Murphy	**Current score**	**15**	**Score Movement**	⟺
Description		Patients referred to Lancashire County Council and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DoLS) authorisation are not being assessed by these agencies within the statutory timescales, or at all, which means the DoLS is in effect unauthorised.		**Gaps and Potential actions to further mitigate risk**		1. Supervisory Body unable to process assessments within set statutory provisions. This remains outside the control of the Trust who are, as a consequence, unable to extend urgent authorisations beyond the required timescales set at 14 days. 2. In the absence of assessments being undertaken by the Supervisory Body, patients will not have a DoLS authorised and will not have had the relevant checks undertaken to ensure they are being legally detained. This can lead to patients being detained without authorisation as not doing so would present an even greater risk. 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		Controls 1. Policy and procedures relating to the Mental Capacity Act (MCA) and DoLS updated to reflect the 2014 Supreme Court judgement ruling. 2. Mandatory training on the MCA and DoLS available to all clinical professionals. 3. Improvement plan introduced for the management of DoLS applications following internal audit to enable timely and accurate recording of applications made and to demonstrate application of MCA in absence of Local Authority (LA) review. 4. Applications being tracked by the Safeguarding Team 5. Changes in patient status relayed back to the Supervisory Body Assurances 1. Quarterly review of risk undertaken by the Internal Safeguarding Board. 2. Policy and procedural arrangements being adhered to by wards along with applications made in a timely manner. 3. Supervisory Body made aware of risk. 4. Legal advice and support readily available. 5. Additional support available for all ward based staff and provided by the MCA Lead and Safeguarding Team. 6. Despite challenges presented by the legal framework it is expected patients will not suffer any adverse consequences or delays in treatment etc. and that the principles of the MCA will still apply.				
Update since the last report		**Update 19/06/2023** Risk reviewed. No change in risk score. This risk has been reduced to the lowest possible score within our control. **This risk will be recommended to move to tolerated risk register following discussion at ERAG re any potential further internal action.** **Next review date 19/07/2023**		**Date last reviewed**		**19/06/2023**
				Risk by quarter 2023/24	**Q1**	**Q2**	**Q3**	**Q4**
					15			
				8-week score projection	**15**			
				Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

TRUST BOARD REPORT

12 July 2023

Item 87

Purpose Information
Action
Monitoring

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

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

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

Recommendation: The Board is asked to review the new BAF risks for 2023-24, including the risk scores and the Risk Appetite Statement and approve them for the current financial year.

Report linkages

Related Trust Goal

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

Impact

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

Previously considered by:

Executive Directors and Director of Corporate Governance.

Board Workshop, 4 May 2023

Finance and Performance Committee (via email)

Quality Committee, 28 June 2023

Audit Committee, 10 July 2023

Introduction

The Directors have undertaken the annual review of the Board Assurance Framework (BAF), which commenced in March 2023. The review has been carried out utilising the Improving Safe, Personal and Effective Care (SPE+) Improvement Methodology which emphasises the need to take a co-design and continuous improvement approach.

The Executive Team met together on 21 April 2023. In addition, the Executive Directors with BAF risks assigned to them have met individually with the Director of Corporate Governance to develop the content of the individual risks.

The Board also met collectively on 4 May 2023 to review, discuss and provide feedback on the newly developed draft framework.

Development of BAF risks

Following discussions held with Executive Directors and review of exemplar Trusts' BAF documents, the proposal was made to reduce the number of strategic risks from twelve to five. The new risks are set out below:

1. **Risk 1: (Risk Score 16 (C4 x L4)** The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
2. **Risk 2: (Risk Score 20 (C5 x L4)** The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
3. **Risk 3: (Risk Score 16 (C4 x L4)** A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
4. **Risk 4: (Risk Score 16 (C4 x L4)** The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
5. **Risk 5: (Risk Score 25 (C5 x L5)** The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

The full BAF will be presented to the Committees for completeness and information, however, the Committees will only be asked to discuss the risk scores and the mitigations and actions for the risks that are within their remit as follows:

a) Finance and Performance Committee: BAF 1, BAF 3 and BAF 5.
b) Quality Committee: BAF 2 and BAF 3.
c) People and Culture Committee: BAF 4 (from September 2023).

The full BAF will also be presented to the Audit Committee on a bi-annual basis.

Proposed Risk Appetite Statement 2023-24

The Board also agreed to undertake a review of the Trust's Risk Appetite Statement for 2023-24. The appended statement has been agreed by the Executive Directors and discussed at the Board session on 4 May 2023. The Board is asked to review and approve the document attached in appendix 1.

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

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

Connection with the CRR

BAF Risk	Linked CRR Risks	CRR Score
1: Integrated Care /Partnerships/ System Working	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 1.	N/A
2: Quality and Safety	ID 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 8033: Complexity of patients impacting on ability to meet nutritional and hydration needs. ID 9296: Inability to provide routine or urgent tests for biochemistry requests. ID 7165: Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). ID 8960: Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained. 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.	20 20 20 16 16 16 15 15 15
3: Elective Recovery and Emergency Care Pathway	ID 8061: Management of Holding Lists ID 9336: Lack of capacity can lead to extreme pressure resulting in a delayed care delivery. ID 8941: Potential delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology.	20 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.	16
	ID 8839: Failure to achieve performance targets.	15
	ID 8257: Loss of transfusion service.	15
	ID 7008: Failure to comply with 62-day cancer waiting time target.	15
4: Workforce	ID 5791: Failure to recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance.	15
5: Financial Sustainability	ID 9771: Failure to meet internal and external financial targets for the 2023-24 financial year.	25
	ID 9222: Failure to implement the NHS Green Plan	16

The development of the BAF for 2023-24 continues and the Directors are looking at reducing the controls and sources of assurance to only include the ones that are mitigating the current risks as opposed to the 'business as usual' measures in place for management of risks, which are currently included. This will help to reduce the size of the BAF going forward. In addition, the Executive Directors are working on finalising the tolerated risk scores for each BAF risk which are being presented to the Board for discussion and agreement.

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

The heatmap is presented for the risks for 2022-23 and for the new risks for 2023-24 for comparison.

2022-23

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

2023-24

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

Recommendation

The Board is asked to discuss the risks, the risk scores and the Risk Appetite Statement and approve them for use in the 2023-24 year.

BAF Risk 1 – Integrated Care / Partnerships / System Working

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

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

Strategy: ELHT Strategic framework (Partnership Working)

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

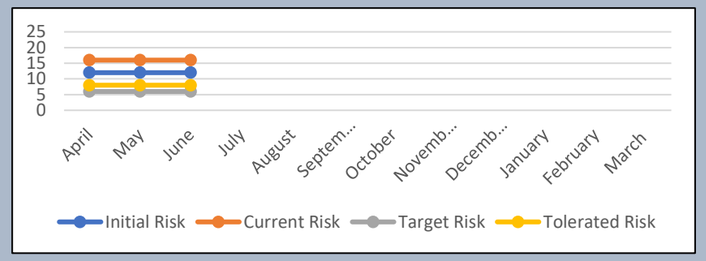
Date of last review: Executive Director: June 2023
ERAG: Due to the implementation of the EPR system in June 2023 there has not been an ERAG meeting. The next meeting will be in July 2023.

Lead Committee: Finance and Performance Committee

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

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

Current Risk Rating:	**C4 x L4 = 16**
Initial Risk Rating:	C4 x L3 = 12
Tolerated Risk	C4 x L2 = 8 – to be determined
Target Risk Rating:	C3 x L2 = 6



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)

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

- The ICB operating model and key system-level strategies and priorities are developing but not yet mature.
- An ICS System Programme Delivery Board is established to oversee delivery of key priority programmes (Transforming Community Care, Clinical Services Transformation, System Infrastructure, Central Services and Finance Recovery & Performance) with a Programme Management Office being established to oversee and support delivery. Limited mechanisms yet developed to support monitoring of benefits realisation of system-wide programmes.
- 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.
- Development and testing of L&SC System Model for Improvement (Engineering Better Care) underway alongside other system-wide programmes utilising improvement methodology to support delivery.

<u>Provider Collaborative Board (PCB):</u>

- The PCB Business Plan outlines priorities for 2023-24 covering Clinical Services and Central Service redesign which feed into PCB Governance Structures and System Programme Delivery Board.
- A Joint Committee has been formed to enable effective decision making for specified Programmes.
- ELHT plays a key role in the PCB including Chief Executive and Chair at PCB Provider Collaborative Board, lead Director Senior Responsible Officer (SRO) roles 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.
- A PCB Clinical Strategy is in development and planned engagement activities are underway.
- Chief Executive is the Chair of the Clinical Programme Board for the PCB.

<u>Place-Based Partnership (PBP):</u>

- Blackburn with Darwen Place and Lancashire Place including East Lancashire priorities are in final stages of development. Place-based directors are establishing their structures to support delivery.

<u>ELHT:</u>

- ELHT Strategic framework has been developed to ensure clear alignment of organisational aims to wider system aims.
- Key organisational strategies have been developed/in development to clearly outline ELHT priorities for development as a partner in the wider system.
- Strategy deployment framework/process will support development and delivery of organisational plans aligned to wider system, supported by Accountability Framework to monitor delivery.
- 11 Key Delivery and Improvement Programmes have been identified to ensure delivery against organisational aims and objectives and aligned to wider system programmes.
- ELHT Improvement Practice (Improving Safe, Personal and Effective Care (SPE+), developed to support delivery and build capacity for Improvement. Detailed Improvement Practice Development Plan (2022-25) in place with 1 year delivery plans generated each year to support embedding of improvement across the organisation.

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>

- 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.
- Weekly monitoring of Key Delivery Programmes via Executive Improvement Wall
- Trust Improvement Register monitored at Divisional Transformation Boards and Clinical Effectiveness Committees.
- Organisational plans for operational planning established and agreed via Trust and System planning processes.
- Accountability Framework implemented form January 2023 including weekly Improvement Wall updates as part of the weekly Executive Team meetings, Senior Leadership Group and quarterly Divisional Performance meetings.

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

- 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. ELHT Key Delivery and Improvement Programmes established with relevant Programme Boards in place which feed into Trust sub-committees to report progress and give assurance

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

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

BAF Risk 1 – Integrated Care / Partnerships / System Working

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	System strategies and delivery plans not yet sufficiently developed to give confidence in delivery of tangible outcomes and progress not always consistently clear.	Work with partners to finalise system strategies, priority programmes and delivery structures for 2023-24	Director of Service Development and Improvement with SRO leads	End July 2023	L&SC ICP Strategy and Joint Plan in development and to be finalised by June System-wide programmes in process of being finalised PMO review/methodology development complete but resourcing of PMO to be finalised.	A
2.	PCB Clinical Strategy development process needs clarifying to ensure clear alignment to wider ICS, New Hospitals programme, organisational strategies.	Liaison with system colleagues to agree next steps.	Executive Medical Director/ Director of Service Development and Improvement	September 2023	PCB Clinical Strategy engagement plans now agreed and underway. Programme Board underway alongside development of clear programme plan and priorities for 23/24 agreed to deliver key clinical change programmes. The Trust's Chief Executive is the Chair of this group. Next update on progress to the Committees and Board in September 2023	A
3.	PCB Central Services workstreams priority and deliverables for 2023-24 and beyond need signing off and benefits realised	Work with PCB via Central Services Board to clarify priorities/benefits, delivery methodology, consultation and sign off mechanisms.	Senior Responsible Officers	End July 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
4.	Place priorities and delivery programmes not yet sufficiently developed	Work with Place partners to shape priorities and delivery structures for 2023-24	Executive Director of Integrated Care, Partnerships and Resilience	September 2023	Ongoing participation in Place workshops and discussions to finalise priorities and delivery structures Quarterly reporting to PCB by place directors since May 2023 – next update due September 2023.	A
5.	Full alignment of System and Place priorities to ELHT Strategic Framework and Key Delivery and Improvement Programmes required to give assurance of priority alignment and delivery / benefits realisation monitoring	Review and update/sign off ELHT Key Delivery and Improvement Programmes for 2023-24 to be reflective of system programmes	Executive SROs	September 2023	Completion of 2023-24 planning processes Ongoing review and update of key Trust strategies to ensure alignment to place and system plans as they evolve Final key delivery and improvement programmes and key measures being refreshed to support delivery during 2023-24	A
6.	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	Review of options ongoing and proposals in development. Next update to the Board in September 2023.	A
7.	Ongoing development of SPE+ improvement Practice and wider system Improvement Model which is aligned to the new NHS improvement approach to build capacity and support delivery of improvement work.	System review and response upon publication	Director of Service Development and Improvement	TBC once national timescales published	Sign off SPE+ Practice plan delivery plan for 2023-24 and monitor via Executive Improvement Wall. Engineering Better Care for L&SC launched and being tested as the system for improvement with Frailty as first programme area. Review of recommendations from NHS delivery and continuous improvement review underway.	A
8.	System and organisational capacity to support delivery of all agreed priorities	Continue to review demand and capacity and shape discussions on best way to configure system resources to support delivery	Senior Responsible Officers	End July 2023	System Programme Management Office and programme methodology in development. System resource scoping underway to align to Programmes for 2023-24. Ongoing review of ELHT capacity requirements.	R
9.	Full implementation of ELHT Accountability Framework	Full implementation of Trust Accountability Framework	Director of Finance/Director of Service Development and Improvement	End July 2023	Final review of framework underway, sharing with Trust Board and Senior Leadership Group planned. Quarterly review meetings to commence in July for Q1	A

BAF Risk 2 – Quality and Safety

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 Executive Director of Nursing	
Strategy: Quality Strategy	**Links to Key Delivery Programmes:** Quality and Safety Improvement Priorities	**Date of last review:** Executive Director: June 2023 ERAG: Due to the implementation of the EPR system in June 2023 there has not been an ERAG meeting. The next meeting will be in July 2023	**Lead Committee:** Quality Committee

Links to Corporate Risk Register:

Risk ID	Risk Descriptor	Risk Rating
9557	Patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provision.	**20**
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**20**
8126	Risk of compromising patient care due to lack of electronic patient record (EPR) system.	**20**
8033	Complexity of patients impacting on ability to meet nutritional and hydration needs.	**16**
9296	Inability to provide routine or urgent tests for biochemistry requests.	**16**
7165	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	**16**
8960	Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained.	**15**
8808	Burnley General Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke.	**15**
7764	Royal Blackburn Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke.	**15**

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

Current Risk Rating: **C5 x L4 = 20**
Initial Risk Rating: C5 x L3 = 15
Tolerated Risk C5 x L2 = 10 – to be determined
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.

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, Blood transfusion committee, organ donation

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.
- Patient champions in A&E
- Use of 24/7 ambulatory care on an intermittent basis to assist acute care (staffing dependent).
- Work is being undertaken with colleagues in primary care regarding patient pathways.
- Medical Examiners review the care provided to patients who have died in the Trust and can make recommendations or seek further action dependent upon their findings.
- Clinical Harms Review commenced from mid-December 2022 for patients waiting 52 weeks for treatment. It is being rolled over to specialties to assist in the management and prioritisation of waiting lists.
- Complex Case meeting weekly to monitor and allocate for investigation any patient/staff safety incidents identified.

committee, health and safety 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. Every morning at 8am, there is exec lead clinical safety meeting with A&E, divisions and flow team to manage and monitor patient admissions and flow.
- A&E Delivery Board lead by an Executive Director ensures processes are in place to help co-ordinate the care of patients between community, primary care, NWAS and ELHT

- The Patient Safety Incident Response Framework implementation was reviewed through a workshop with Non-Executives present in November. This confirmed learning from the first 12 months and a core focus on continuing to improve systems and culture during 2023-24.
- Monthly complaints and inquest drop-in sessions with each Division to monitor performance and highlight risk.
- 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.
- Due to improvement in its performance ELHT has now been stepped down from Tier system for monitoring cancer and elective 78-week patients.
- New PSIRP priorities are planned to be identified via an inclusive workshop to be held in Quarter 1.

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

- Integrated Care Board (ICB) have confirmed their contract requirements in relation to Quality reporting. Internal systems have been updated to ensure timely data and exception submission. First submission completed at the end of Q2.
- 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.
- Regular Updates on ICB EPRR.

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

- Annual organisational appraisal report.
- CQC inspections and preparation/evidence gathering ongoing.
- The Internal Audit Plan for 2023-24 has being developed by the Mersey Internal Audit Agency (MIAA) in conjunction with Trust colleagues and improvement actions plan reporting to Audit Committee.
- Regular Engagement meetings with General Medical Council (GMC). Coroner reviews of care provided through Inquest Processes.
- Public Participation Panel (PPP) involvement in improvement activities and walk rounds.
- PHSO complaints monitoring and external reports.
- Elective Care Recovery Board which includes regional and ICS level representation and scrutiny.
- Quarterly Guardian of Safe Working report (GOSW) for junior doctors.
- JAG accreditation in Endoscopy
- Regular GIRFT assessment and bench marking
- Annual organ transplant report to NHSE
- Patient Safety Walkrounds
- Board sign-off for SPEC recommendations
- Review of MHUAC with Stakeholders

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Fragility and availability of the 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	December 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. People and Culture Committee from September 2023. This will have an oversight on the workforce, wellbeing, education and training and leadership development	G Amber?
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.	Executive Medical Director/ Executive Director of Nursing/ Executive Director of People and Culture	March 2024	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.	G

		Ongoing improvement work to identify internal efficiency opportunities. Continued effort to appoint consultant to current gaps in the department			Early evidence of improvement work having impact on Histopathology turnaround times. 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. Histopathology risks combined on the Corporate Risk Register to enable clearer focus on impact and improvements required Work on going to implement digital pathology, this has an oversight from the pathology board, diagnostic board and ICB digital strategy board.	
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 September 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	September 2023 Registration agreed as no earlier than September 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. SLA is in the process of being signed. Individual patient MH risk assessment and MH strategy shared by LTHT, currently being adapted for adoption at ELHT.	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	September 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 Amber
6	Unprecedented demand on the Quality Governance team	a) 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 Next update to the Board will be in September 2023.	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.	G

					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.	
		b) 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. We are attempting to offer this PSP role as an opportunity to volunteers who are already engaged with the organisation.	Funding for these permanent posts will be required Role Descriptions completed A business case to fund the posts completed. Project Lead briefed Trust staff groups and some external organisations regarding the role and how to apply. Public engagement to continue until 2023, with a focus on awareness raising and ensuring an inclusive approach. Project Lead and the Trust's Communications Team have created a draft website in respect of communication package 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	A
8	Financial Constraints	Constraints in finances will result in lack of investment into workforce, development of service, capital investment and revenue. this has the potential to negatively impact on quality and safety	Executive Director of Finance / all Executive Directors	March 2024	Organisational focus on improvement methodology to improve productivity and efficiencies Waste reduction programme with Execs leading as SRO for various workstream – chaired by the CEO. Consolidation of previously approved schemes and QIA for ongoing projects and the ones which have been deferred for a later date. Ongoing work through PCB on clinical strategy and services.	Amber
9	Frequent industrial actions	a wide range of workforce, not limited to but including junior doctors, nurses, physiotherapist, pathology staff, teachers, transport staff, taking industrial action on a regular basis is posing significant risk to delivery of safe and timely service to patients. Negative impact on the wellbeing of the staff.	Lead is Peoples director but all exec directors	March 2024	Managing each industrial action through IMT. Constant attention and micro-management of waiting lists. Regular engagement with different trade unions Support from wellbeing team for workforce.	A

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

Risk Descriptor: A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.

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

Strategy: Clinical Strategy & Operational Strategy

Links to Key Delivery Programmes: Elective and Emergency Pathway Improvement

Date of last review: Executive Director: June 2023
ERAG: Due to the implementation of the EPR system in June 2023 there has not been an ERAG meeting. The next meeting will be in July 2023

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register

Risk ID	Risk Descriptor	Risk Rating
8061	Management of Holding Lists	**20**
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**20**
8941	Potential delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology.	**16**
6190	Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales.	**16**
8839	Failure to achieve performance targets.	**15**
8257	Loss of transfusion service.	**15**
7008	Failure to comply with 62-day cancer waiting time target.	**15**

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

Current Risk Rating: **C4 x L4 = 16**

Initial Risk Rating: C4 x L5 = 20

Tolerable Risk Rating: C4 x L3 = 12 – to be determined

Target Risk Rating: C4 x L2 = 8

Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Moderate

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

Overall planning and delivery processes:

- Robust annual planning processes and review processes in place to continually assess clinical and operational demand and capacity across all specialities, modalities and points of delivery.
- Demand and capacity at specialty and Point of Delivery level in place. This has been incorporated in the 2023/24 delivery plan with capacity approved investment against the 109% activity plan.
- Elective and Emergency pathway improvement are Key Delivery Programmes as part of the Trust Strategic Framework and supported by the ICB recovery plan (inclusive of theatres, diagnostics, cancer, endoscopy and outpatient).
- Improvement plans include theatre utilisation (85%) and monitoring of the diagnostic national minimal optimisation standards for CT and MRI.
- Trust clinical strategy developed covering a 5-year period to support ongoing delivery and development of elective and emergency care services.
- Development of systems and processes to support reduction in risk to Health Equity supported by a plan to address health inequalities at place level.
- Development of system and processes to assess and reduce risk of clinical harm potential for patients on both the elective waiting lists and emergency care pathways ensuring safe, personal and effective care.
- Collaborative working across Lancashire and South Cumbria on the delivery and development of both elective and emergency care services with programmes of work identified.
- Additional elective capacity provided through insourcing, Independent Sector contracts and Mutual Aid arrangements within Lancashire and South Cumbria ICB.
- Detailed 2023/24 activity plan aligned to performance trajectories taking into account the impact of TIF, anticipated efficiency gains, Community Diagnostic Centres (CDC) and the implementation of Cerner.
- Diagnostic modality level demand and capacity model completed across the ICB with trajectory to deliver 95% < 6 weeks by March 2025.

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

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

- The Trust met its trajectory to achieve the target in relation to 78-week waiters by 31 March 2023. There is further focus on preventing build up and reduction of >65 weeks in 2023/24 towards eliminating over 65 week waits by March 24.
- 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.
- Theatre utilisation (Capped) at >85% and to be sustained.
- Performance against the trajectory for achieving 76% of the 4-hour UEC standard by March 24.
- Ambulance handover times.
- Average time for senior clinical review within 60 minutes of arrival.
- 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 (zone working).
- 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.
- 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.

Specialist support, policy and procedure setting, oversight responsibility:

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

- Cancer 28 day Faster Diagnostic Standard (75% achievement by March 24) and > 62-day backlog (155 by March 24) agreed trajectory in place and monitored on a weekly basis.
- Cancer Tier 2 now stepped down following good assurance on sustained progress to NHSE colleagues.
- Annual business planning and review of progress against delivery in place. This includes performance trajectories for Urgent and Emergency Care including out of hospital (virtual ward, 2-hour Urgent Community Response), front door services (ambulance handover times, 76% 4 hour standard by March 24) same day emergency care (SDEC) and in-patient capacity planning supported by the bed model.
- A joint place delivery and improvement plan (via the Accident and Emergency Delivery Board (AEDB)) for urgent and emergency care (UEC) in place. Further work around primary care access needs to be confirmed from place leads/ICB.
- Internal executive led (triad) daily weekday 08:00 assurance huddle (15 mins) in place with service leads as part of the escalation process. This will be stood up during times of pressure.
- Robust planning arrangements in place for planned strike, winter and bank holidays to ensure appropriate capacity planning in response to the demand forecast.
- Visible performance dashboard for assurance (Emergency and Elective care) in place ensuring strengthened grip and control.

<u>Operational Management processes:</u>

- Robust daily operational management processes in place to support ongoing monitoring of activity, demand and performance. This includes forward projection of > 65-week RTT pathway delays ensuring equitable access based on clinical urgency and then chronological waits.
- Daily operational forecast of cancer waits including the 28 day Faster Diagnostic Standard and >62 day pathway level delays ensuring prevention of breaches.
- Weekly monitoring of activity delivery plan ensuring remedial actions at divisional and specialty level by point of delivery (PoD) – this includes monitoring of backlog reduction for RTT.
- Weekly Patient Tracking List (PTL) meetings with specialty leads including for cancer to ensure tracking at individual patient level
- Active implementation and monitoring of elective improvement plans for 2023/24 including theatre productivity (now at 85%), diagnostic clearance plans and OP booking to ensure effective support for delivering the overall plan.
- Successful implementation of waiting list validation (including chatbot) in place with value for money alternatives being explored. Validation status being monitored based on the national metrics ensuring 12-week cycle. The Trust is currently compliant against this.
- Holding list management to be a key area for OP improvement focus in 2023/24 alongside OP booking process to increase utilisation at 6 weeks ahead.
- Daily emergency care battle rhythm in place including high visibility of flow information from the executive team to frontline colleagues.
- Fortnightly Emergency Care Improvement Programme (ECIP) in place providing assurance for inflow (front end including SDEC) and flow (ward discharge process) improvements.
- Flow delivery group in place to oversee the operational implementation plan for the discharge process.
- 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
- Sustaining ambulance handover improvement and extending this to SDEC areas to spread ambulance handover performance.
- Systematic 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).
- Refreshed support to continue to strengthen internal ED processes to manage maximum time in department to 12-hours from arrival to discharge. This includes activation of enhanced escalation during surge and work in progress to finalise additional bed capacity on wards (Led by the Chief Nurse).
- Embedding successful improvements from the test of change weeks in Same Day Emergency Care (SDEC) areas such as the acute frailty pathway via Older Peoples Response Area (OPRA)
- Manage maximum length of stay (LoS) over 3 days on the Acute Medical Unit (AMU) and Emergency Surgical Unit (ESU) to maintain acute flow.
- Improve Multi-disciplinary Team (MDT) compliance against the agreed ward discharge process based on the best practice discharge bundle and board round effectiveness. A clinically led safe discharge MDT steering group in place.
- Clinical engagement with the required compliance to agreed standards and change plans ensuring ownership for discharge planning on admission.
- Sustaining community response services for both step-up (admission/attendance avoidance) and step down (timely discharge facilitation) care to maximise opportunities for admission avoidance and reduce demand for inpatient beds.
- Manage acute beds No Medical Criteria to Reside (NMC2R) to less than 10% of bed base with a stretch target of 5% of bed base in line with national requirements to maximise acute bed capacity for appropriate acute needs.

- 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 2 requirements.
- 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% by March 25, plans implemented at modality level.
- The clinical strategy is in place and now aligned with the LSC plans and the annual planning process.
- System level plan monitoring at Pennine Lancashire via AEDB and Integrated Care Board (ICB) level via relevant system forums
- National UEC recovery plan requirements aligned to place based plans.
- Enhanced escalation policy which is activated when patients have been in the emergency department for an excessive amount of time (12 hours from arrival) in place 24/7supported by surge escalation capacity on the inpatient wards during times of pressure.

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

- Elective recovery and annual plans signed off by Lancashire and South Cumbria Integrated Care Board (ICB), regional and national teams.
- Tier 2 meetings for cancer now de-escalated due to assurance on sustained progress. Cancer Alliance oversight in place as part of the ICB assurance model.
- Weekly NHSE submission for >78 week risks signed off by the CEO.

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

- A total escalation bed reduction of 53 beds (27 community and 26 acute medical beds) from April 23 has warranted increased mitigation including revised surge escalation capacity. Impact of the bed reduction plan to release a decant ward for fire prevention works will be monitored against the bed demand and capacity model.
- Winter arrangements will consider a further 48 escalation beds once the fire prevention works is completed and the Heart Centre is in place.

Oversight arrangements:

- Theatre improvement Outpatient improvement boards chaired by Chief Operating Officer (COO) and Director of Service Development and Improvement respectively for assurance on delivery of performance and improvement plan
- Monthly outpatient steering group chaired by the Executive Director of Service Development and Improvement overseeing outpatient improvement plan with Patient and Public Panel representatives.
- Weekly Operational performance meetings focusing on high-risk areas and delivery of agreed improvement trajectories.
- Weekly monitoring of Referral to Treatment (RTT) and cancer wait time position using performance dashboard at specialty/tumour site level.
- Theatre Utilisation Improvement Board in place and aligned with GIRFT requirements, targeting over 85% utilisation.
- Governance processes have been reviewed around theatre utilisation and introduced support and challenge sessions with the Chief Operating Officer and Deputy Medical Director for Performance for any specialties that do not achieve trajectory as intensive support.
- 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 during potential/actual site pressures.
- ELHT Emergency Care Improvement Steering Group meets every 2 weeks to monitor the implementation of the UEC improvement plan across ELHT covering inflow and flow with a Quality Improvement (QI) focus.
- AEDB meets every 2 weeks to oversee the implementation of the system UEC improvement plan with primary care, place based leads and ICB representatives.

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Activity 109% of 2019-20 levels not achieved consistently	The controls and weekly monitoring taking place to work towards the achievement of the 109% trajectory.	Chief Operating Officer	March 2024	Weekly monitoring meetings with Chief Operating Officer/ deputy.	A
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 completed, and discussion are ongoing around mutual aid to across the Lancashire and South Cumbria area ensuring patients have equity of access. Endoscopy is a key area of risk due to demand volumes.	A
3	Increased >62-day backlog	Joint work with the Cancer Alliance on improvement Continued Tumour site level detail to prevent backlog Implement 0-day Patient Treatment List (PTL) management Continued focus on delivering 75% cancer related diagnostics within 28 days of urgent GP referral Continued transparency of backlog delays at tumour site level for targeted preventative interventions	Chief Operating Officer	March 2024	De-escalated from Tier 2 due to sustained assurance on the backlog reduction (as per NHSE feedback) with good examples of best practice. Further work in progress to include 0-day PTL management, tele-dermatology service and embedding FIT for colorectal referrals.	A
4	Low Outpatient (OP) utilisation (6 weeks ahead)	Monitor utilisation at aggregate and specialty level 6 weeks ahead and 6 weeks retrospective performance Review and improve the booking process as part of the Trust QI process ensuring standardisation	Chief Operating Officer	September 2023	OP Dashboard in place. QI booking process kick off on the 12th April 2023. Further work up on the booking process post Cerner implementation.	A

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

5	Increase and sustain capped theatre utilisation to 85% by March 2023	Improvement trajectory in place Performance oversight and support in place Sustain improvements in achieving specialties and intensive support for other specialties	Chief Operating Officer	August 2023	Currently, aggregate position at 86% (March 2023). Risks to sustain continue.	**A**
6	Continued risk of >78 week RTT breaches and risk of not delivering < 65 week maximum wait by March 2024.	Daily forward look for 3 months ahead in place Demand and capacity at specialty review completed with improvement actions Aim to work on preventing >65 week waits by end of Q2 with clearance at 65 – 70 weeks by end of Q1 2023/24 Junior Doctor strikes remain a risk to delivery. Mitigating plans in place focusing on clinical urgency, cancers and long waits as priority groups for any residual activity during this time. Rescheduling managed a working day before the strike to ensure managed displacement of slots.	Chief Operating Officer	October 2023	Nil >78-week breaches in March 23. April 23 has 15 at risk and all dated in month. This is being monitored daily under the Deputy COO leadership with the DDoP team.	**A**
7	Workforce gaps causing delay in treatment access and financial deficit may restrict locum/agency capacity	Demand and capacity review in place at specialty level Recruitment and locum cover sought to ensure gaps are addressed in key specialties Insourcing capacity where required if workforce availability is limited (such as endoscopy) Monthly review of financial spend and real time escalation by divisional triad to COO/Deputy COO of locum/agency needs in pressured specialties to review on a case-by-case basis with a clear exit plan with the Executive Director of Finance	Chief Operating Officer	End of July 2023	Current activity plan for 109% predicated on resource support for investment. This will also support the delivery of <78 weeks progressing to <65 weeks RTT wait by March 24. The >62 day backlog trajectory of 155 by march 24 is also reliant on capacity investment including locum support (e.g. Colorectal).	**A**
8	Mental Health inpatient capacity constraints pathways requiring further plans with LSCFT to minimise delays for MH patents 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 of July 2023	Revised operating model by LSCFT to support timely mental health assessment treatment and/or intervention. Improved responses to delayed admissions of patients with MH needs requiring admission to LSCFT facilities/Out Of Area MH provider. However, delays still experienced and will require close monitoring in combination with LSCFT colleagues with escalation process.	A
9	Improved ED processes for managing to a maximum of 12-hours total time from arrival to discharge, transfer or admission to ward	Support consistent compliance to agreed internal ED processes to ensure timely senior reviews, decision making and use of alternative pathways including a stronger focus on reducing delays for patients on non-admitted pathways. Support timely access to ward admissions from ED through the improvement in flow principles and the Trust escalation capacity for managing a time limited surge/overcrowding in ED	Executive Director of Integrated Care Partnerships and Resilience / Chief Operating Officer	End of September 2023	Refresh of the support plan in progress with oversight from the Medical Director. This includes OD as part of the wider development programme scheduled to commence by September 2023. The Flow Delivery Group will be implementing the discharge pathway 0 principles through a focused MDT steering group across RBH from July 23 (following Cerner implementation and transition).	A
10	Strengthen ward discharge bundle and clinical ownership for timely discharges	Embed the discharge bundle across all wards with clinical champions to promote best practice. Release the discharge matron colleagues from community bed management functions to enable a dedicated focus on pathway 0 discharges and ward support for preparing pathways 1, 2 and 3 patients for the community teams to case manage.	Executive Medical Director/ Executive Chief Nurse/Executive director of Integrated Care Partnerships and Resilience	End of September 2023	The discharge bundle has been introduced across all wards. Initial internal audit (draft) suggests low compliance. Plans in place to re-establish the discharge matron focus on pathway 0 discharges by 17th April 23. Safe Discharge Multi-disciplinary team (MDT) steering group established in May 23 to drive through clinical changes at ward level. NHSE visit in May 23 following the Trust rated as one of the top 11 organisations for high discharge pathway 0. Positive feedback received from NHSE on observed best practice during the visit.	A
11	Bed model for medicine suggests a gap of around 100 beds (including the 53 de-escalated beds). This is further exacerbated with the immediate need to create decant wards at BGH and RBH sites resulting in a 53-bed reduction from 17th April 23.	Monitor impact of 53 bed reduction. Increased efforts around pathway 0 discharges with the discharge matron team. Continued admission avoidance via ED and SDEC pathways as well as IHSS team.	Executive Director of Integrated Care Partnerships and Resilience/ Chief Operating Officer	End of October 2023	Bed model in place. Further work around non-elective LoS at specialty level in progress although overall LoS is within national average. Discharge matrons to re-focus on pathway 0 from 17th April 23.	**A**

		Home including rehab as a default for pathways 2. Increased use of pathway 1.				
12	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 of July 2023	The aim is to reduce by 50% the number of patients who take more than 30 minutes for handover. 40% reduction was achieved in March 23.	A

BAF Risk 4 – Culture Workforce Planning & Redesign

Risk Description: The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.

Executive Director Lead: Executive Director of People and Culture

Strategy: People Plan

Links to Key Delivery Programmes: People Plan Priorities

Date of last review: Executive Director: June 2023
ERAG: Due to the implementation of the EPR system in June 2023 there has not been an ERAG meeting. The next meeting will be in July 2023.

Lead Committee: Quality Committee

From September 2023 this will be People and Culture Committee

Links to Corporate Risk Register:

Risk Number	Risk Descriptor	Risk Rating
5791	Failure to recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance.	15

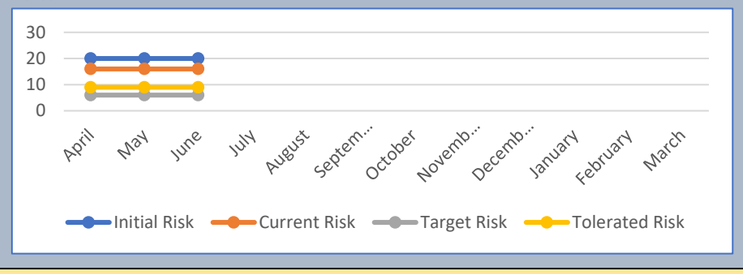
Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: **C4 x L4 = 16**

Initial Risk Rating: C4 x L5 = 20

Tolerated Risk Rating: C3 x L3 = 9 – to be determined

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 and 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.
- 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.

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.
- Seven 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
  - Internationally trained nurses
- 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.

BAF Risk 4 – Culture Workforce Planning & Redesign

• 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. • Recruitment and retention strategy group established which is Executive led. This group is developing the Trust recruitment and retention strategy and identifying improvements that can be made to help attract and retain nurses in to the ELHT workforce. • 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.	• The Trusts new SPE+ leadership programme has been launched with the first cohort underway. Roll out of the management pathway and additional leadership modules will be launched in September. • 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. • . • 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> • Director of People and Culture is involved in a national staff experience forum. • Integrated Care System (ICS) Equality, Diversity and Inclusion (EDI) collaborative is in place to support the development and sharing of best practice. • ICS Culture and Belonging Strategic Group established • Trust Chair and NED EDI lead are members of the regional BAME Assembly. • The Trust has received bronze accreditation as part of the National Rainbow Badge Accreditation Programme and has a robust action plan in place based on learning from this. • The Trust has a Partnership Officer (link between the Unions and Trust) who works with the Director of People and Culture 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. • Recruitment, retention and staff in post data is monitored through IPR and Quarterly Workforce Report to FPC. • Policies and procedures at a workforce level are done through engagement at divisional level and with staff networks, work with staff side colleagues and through agreement via the policy group and ratification at a Trust Board and Sub-Committee level. • Human Resources (HR) Directors Group across the ICS inform and monitor delivery of the system level workforce agenda but also direct Trust activity where collaboration has been agreed or where opportunities have been identified. <u>Independent challenge on levels of assurance, risk and control:</u>

- 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.
- 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	Full roll out of the behaviour framework	Additional communications and OD support with individual teams inclusion in the recruitment process.	Executive Director of People and Culture	End of September 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 should have been presented to the Quality Committee in March 2023, however this had to be deferred due to time. It is proposed that this is now taken to the new People and Culture Committee in September	G
2	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	End of 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. There will be a review of the Trust's commitment to the inclusion agenda to reflect delivery based on the newly published NHS England national Equality, Diversity and Inclusion improvement plan.	A
3	Reducing the Trust vacancy gap	To achieve zero registered nurse vacancies and improve turnover through recruitment and workforce transformation activity.	Executive Director of People and Culture	End of July 2024	A recruitment and retention group has been established and has developed a trajectory to deliver zero vacancies by July 2024. This group is also developing initiatives to assist in retention of staff through greater flexible careers, flexible working, benefits etc. The Trust is working with colleagues across the ICS to deliver a workforce capacity programme aimed at reducing vacancies and securing future workforce pipelines. Specific work is underway to address shortages in specific roles, leading to fragile services such as diagnostics.	G

BAF Risk 4 – Culture Workforce Planning & Redesign

4	Improve Trust retention levels / Develop Retention Strategy	Implementation of targeted plan to deliver the national People Promise of Flexible Working and development of a Trust Retention Strategy.	Executive Director of People and Culture	End of July/September 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. Work on developing the Trust's retention strategy is ongoing, the strategy to go through Executive Team and then be presented to Quality Committee/ People and Culture Committee. The wider retention strategy requires further development and will be taken through the Executive Team and then be presented to Quality Committee/ People and Culture Committee. 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.	G
5	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	End of July 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 is being developed. This plan will be routed through PCB and ICB People Board as part of the governance for the Workforce Resilience and Sustainability Programme.	A
6	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	End of September 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. Now that the PCB have agreed a target operating model for the central services function, work will progress to determine the future direction for OHWB The OD and Well team are continuing to explore how staff can be further supported during this ongoing period of unprecedented demand.	G
7	Risk of loss of service due to national industrial action.	Ongoing management of action through Industrial Action Cell.	Executive Director of Integrated Care, Partnerships and Resilience	Next update to the Board in July 2023.	The potential impact of ongoing industrial action is monitored through the Industrial Action cell which meets weekly. Regular discussions with staff side colleagues both within the Trust and across the ICS are taking place to maintain relationships and to enable partnership approach to managing the impact of any further action.	G

BAF Risk 5 – Financial Sustainability

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

Executive Director Lead: Executive Director of Finance

Strategy: Finance Strategy

Links to Key Delivery Programmes: Waste Reduction Programme

Date of last review: Executive Director: June 2023
ERAG: Due to the implementation of the EPR system in June 2023 there has not been an ERAG meeting. The next meeting will be in July 2023.

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR):

Risk ID	Risk Descriptor	Risk Score
9771	Failure to meet internal and external financial targets for the 2023-24 financial year	25
9222	Failure to implement the NHS Green Plan	16

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

Current Risk Rating: C5 x L5 = 25

Initial Risk Rating: C5 x L4 = 25

Tolerated Risk Rating: C5 x L3 = 15- to be determined

Target Risk Rating: C5 x L2 = 10

Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/Moderate

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

Organisation

- Financial Recovery plan (short term) in place including additional controls
- Financial plans for 2023-24 developed via annual planning process, not currently signed off or agreed
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations. The last review was completed in April 2023.
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Waste reduction programme 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:

- 2022-23 financial targets achieved in accordance with agreed stretch plan to break even.
- 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, savings not fully identified.
- Additional financial controls are in place to reduce spend.
- Draft Financial Plans for 2023-24 were presented to Finance and Performance Committee March 2023, not yet approved nationally. Stretch target being requested.
- Financial recovery actions underway.
- In-depth review of the additional financial pressures identified in year have been determined. Mitigations etc will be reported through Finance and Performance Committee.
- Financial controls document has been developed and circulated through the Trust.

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 2023-24, clean Head of Internal audit opinion received, clean external audit of annual accounts for 2021-22 received (awaiting 2022-23 through final accounts sign off), counter fraud workplan for 2023-24 agreed.
- Mersey Internal Audit Agency (MIAA) audit of Care Quality Commission (CQC) Well-led evidence underway.

BAF Risk 5 – Financial Sustainability

	• Re-accreditation at Finance Staff Development (FSD) level 3 (the highest level) for financial management within the finance team and supporting the wider organisation. High level of qualified staff in department (53%) with a further 35% in training.

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	No signed contract nor agreed financial plan for 2023-24	Continue to develop plans for system, region and national sign off, and documenting all risks of reducing expenditure in line with expectations.	Executive Director of Finance	End of July 2023	System plan agreed internally but with significant financial risk. Awaiting national sign off.	A
2	Fully identified Waste Reduction Programme (WRP) 2023-24/Financial recovery plan. Risk to elective recovery, quality and safety of stretch target financial plans	Continue work with Divisions and central to develop plan for 2023-24. Ensure all schemes have Quality Impact Risk Assessments (QIRA) assessment, and document risks of non-delivery, cost reduction. Ensure Board oversight of all risks. Ensure safety not compromised.	Executive Director of Finance / Executive Directors	End of July 2023	WRP target levels still to be determined. C£35m identified to date. Exec and SLG focussed sessions taken place. Anticipated that 70% of the WRP will be identified by the end of Q1 2023-24. All schemes will have QIRA assessments.	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	End of July 2023	ICB proposals being reviewed by provider governance.	A
4	Lack of full knowledge of system financial flows recognised in the NHSE review	Work with system CFOs to determine full flows and impact on ELHT	Executive Director of Finance	Q2 2023-24	Work to continue through Provider Finance Groups.	R
5	ICB/PCB workplan identification and capacity	Work with system to ensure plan developed and capacity gaps rectified and mitigated	Executive Director of Finance	End of July 2023	2 system meetings to identify specifics. Joint meeting CFOs/Operational colleagues to take place.	R

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

12 July 2023

Item 88

Purpose Information / Decision

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 the outcome of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel decision-making process on high level investigation reports.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 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. A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Impact

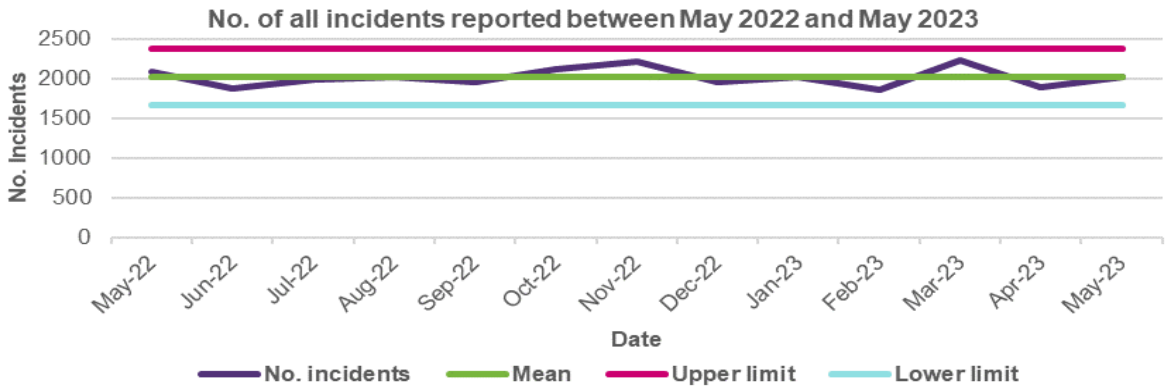
Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: No formal Committee

Safe | Personal | Effective

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. Most harm types have remained at a similar level for the past few months.

1.3 There was a spike in incidents resulting in severe harm in April which equated to 6 compared to 1 in March 2023, this increase did not continue into May 2023. Of the 6 reported in April, 3 of the incidents were falls resulting in a fractured neck of femur, 2 of which were related to the same patient.

1.4 Discharge or transfer incidents have continued to increase over the last 3 months; however, this is not unexpected with the current pressures.

1.5 Incidents of slips, trips and falls have continued to increase for the past 4 months, there has been an increase into May 2023 of slips, trips and falls resulting in Low/Minor harm. Falls Steering Lead has been informed and will review data and discuss in the Falls Steering Group.

2. Duty of Candour

2.1 There have been 19 reported incidents of moderate and above harm in May 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). Table 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.

Table 1: National and Local incidents reported by categories by fiscal year since 1st Dec 2021

Category	Priority	2021/22	2022/23	2023/24	Total
Local	ED Transfer/Handover	0	2	1	3
Local	Fall Fracture Neck of Femur	1	2	0	3
Local	NBM+5 days Vulnerable Adult	1	3	0	4
Local	104-day cancer breach	0	1	0	1
Local	DNACPR	1	1	0	2
National	Death	8*	13	1	22
National	Never Event	1	2	4	7
National	Screening Incident	0	1	0	1
National	HSIB Investigation - Maternity	2	6	0	8
National	Neonatal Death	0	2	1	3
National	Safeguarding	0	1	0	1
Total reported		14	34	3	55

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

3.2 Of the 55 reported PSIIs:

- 26 have been fully investigated and either de-escalated or approved for closure by the Trusts PSIRI panel.
- Of the 29 incidents currently under investigation
  - There are 21 investigations currently open to the ELHT Patient Safety Incident Investigation Team.
  - A further 8 Incidents are currently being investigated by the Healthcare Investigation Branch (HSIB) on average these take 6 months before the Trust receive the final report.

4. Never Events (reporting 2023)

4.1 Of the 28 incidents currently open to investigation 5 of these are Never Events which have been reported since the 1st January 2023. The table below provides a brief overview of these incidents.

Table 2: Never Events Overview

Incident type	Reported	Division	Comments	Immediate learning/actions identified from round table discussions	Action Plan
Wrong site surgery (Nerve block) Low Harm	Feb 2023	SAS	The incident has been reported in StEIS as a Never Event. Round table meeting completed, and immediate learning identified regarding 'stop before you block'. PSII investigator appointed working with Division.	New National guidance for Prep, Stop, Block not implemented which introduces a new step of Prep then stop and check. • Update of current 'Stop before you block' guidance in line with new national guidance. • Anaesthetic & theatre staff training on prep, stop, block. • Posters displayed in all anaesthetic rooms as a visual reminder to staff	Investigation ongoing
Transfusion of ABO-incompatible blood components	Apr 2023	MEC	The incident has been reported on StEIS as a Never Event and has been SHOT reported. A round table has taken place. PSII investigator has been appointed.	Final Patient ID checks not completed in line with policy. Staff unaware the policy states agency staff cannot lead on transfusion process. • Staff Blood transfusion training compliance reviewed by division to identify any staff requiring update training. • Incident shared for dissemination with all matrons and ward managers at team staff huddles (importance of following safety checks and policy)	Investigation ongoing
Wrong site surgery (injection)	Apr 2023	SAS	The incident has been reported on StEIS as a Never Event. A round table has taken place with immediate learning identified. PSII investigator has been appointed.	No clear guidance for 'List Me' app when a procedure is not on drop down list when booking patients for theatre. • Email sent to all SAS staff, important of checking the last clinical notes before completing consent forms and operation. • 'List Me' drop down discussed with theatres operation team to use OTHER if procedure not on drop down list.	Investigation ongoing

				• Communication regarding allocation of patient on theatre lists when they are cancelled or changed	
Wrong implant	May 2023	SAS	The incident has been reported on StEIS as a Never Event. A round table has taken place with immediate actions identified. PSII investigator has been appointed.	Nobody at the time visually confirmed the laterality of the implant but this was clearly written on the box. • Implantation step been updated and including in online training. • Implanting will form a formal recognised step of SOP I line with new national NatSSIPs 2 guidance. • SOP re-circulated to all theatre staff with reminder	Investigation ongoing
Misplaced naso-gastric tuber	Jun 2023	SAS	The incident has been reported on StEIS as a Never Event. A round table has taken place with immediate actions identified. PSII investigation has been appointed.	Staff understanding of when to use NG Care bundle due to title stating 'Feeding'. • All wards undertaking point prevalence audit on NG tube documentation / use of care bundles. • Reiterated to all staff, importance of completing the NG Tube care bundle and documented clearly in case notes.	Investigation ongoing

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 B provides a breakdown of the types of PSR investigations and numbers undertaken as of 23rd June 2023.

5.2 Of the 1623 PSRs requested, 931 (57%) are for pressure ulcers.

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.

6. PSIRI Panel Approval and Learning from Reports

6.1 During April and May 2023, 2 new PSII reports were presented at the Trusts PSIRI panel. Both reports were approved by the panel with some minor amendments required, however the safety improvement plans are still required to be submitted to the panel by the Divisions.

6.1.1 Incident resulting in death: (eIR1234124) – The report highlighted opportunities to develop the learning for doctors and nurses in relation to presentation, diagnosis, investigation, management and investigation of bowel obstructions, perforations, acute kidney injury and cardio-renal syndrome. Other improvements highlighted were in relation to the referral pathways between specialities, and the quality, awareness, and accessibility of the bowel obstruction pathway. Some audits were also suggested to identify further themes and trends and potential areas for further improvements.

6.1.2 Incident resulting in death: (eIR1241011) – The report highlighted opportunities to improve the processes regarding the use of National Early Warning Scores in line with Trust Policy within the Emergency Department.

6.2 Five further PSII reports that had been previously reviewed by the panel, were returned for approval of amendments and safety improvement plans. All were approved but 1 required the further work on the safety improvement plan and to be resubmitted to the panel.

6.3 One HSIB report relating to Hypoxic Ischaemic Encephalopathy was presented to the panel in April 2023. The actions raised were to be added to the overarching Maternity action plan, it was also requested that future HSIB action plans be annotated to demonstrate recommendations already linked to ongoing workstreams.

7. Themes, Trends and Learning

7.1 Since January 2023 the Trust has reported 5 Never Events (as in section 4), key messages have been developed and communicated across the Trust to raise awareness of these events with staff. The key message focus was highlighting the importance of staff completing all safety checks before any safety critical procedure. Communication has included:

- Patient Safety Bulletin published in April 2023
- Never Event Poster developed by SAS Division but covers all 5 incidents and shared across all division to display in staff areas in June 2023
- Several re-focus messages on safety checks communicated within Trusts weekly bulletin
- Use of multi-media to share information with staff

7.2 A Patient Safety Summit was held on 26th June on the 5 Never Events reported in the Trust since January 2023 with a focus on Back to Basics. Learning from the event is currently being reviewed and will be disseminated across the Trust and will help inform the Never Event safety improvement plans. The agenda of the summit focused on:

- What has happened (breakdown of reported Never Events and incident Learning)
- Understanding why? (What impacts on pathway completion)
- Understanding How? (What is ELHT's Patient safety culture)
- Psychological safety (What does it mean and why is it important to patient safety)
- What works? (Identifying good practice for sharing)

- What next? (Expectations of attendees, rising the profile of patient safety as business as usual)

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.

8.2 Nil by mouth (NBM) in vulnerable adults – two investigations completed and two 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. Quality Improvement currently working with key staff to develop improvement programme.

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. Quality Improvement currently working with key staff to develop improvement programme.

8.4 Falls, fractured neck of femurs (#NOF) - two investigation completed. 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. Quality Improvement currently working with key staff to develop improvement programme.

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. Quality Improvement currently working with key staff to develop improvement programme.

9. Mandatory National Patient Safety Syllabus Training Modules

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

9.2 Staff roles determine which level(s) they need to complete but all staff must complete level 1a. The target is for 95% of staff to have completed training by the end of March 2024. All levels are on target.

Table 3: Patient Safety Syllabus Training (as of 29th June 2023)

Patient Safety Training Modules	KPI Target Q1	% of staff completed training
Patient Safety Level 1a – all staff	50%	73.9%
Patient Safety Level 1b – Boards and senior leadership	50%	55.5%
Patient Safety Level 2 – Essential to role	50%	65.6%

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

10.1 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 50 maternity related incidents have been reported on StEIS of which:

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

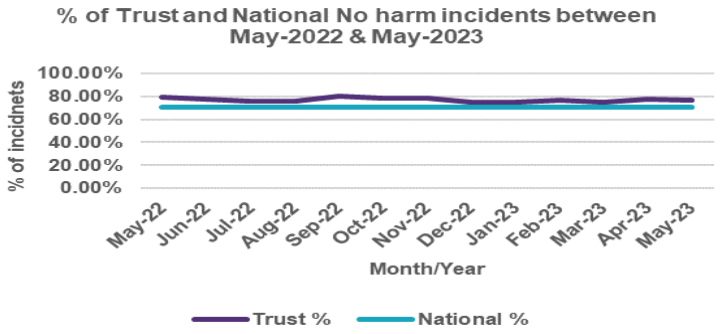
10.2 The Family care divisional PMRT update will continue to be presented at ELHT Trust Board each quarter detailing any deaths that have occurred and cases that have been reviewed with any learning or issues identified. This is a specific ask of CNST safety action one. Prior to trust board submission these cases will be reflected through the divisional mortality report with any exceptions

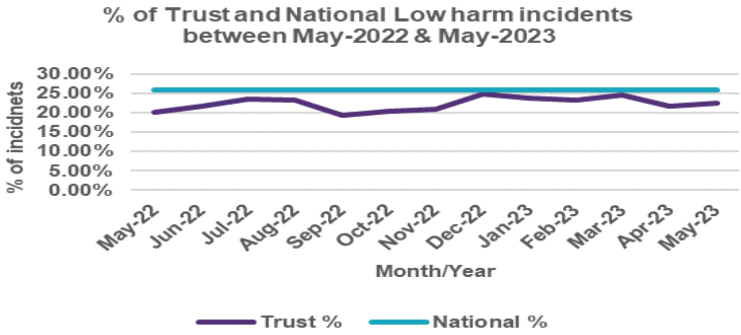
to be reported at trust wide patient safety group aligned with CNST submissions. In addition, specific details for CNST Year four, safety action 1 and the required standards aligned with the Perinatal mortality review process is reflected in the maternity and neonatology update being presented to trust board on the 12th July 2023.

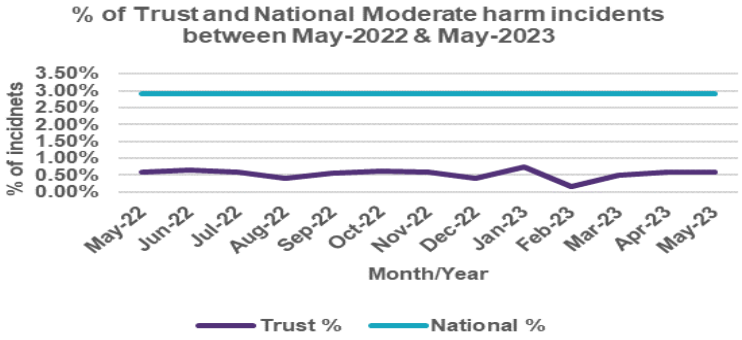
Jacquetta Hardacre, Assistant Director of Patient Safety and Effectiveness

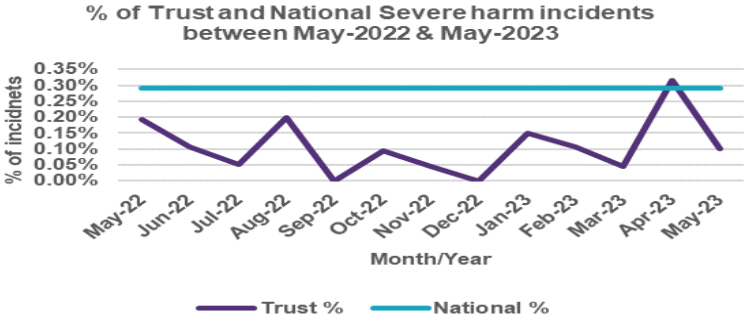
Lewis Wilkinson, Incident and Policy Manager

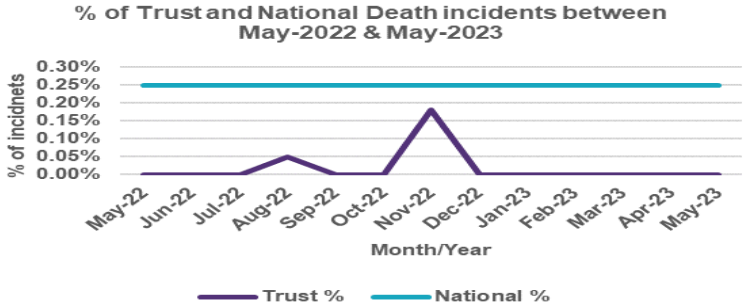
Appendix A: ELHT Incidents by Level or harm Vs National Average



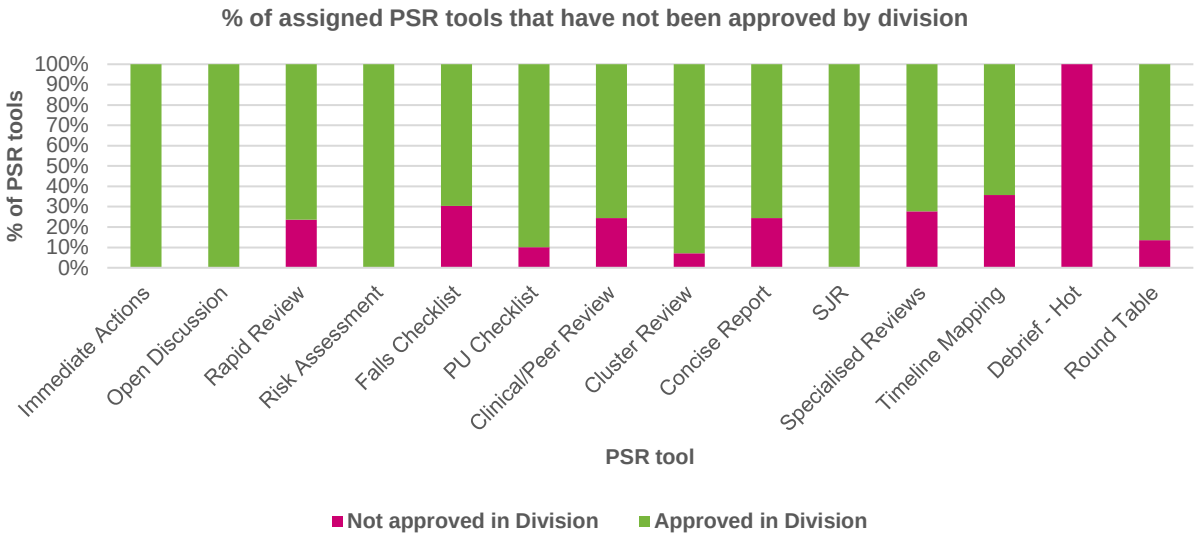


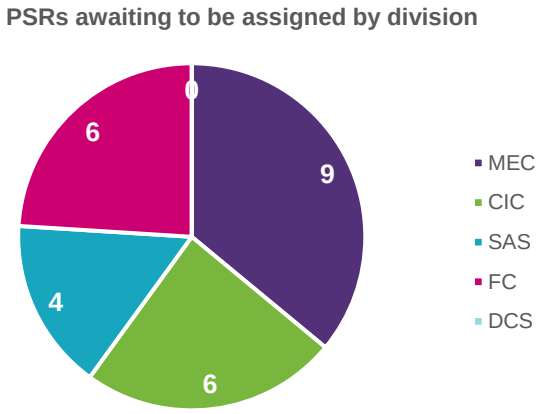






Appendix B: Patient Safety Response Overview





No. of PSRs	
Investigation tool	**No.**
Immediate actions	1
Open discussion	5
Rapid review	246
Risk assessment	1
Falls checklist	46
Pressure checklist	931
Clinical/Peer review	78
Cluster review	14
Concise report	123
SJR	1
Specialised reviews	101
Timeline mapping	28
Debrief - Hot	1
Round table	22
Awaiting to be assigned	25
Total	1623

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

12 July 2023

Item 89

Purpose Information Assurance

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

Summary: This paper presents the corporate performance data at May 2023

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 strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2. The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3. A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4. The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5. The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

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

- The Cancer 28 day faster diagnosis standard was achieved in April at 79.5%.
- Average fill rates for registered nurses/midwives and care staff remain above threshold and staffing in May has been slightly less challenging.
- Friends & family scores remain above threshold for inpatients, outpatients and community.
- The overall Trust performance from the range of patient experience surveys was above the threshold of 90% for all of the 4 competencies.
- There were 60 Delayed discharges at the end of May, below trajectory (79).
- There were 45 operations cancelled on the day (non-clinical). This continues to show a significant reduction.
- The Trust turnover rate is showing a significant reduction this month at 6.4%
- In May, there was 2 breaches of the 28 day standard for operations cancelled on the day.

Areas of Challenge

- There was 1 MRSA infections detected in month
- There were 3 Steis reportable incidents in May. 1 of these was a never event
- There were 4 healthcare associated clostridium difficile infections, 11 post 2 day E.coli bacteraemia and 2 Klebsiellas detected in month.
- There were 2 P.aeruginosa bacteraemia identified in May bringing the year to date total to 5 vs the annual trajectory of 7.
- Friends & family scores in A&E and maternity 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 May at 76.4%, but was above the 70% improvement trajectory.
- There were 968 breaches of the 12 hour trolley wait standard (39 mental health and 929 physical health).

- There were 406 ambulance handovers > 30 minutes and 16 > 60 minutes. Following validation, 5 were due to ED delays and 11 were due to non-compliance with the handover screen.
- Performance against the cancer 62 day standard remains below threshold in April at 63.6%.
- There were 13.5 breaches of the 104 day cancer wait standard.
- The 6wk diagnostic target was not met at 8.4% in May.
- In May, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 53,184, which is below the trajectory.
- The number of RTT pathways over 65 weeks has increased to 167. This is just 4 above the trajectory.
- In May, there were 1696 breaches of the RTT >52 weeks standard.
- Length of stay - non-elective continues to be above baseline and has moved into quartile 3, just above national average (Model Health data)
- Sickness rates are above threshold at 5.5%
- The Trust vacancy rate is above threshold at 6.2%
- Compliance against the Appraisal (AFC staff) remains below threshold. Appraisals were on hold until March 21.
- Compliance against the Information Governance Toolkit remains below the 95% target at 93%.
- Temporary costs as % of total pay bill remains above threshold at 14%.
- The Trust is reporting a breakeven duty deficit of £9.3m for the 2023-24 financial year to date, £3.2m behind plan, largely due to a £2.5m underachievement of the Waste Reduction Programme.

No Change

- The Summary Hospital-level Mortality Indicator (SHMI) has remained as expected at 1.07.
- The complaints rate remains below threshold and is showing no significant variation.
- Venous Thromboembolism (VTE) risk assessment performance remains above threshold.
- The emergency readmission rate is showing no change to baseline.
- CQUIN schemes are in operation for 2023/24, although many of the schemes are continued from 2022/23. With the reintroduction of partly variable Commissioner contracts, there is a risk of clawback for under-performance against scheme targets and thresholds.

Introduction

This report presents an update on the performance for May 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
M65	MRSA	0	1		
M64	Clostriduim difficile (C.diff) - 'Hospital onset healthcare associated (HOHA)'	n/a	3		
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	1		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	53	11		
M124	E-Coli (HOHA)	n/a	6		
M124.ii	E-Coli (COHA)	n/a	5		
M124.iv	E-Coli cumulative from April (HOHA & COHA)	129	22		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	0		
M155.ii	P. aeruginosa bacteraemia (COHA)	n/a	2		
M155.3	P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)	7	5		
M157	Klebsiella species bacteraemia (HOHA)	n/a	1		
M157.ii	Klebsiella species bacteraemia (COHA)	n/a	1		
M157.3	Klebsiella species bacteraemia cumulative from April (HOHA& COHA)	41	2		
M66	Never Event Incidence	0	1		
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	10.3		
M69	Serious Incidents (Steis)	No Threshold Set	3		
M70	Central Alerting System (CAS) Alerts - non compliance	0	2		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	97%		

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	97%		
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	37%		
C40	Maternity Friends and Family - % who would recommend	90%	91%		
C42	A&E Friends and Family - % who would recommend	90%	77%		
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%	95%		
C15	Complaints – rate per 1000 contacts	0.40	0.16		
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.07		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at Feb-23)	Within Expected Levels	111.2		
M74	Hospital Standardised Mortality Ratio - Weekday (as at Feb-23)	Within Expected Levels	109.6		
M75	Hospital Standardised Mortality Ratio - Weekend (as at Feb-23)	Within Expected Levels	115.9		
M159	Stillbirths	<5	2		
M160	Stillbirths - Improvements in care that impacted on the outcome	No Threshold Set	n/a		
M89	CQUIN schemes at risk	CQUIN schemes have been reintroduced for 2022/23			

Responsive

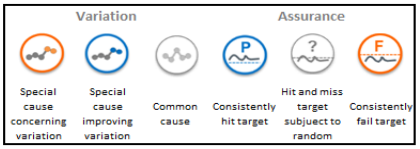
	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95.0%	75.1%		F
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95.0%	76.4%		F
M62	12 hour trolley waits in A&E	0	968		F
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	406		F
M84	Handovers > 60 mins (Arrival to handover)	0	16		F
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	44.3%		
C3	Referral to Treatment (RTT) non admitted pathways: percentage within 18 weeks	No Threshold Set	67.9%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	55,757	53,184		
C37.4	Referral to Treatment (RTT) 65 Weeks (Ongoing)	163	167		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	1450	1696		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	5.0%	8.4%		P
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	63.6%		?
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	75.9%		?
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	84.3%		?
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	98.4%		P
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	86.7%		?
C36	Cancer 62 Day Consultant Upgrade	85.0%	77.2%		?
C25.1	Cancer - Patients treated > day 104	0	13.5		?
C47	Cancer - % Waiting over 62 day (Urgent GP Referral)	N/A	9.50%		
C46	Cancer - 28 Day faster diagnosis standard	75.0%	79.5%		?
M9	Urgent operations cancelled for 2nd time	0	0		
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	2		?
M138	No.Cancelled operations on day	No Threshold Set	45		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re admissions within 30 days	No Threshold Set	12.8%		
M90	Average length of stay elective (excl daycase)	No Threshold Set	3.6		
M91	Average length of stay non-elective	No Threshold Set	5.6		

Well Led

	Indicator	Target	Actual	Variation	Assurance
M77	Trust turnover rate	12.0%	6.4%		
M78	Trust level total sickness rate	4.5%	5.5%		
M79	Total Trust vacancy rate	5.0%	6.2%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	74.0%		
M80.35	Appraisal (Consultant)	90.0%	98.0%		
M80.4	Appraisal (Other Medical)	90.0%	94.0%		
M80.2	Safeguarding Children	90.0%	96.0%		
M80.21	Information Governance Toolkit Compliance	95.0%	93.0%		
F8	Temporary costs as % of total paybill	4%	14.0%		
F9	Overtime as % of total paybill	0%	0%		
F1	Cumulative variance to planned financial performance (deficit) (£m)	£0.0	-£3.2		
F2	WRP achieved YTD - variance to plan (£m)	£0.0	(£2.5)		
F3	Liquidity days	-25.8	-19.4		
F4	Capital spend v plan	85.0%	88%		
F18a	Capital service capacity	0.6	-0.4		
F19a	Income & Expenditure margin	-3.5%	-8.1%		
F21d	Agency spend as a proportion of total pay bill (£m)	3.7%	3.9%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	93.6%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	99.1%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	95.8%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	98.0%		

NB: Finance Metrics are reported year to date.

KEY

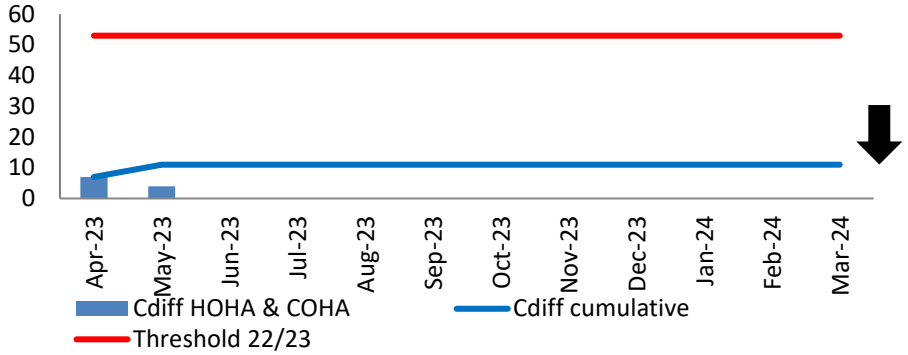


SPC Control Limits

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

SAFE

C Difficile (HOHA &



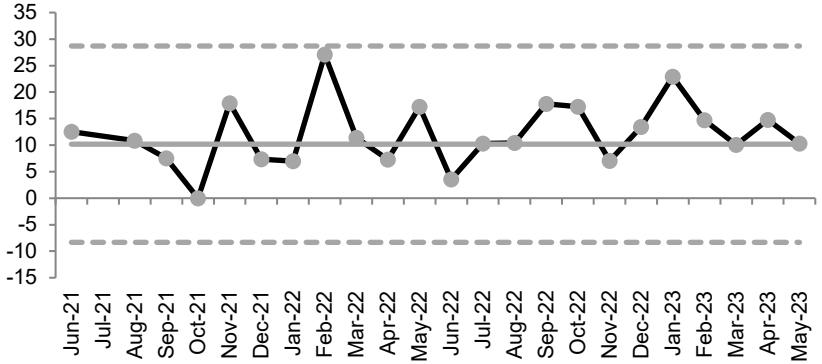
There was 1 post 2 day MRSA infection reported in May. So far this year there has been 1 case attributed to the Trust.

The Clostridium difficile objective for 2023/24 is to have no more than 53 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)'. The final figure for cases reported in 2022/23 was 65.

There were 4 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in May; 3 cases were HOHA and 1 case was COHA.

The year to date cumulative figure is 11 (HOHA & COHA). The detailed infection control report will be reviewed through the Quality Committee.

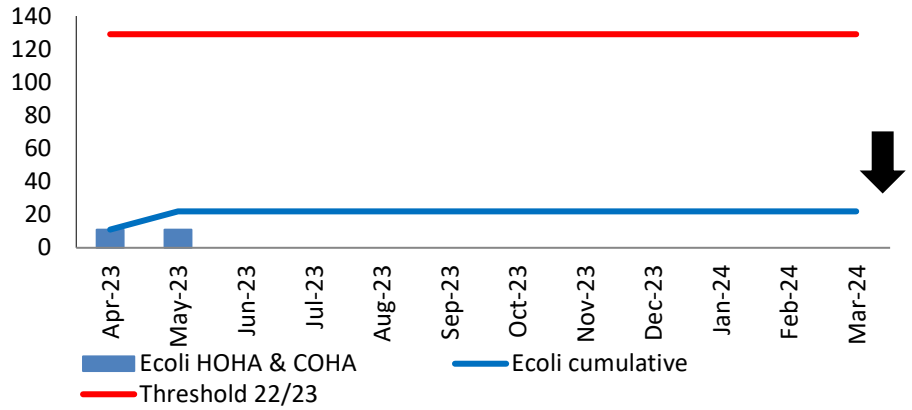
C Diff per 100,000 Occupied Bed Days (HOHA)



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

SAFE

E. Coli (HOHA & COHA)

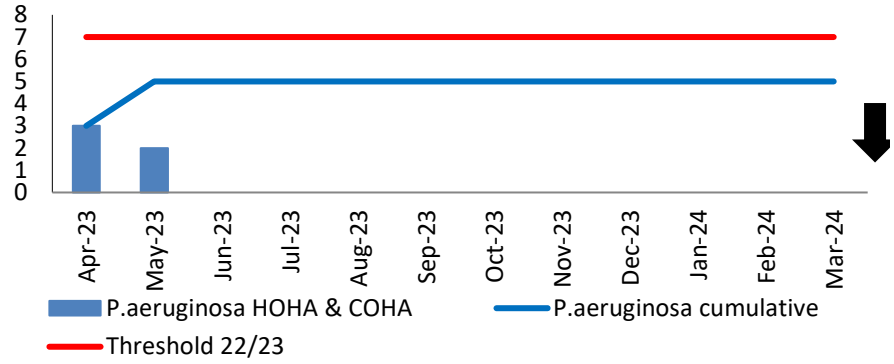


The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

The 23-24 trajectory for reduction of E.coli is 129 HOHA & COHA. The final total for 2022-23 was 131.

There were 11 reportable cases of E.coli bacteraemia identified in May;6 HOHA and 5 COHA. The year to date total is 22.

P.aeruginosa

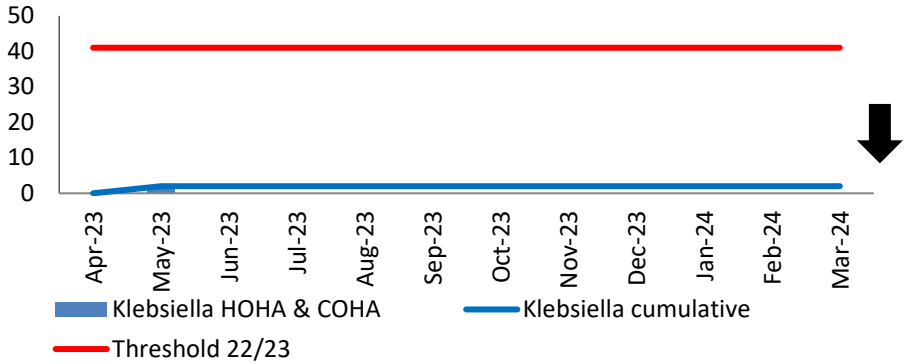


From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England.

From 21/22 a trajectory was been introduced for Klebsiella and Pseudomonas. The Trust should have no more than 7 cases for Pseudomonas and 41 cases this year for Klebsiella.

There were 2 reportable cases of Pseudomonas identified in May. Both cases were COHA

Klebsiella



There were 2 reportable cases of Klebsiella identified in May. 1 COHA and 1 COHA

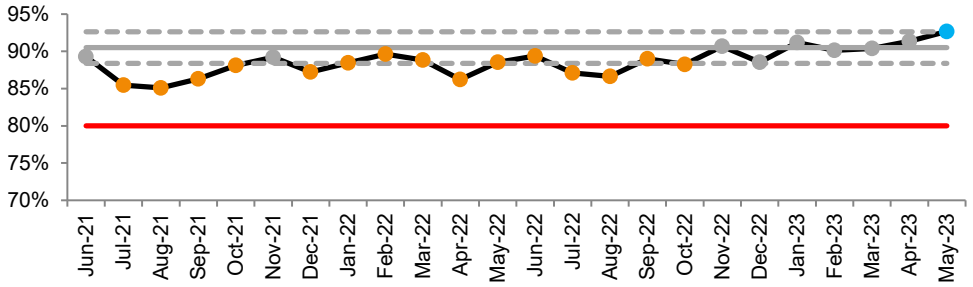
Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

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

SAFE

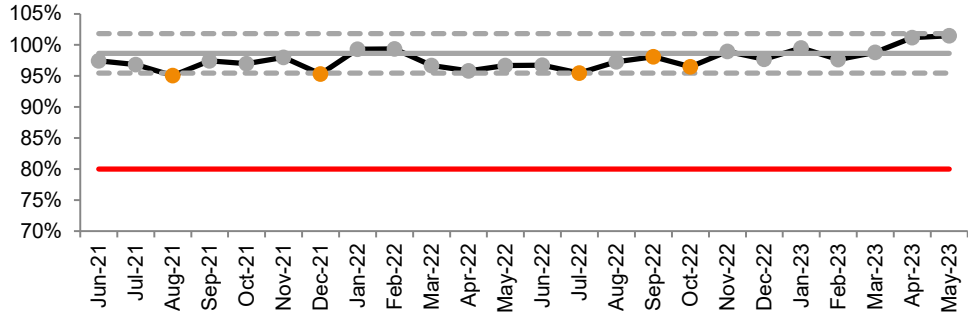
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



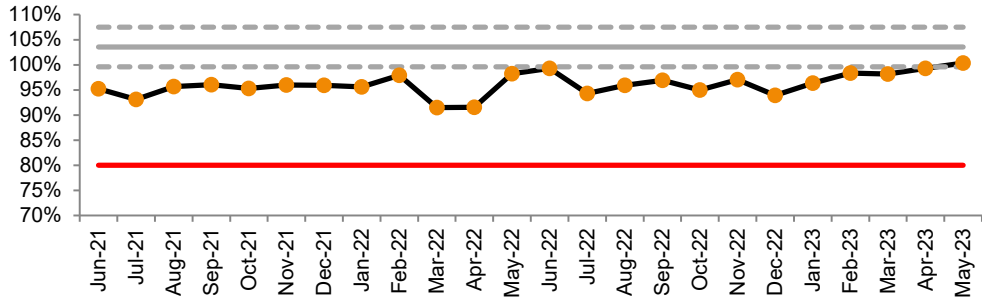
The average fill rate for registered nurses/ midwives during the day has shown an increase when compared to the pre covid levels levels. Based on current variation will consistently be above threshold.

Registered Nurses/ Midwives - Night



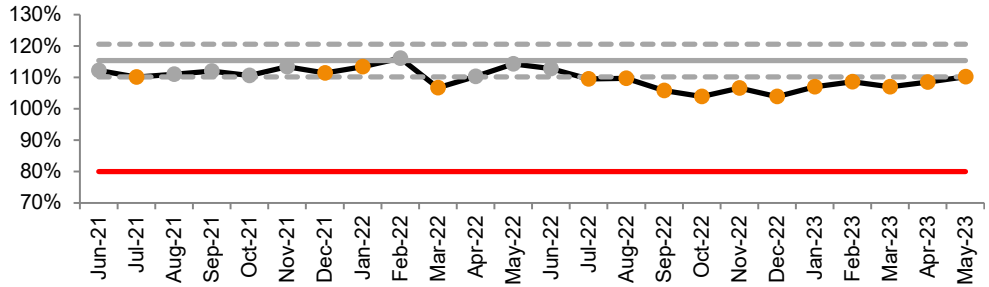
The average fill rate for registered nurses/ midwives at night is similar to pre-covid levels and based on current variation will consistently be above threshold.

Care Staff - Day



The average fill rate for care staff during the day continues to be below the pre covid levels, however based on current variation will consistently be above the threshold.

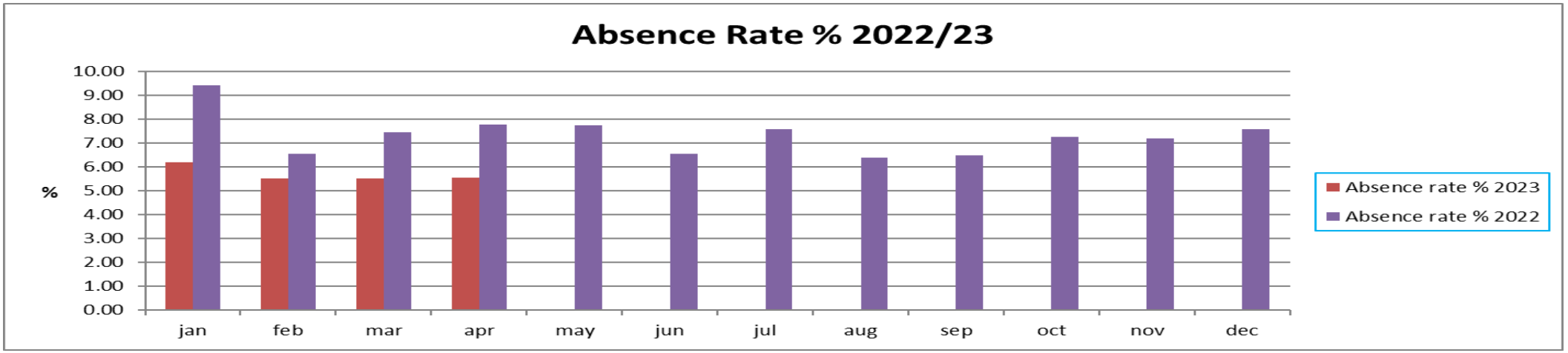
Care Staff - Night



The average fill rate for care staff at night remains above threshold, however is showing a reduction on pre covid levels. Based on current variation will consistently be above threshold.

SAFE

Staffing in May 2023 has been slightly less challenging. Overall Nursing and Midwifery sickness and absence rates have reduced, the data below shows the trends for 2022/23 taken from Power Bi (May data not available at the time of the report).



The already established vacancies, maternity leave, and effect of acuity also impacts on staffing. Lots of cross cover between wards and the high use of bank and agency staffing continues.

In May 2023, 1 area fell below the 80% for Registered Nurses/Midwives for the day shifts. This is 1 more than the last 2 months.

MEC

Ward B6 – 75.6 % The shortfall was due to the early and late coordinator shifts not being covered. None of the shifts fell below 1:8 ratio during the day.

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
May-23	92.7%	100.3%	101.5%	110.2%	29,172	8.95	1	1	0	0

SAFE

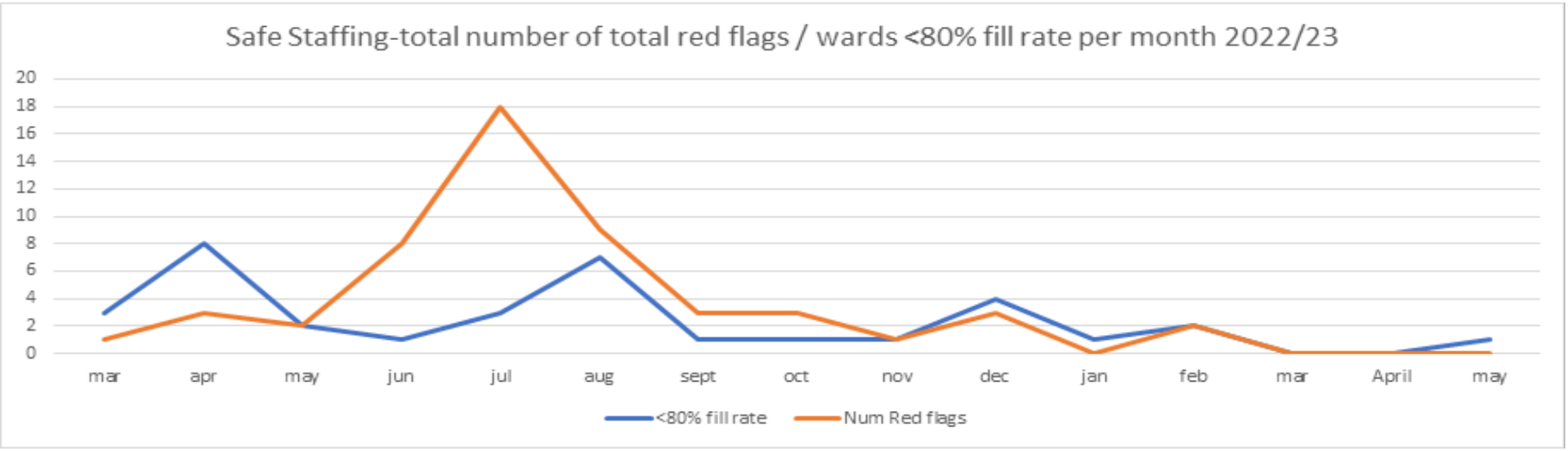
Monthly Trend

	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 (%)
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
Feb-23	90.1%	98.3%	97.6%	108.6%	27,193	8.62	2	1	0	0
Mar-23	90.4%	98.2%	98.8%	107.0%	29,788	8.67	0	1	0	1
Apr-23	91.4%	99.3%	101.2%	108.5%	27,103	9.17	0	1	0	0
May-23	92.7%	100.3%	101.5%	110.2%	29,172	8.95	1	1	0	0

National Nursing Red Flags

On reviewing May 2023 data there was 1 red flag in reported. This was in Family Care Division
Breast and Gynaecology Ward (relocated on to ward 16) – less than 2 RN present on a ward during any shift. Due to ward fireworks relocation, the transfer time to theatre has increased and resulted in an RN being on their own during a shift for 13 mins. No harm came to any patients. Highlighted in division as a staffing red flag incident, with plans to address the temporary risk.

The graph below demonstrates the total number of reported **Nursing and Midwifery** Red Flags and numbers of areas <80% fill rate per month in 2022/23



Usage of a high proportion of agency staff, junior skill mix, and the constant moving of staff to support other areas can potentially affect morale. 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

SAFE

* Recruitment Strategy, this continues as an internal QI project, with the most recent workshop focusing on the nurse recruitment / vacancy data.

* Nurse recruitment lead continues to work closely with divisions. The divisional meetings and support are being strengthened to ensure attendance and monitor outcomes

* A 2023 ELHT strategy to recruit 244 international nurses over 12 months, this commenced in April 2023 and 20 were recruited in April and 18 in May with 20 planned for June. .

* ELHT has agreed to recruit 8 international midwives. 5 have passed their OSCEs and working as qualified midwives. 3 more will arrive before December 2023

SAFE

Family Care Staffing Summary – May 2023

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

Maternity (Midwife to Birth Ratio)

Month	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Staffed to full Establishment	01:27	01:27	01:28	01:27	01:28	01:28	01:27	01:27	0.060856	01:27:31	01:27	1:26
Excluding mat leave	01:28	01:27	01:28	01:27	01:29	01:27	01:27	01:27	01:27	0.06144	01:27	1:26
Maternity leave	-	-	-	-	-	-	-	-	03:50	4.52	3.40	3.40
With gaps filled through ELHT Midwife staff bank Per week	Bank □ Usage 14.87	Bank Usage 23.9	Bank Usage 16.10	Bank Usage 20.75	Bank Usage 30.56	Bank Usage 21.74	Bank Usage 17.99	Bank Usage 25.73	Bank Usage 25.73	Bank Usage 25.71	Bank Usage 18.25	Bank Usage 16.77
Midwifery vacancies (Maternity VRS) -11wte	-	-	-	-	-	-	-	-	25 wte (14) 11 mat VRs to recruit	26 wte (15) 11 VRs for mat	26 wte (15) 11 VRs for mat	25 wte (14)

Maternity- April bank filled hours filled 16.77 wte.

Safe midwifery staffing levels also continue 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. Local midwifery red flags noted at each handover.
Daily and weekend staffing plans are summarised with a further review of skillset and experience for each midwife/ Maternity support worker prior to redeployed all plans these are all available on share point. Following recruitment and retention planning and events starters. 25 new starter midwives are scheduled to start at the end of September 2023.

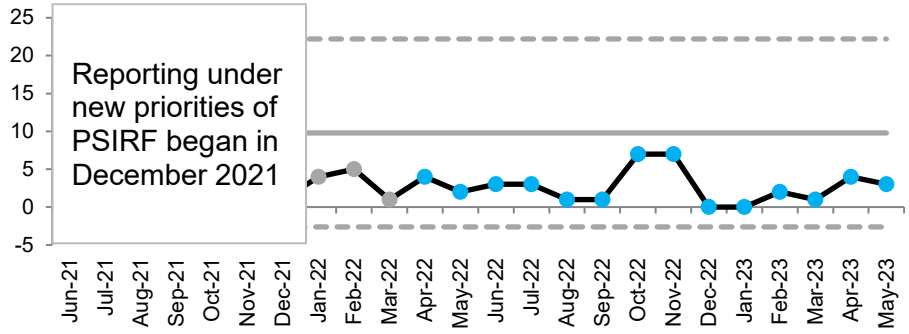
Neonatology – No staffing exceptions. Staffing reviews continue to be part of the daily maternity /neonatology safety huddles inclusive of the safe staffing tool. High acuity at periods during the month of May – days closed to external admissions in view of this and to support safe staffing levels.

Paediatrics – No staffing exceptions.

Gynaecology – No staffing exceptions, temporary ward move to 16 at BGH due to the Trust regulation fireworks. Due to the geographical location this is impacting on transfer time to theatre and has resulted in the aforementioned national nursing red flag.

SAFE

Serious Incidents



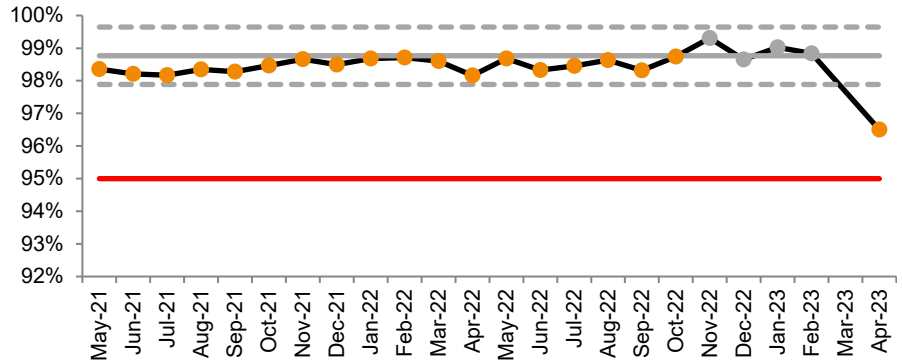
PSIRF Category	No. Incidents
PSIRF Early Adopter - Never Event	1
PSIRF Early Adopter - Incident resulting in death	2

There was 1 never event reported in May.

Three incidents meeting a national or local priority and whereby a patient safety incident investigation (PSII) is underway, have been reported onto STEIS in May.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.

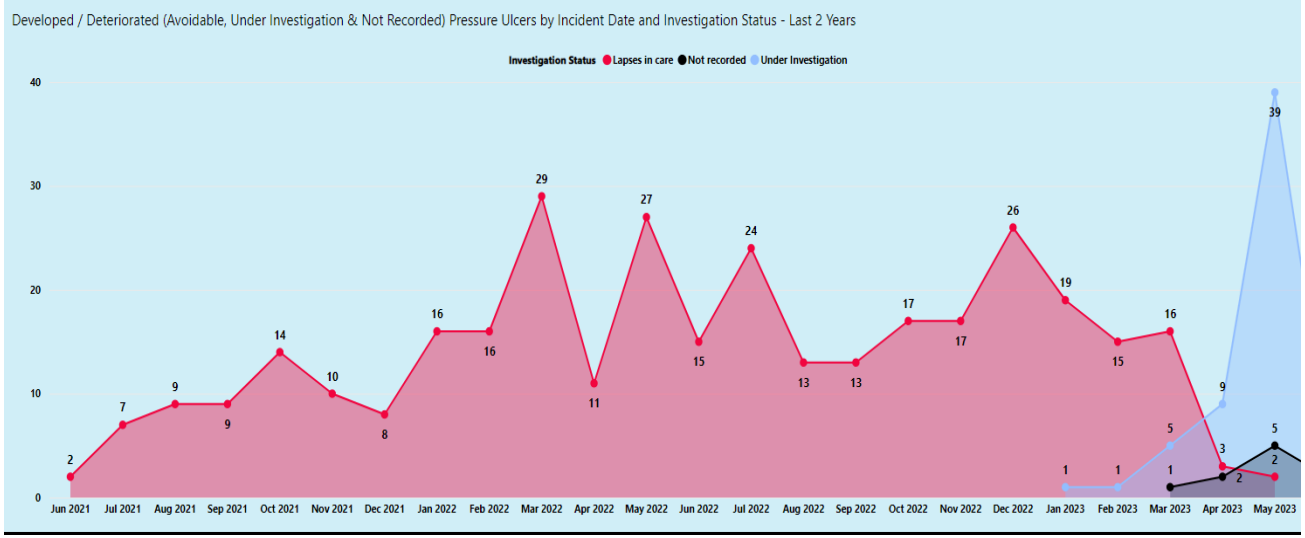
VTE assessment



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

Pressure Ulcers

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



Category of pressure ulcer	Total Number Lapses in Care			
	2020/21	2021/2022	2022/2023	2023/2024 (Apr-May)
2	32	44	79	0
3	14	14	7	0
4	0	3	9	0
Deep Tissue Damage	9	53	91	5
Unstageable	15	25	34	0
TOTAL	70	139	220	5

The final position for lapses in care during 2022-2023 is not yet finalised, however it is evident that has been an increase in all categories except for Category 3 . Themes identified include non- adherence to Pressure Ulcer policy, poor record keeping and a lack of preventative focus.

An improvement plan is in place involving the Quality Improvement team and DERI; recent actions include the requirement of the uploading of clinical photography of the wound at the time of reporting and the writing of a briefing paper to ensure that to ensure that staff are equipped with the right knowledge.

The National Wound Care Strategy Programme consultation on 'Pressure Ulcer Clinical Recommendations and Clinical Pathway' is now closed however no final paper has been released.

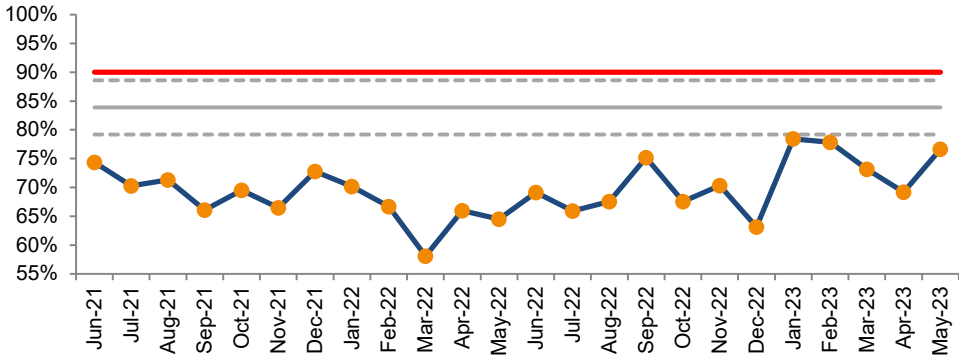
Ongoing work continues with our North West colleagues to establish a benchmarking position.

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.

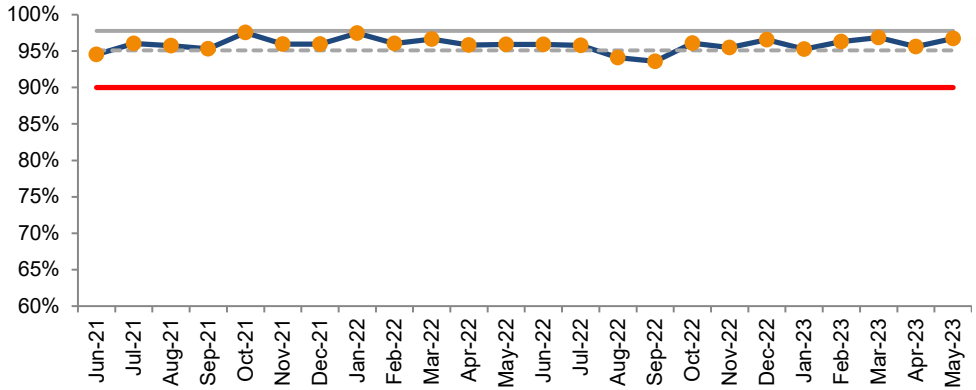
Baseline period for SPC comparison is Apr 18 - Mar 20

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.

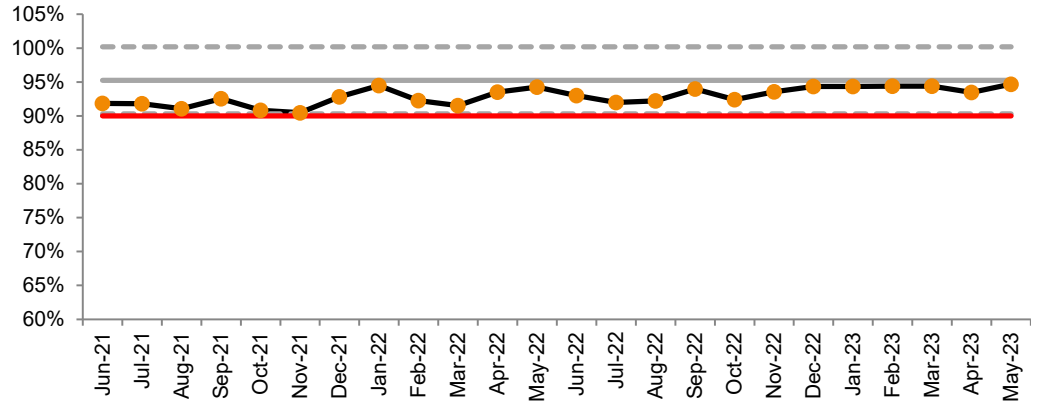
Friends & Family Inpatient



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

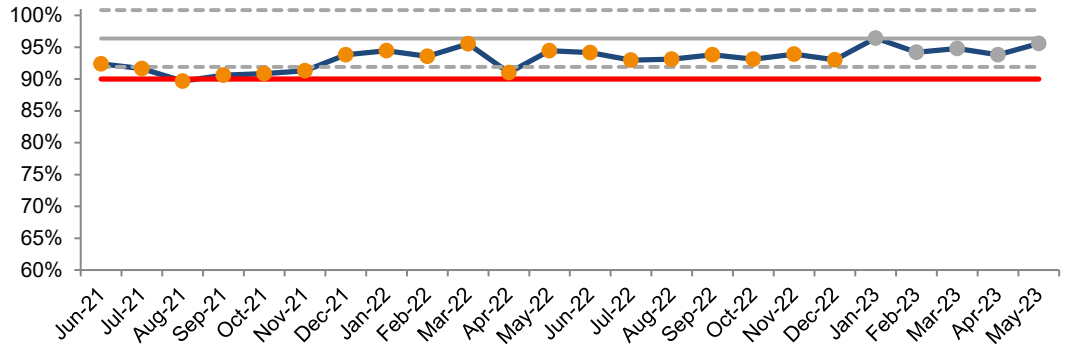
Friends & Family Outpatients



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.

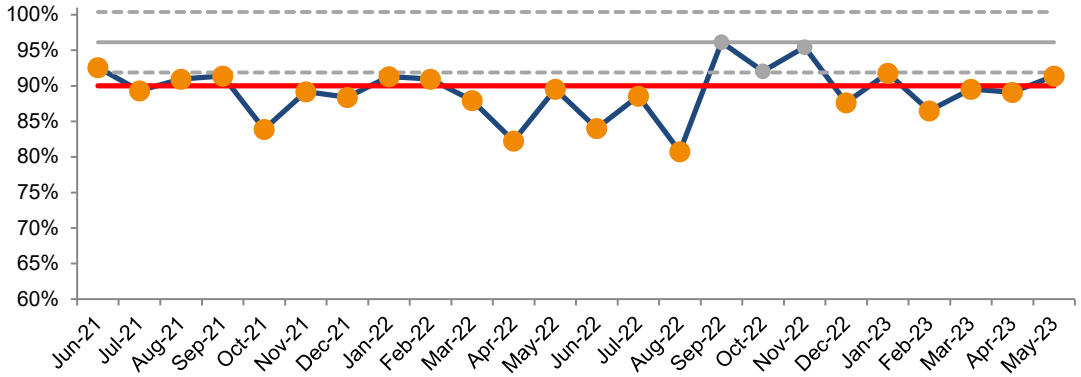
Friends & Family Community



Community scores are above target 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

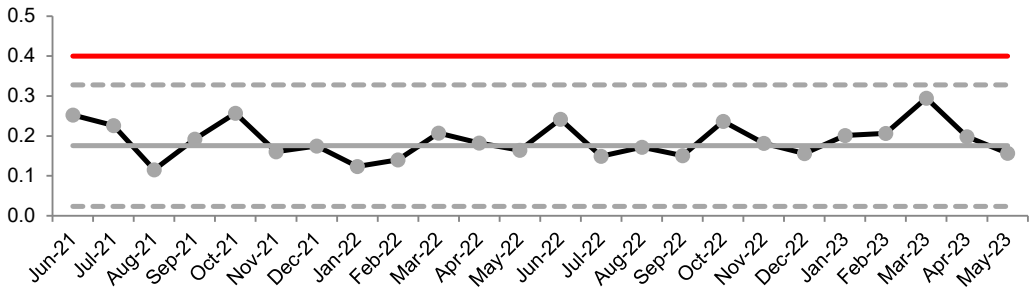


Maternity scores are below target this month and are showing deterioration compared to the pre-covid baseline.

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

CARING

Complaints per 1000 contacts



The Trust opened 19 new formal complaints in May.

ELHT is targeted to achieve a threshold of at or less than 0.4 formal complaints per 1,000 patient contacts – made up of inpatient, outpatient and community contacts.

For May the number of complaints received was 0.16 Per 1,000 patient contacts.

The trend is showing usual variation and based on variation will consistently acheive the target.

Patient Experience

		Dignity	Information	Involvement	Quality	Overall
Type	**Division**	Average Score	Average Score	Average Score	Average Score	Average Score
Antenatal	Family Care	100	100	100	99.09	99.61
Community	Community and Intermediate Care Services	93.02	91.28	90.61	94.99	92.17
Community	Diagnostic and Clinical Support	100	100	100	-	100
Community	Family Care	95.83	100	-	97.12	97.06
Community	Surgery	100	97.69	-	-	98.34
Delivery	Family Care	100	80	100	97.1	95
ED_UC	Medicine and Emergency Care	75	59.38	83.33	43.75	64.47
Inpatients	Community and Intermediate Care Services	87.5	81.7	86.18	84.9	85.24
Inpatients	Diagnostic and Clinical Support	98.04	93.37	95.07	97.62	95.71
Inpatients	Family Care	94.07	92	93.44	92.61	93.13
Inpatients	Medicine and Emergency Care	94.01	81.94	82.53	87.62	85.7
Inpatients	Surgery	93.69	88.6	92.41	90.74	91.54
OPD	Diagnostic and Clinical Support	99.28	96.98	98.02	94.11	97.48
OPD	Family Care	97.62	90.38	97.27	90.68	94.23
OPD	Medicine and Emergency Care	100	97.58	99.78	97.25	98.4
OPD	Surgery	100	97.87	100	-	98.83
Other	Surgery	100	80	100	100	93.33
Postnatal	Family Care	100	100	100	100	100
SDCU	Family Care	90.83	92.31	91.03	90.28	91.15
	Total	**95.88**	**93.44**	**92**	**94.1**	**93.76**

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

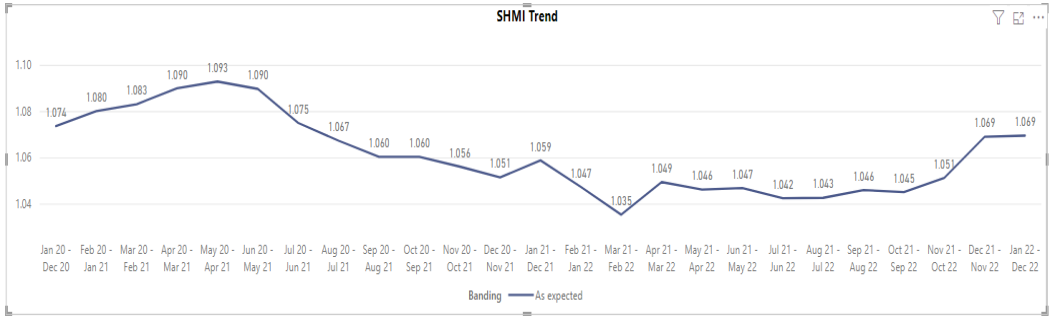
The threshold is a positive score of 90% or above for each of the 4 competencies.

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

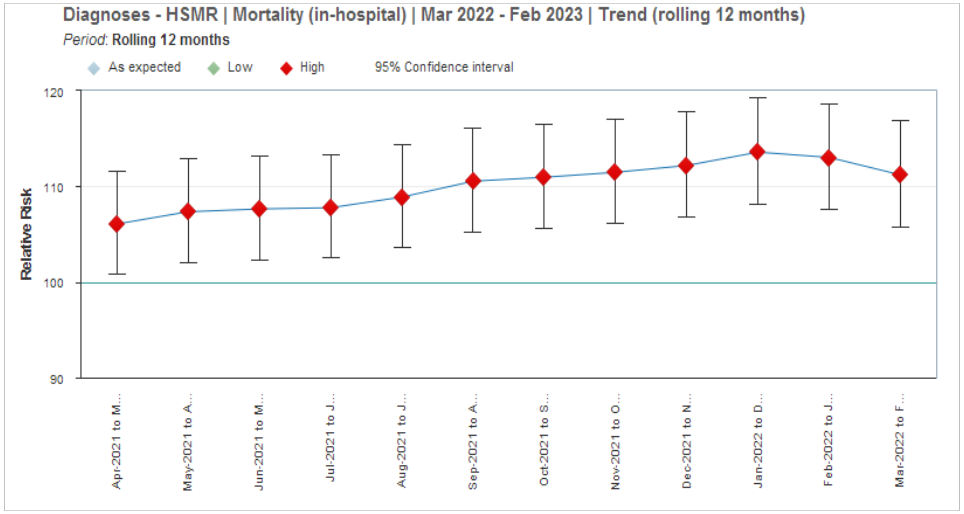
SHMI Published Trend



Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month Mar 22 – Feb 23
	ALL
TOTAL	111.2
Weekday	109.6
Weekend	115.9

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 Jan 22 to Dec 22 has increased from last month, however remains within expected levels at 1.07, as published in May 23.

The latest indicative 12 month rolling Hospital Standardised Mortality Ratio (HSMR), (Mar 22 – Feb 23) has reduced from last month but remains 'above expected levels' at 111.2 against the monthly rebased risk model.

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

There are currently seven diagnostic groups with a significantly high relative risk score on the HSMR: Pneumonia, Congestive heart failure nonhypertensive, COPD, Aspiration pneumonitis, Cancer of bladder, Repiratory failure and Secondary malignancies.

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.

EFFECTIVE

Structured Judgement Review Summary

Stage 1	Month of Death: 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- Mar 23	Apr-23	May-23	TOTAL
Deaths requiring SJR (Stage 1)	46	212	250	262	214	163	219	17	5	22
Allocated for review	46	212	250	262	214	163	219	17	5	22
SJR Complete	46	212	250	262	214	162	186	3	0	3
1 - Very Poor Care	1	1	0	0	1	1	0	1	0	1
2 - Poor Care	8	19	22	34	35	22	35	1	0	1
3 - Adequate Care	14	68	70	70	65	49	60	0	0	0
4 - Good Care	20	106	133	129	103	78	87	1	0	1
5 - Excellent Care	3	18	25	29	10	12	4	0	0	0
Stage 2										
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	35	2	0	2
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	3	0	0	0
Allocated for review	6	18	21	30	35	22	32	2	0	2
SJR-2 Complete	6	18	21	30	35	22	31	0	0	0
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0
2 - Poor Care	3	6	7	13	13	10	18	0	0	0
3 - Adequate Care	2	10	13	13	21	10	10	0	0	0
4 - Good Care	0	1	0	2	1	1	2	0	0	0
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0

The new structured judgement review process was launched at the beginning of December 2017 for deaths meeting specified criteria. A team of reviewers have been trained on how to complete SJR's and are now undertaking the monthly reviews.

The table shows a breakdown of SJR's completed and the scores allocated. Any death allocated a SJR score of 1 or 2 will have a stage 2 SJR completed.

The stage 2 SJR reviewer will determine whether or not any lapses in care may have contributed to the death and if so a SIRI and RCA will be triggered.

	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- Mar 23	Apr-23	May-23	Total
stage 1 requiring allocation	0	0	0	0	0	0	0	0	0	0
stage 1 requiring completion	0	0	0	0	0	1	33	14	5	19
Stage 1 Backlog	0	0	0	0	0	1	33	14	5	19
stage 2 requiring allocation	0	0	0	0	0	0	0	0	0	0
stage 2 requiring completion	0	0	0	0	0	0	10	4	5	114
Stage 2 Backlog	0	0	0	0	0	0	10	4	5	114

Learning Disability Mortality Reviews

The NHS Long Term Plan made a commitment to continue learning from deaths (LeDeR) and to improve the health and wellbeing of people with a learning disability and autism.

The LeDeR programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and autism and to reduce health inequalities. By finding out more about why people died we can understand what needs to be changed to make a difference to people's lives.

ELHT contribute to this process by notifying NHS England of all the deaths of people with a learning disability or autism. Following the notification of death a structured judgement review is completed and recommendation and actions for learning are shared within the organisation at the Lessons learnt groups and with the LeDeR programme. Thematic cause of death is also reported annually to NHS England's national standards.

This year there have been 34 deaths reported to LeDeR (not updated)

EFFECTIVE

Commissioning for Quality and Innovation (CQUIN)

The table below shows the CQUIN schemes in operation for 2023/24.

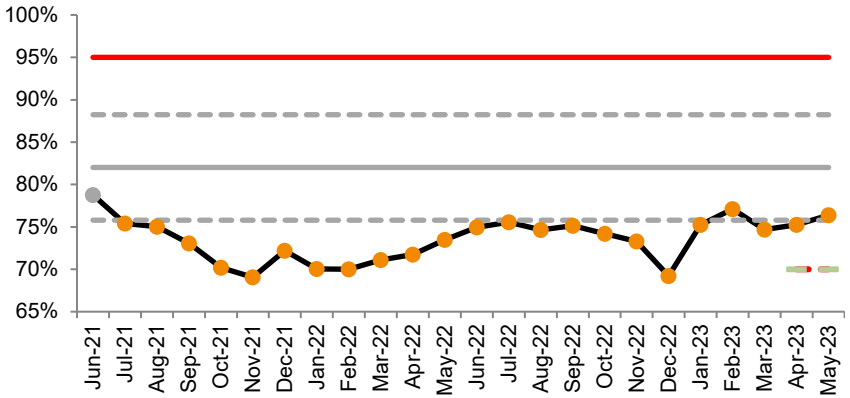
With the reintroduction of partly variable Commissioner contracts, there is a risk of clawback for under-performance against scheme targets and thresholds.

CQUIN data is submitted to commissioners quarterly and compliance is monitored internally by the Clinical Effectiveness Group.

CQUIN02: Supporting patients to drink, eat and mobilise after surgery
CQUIN03: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria
CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
CQUIN07: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
CQUIN15a: Routine outcome monitoring in community mental health services

RESPONSIVE

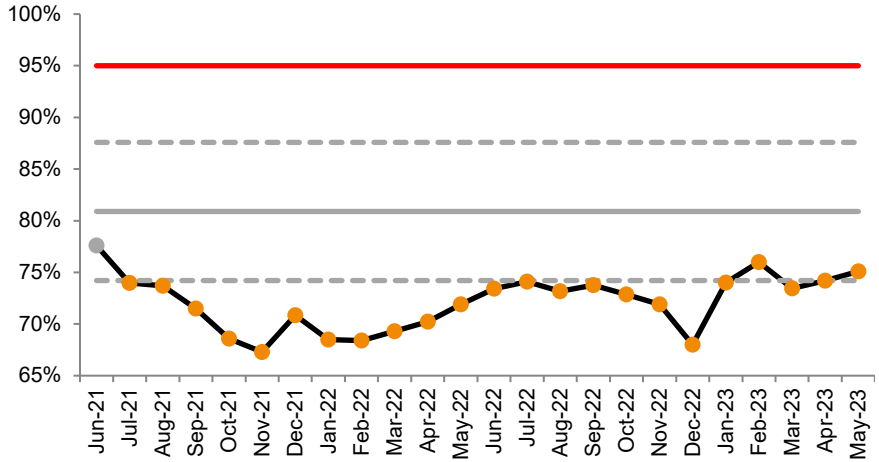
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 76.38% in May, 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.

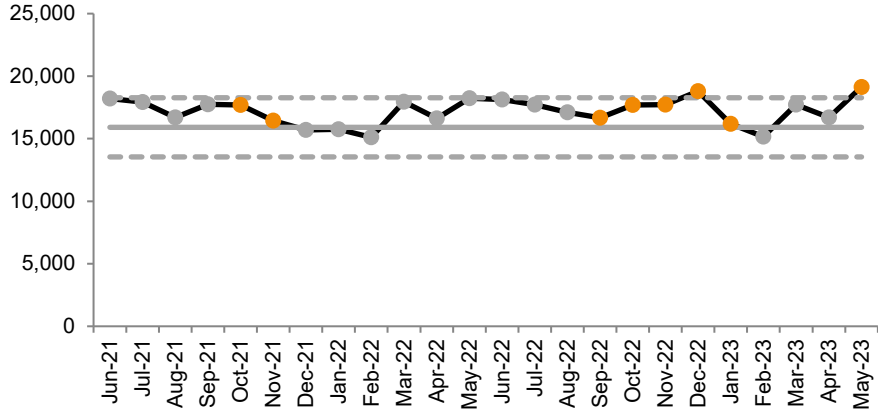
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 75.09% in May.

The national performance was 74.0% in May (All types) with 0 of the 109 reporting trusts with type 1 departments achieving the 95% standard.

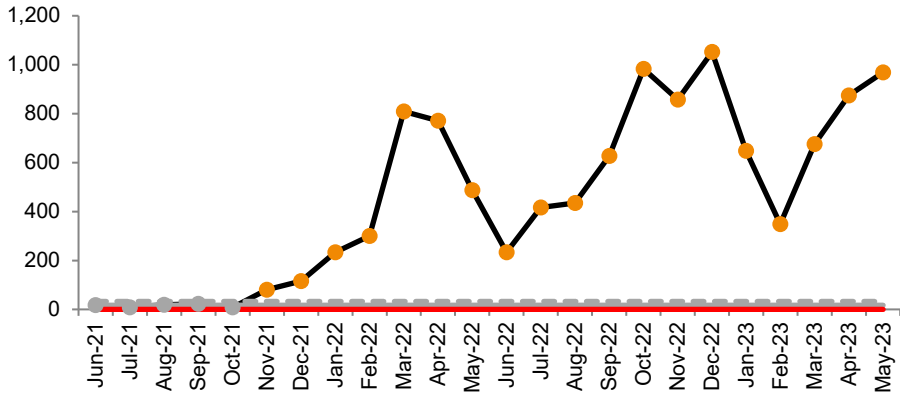
A&E Attendances - Trust



The number of attendances during May was 19,135, which is above the nornal range when compared to the pre-covid baseline.

RESPONSIVE

12 Hr Trolley Waits

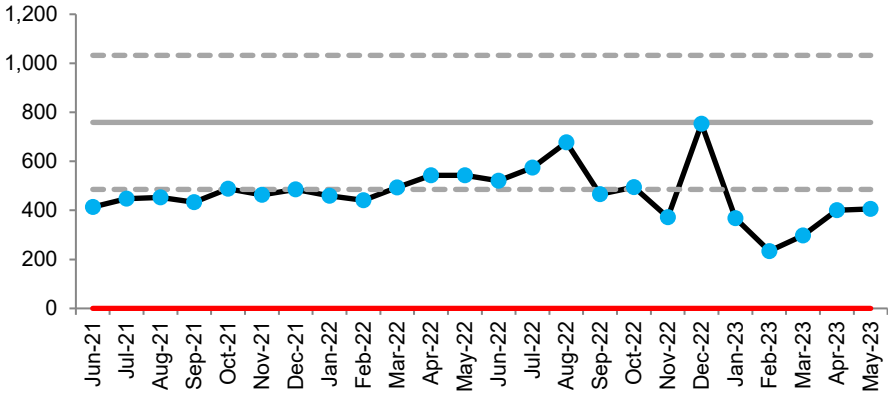


There were 968 reported breaches of the 12 hour trolley wait standard from decision to admit during May, which is higher than the normal range. 39 were mental health breaches and 929 were physical health.

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

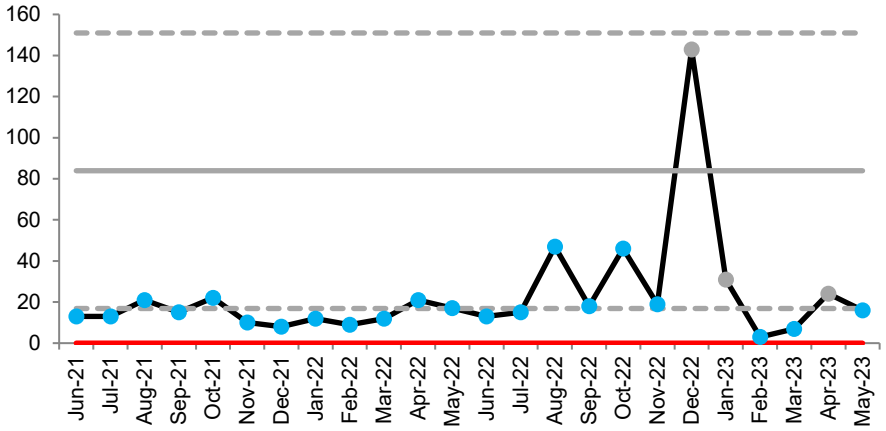
	Mental Health	Physical Health
No. 12 Hr Trolley Waits	39	929
Average Wait from Decision to Admit	39hr 50 min	19hr 22 min
Longest Wait from Decision to Admit	116hr 16 min	47hr 0 min

Ambulance Handovers - >30Minutes



There were 406 ambulance handovers > 30 minutes in May. The trend is still showing significant improvement from the pre-covid baseline levels, but based on current variation is not capable of hitting the target routinely.

Ambulance Handovers - >60 Minutes



There were 16 ambulance handovers > 60 minutes in May, which continues to demonstrate a significant improvement from the pre-covid baseline.

Following validation, 5 were due to delays in ED and 11 were due to non-compliance with the handover screen.

The average handover time was 21 minutes in May and the longest handover was 2hr 13.

RESPONSIVE

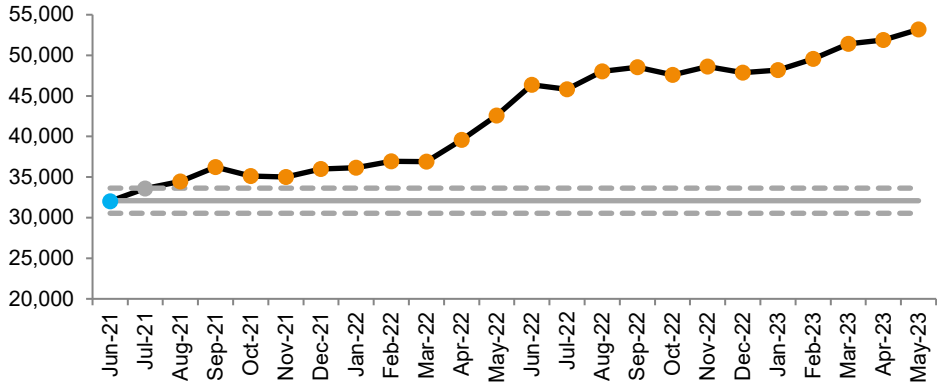
At the end of May, there were 53,184 ongoing pathways, which has increased on last month and is above pre-COVID levels.

There were 1696 patients waiting over 52 weeks at the end of May which has increased on last month and is above trajectory.
There were 167 patients waiting over 65 weeks at the end of May which has increased on last month and is just above trajectory.

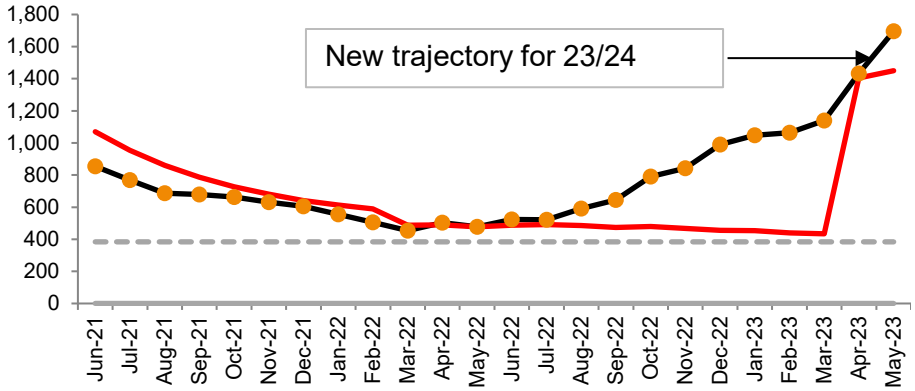
There were no patients waiting over 78 weeks.

Trajectory
Actual

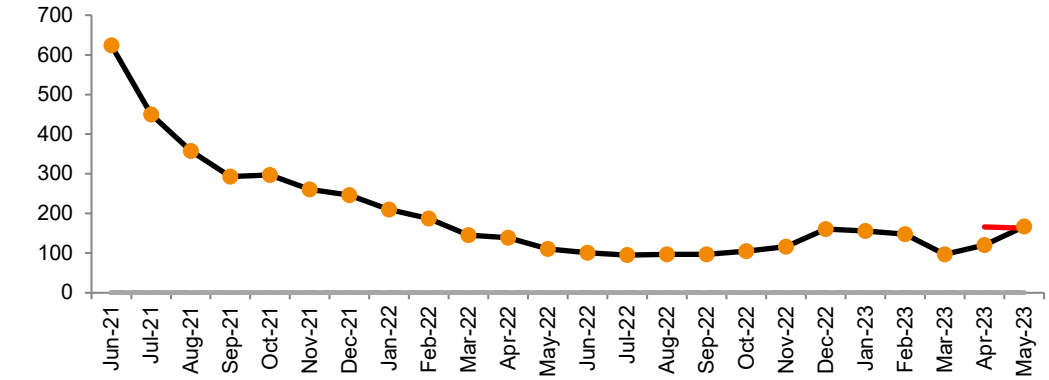
Referral to Treatment (RTT) Total Ongoing



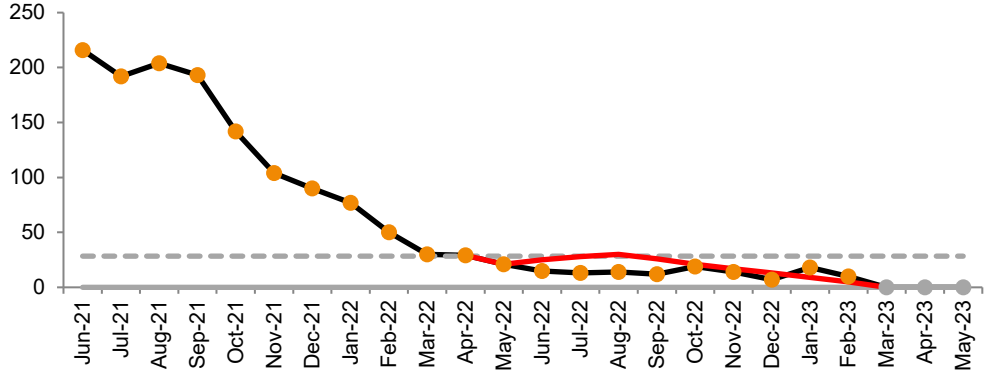
RTT Total Over 52 wks



RTT Total Over 65 wks



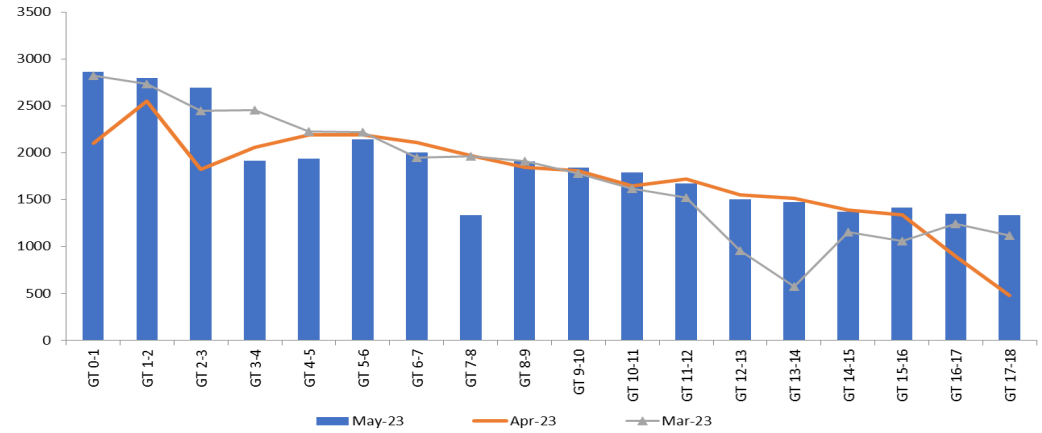
RTT Total Over 78 wks



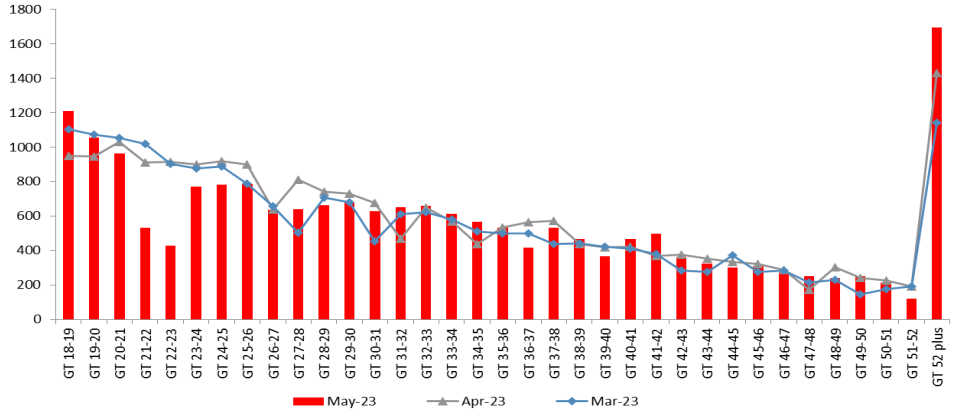
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

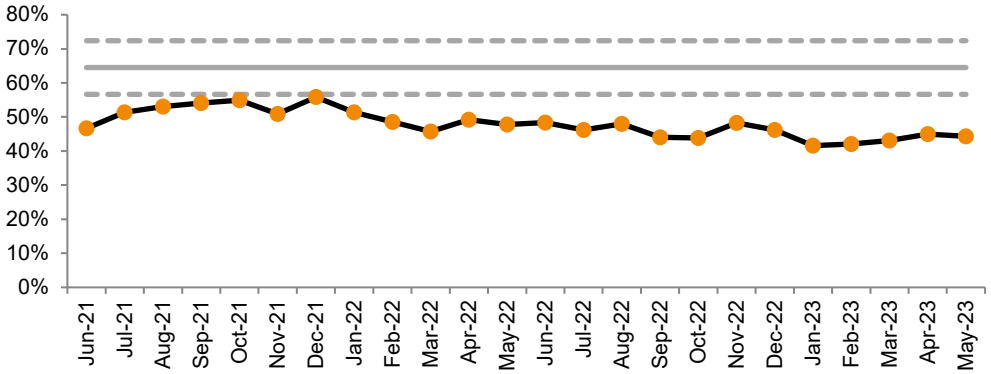


RTT Over 18 weeks

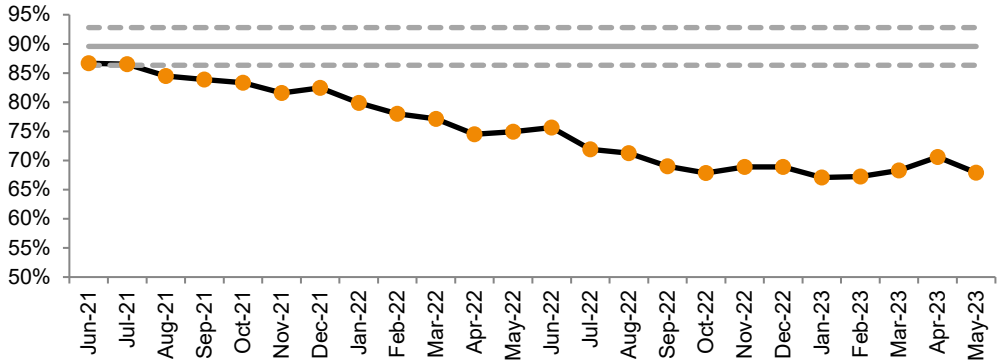


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted

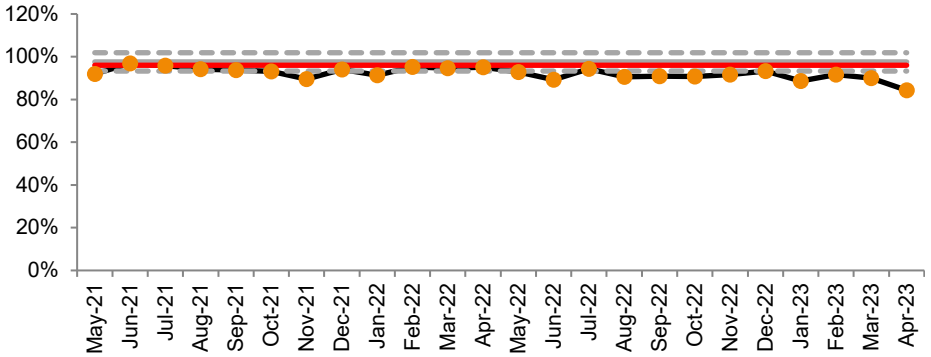


RTT Non-Admitted



RESPONSIVE

Cancer 31 day

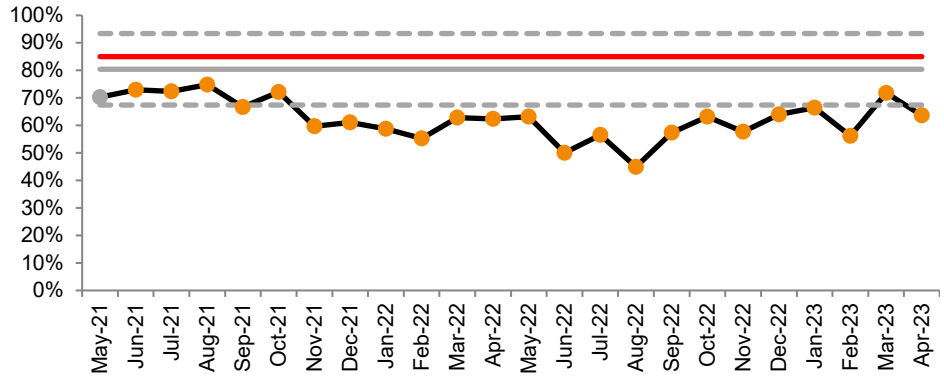


The 31 day standard was not achieved in April at 84.3%, below the 96% threshold.

National position - 90.5%

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

Cancer 62 Day

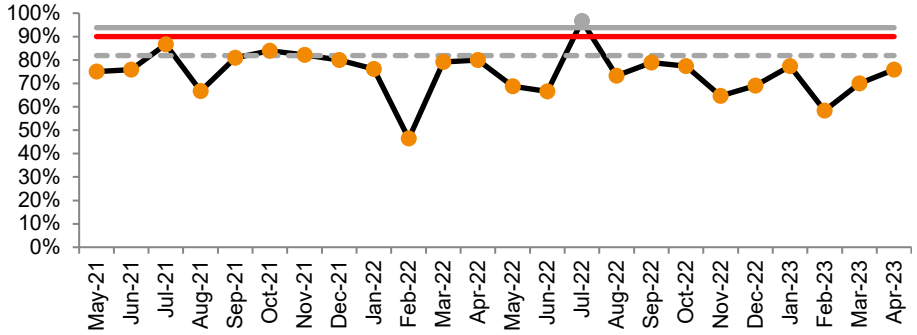


The 62 day cancer standard was not achieved in April at 63.6% below the 85% threshold.

National position - 61.0%

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



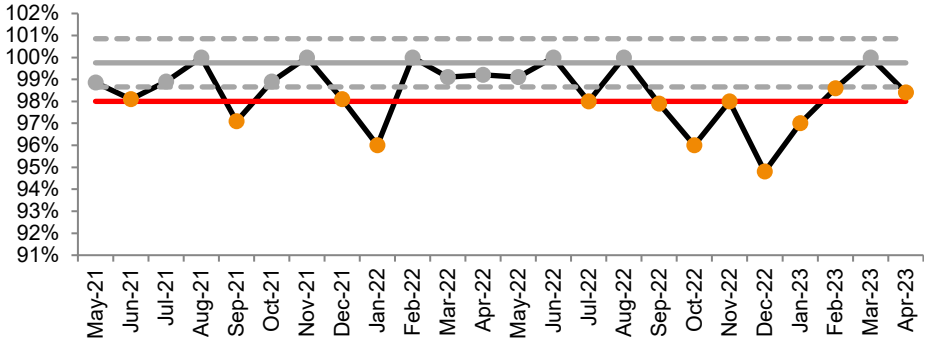
The 62 day screening standard was not achieved in April at 75.9%, below the 90% threshold.

National position - 67.8%

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)

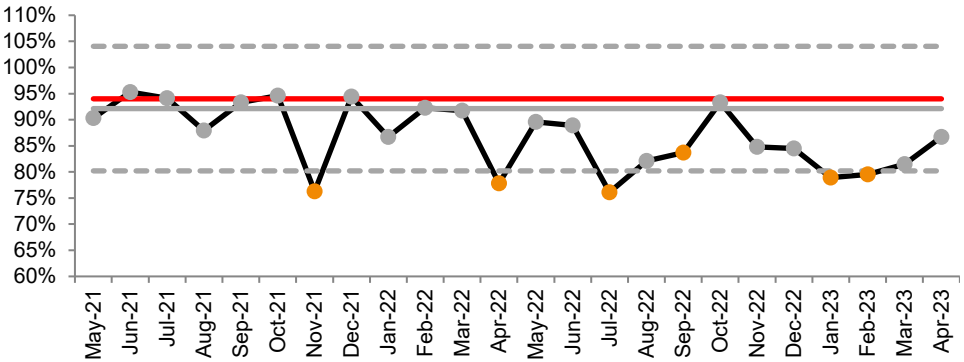


The subsequent treatment - drug standard was above target in April at 98.4%

National position - 97.4%

The trend is showing deterioration, however based on the normal variation, the indicator should consistently achieve the standard.

Cancer - Subsequent treatment within 31 days (Surgery)

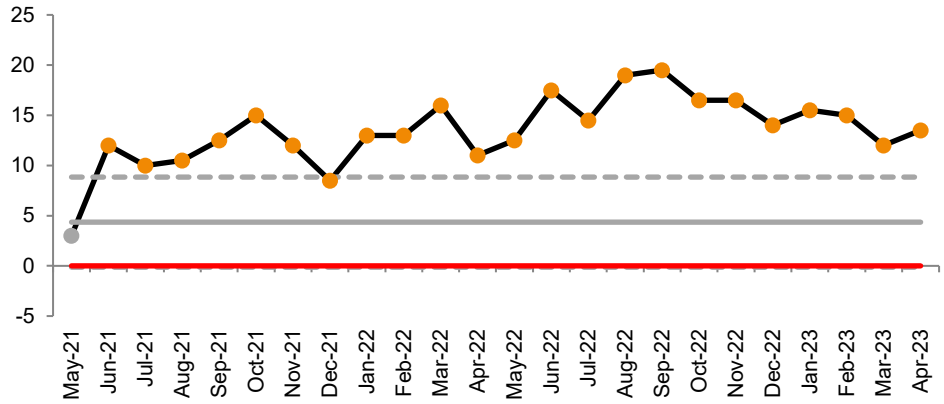


The subsequent treatment - surgery standard was not met in April at 86.7%, below the 94% standard.

National position - 76.8%

The trend is showing normal variation compared to the pre-covid baseline and based on the current variation, the indicator remains at risk of not meeting the standard.

Cancer Patients Treated > Day 104

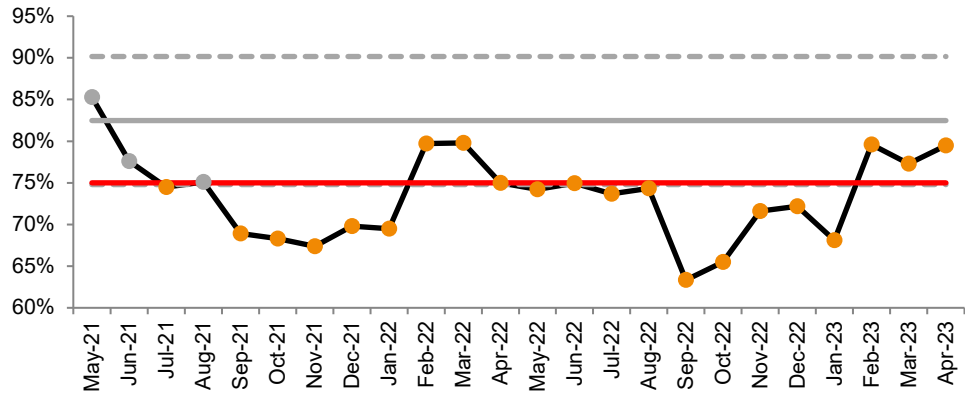


There were 13.5 breaches allocated to the Trust, treated after day 104 in April and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the consultants involved in the pathway as required.

The trend is showing a significant increase on the baseline.

RESPONSIVE

Cancer 28 Day faster diagnosis

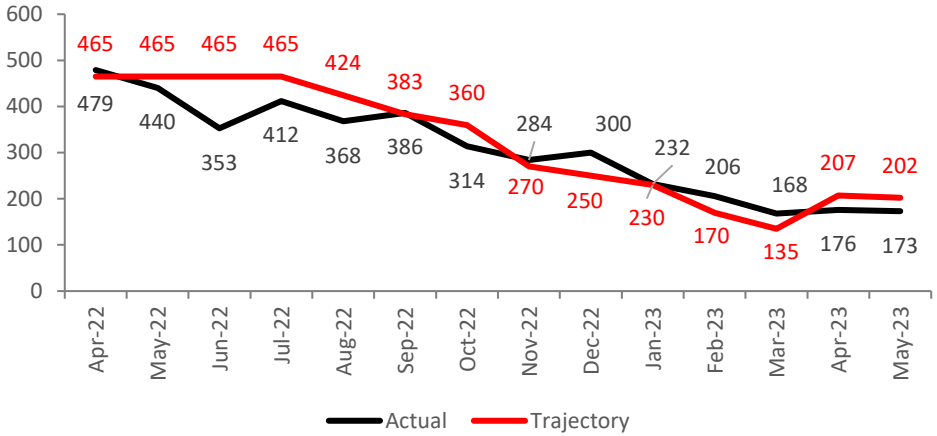


The 28 day faster diagnosis standard acheived the target in April at 79.5%

National position - 71.4%

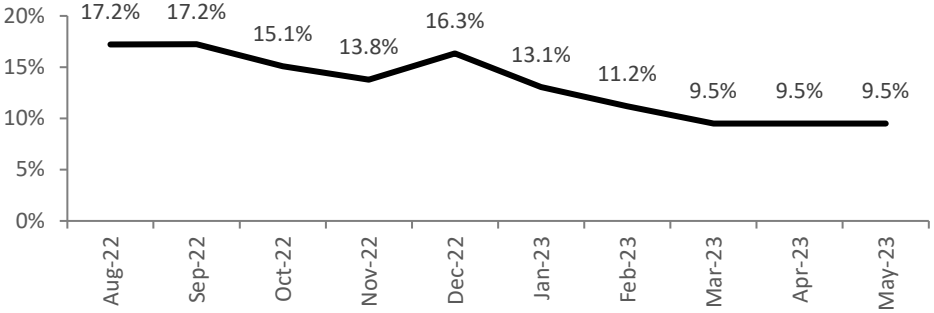
The trend is showing significant deterioration when compared to the pre-covid baseline.

Cancer >62 day vs trajectory



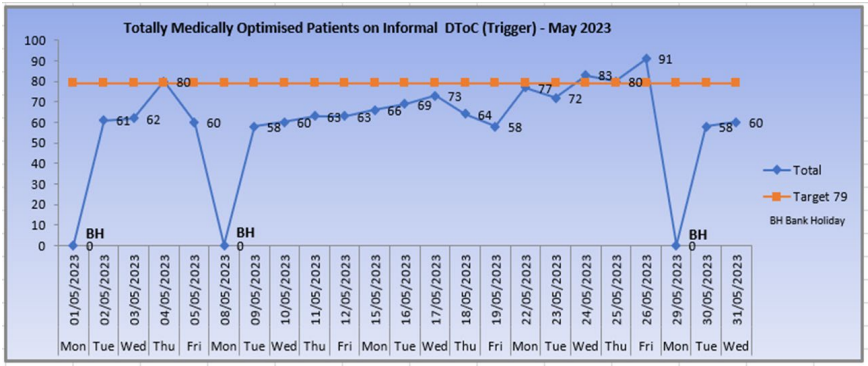
At the end of May the number of patients >62 days was 173 vs 202 trajectory. This was 9.5% of the total wait list.

Cancer % Waiting >62days (Urgent GP Referral)



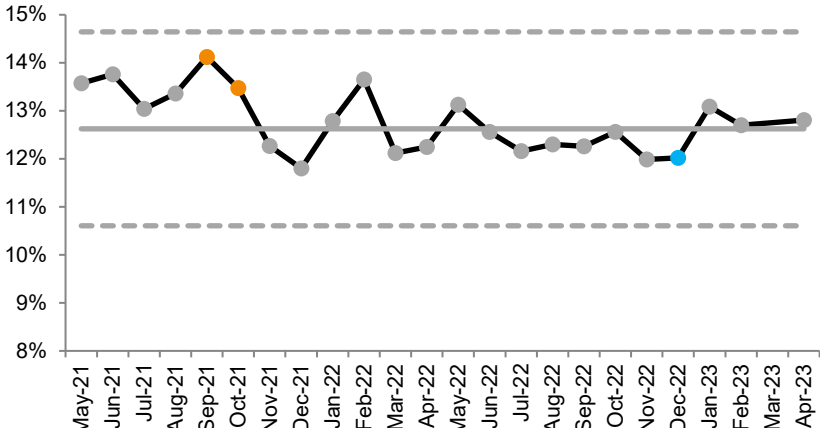
RESPONSIVE

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, 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.

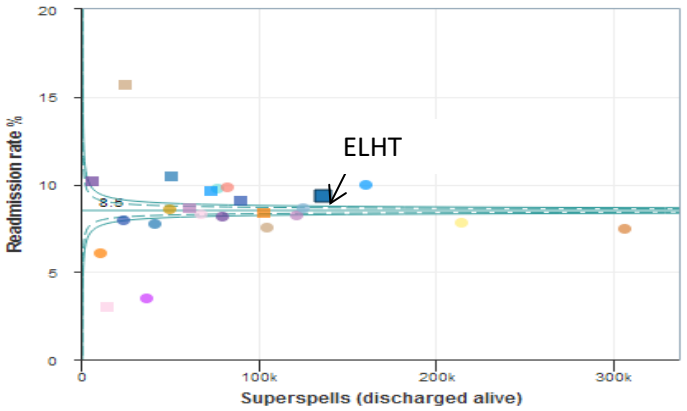
Emergency Readmissions



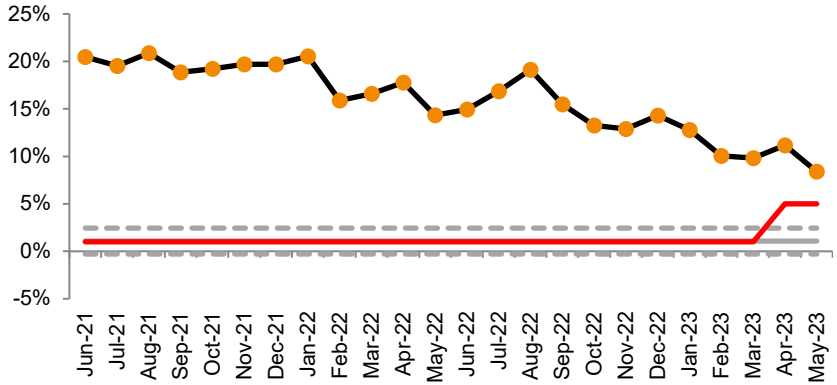
The emergency readmission rate is showing normal variation this month.

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

Readmissions within 30 days vs North West - Dr Foster
November 2021 - October 2022



Diagnostic Waits



In May, 8.4% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is above the 5% threshold. (95% of patients to receive a diagnostic test within 6 weeks by March 2025)

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

Nationally, the performance is failing the 1% target at 27.6% in April.

RESPONSIVE

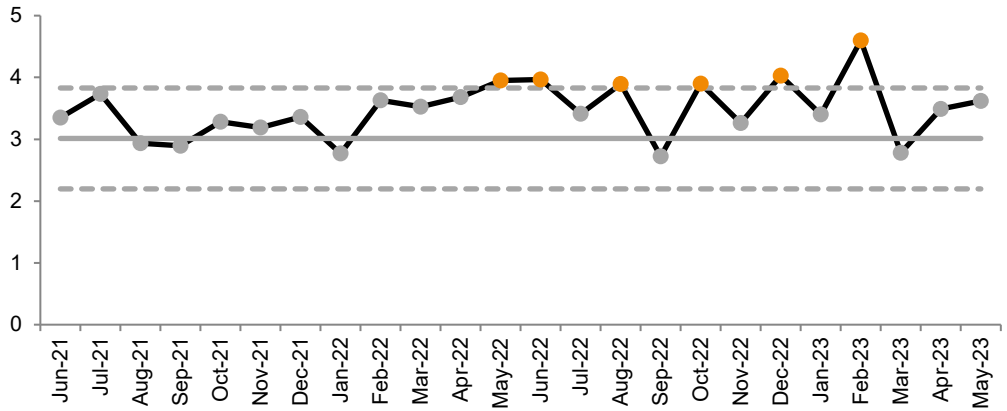
Average length of stay benchmarking

Dr Foster Benchmarking Feb 22 - Jan 23

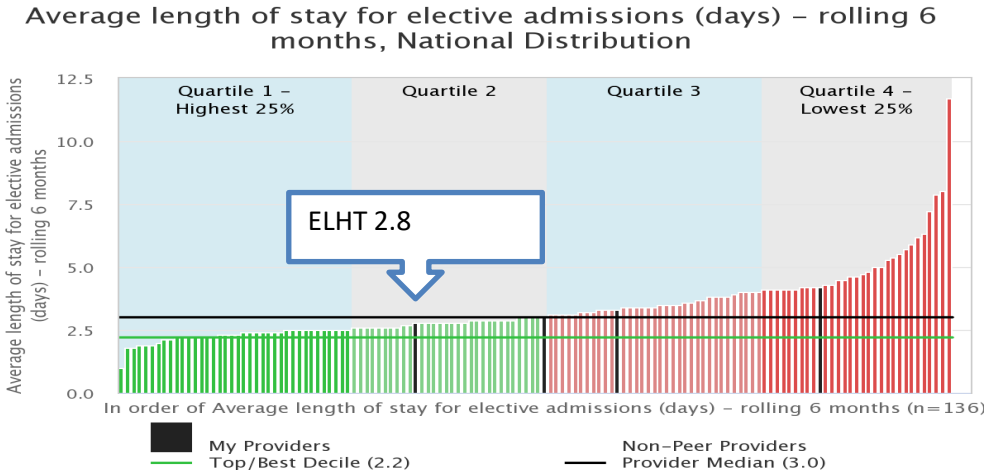
	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	61,614	10,235	51,379	3.4	2.7	-0.7
Emergency	62,725	62,725	0	4.1	4.5	0.4
Maternity/ Birth	12,736	12,736	0	2.3	2.2	-0.1
Transfer	221	221	0	7.7	24.0	16.3

Dr Foster benchmarking shows the Trust length of stay to be above expected for emergency and below expected for elective, when compared to national case mix adjusted.

Average length of stay - elective

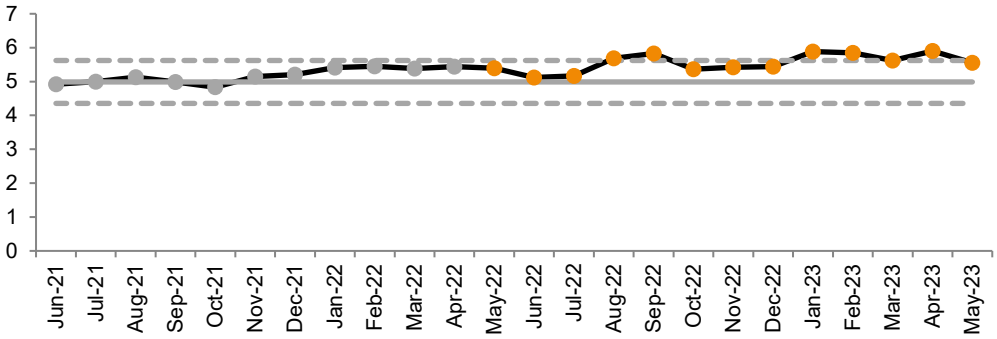


The Trust elective average length of stay is within normal range this month.

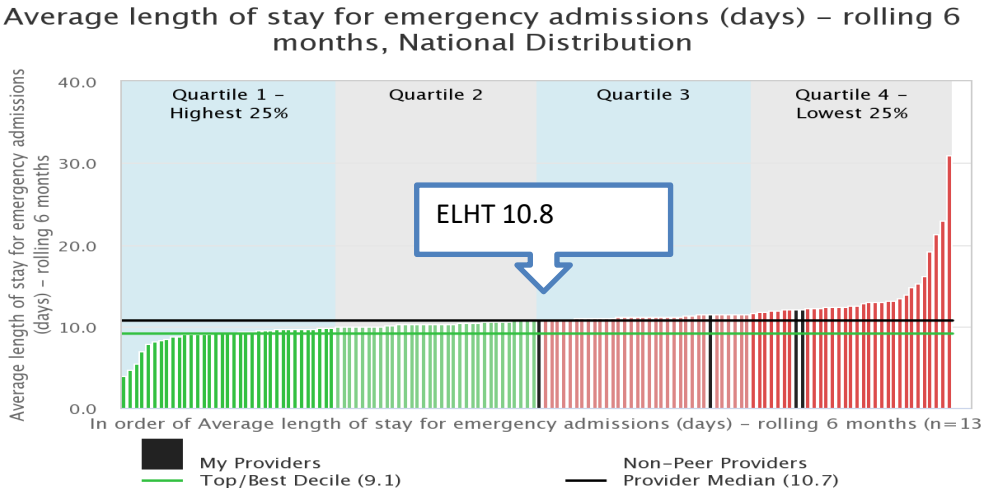


Data up to Feb 23 from the model health system shows ELHT in the second quartile for elective length of stay. Excludes day case.

Average length of stay - non elective

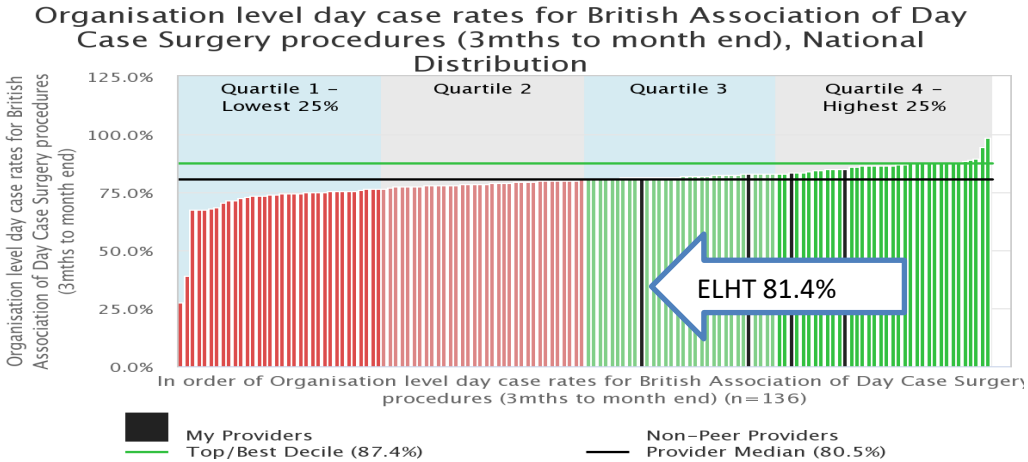


The Trust non-elective average length of stay is showing deteriorating performance this month, when compared to the pre-covid baseline.



Model health system data up to Feb 23 shows ELHT in the third quartile for non-elective length of stay. Data excludes length of stays of 0 or 1 day.

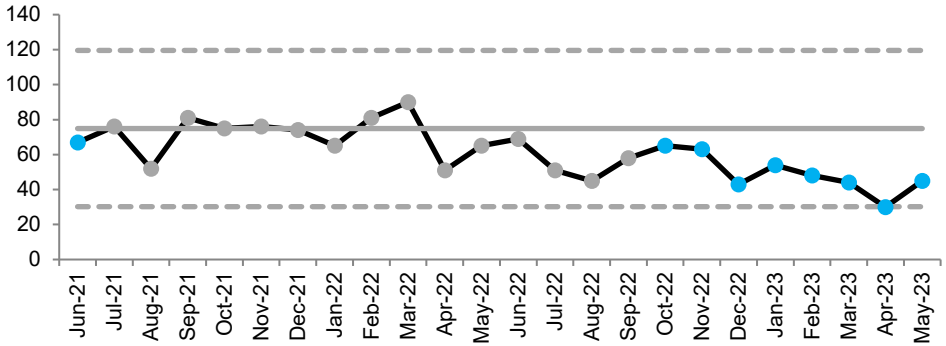
Daycase Rate



Model health system data based on latest 3 months up to Feb 23, shows ELHT in the third quartile for daycase rates at 81.4%. Data is for adults only

RESPONSIVE

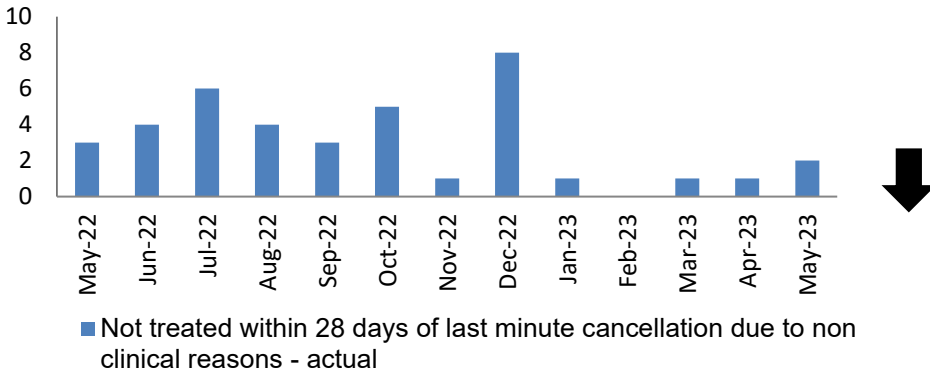
Operations cancelled on day



There were 45 operations cancelled on the day of operation - non clinical reasons, in May.

The trend is showing a reduction on baseline levels.

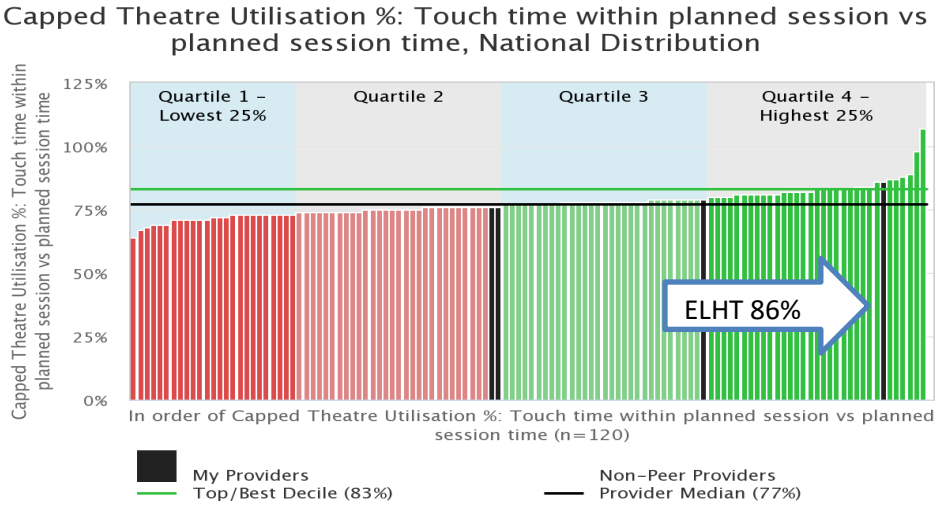
Operations cancelled on day - breaches of 28 day



There were 2 ‘on the day’ cancelled operations not rebooked within 28 days in May.

Patients that had procedures cancelled on the day are monitored regularly to ensure dates are offered within the 28 days. Risks are escalated to senior managers and escalated at the weekly operations meeting.

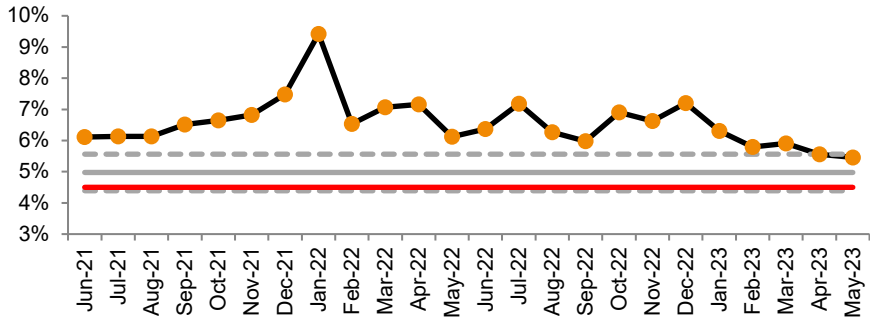
Theatre Utilisation



Data taken from 'The model hospital' shows capped theatre utilisation at 86% for the latest period to 21st May 23. This is in the fourth quartile nationally, with 4 being the highest and 1 the lowest.

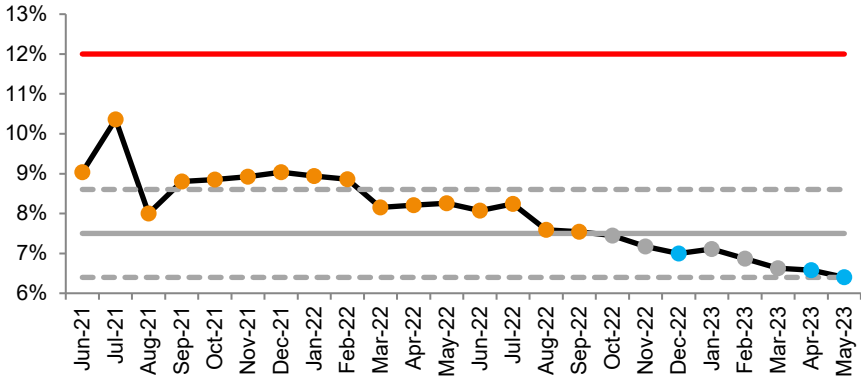
WELL LED

Sickness



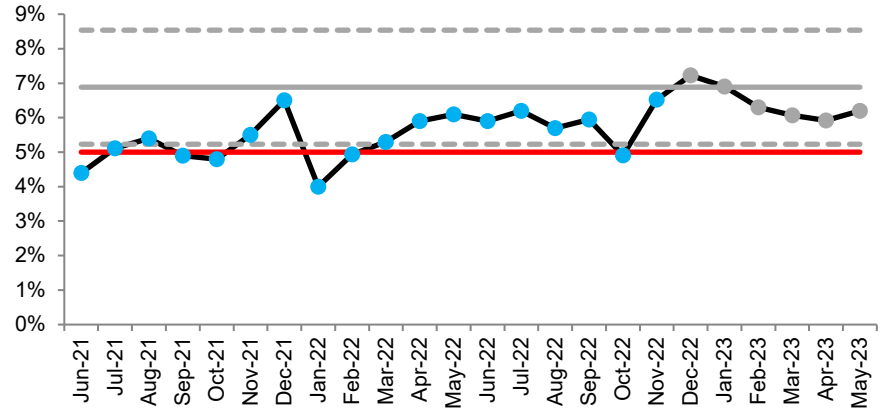
The sickness absence rate was 5.5% for May which is above the threshold of 4.5%. The trend is significantly higher than the pre covid baseline and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 6.4% in May and remains below threshold. This is showing a significant reduction when compared with baseline. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



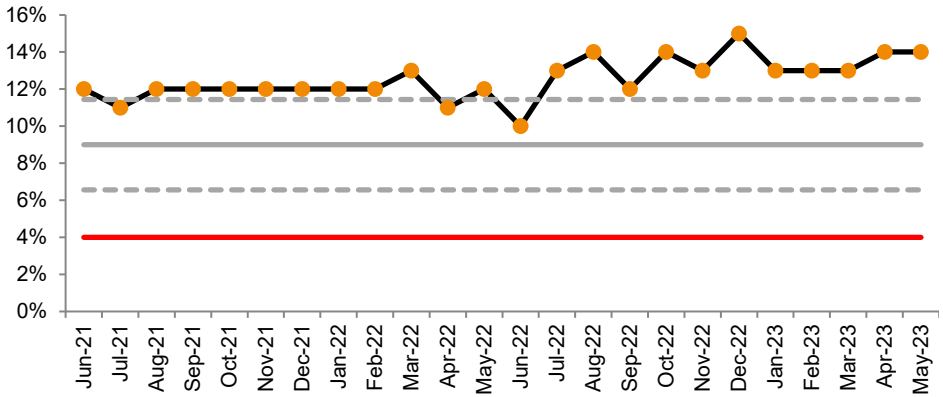
The vacancy rate is 6.2% for May which is above the 5% threshold.

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 May 2023, £5.7 million was spent on temporary staff, consisting of £1.6 million on agency staff and £4.1 million on bank staff.

WTE staff worked (9,769 WTE) was 90 WTE less than is funded substantively (9,859 WTE).

Pay costs are £1.1m more than budgeted establishment in May

At the end of May 23 there were 586 vacancies

The temporary staffing cost trend shows a significant increase when compared to pre covid levels and is not capable of hitting the target.

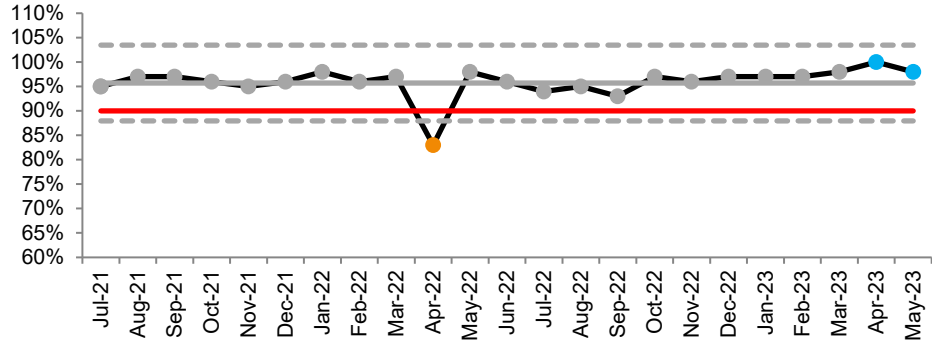
Job Plans

Stage	Consultant	SAS Doctor
Not Published	0	0
Draft	1	1
In discussion with 1st stage manager	132	23
Mediation	0	0
Appeal	0	0
1st stage sign off by consultant	48	14
1st stage sign off by manager	56	6
2nd stage sign off	56	18
3rd stage sign off	16	6
Signed off	48	17
Locked Down	0	0

As at May 2023, there were 357 Consultants and 85 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.

WELL LED

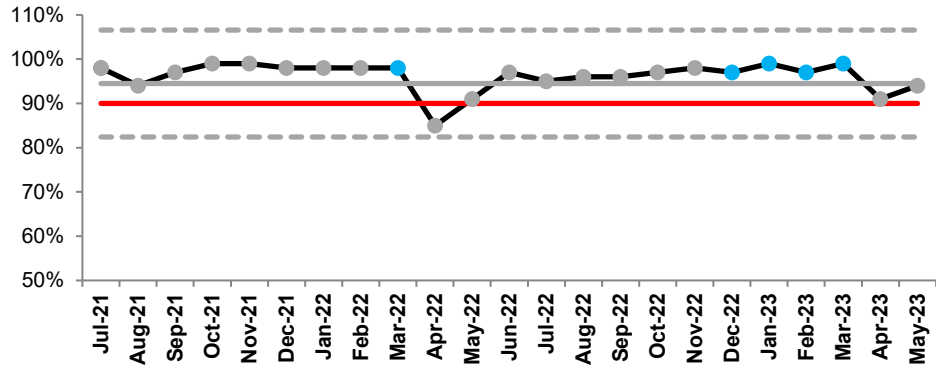
Appraisals, Consultant



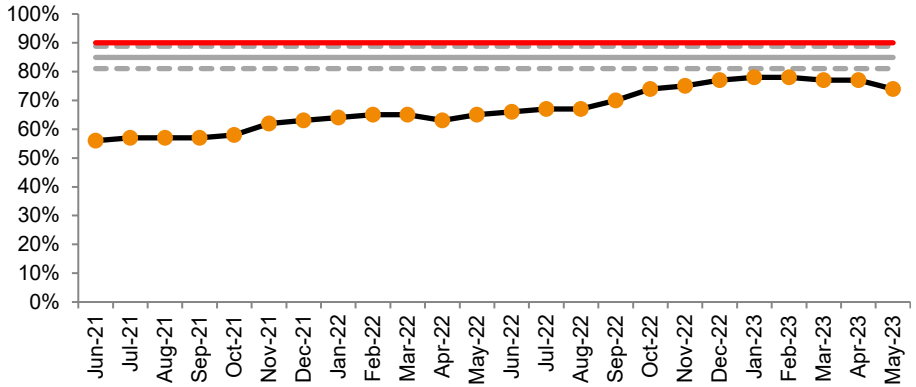
The appraisal rates for consultants and career grade doctors are reported for Apr - May 23 and reflect the number of reviews completed that were due in this period.

They both continue to be above target with 96% completed that were due in the period. 10% of all appraisals due for 23-24 were due in this period.

Appraisals, Other Medical



Appraisals Agenda for Change (AFC) Staff



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

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

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

WELL LED

Core Skills Training % Compliance

	Frequency	Target	Compliance at end May
Basic Life Support	2 years	90%	90
Conflict Resolution Training L1	3 years	90%	97
Equality, Diversity and Human Rights	3 years	90%	96
Fire Safety L1	2 years	95%	94
Health, Safety and Welfare L1	3 years	90%	96
Infection Prevention L1	3 years	90%	97
Infection Prevention L2	1 year	90%	90
Information Governance	1 year	95%	93
Preventing Radicalisation Level 1	3 years	90%	96
Preventing Radicalisation Level 3 †	3 years	90%	69
Safeguarding Adults L1	3 years	90%	94
Safeguarding Adults L2	3 years	90%	93
Safeguarding Adults L3*	3 years	90%	41
Safeguarding Children L1	3 years	90%	96
Safeguarding Children L2	3 years	90%	96
Safeguarding Children L3	3 years	90%	77
Safeguarding Children L4	3 years	90%	100
Safer Handling Level 1	3 years	95%	96
Safer Handling Level 2 (Patient Handling)	3 years	95%	90

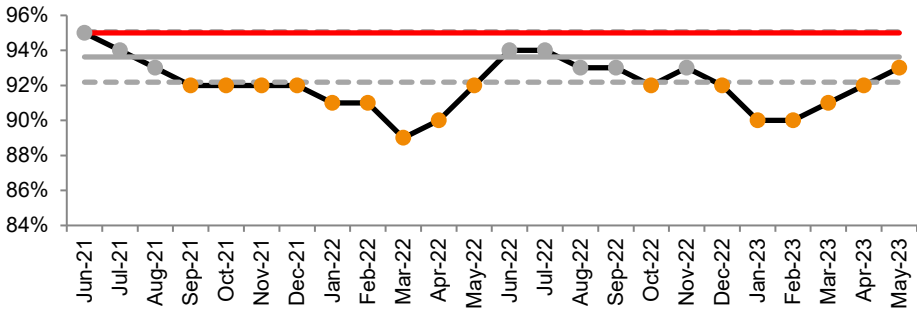
The core skills framework consists of eleven mandatory training subjects, with 19 modules in total. Training is via a suite of e-learning modules and knowledge assessments on the learning hub.

The threshold has been set at 90% for all areas except Information Governance, Fire Safety and Safer Handling which have thresholds of 95%

6 of the 19 modules are below threshold in May. Preventing Radicalisation Level 3 and Safeguarding Adults Level 3 are new mandatory requirements for some staff from April 23.

New starters are now being requested to complete as much of their Core Skills e-Learning requirements as possible prior to attending the Trust Induction training programme via the e-Learning for Healthcare platform. Additionally, there will be a limited amount of time for new starters to undertake any incomplete Core Skills e-Learning/training during the one-day Trust Induction training programme.

Information Governance Toolkit Compliance

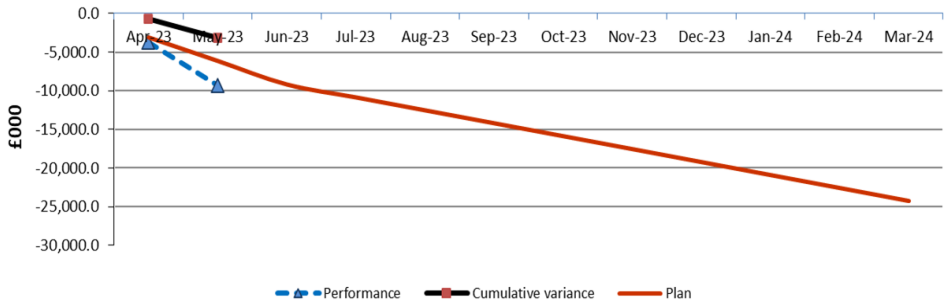


Information governance toolkit compliance is 93% in May which is below the 95% threshold. The trend continues to be below the pre covid baseline and is at risk of not meeting the target.

WELL LED

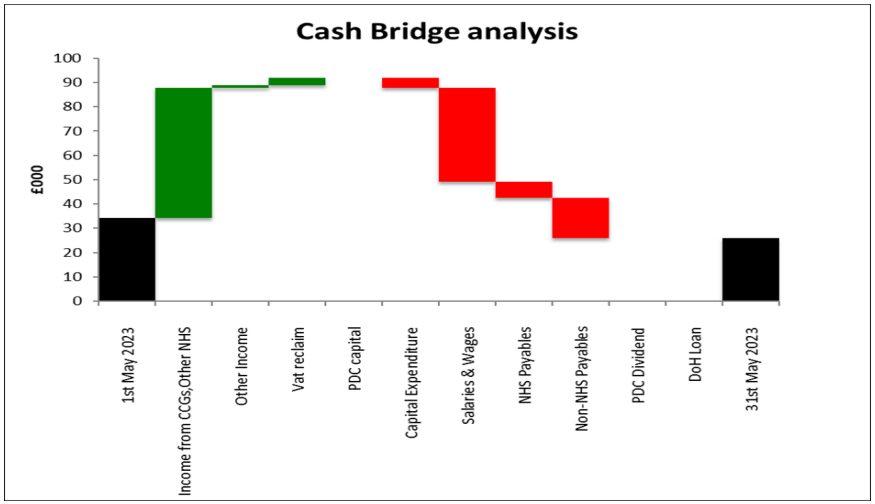
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



The Trust is reporting a breakeven duty deficit of £9.3m for the 2023-24 financial year to date, £3.2m behind plan.

Cash



The Trust's cash balance is £26.1 million as at 31st May 2023.

The Trust is reporting a draft annual planned deficit of £24.3m Within the deficit is a £42.3m waste reduction programme programme and a share of a system planning gap at £12.3m.

The Trust is reporting a breakeven duty deficit of £9.3m for the 2023-24 financial year to date, £3.2m behind plan, largely due to a £2.5m underachievement of the Waste Reduction Programme.

The Trust is now working to a £27.9m capital programme for 2023-24, a £0.6m increase from the position reported the previous month, with £1.5m spent against a planned figure of £1.7m for the year to date.

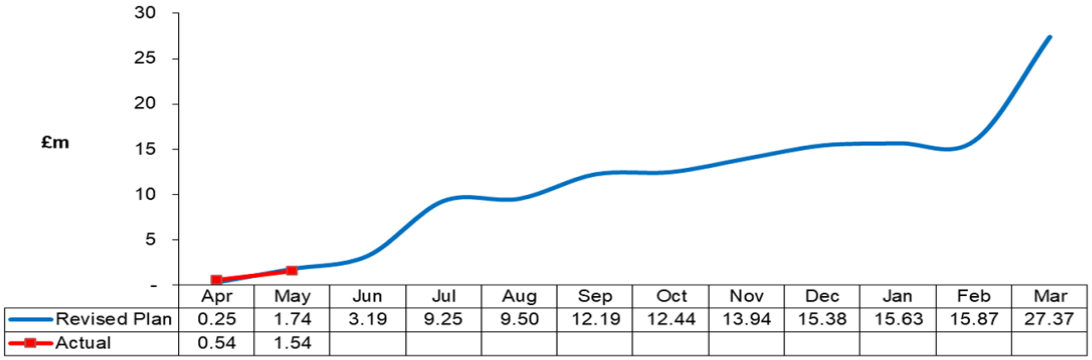
The cash balance on 31st May 2023 was £26.1m, a reduction of £8.3m compared to the previous month, largely due to the £5.6m in month deficit.

The Trust has met the Better Payment Practice Code (BPPC) target to pay 95% of NHS invoices on time. While Trust performance was slightly below this target for the payment of non-NHS invoices by volume, 99.1% of non-NHS invoices were paid on time by value.

WELL LED

Capital expenditure

Capital expenditure profile



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	0.25	1.74	3.19	9.25	9.50	12.19	12.44	13.94	15.38	15.63	15.87	27.37
Actual	0.54	1.54										

The Trust is £0.2m behind its planned capital spend as at 31st May 2023.

Waste reduction programme

WRP schemes analysis

Identified schemes in tracker

Division	Green £000s	Amber £000s	Red £000s	Non Rec £000s	Rec £000s	Identified Schemes £000s	Annual Target £000s
Trust Wide Schemes	4,121	0	18,584	9,467	13,238	**22,705**	48,530
Medicine & Emergency Care	204	68	1,854	1,896	230	**2,126**	1,294
Community & Intermediate Care	2,027	0	0	2,027	0	**2,027**	410
Surgical & Anaes Services	48	173	0	48	173	**221**	1,338
Family Care	0	0	0	0	0	**0**	809
Primary Care	0	0	0	0	0	**0**	30
Diagnostic & Clinical Support	0	595	385	0	980	**980**	1,058
Estates & Facilities	0	0	2,700	1,100	1,600	**2,700**	622
Corporate Services	0	0	3,358	3,150	208	**3,358**	387
Education, Research & Innov'N	0	0	0	0	0	**0**	140
Total	6,401	836	26,881	17,688	16,429	34,117	54,618

Schemes to the value of £4.6m have been transacted in the year to date. Additional identified schemes will be assessed for

TRUST BOARD REPORT

12 July 2023

Item	**90**
Purpose	Information Action Monitoring

Title	Maternity and Neonatal Services Update
Executive sponsor	Mr P Murphy, Chief Nurse. (Board Level Maternity / Neonatal Safety Champion)

Summary: The purpose of this report is to provide:
1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Maternity Safety Ambition, specifically relating to the ten CNST maternity safety actions included in year five of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. (Appendix 1 - CNST year 5 criteria)
2. Updates regarding ELHT (East Lancashire Hospitals Trust) maternity services response to the NHS England/Improvement (NHS E/I) – Ockenden review of maternity services/Three-year plan
3. Safety intelligence within maternity or neonatology care pathways that pose any potential risk in the delivery of safe care to be escalated to the trust board.
4. Service improvements, progress, and celebrations.

Recommendation:
The Board of Directors are asked to.

- Receive and discuss the CNST-MIS update report and recommendations.
- Have full oversight through direct reporting to ELHT trust board any barriers that may impact on the implementation and longer-term sustainability plans for delivery aligned with the maternity and neonatology safety ambition.

Report linkages

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

workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.

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

Impact

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

Previously considered by:

1. INTRODUCTION

The purpose of this report is to provide:

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

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

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

4. ELHT Regular updates aligned to the three-year delivery plan March 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. CNST - MATERNITY INCENTIVE SCHEME

2.1 Year 5 Reporting Period – Commencement

CNST – MIS guidance was released by NHS Resolution on the 31st of May 2023, and covers the reporting period of 30th May 2023 – 7th December 2023 with a final submission date of Thursday 1st February 2024.

A programme of works schedule with the specialist multi-disciplinary teams for each safety action will be led and in place by the Maternity and Neonatal Programme Manager and Improvement Support Officer with full oversight of the Maternity and Neonatal Quadrumvirate Team. This will then be reflected in Quality Committee and Trust Board paper reports.

2.2 Key safety action updates/ matters of assurance.

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

Please see below a progress tracker for Trust Board reflecting PMRT compliance against the CNST standards, this reflects all eligible cases between April – June 2023.

Table 2 Perinatal Mortality Review Tool – Deadlines by Month

Deadline (Target)	April		May		June	
MBRRACE notification with 7 working days (100%)	Number due	0	Number due	3 (100%)	Number due	5 (100%)
	Hit	N/A	Hit	3	Hit	5
	Miss	N/A	Miss	0	Miss	0
	Exceptions		*Exceptions*		*Exceptions*	
Surveillance data complete within 1 calendar month. (100%)	Number due	2 (100%)	Number due	1 (100%)	Number due	3 (100%)
	Hit	2	Hit	1	Hit	3
	Miss	0	Miss	0	Miss	0
	Exceptions		*Exceptions*		*Exceptions*	
PMRT tool opened, and factual questions complete within 2 months. (95%)	Number due	3 (100%)	Number due	2 (100%)	Number due	2 (100%)
	Hit	3	Hit	2	Hit	2
	Miss	0	Miss	0	Miss	0
	Exceptions		*Exceptions*		*Exceptions*	
Draft report started within 4 months. (60%)	Number due	4 (50%)	Number due	2 (100%)	Number due	3 (66%)
	Hit	2	Hit	2	Hit	2
	Miss	2	Miss	0	Miss	1
	Exceptions	*Delay in timeline creation due to clinician workload*	*Exceptions*		*Exceptions*	*Case delayed due to meeting postponement*
Report published within 6 months. (60%)	Number due	4 (75%)	Number due	5 (80%)	Number due	4 (100%)
	Hit	3	Hit	4	Hit	4
	Miss	1	Miss	1	Miss	0
	Exceptions	*Case requiring input from another Trust*	*Exceptions*	*Case also going through risk hence delay*	*Exceptions*	

Table 3 Perinatal Mortality Review Tool – New cases by month

MBRRACE ID	Date of death	Deadline met?				
		MBRRACE notification	Surveillance data	PMRT start	Draft report	Report publication
87049	*18/04/23*	*External Trust case therefore deadlines not enforced*				
87149	24/04/23	Yes	Yes	Yes		
87439	11/05/23	Yes	Yes	Yes		
87536	20/05/23	Yes	Yes			
87657	26/05/23	Yes	Yes			
87917	12/06/23	Yes	Yes			
87993	16/06/23	Yes	Yes			
88001	16/06/23	Yes				
88002	17/06/23	Yes				
88101	23/06/23	Yes				

An ongoing action plan is in place following the reviews using the PMRT tool as below:

PMRT Action tracker July Board Report.pdf

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

'Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the 'Clinical negligence schemes for trusts: scorecard' in the 'Maternity services monthly statistics publication series for activity in July 2023'.

Year 5 guidance increases the requirement for compliance with data quality assurance from 9 out of 11 CQIMs to 10 out of 11 CQIMs to pass. Final data for July 2023 data will be published as above during October 2023 and reported to Trust Board following this.

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

The requirement of CNST-MIS is that the transitional care policy demonstrates 'Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams participate in decision making and planning are for all babies in transitional care. The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.'

ELHT Trusts first audit of the Year 5 reporting period will include data from April, May, June 2023 and will be reported to Trust Board via Quality Committee in August 2023 and or Trust board in September 2023.

Safety action 4 – Can you demonstrate an effective system of clinical workforce planning to the required standard?

Obstetric medical workforce-

No exceptions to ELHT trust board in July 2023. Works programme commencing regarding audits of 6 months' activity for obstetric medical workforce.

Anaesthetic medical workforce

24-hour rota in place and compliant with anaesthesia clinical service accreditation (ACSA) standard. ELHT Trust to evidence position by 7th December 2023

Neonatal medical workforce

ELHT Trust required to formally record in trust board minutes whether it meets the relevant BAPM recommendations of the neonatal workforce. If the requirements are not met trust boards to agree and action plan to address shortfalls

Neonatal nursing workforce

ELHT Nursing workforce review will be undertaken at least once during year 5 reporting period 30 May 2023 – 7 December 2023

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

'A systematic, evidence-based process to calculate midwifery staffing establishment is completed.' This has been completed as per the Birth-rate+ exercise and subsequent report reflected to in the Maternity Safe Staffing Update report to ELHT Trust Board in November 2022.

All 'Trust Boards to evidence a plan of midwifery staffing budgets to reflect funded establishment as calculated in above BR+ report.' ELHT maternity services have submitted an action plan which was agreed as per CNST – MIS Year 4 requirements, reflected in the Maternity and Neonatal Service Update Report to Trust Board in March 2023. It was agreed that a business case to meet the full requirements of the Birth-rate+ midwifery workforce report findings would be presented to Trust Board, due to the focussed resource required to support

the implementation of Electronic Patient Record this has been delayed and will be brought to Trust Board in September 2023.

The biannual midwifery staffing oversight reports will cover any staffing or safety issues, these reports are scheduled for completion in July and December 2023, this is a required standard for safety action 5. Please note any midwifery red flag incidents/ staffing shortfalls and mitigation are reviewed monthly and will be included in the oversight reports retrospectively. Safe midwifery staffing levels are risk assessed four times daily at the maternity/ Neonatology Safety huddles to cover any shortfalls. This mitigation is aligned with ELHT Safe Nursing and Midwifery Staffing Escalation Policy.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Saving Babies' Lives Care Bundle Version Three was published on the 12th of June 2023. The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. A new implementation tool will be available by the end of June 2023 to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three. The tool will be based on the interventions, key process and outcome measures identified within each element, so providers can begin implementation of the Care Bundle Version 3 with confidence. Assurance of progress with implementation will be reported to ELHT Trust Board reflecting tool compliance once available. The tool is due for national publication in July 2023.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023). Parents and families with neonatal experience may give feedback via the MNVP and Parent Advisory Group.
2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. (ELHT has completed this action plan with monitoring through divisional and trust meetings scheduled for 2023.)

3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. (ELHT maternity training team will action the local training plan)

2. The plan to be agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. (Once completed in July 2023, this will be added to August quadrumvirate agenda for trust board agenda in September 2023.

3. The training plan is developed based on the "How to" Guide developed by NHS England.

12 consecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme.

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. The minimum evidence requirement for this is 'Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st July 2023.' This has been in place as per Year 4 requirements and is visible to all staff in working areas and accessible via SharePoint **[Appendix 2]**

b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan using the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings. The minimum evidence requirement for this is 'Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set **[Appendix 3]** to include a review of thematic learning of all maternity Serious Incidents (SIs).'

'Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.' This meeting is scheduled to take place w/c 10th July 2023 as a directorate meeting with attendance from Board Level Safety Champions, outcomes will be reported to the Trust Board 13th September 2023 and minutes will be included as appendices. 'At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan.' This will be scheduled in October 2023.

c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.

Minimum evidence requires 'Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated Future NHS workspace to access the resources available no later than 1 July 2023' This access has been shared with our Board Level Safety Champions to evidence this ask.

'Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented. This must have been undertaken within 9 months of their teams starting the Perinatal Culture and Leadership 'Quad' Programme.' Please see the below information and update regarding the perinatal quadrumvirate culture & leadership programme which provides the response for this:

Perinatal Quadrumvirate Culture & Leadership Programme (Safety Action 9. Point C evidence)

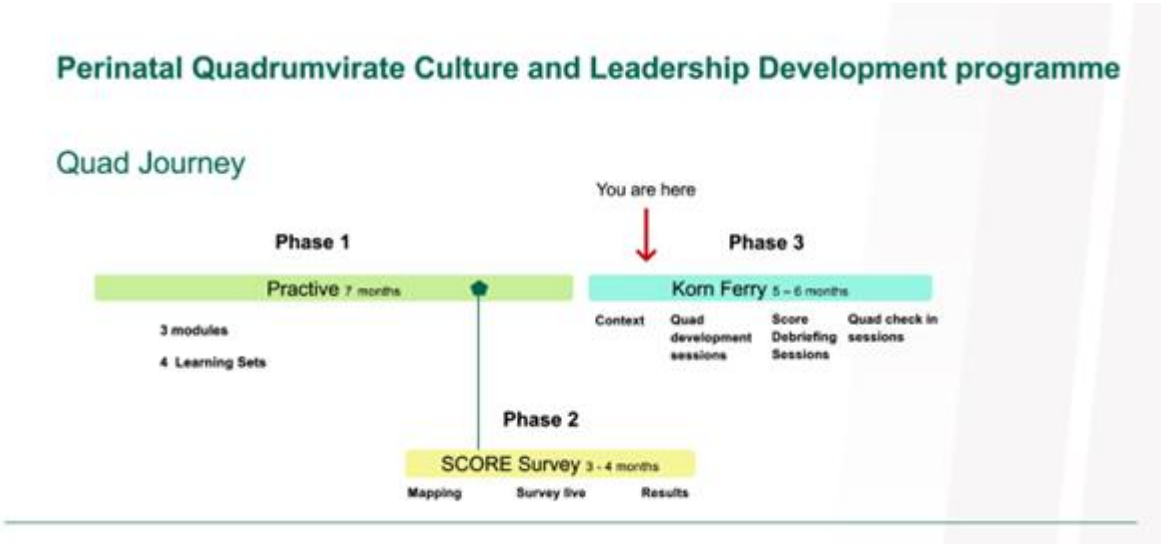
The three-year Maternity and Neonatal service delivery plan outlines the aim of NHS England: 'By April 2024, offer the perinatal culture and leadership programme to all maternity and neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads. This includes a diagnosis of local culture and practical support to nurture culture and leadership.'

ELHT Maternity and Neonatal Quadrumvirate team have been involved in the first cohort of this programme which commenced mid-November 2022 (this update therefore is submitted within the 9 months requirement of CNST from ELHT team starting the programme.) The quadrumvirate team have attended 3 modules and 4 learning sets supported by Practive, followed by the re-launch of the SCORE (Safety Culture, Operational Risk, Reliability/burnout, and Engagement) survey: The SCORE survey provides an internationally recognised way of measuring and understanding culture that exists within organisations and teams. It is an anonymous, online tool that can be used to gain insight into your team's safety culture to help you all identify strengths and opportunities, and to understand the role that relationships have in supporting improvement.

ELHT maternity and neonatal services successfully achieved +40% response rate from across our staff and will receive the results of the survey and be supported to input improvements based on themes and trend from the organisation consultancy firm Korn Ferry. The first quadrumvirate meeting on site at ELHT with Korn Ferry has taken place on the 29th of June 2023 following introductory meetings over the previous few months with all Maternity and Neonatal Safety Champions including Board Level Safety Champions executive and non-executive Board Safety Champions.

The next meeting is scheduled for Monday 17th July 2023 followed by the 6th of September 2023. The four debrief sessions with all staff to discuss the results will take place as a minimum with 3 groups i.e., Delivery Suite, Antenatal and Postnatal Ward etc with Korn Ferry to lead the debriefing. The fourth debrief session led by Korn Ferry will be an open session for any staff member to attend. Following these sessions ELHT can run as many additional debrief sessions with teams once the Korn Ferry debriefer has completed the first four. Dates for these will be arranged once the SCORE survey results are available due to released.

The below image illustrates the timeline and our current position as described above:



Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

A) Reporting of all qualifying cases to HSIB/CQC//MNSI from 30 May 2023 to 7 December 2023.

B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 until 7 December 2023.

C) For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that:

i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme.

and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

A direct focus of the minimal evidential requirements for Trust Board for this safety action will be reported to Trust Board on 13th September 2023.

3. SAFETY INTELLIGENCE – ESCALATION

A Team engagement session was held on Friday 23rd June 2023 following the first week of Electronic Patient Record (Cerner) implementation following escalation of safety intelligence / concerns relating to the new system and the booking of antenatal appointments. A log of the issues raised with urgent actions had been collated within the division and logged as tasks with the BGH command centre, due to the number of tasks and urgency with the delay in booking the time critical follow up appointments and ultrasound scans, further escalation at ELHT trust IMT meeting by the divisional director of midwifery and clinical director of obstetrics to trust board members was sought, a bespoke meeting was arranged within two hours of escalation to support the unforeseen issues.

Maternity Antenatal Clinic – Cerner EPR Implementation

Following on from the above safety intelligence identification of the workflows completed for the Ante natal outpatient clinic (ANOC) pathways have presented with several unexpected system issues resulting in Antenatal clinic scan booking and AN follow up appointment being delayed. Access to the systems both for midwives and administration staff has been limited due to incorrect codes generated in the Cerner system at present. This was identified within the first few days of Cerner EPR go live and actioned as above, close surveillance and due diligence remains a matter of high priority.

4. CONCLUSION

On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board will provide progress with assurances of the ten CNST maternity safety action submissions throughout the Year 5 reporting period. The progress and assurances with updates of the other objectives as outlined in the summary will continue to be reported aligned with ELHT twelve-month schedule adapted from National policy, independent reports, and recommendations. Any other matters of safety or concerns if apparent will be reported through the bimonthly maternity and neonatology safety champions floor to board agendas and reflected within trust board papers.

Appendix 1 – CNST-MIS Y5 Guidance

MIS-year-5-FINAL-31-5-23.pdf

Appendix 2 – Perinatal Quality Surveillance Model, pathway of safety intelligence

Mat_Neo CNST Reporting Process v3

Appendix 3 – Perinatal Quality Surveillance Model, minimum data set

PQSM - Minimum Data Set - may 23.pdf

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

12 July 2023

Item 91

Purpose Information

Action

Title	Inclusion and Belonging: NHS EDI Improvement Plan and Anti-Racism Framework
Executive sponsor	Mrs K Quinn, Executive Director of People and Culture

Summary: This paper shares two critical documents linked to Inclusion and Belonging which are of strategic importance to the Trust as we aim to deliver safe, personal and effective care, improve health equity and develop an outstanding culture. By focusing on inclusion and belonging for patients, families, and our workforce we will develop a culture where everyone feels safe, respected, and supported to develop a fulfilling career in line with their full potential. We will also better meet the needs of our diverse community through provision of personalised care, transforming services that are equitable, and by providing high quality education, training, and employment as an anchor institution.

This is critical for ELHT if we are to deliver the ambitions of the Long Term Plan and the newly published NHS Long Term Workforce Plan. Inclusive cultures are necessary if we are to 'Train, Retain and Reform' and require a strategic focus from Boards and senior leaders as well as the wider workforce if we are to retain current staff and attract new talent.

The following documents are attached for information for the Board as will form a large part of the People and Culture and Health Equity objectives and will require review to ensure our readiness, galvanise our collective action and ambition, and agree outcomes for which we will be accountable:

a) NHS England has published the first **NHS workforce equality, diversity and inclusion (EDI) improvement plan** which sets out six high impact actions for NHS organisations, addressing inequalities across the nine protected characteristics as prescribed in the Equality Act 2010. Addressing all forms of discrimination and inequalities, will enable our workforce to use their full range of skills and experience to deliver the best possible care to our patients and service users. By promoting equality of opportunity for progression and growth within the NHS, we can have a positive impact on health inequalities and social mobility, enhancing the NHS's role as an anchor institution within the communities we serve and attracting diverse talent to our workforce. The plan sets out high impact actions for the Board, senior leaders and Trust to take.

b) **North West BAME Assembly Antiracist Framework** – shared with Chief Executives and Chairs with an accompanying letter – this framework provides support for organisations to address longstanding racial inequalities. As leaders we are asked to commit to taking sustained action and demonstrate visible leadership on addressing racism in all its forms – interpersonal, structural, and institutional and prioritise addressing racial inequalities within the Trust. It contains a step-by-step guide which helps the Trust to review the current status of the organisation, assess inequalities, celebrate successes and encourage continuous improvement. Boards are asked to publicly commit to the Antiracist Framework and on becoming intentionally Antiracist.

Recommendation: The Board is asked to:

1. Note the NHS Workforce EDI Improvement plan and allocate a future board development session or strategy session for a focused discussion to explore the current state, review the impact of current actions, and agree our priorities and qualitative and quantitative outcomes for the coming year/s.
2. Note the BAME Assembly Antiracist Framework and consider the merits of adopting this as the Trust approach and in doing so, making a public commitment to this at a Trust and System level.
3. Consider what the role is of the Board around inclusion, belonging and antiracism, and how the newly established People and Culture Committee will provide the necessary governance and assurance.

Report linkages

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

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by: N/A

NHS equality, diversity, and inclusion improvement plan

NHS equality, diversity, and inclusion improvement plan

Contents

A note on language

In the pursuit of equality, diversity and inclusion, language is powerful and can help to shift attitudes and behaviours.

This plan acknowledges that some definitions and terminology in legislation do not always reflect the identities or lived experience of individuals.

Achieving equality of health outcomes requires identification of barriers and biases, and targeted action to overcome specific inequalities, discrimination and marginalisation experienced by certain groups and individuals. This includes, but is not limited to, those with protected characteristics under the Equality Act 2010[1].

The aim of this plan is to improve equality, diversity and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience. Therefore, while we refer to the protected characteristics as defined in the Equality Act 2010, the actions set out here are intended to positively impact groups and individuals beyond these terms and definitions.

We have developed the high impact actions in this plan to be intersectional. This recognises that people have complex and multiple identities, and that multiple forms of inequality or disadvantage sometimes combine to create obstacles that cannot be addressed through the lens of a single characteristic in isolation[2].

Some specific points on language

When referring to ethnicity, we use the term Black and minority ethnic (BME) to be consistent with *NHS Workforce Race Equality Standard terminology*.

We use the term 'disability' as it is defined in the Equality Act 2010 recognising that the Act's intention is both positive and protective for disabled people. However, we recognise that 'disability' is a dynamic term, within which terms such as 'neurodivergence' and 'neurodiversity' are emerging and changing, including the relationship between neurodivergence and definitions of disability.

We use the acronym LGBT+ is used in this document, where the 'plus' includes all those identities and sexual orientations not specifically referenced. To promote the use of inclusive language, this document uses the terms 'trans and non-binary', 'gender identity' and 'sexual orientation'.

Foreword

"The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms"

NHS People Plan 2020

Amanda Pritchard,
Chief Executive,
NHS England

It is our privilege to introduce the NHS's first *equality, diversity and inclusion (EDI) improvement plan*. The NHS workforce is more diverse today than at any point in its 75-year history, and that brings benefits for patients and taxpayers alike.

Our NHS is built on the values of everyone counts, dignity and respect, compassion, improving lives, working together for patients, and commitment to quality. These values underpin how healthcare is provided, but must also extend to our NHS workforce.

Staff are at the heart of everything the NHS does, and always will be. To support the recovery of services following the COVID-19 pandemic, we need to increase capacity by growing our workforce and find new ways of working to enhance productivity.

To build for the future, we must inspire new staff to join and encourage existing staff to stay.

Ensuring our staff work in an environment where they feel they belong, can safely raise concerns, ask questions and admit mistakes is essential for staff morale - which, in turn, leads to improved patient care and outcomes[3].

This can only be done by treating people equitably and without discrimination.

An inclusive culture improves retention, supporting us to grow our workforce, deliver the improvements to services set out in our Long Term Plan, and reduce the costs of filling staffing gaps.

Delivering that kind of working environment in an organisation of any size takes deliberate focus, listening and action.

The NHS People Plan, sets out the priorities for supporting the 1.3 million people who work in the NHS in England[4], with specific actions for improving their sense of 'belonging' in the NHS. This *plan* builds on the People Promise and the People Plan, using the latest data and evidence to identify six high impact actions organisations across the NHS can take to considerably improve equality, diversity and inclusion.

It is also right that NHS England holds itself to account to the same standards as the NHS as a whole, so we will be implementing this plan in our organisation.

We would like to acknowledge the contributions, expertise and lived experience shared with us by staff, staff networks, managers and system leaders in the development of this plan, which have provided us with invaluable insights on improving the experience of staff across the NHS.

We would also like to acknowledge the inputs from our strategic partners, including the Health and Care Women Leaders Network, the Race and Health Observatory, NHS Employers, NHS Providers, NHS Confederation, and many more.

On behalf of the whole NHS leadership team, we want to thank you for working with compassion, putting our patients and people at the helm and rising to the challenges we face.

We hope this plan provides the framework for making the NHS the best place to work whoever you are, where all staff feel they belong, can thrive, and – ultimately - deliver the best possible service for our patients.

Dr Navina Evans
Chief Workforce, Education and Training Officer,
NHS England

Introduction

This improvement plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

It has been co-produced through engagement with staff networks and senior leaders.

The plan:

- Sets out why equality, diversity and inclusion is a key foundation for creating a caring, efficient, productive and safe NHS
- Explains the actions required to make the changes that NHS staff and patients expect and deserve, and who is accountable and responsible for their delivery
- Describes how NHS England will support implementation
- Provides a framework for integrated care boards to produce their own local plans.

The findings and recommendations of the Messenger Review- Leadership for a collaborative and inclusive future (July 2022) reaffirmed the need for this plan's actions , which forms part of our response to recommendation two of the review. Future iterations of this plan will address how we tackle EDI challenges within social care, and will be developed in collaboration with integrated care boards (ICBs) and other key stakeholders including the Department of Health and Social Care (DHSC).

The NHS Long Term Workforce Plan will define the size, shape, mix and number of staff needed to deliver high quality patient care, now and into the future. This EDI improvement plan supports the Long term workforce plan by improving the culture of our workplaces and the experiences of our workforce, to boost staff retention and attract diverse new talent to the NHS. The plan also supports the achievement of strategic EDI outcomes, which are to:

- **Address discrimination**, enabling staff to use the full range of their skills and experience to deliver the best possible patient care
- **Increase accountability of all leaders** to embed inclusive leadership and promote equal opportunities and fairness of outcomes in line with the NHS Constitution, the Equality Act 2010, the Messenger Review
- **Support the levelling up agenda** by improving EDI within the NHS workforce, enhancing the NHS's reputation as a model employer and an anchor institution, and thereby continuing to attract diverse talents to our workforce
- **Make opportunities for progression equitable**, facilitating social mobility in the communities we serve.

These actions should be implemented in partnership with trade unions / staffside colleagues and forums, and in collaboration with staff networks. In line with our operating framework, NHS England will provide guidance to assist trusts and ICBs in adopting an improvement approach to the implementation of this plan, supported by a repository of good practice and a dashboard to enable the measurement of progress. We will also implement this plan internally to ensure consistency with the NHS as a whole.

The case for change

Where diversity – across the whole workforce – is underpinned by inclusion, staff engagement, retention, innovation and productivity improve. Inclusive environments create psychological safety and release the benefits of diversity – for individuals and teams, and in turn efficient, productive and safe patient care.

Staff survey and workforce data reflecting the lived experience of NHS staff demonstrates that we have more to do before we can say inclusive workplace environments are the norm across the NHS[5]. For example, women make up 77% of the NHS workforce but are under-represented at senior level[6]. Just over 24% of the workforce are from black and minority ethnic (BME) backgrounds but face discrimination across many aspects of their working lives The 2022 Workforce Race Equality Standard (WRES) data showed that 27.6% of Black and minority ethnic (BME) staff experienced bullying, harassment or abuse from other staff in the preceding year; The NHS Staff Survey along with the Workforce Disability Equality Standard (WDES) shows that disabled staff in the NHS are under-represented when compared to the general population. The NHS staff survey data shows that 25% of disabled staff have experienced bullying from their colleagues, compared to 16.6% of non-disabled staff. Similarly, 23.5% of our LGBT+ colleagues face bullying and harassment at work compared to 17.9% of heterosexual staff.

Organisational efficiency correlates with staff and patient experience:

- Staff who are bullied are less likely and less willing to raise concerns and admit mistakes[7].
- Increased leadership diversity correlates with better financial performance[8].
- In hospital settings, managing staff with respect and compassion correlates with improved patient satisfaction, infection control, Care Quality Commission (CQC) ratings and financial performance[9].
- High work pressure, staff perceptions of unequal treatment, and discrimination against staff all correlate adversely with patient satisfaction[10].
- A workforce that is compassionate and inclusive for all has higher levels of engagement, motivation and wellbeing, which results in better care and reduced staff turnover[11].
- Fair treatment of every individual in the workforce helps reduce movement of substantive staff into bank and agency roles to avoid discrimination at work
- A diverse workforce that is representative of the communities it serves is critical to addressing the population health inequalities in those communities[12].
- Organisations with more diverse leadership teams are likely to outperform their less diverse peers[13].
- Psychologically safe work environments, where people feel they are treated with dignity and respect, achieve more effective, safer patient care[14].

Simply put, a diverse workforce in an inclusive environment will likely improve staff engagement, lower turnover and enhance innovation

Elective recovery is a top priority for the NHS[15]. Key to our success is boosting capacity, by filling vacancies, reducing turnover and improving morale[16]. To achieve this stability and to lay the foundations from which to grow the workforce of the future, the NHS must improve staff experience across all protected characteristics if we are to sustainably reduce staff turnover, increase recruitment, reduce absenteeism and create more inclusive and productive teams.

High-impact actions

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

High Impact Action 1

Chief executives, chairs and board members must have **specific and measurable EDI objectives** to which they will be individually and collectively accountable.

Leaders set the tone and culture of their NHS organisation.

Leaders who demonstrate compassion and inclusion, and focus on improvements, are key to creating cultures that value and sustain a diverse workforce. Staff will in turn feel more empowered to deliver great care and patient experience[17].

As highlighted in the Messenger Review, principles of EDI should be embedded as the personal responsibility of every leader and every member of staff. It is in this context that all Chief executives, chairs and board members should have distinct objectives on improving inclusion in their organization and have a personal commitment to mainstream EDI as the responsibility of all, such that the provision of an inclusive and fair culture should become a key metric by which leadership at all levels is judged.

NHS organisations and ICBs must complete the following actions:

- Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process (by March 2024).
- Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025).
- NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).

Success metric for high impact action 1	
Annual chair and chief executive appraisals on EDI objectives.	Board Assurance Framework

Further information and case studies can be found in the EDI repository.

High Impact Action 2

Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

We know diverse boards make better collective decisions for the communities they serve[18]. There has been progress in improving diversity of senior management teams; the total number of BME staff at very senior manager level has increased by 69.7% since 2018 from 201 to 341[19] and the percentage of board members declaring a disability has increased from 2% in 2019 to 4.6% in 2022. However, in relation to the three protected characteristics for which reliable data exists (race, disability and gender); senior teams across the NHS are less representative of their organisation's workforce. For example, WRES data (31 March 2022) shows that BME people make up 24.2% of the NHS workforce[19] but only 13.2% of board members; 85% of people with a disability do not believe that their trust provides equal opportunities for promotion;[20] and women represent 77% of the NHS workforce but only 37% of very senior managers[21].

Talent management strategies must recognise the importance of equitable recruitment and career progression for all staff. If they do not, the NHS risks losing talent because everyone does not see themselves as having the same opportunity, leading to a direct impact on patient care.

The national Inclusive *Recruitment and Promotion Practices framework*[22] highlights the principles for an evidence-driven approach. It supports boards in achieving the aspirations of the Long-Term Workforce Plan by addressing workforce vacancies.

NHS organisations and ICBs are to complete the following actions:

- Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation (by June 2025)
- Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (by October 2024). Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint.

Success metric for high impact action 2	
Relative likelihood of staff being appointed from shortlisting across all posts	WRES and WDES
Access to career progression, training and development opportunities	NHS Staff Survey
Year-on-year improvement in race and disability representation leading to parity over the life of the plan	WRES and WDES
Year-on- year improvement in representation of senior leadership (Band 8C and above) over the life of the plan	WRES and WDES
Diversity in shortlisted candidates	To be developed in year two
Combined Indicator Score metric on quality of training	NETS

Further information and case studies can be found in the EDI repository.

High Impact Action 3

Develop and implement an **improvement plan to eliminate pay gaps**

As an inclusive employer, the NHS should take steps to address gender, ethnicity and disability pay gaps.

The gender pay gap in the UK has been declining slowly over time; over the last decade it has fallen by approximately a quarter among full time employees[23]. The pay gap is relatively small for the 88% of NHS staff employed on Agenda for Change (AfC) terms and conditions. However, it is 47% for the 12% of NHS staff who are not, essentially doctors and senior leaders.

The independent review Mend the gap (2020) describes the actions that the NHS should take to address the gender pay gaps in medicine, such as promoting flexible working for all. Many of its recommendations can also be applied to non-medical senior leaders. For example, for every 80 pence earned by Black female doctors their White counterparts earn £1[24]. In younger age groups, the pay gap favours female doctors, reflecting the large numbers of women joining the NHS, but this reverses between the ages of 30 and 34 and then widens with age[25].

Data on organisational ethnicity and disability pay gaps will become available in the coming years.

NHS organisations are to complete the following actions:

- Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce (by March 2024).
- Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.
- Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns. (March 2024)

Success metric for high impact action 3	
Year-on-year reductions in the gender, race and disability pay gaps	Pay gap reporting

Further information and case studies can be found in the EDI repository.

High Impact Action 4

Develop and implement an improvement plan to **address health inequalities** within the workforce.

In England, 1 in 19 working age adults is employed by the NHS , making NHS[26] organisations one of the largest employers within local communities.

This creates an opportunity to positively impact population health by addressing health inequalities in the workforce[27]. A proactive approach to reducing health inequalities in the workplace[28] can make a significant contribution to the levelling up agenda[29] within local communities, supporting targets set by CORE20PLUS5[30].

NHS organisations should start by delivering action in two specific areas.

Firstly, reducing bullying, increasing civility, and having a robust approach to all abuse and harassment. This will address some common causes of ill health, absenteeism and turnover within the workforce which disproportionately impact on those with some protected characteristics, and will improve inclusive team working, staff health and wellbeing.

Secondly, as anchor institutions in local communities, NHS organisations can make a positive impact by offering routes into employment, good work[31] and career development.

Organisations are to complete the following actions:

- Line managers and supervisors should have regular effective wellbeing conversations with their teams, utilising resources such as the national NHS health and wellbeing framework. (by October 2023).
- Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare (by April 2025).

Success metric for high impact action 4	
Organisation action on staff health and wellbeing.	NHS Staff Survey
National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training	NETS
During 2024/25, NHS England will work with ICBs and other key stakeholders to establish a mechanism for measuring improvements in workforce health inequalities.	

Further information and case studies can be found in the EDI repository.

High Impact Action 5

Implement a **comprehensive induction, onboarding and development programme for internationally-recruited staff.**

Since its inception in 1948, the NHS has benefitted from the expertise, compassion and commitment of internationally recruited healthcare professionals. A warm welcome and comprehensive induction and pastoral support package will make them feel valued from the start and help retain this staff group.

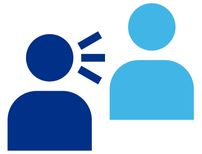
NHS organisations should complete the following actions:

- Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment ; including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options (by March 2024).
- Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured rom, for example, turnover, staff survey results and cohort feedback (by March 2024).
- Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety (by March 2024).
- Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression (by March 2024).

Success metric for high impact action 5	
Sense of belonging for internationally recruited staff	NHS Staff Survey
Reduction in instances of bullying and harassment from team/line manager experienced by (Internationally recruited staff).	NHS Staff Survey

Further information and case studies can be found in the EDI repository.

High Impact Action 6



Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Bullying and harassment at work results in increased sickness absence and employee turnover, diminished productivity, sickness presenteeism, governance and employee relations costs. Workplace bullying therefore adversely impacts patient safety.

In the 2022 NHS Staff Survey 18.7% of NHS staff reported they had experienced bullying by colleagues, 11.1% by line managers and 27.8% by patients or their relatives. These statistics are consistently higher for people with some protected characteristics, and particularly those with a disability or and in the LGBT+ community.[32]

Staff who are bullied in the workplace are less likely to speak up and to admit mistakes, and therefore are less likely to contribute to effective team working. Bullying affects bystanders and witnesses too[33], eroding psychological safety within the workplace culture[34].

Relying on local policies to prevent bullying or discrimination is not enough. A proactive, preventative approach that seeks early informal intervention wherever possible is more likely to be effective, with escalation only where that fails.

NHS organisations are to complete the following actions:

- Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set (by March 2024) and plans implemented to improve staff experience year-on-year.
- Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this (by March 2024).
- Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it. (By June 2024)
- Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff (by March 2024).
- Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence (by March 2024).
- Have mechanisms to ensure staff who raise concerns are protected by their organisation.

Success metric for high impact action 6	
Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)	NHS Staff Survey
Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)	NHS Staff Survey
Bullying & Harassment score metric (NHS professional groups)	NETS

Further information and case studies can be found in the EDI repository.

Make change happen

As England's largest employer, the NHS must lead the way in establishing equitable and inclusive workplace environments.

The key change management principle guiding this work is that EDI is everyone's business – our leaders set the tone and culture, but we all have a role to play. Progressing the EDI agenda requires not only a change in systems and processes, but also cultures and behaviours.

NHS leaders, specifically chairs and chief executives, must lead by example and demonstrate that they are committed to creating an EDI environment for their workforce. Board members should collectively and individually decide what support and development they require to confidently lead this complex and challenging agenda.

We expect **NHS employing organisations** to implement the six high impact actions. They should be confident in explaining to their workforce – especially leaders, HR professionals and line managers – the rationale for this work and what is expected of individuals and teams. Using the repository of good practice, organisations should identify suitable interventions for local implementation, based on local context and conditions. NHS England will support this by collating and disseminating best practice.

Accountability is important for setting clear expectations, coupled with a focus on learning and improvement. NHS England, ICB and provider accountabilities and responsibilities for delivery of the NHS EDI improvement plan follow the principles set out in the NHS Operating Framework and are outlined in the table below. NHS England will provide regulatory accountability and oversight through existing mechanisms, such as the NHS Oversight Framework, and the CQC through the well-led domain of the single assessment framework, which is being refreshed to include a review and assessment of EDI in organisations.

Measurement of progress is critical to guide targeted action. Progress should be measured at organisation and system level to inform delivery, and will be monitored by NHS England to inform the support we provide.

Accountability framework

Providers	ICSs / ICBs	Regional	National
✓ Delivery of high impact actions and interventions by protected characteristic at trust level. ✓ Measure progress against success metrics consistently within the organisation. ✓ Engagement with staff and system partners to ensure that actions are embedded within the organisation. ✓ Effective system working and delivery to ICS strategies and plans ✓ Compliance with provider licence, Care Quality Commissions standards and professional regulator standards.	✓ Effective system leadership overseeing NHS delivery of EDI improvement plan, ensuring progress toward achievement of high impact actions and Long-Term Plan priorities. ✓ Ensuring delivery of ICB statutory functions of arranging health services for its populations and compliance with statutory duties. ✓ Measure progress against success metrics consistently and coordinate a system view. ✓ Compliance with Care Quality Commissions assessment frameworks.	✓ Primary interaction between national and systems ✓ Translate national policy to fit local circumstances, ensuring local health and workforce inequalities are addressed ✓ Agree 'local strategic priorities' with individual ICSs and provide oversight and support. ✓ Measure progress against success metrics consistently and coordinate a regional view.	✓ Set expectations for equality and inclusion through the NHS EDI improvement plan ✓ With regions, facilitate supportive interventions to implement the high impact actions, improve EDI performance and outcomes ✓ Measure progress against success metrics consistently and coordinate a national view.

Support from NHS England

We will work alongside systems and organisations to support the delivery of the NHS EDI improvement plan.

A national EDI repository

We will create a repository of good practice on the Future NHS platform to share examples of what is working in the NHS and in other public and private sector organisations. This will help prevent duplication of effort and promote learning. The repository will be continually updated and include:

- case studies from organisations
- practical toolkits and resources
- the latest research and evidence.

A national EDI dashboard

A national dashboard of key EDI metrics is being developed and will be available in the coming weeks by region, within ICBs and within similarly benchmarked trusts. This will enable local organisations and NHS England to monitor progress, identify challenges and assist peer-to-peer learning alongside the EDI repository. It will incorporate relevant education and training metrics, created by Health Education England.

Data

Reliable, consistent and timely data is crucial to effective progress. There are significant differences in the range and quality of data held for the protected characteristics. This is reflected in the sections for each protected characteristic. In 2023/24, NHS England will seek to improve the range and quality of data, working with DHSC and other partners. So, for example, with the addition of a question to the NHS Staff Survey, data is now available on whether staff are internationally trained. In addition, NHS England will seek to develop a new mandated workforce standard on gender identity (gender/sex) and sexual orientation.

Review and Evaluation

Sustained improvement is central to this NHS EDI improvement plan. Trusts and ICBs will want to adopt implementation approaches that include learning. NHS England will evaluate progress, particularly on the high impact actions, in years 2 and 5 of the plan, to understand the plan's impact in transforming culture to engender a sense of belonging in the NHS across the workforce, and what does and does not work to inform changes to our approach.

There is currently a range of EDI information datasets and we intend the dashboard to provide one source of information that both organisations and regulators, such as the CQC, can use to track the impact and outcomes of the NHS EDI improvement plan.

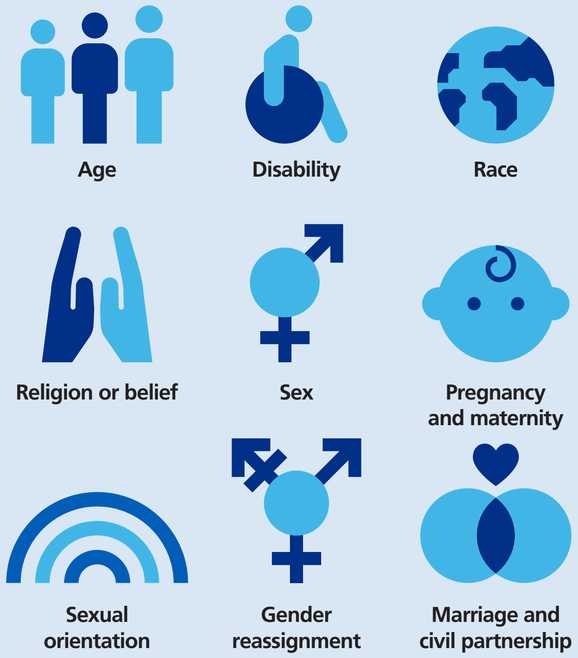
In developing the dashboard, we are conscious that there are limitations on the availability of datasets for certain protected characteristics, such as for transgender colleagues. Furthermore, the declaration rates on the Electronic Staff Record (ESR) for certain characteristics are not a true reflection because the available options, for example, do not reflect that Judaism is a religion and Jewish an ethnic identity. We will continue to work with DHSC and other external stakeholders to harmonise and expand the quality and extent of datasets as we engage with DHSC's Unified Information Standard on Protected Characteristics (UISPC) programme.

We are committed to updating the dashboard with new and refreshed datasets as they become available.

Intervention by protected characteristic

The interventions in the table below address the negative experiences of staff with individual protected characteristics, as defined in the Equality Act 2010. They supplement the intersectional high impact actions and suggest how organisations can go further in specific areas. To inform implementation and prioritisation of their actions, organisations should use robust datasets for each protected characteristic. It is important to note that no person is only one protected characteristic, and so organisations should consider the impact of intersectionality, when implementing these interventions.

The nine protected characteristics as defined in the *Equality Act 2010* are:



Engagement with staff networks informed the decision to combine some protected characteristics who face similar challenges in the workforce. To this end, gender reassignment and sexual orientation are covered together. Similarly, pregnancy and maternity are incorporated into the sex protected characteristic. The following section does not include specific interventions on the protected characteristic of marriage and civil partnership because the available evidence does not currently suggest that there is a need for a national focus on this protected characteristic from a workforce perspective, however this will be kept under review.

Case for change

Age

As the largest employer in the country, all NHS organisations should create an age inclusive culture which addresses the needs of staff from pre-employment to post–retirement. Discrimination against both younger and older workers has been identified in the application and selection processes[35]. The NHS has an ageing workforce across all professions with over 41% of NHS staff now aged 45 years and over[36]. We must proactively seek to retain the skills, experience and knowledge of NHS staff close to retirement.

Disability

Successive reports of the Workforce Disability Equality Standard (WDES) and NHS Staff Survey show that more must be done to achieve parity of experience and outcomes for staff with a disability, in areas such as bullying and harassment and formal capability processes.

Race

The 2022 WRES data report for NHS trusts provides evidence that race discrimination continues to impact every aspect of the working lives of BME staff. This discrimination has an impact on the long term physical[17] and mental health[18] of our workforce contributing to structural health inequalities[19].

Religion or belief

Religious identity is an often overlooked area in the NHS[37]. Approximately two-thirds of our 1.3 million people working in the NHS declare a religion or belief. NHS Staff Survey data shows that staff from all faiths experience discrimination based on their religion or belief, and this is highest against Muslim and Jewish colleagues[38]. Recent data highlights increasing levels of antisemitism in wider society, as well as discrimination against Sikhs and other faiths, and this is likely to be reflected among NHS staff[39].

Sex

77% of the NHS workforce are women, so addressing sex discrimination must be a key focus for organisations. The discrimination is multifaceted – bias in recruitment and career progression and contributing to the gender pay gap, under-representation within senior leadership teams, sexual harassment and inflexible working practices – and may deter potential recruits or force talented women to leave the NHS[40].

Elimination of the gender pay gap would bring social economic benefits as would likely lower poverty rates among women and reduce the gender gap in old age pensions. Government's Women's Health Strategy for England reports a strong correlation between the lack of support for, and understanding of, how women's health affects their experience in the workplace including progression, retention and productivity levels.

Pregnancy and maternity

There is a growing evidence that the protected characteristic of pregnancy and maternity is associated with poor employment outcomes and health inequalities, and health-related outcomes may be poorer as a result of pregnancy and maternity. Additionally, in a survey of over 6,000 women and employers, over three-quarters of mothers reported negative or possibly discriminatory practices during pregnancy, maternity and/or on their return to work[41]. Women also experience specific inequalities in relation to the menopause.

It is important to acknowledge that trans, non-binary and intersex staff may also experience inequalities in relation to pregnancy and menopause and may require specific support during these times. The CQC's Maternity Survey reported that trans respondents experienced inequalities, including in to how they were communicated with during labour and birth, their length of hospital stay after giving birth and the information and care they received after leaving hospital[42 43].

The recommended interventions to address this inequity are similar for colleagues of one or both protected characteristics and have been reflected as such in this document.

Gender reassignment and sexual orientation

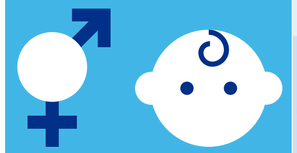
LGBT+ staff are more likely to face discrimination from their colleagues and patients,[44] and this can have a detrimental impact on their health[45].

The 'plus' within the term LGBT+ acts to include those identities and sexual orientations not specifically referenced. However, we recognise that this group is diverse and their lived experience is varied.

A significant barrier in understanding the experiences of LGBT+ staff is the absence of complete and accurate data. The DHSC Unified Information Standard for Protected Characteristics (UISPC) programme is considering the current data limitation within the ESR with respect to LGBT+ staff declarations. NHS England is working with DHSC and other key stakeholders to expand the workforce data currently available on ESR to make it accurate and representative.

Protected characteristic	Interventions	Corresponding high impact actions
Age 	Review recruitment practices to ensure they are fully inclusive of all ages, removing bias and improving accessibility for people wishing to join the NHS for the first time.	2
	Line managers should have meaningful conversations with their teams, to align personal aspirations with job roles and requirements. This should include the option of phasing retirement and exploring alternative work patterns.	2
	Organisations should encourage flexible working as part of local attraction, recruitment, retention and return plans. The plan should embed the NHS Pension Scheme and highlight its value across the career journey, with special focus on flexible retirement for staff in late stage careers.	2
	NHS organisations should work in partnership with local educational institutions and voluntary sector partners to support social mobility by improving recruitment from local communities, and by considering alternative entry routes to the NHS, such as apprenticeships and volunteering.	2, 4
Disability 	Demonstrate year-on-year improvement in disability declaration rates so that ESR data is accurate about people with a disability, as measured by the WDES.	ALL
	Promote the visibility of leaders with a disability through effective campaigns alongside providing leadership and career development opportunities tailored to disabled staff, such as the Calibre Leadership programme[46] or Disability Rights UK[47] development programmes. Progress can be measured by tracking the number of disabled staff in leadership roles.	2
	Implement recommendations from the inclusive recruitment and promotion practices programme, and ensure each stage of the recruitment pathway is accessible, does not discriminate and encourages people with disabilities to apply for roles in the NHS. This can be tracked via the WDES, using Trac data.	2
	Commissioners and providers of talent management and career development programmes must ensure that these are fully accessible and inclusive. Progress can be measured by tracking the number of Disabled people in leadership roles.	2
	NHS organisations should take steps to address the disproportionate levels of bullying and harassment experienced by disabled staff. Progress can be measured from NHS Staff Survey results.	6
	NHS organisations should ensure that their reasonable adjustments policy is effectively and efficiently implemented and achieves year-on-year improvement in NHS Staff Survey metrics relating to reasonable adjustments at work.	2,4

Protected characteristic	Interventions	Corresponding high impact actions
Race 	Boards should be able to demonstrate their understanding of and progress towards race equality, an essential criterion in job descriptions for board members and all very senior manager (VSM) grades. Appraisals of senior executives will include a focus on EDI, as recommended by the Messenger Review.	1
	Board will use the EDI dashboard to establish internal data driven accountability and scrutinise progress at an organisational, divisional, departmental, occupation, and site level to address under-representation and pay gaps.	2,3
	To tackle race discrimination effectively, Boards must give due consideration to national policies and recommendations from other Arms Lengths Bodies such as the Equality and Human Rights Commission inquiry[48] and General Medical Council[49] In addition, boards must proactively raise awareness of their commitment with patients and public.	1,6
	Boards should ensure concerns raised about race discrimination are dealt with in a proactive, preventative, thorough and timely manner, including encouraging diversity in Freedom to Speak Up Guardians[50].	6
Religion or belief 	ESR and qualitative data should be tracked to highlight the experience of people with different faiths or no faith through all stages of the employment journey. For example, NHS organisations can track turnover data by religion to identify and address trends.	ALL
	NHS organisations should review their policies and processes to ensure they are supportive of religious expression in the workplace. This includes access to facilities for prayer, understanding of cultural differences, including religious clothing, and flexibility around religious observances such as the Sabbath and Ramadan.	ALL
	Boards should ensure concerns raised about religious discrimination are dealt with in a proactive, preventative, thorough and timely manner, including by encouraging diversity in Freedom to Speak Up guardians[51].	6

Protected characteristic	Interventions	Corresponding high impact actions
Sex and pregnancy and maternity 	NHS organisations to focus on closing the gender pay gap and improving the experiences of the lowest paid people, extending the Mend the gap review recommendations for medical workforce to the wider workforce.	2,3
	NHS organisations should ensure that their flexible working policy is easily accessible and suitable for all their staff; supporting their work–life balance, management of caring responsibilities, health and wellbeing, and enabling continued professional development.	2
	NHS organisations are encouraged to adapt NHS England's policy on menopause awareness as applicable to their local workforce. They should also adopt and implement the Supporting our NHS people through menopause: guidance for line managers and colleagues. This will ensure they fully support colleagues experiencing menopause, maximising their wellbeing and allowing them to work for as long as they wish to contribute.	ALL
Gender reassignment and sexual orientation 	Where colleagues feel comfortable, actively encourage LGBT+ staff to self-declare their sexual orientation on ESR and TRAC, emphasising how this can improve the experiences of LGBT+ staff. We recognise that national changes to ESR must be made before trans and non-binary staff are able to do so.	ALL
	Review organisational data for LGBT+ staff across multiple sources such as ESR, TRAC, NHS Staff Survey and local qualitative and quantitative data from LGBT+ staff networks and communities. This will inform the key areas of concern that need to be addressed.	ALL
	Organisations to ensure that diversity training on gender reassignment and sexual orientation is included within mandatory training.	1
	Executive teams within the organisations should actively talk about the benefits of allyship as well as champion and sponsor LGBT+ staff networks. They should also build the concept of allyship into existing and new development programmes .	1
	Organisations to ensure that LGBT+ staff are closely involved in the development and delivery of its LGBT+ training and educational interventions and its health & wellbeing programmes so that these are fully inclusive.	ALL

Conclusion

Our organisations must be more inclusive and our leadership more diverse. We have an obligation to improve the experience of staff so that they feel like they belong. This plan articulates meaningful action to transform the lived experience of our staff and realise the benefits that we know come from greater equality, diversity and inclusion.

There is a wealth of evidence that shows having a diverse workforce and making sure everyone feels part of a team delivers the best care for patients.

It is the job of NHS leaders to ensure we deliver, taking an active role in ending all forms of discrimination, role-modelling inclusive behaviours and creating an environment in which our workforce feel safe and empowered. But everybody has a role to play supporting, encouraging and promoting inclusion.

References

[1] Equality, diversity and inclusion in the Workplace | Factsheets | CIPD

[2] https://www.gov.scot/publications/using-intersectionality-understand-structural-inequality-scotland-evidence-synthesis/pages/10/

[3] West M (2021) Compassionate Leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care

[4] Hemmings, N et al (2021) Attracting, supporting and retaining a diverse NHS workforce https://www.nuffieldtrust.org.uk/files/2022-10/1636121852-nhs-workforce-diversity-web.pdf

[5] Cambridge Dictionary definition for 'lived experience' - the things that someone has experienced themselves, especially when these give the person a knowledge or understanding that people who have only heard about such experiences do not have

[6] NHS Confederation (2020) Action for Equality: the time is now https://www.nhsconfed.org/system/files/media/Action-for-equality-the-time-is-now_4.pdf

[7] Lucian L Leape , Miles F Shore, Jules L Dienstag, et al (2012) Perspective: a culture of respect, part 1: the nature and causes of disrespectful behavior by physicians. Acad Med. 2012 Jul;87(7):845-52. doi: 10.1097/ACM.0b013e318258338d.

[8] Gomez LE, Bernet P (2019) Diversity improves performance and outcomes. J Natl Med Asso 111(4): 383-392. doi: 10.1016/j.jnma.2019.01.006. Epub 2019 Feb 11. https://pubmed.ncbi.nlm.nih.gov/30765101/

[9] Dixon-Woods M, Baker R, Charles K, et al (2014) Culture and behaviour in the English National health service: overview of lessons from a large multimethod study. BMJ Qual Saf 2014;23:106–15.doi:10.1136/bmjqs-2013-001947 See also West M (2021) Compassionate leadership: sustaining wisdom, humanity and presence in health and social care.

[10] Dawson J (2018) Links between NHS staff experience and patient satisfaction: Analysis of surveys from 2014 and 2015 links-between-nhs-staff-experience-and-patient-satisfaction-1.pdf (england.nhs.uk); see also West M (2021) Compassionate leadership: sustaining wisdom, humanity and presence in health and social care.

[11] West M (2021) Compassionate leadership: sustaining wisdom, humanity and presence in health and social care and King's Fund (2022) What is compassionate leadership.

[12] Public Health England (2021) Addressing health inequalities through collaborative action. Briefing note.

[13] Gomez LE, Bernet P (2019) Diversity improves performance and outcomes[1] J Natl Med Asso 111(4): 383-392. doi: 10.1016/j.jnma.2019.01.006. Epub 2019 Feb

[14] Edmondson A (2018) The fearless organisation: creating psychological safety in the workplace for learning, innovation and growth. Harvard Business School: Whiley

[15] NHS England (September 2022) NHS delivers on elective recovery plan with progress on treatment and tests. https://www.england.nhs.uk/2022/09/nhs-delivers-on-elective-recovery-plan-with-progress-on-treatment-and-tests/

[16] National Audit Office (2022) Managing NHS backlogs and waiting times in England

[17] Ashikali T, Groeneveld S, Kuipers B (2021) The role of inclusive leadership in supporting an inclusive climate in diverse public sector teams. Review of Public Personnel Administration 41(3): 497–519. https://doi.org/10.1177/0734371X19899

[18] NHS Improvement (2018) NHS provider board membership: survey and findings. https://www.england.nhs.uk/1sthi5thew4y/wp-content/uploads/sites/54/2020/08/NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf

[19] NHS England » NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts

[20] Statistics » NHS Staff Survey in England

[21] Narrowing of NHS gender divide but men still the majority in senior roles - NDRS (digital.nhs.uk)

[22] NHS Employers (2021), Inclusive recruitment: Leading positive change.

[23] Appleby J, Schlepper L (2019) The gender pay gap in the English NHS. Analysis of some of the underlying causes.

[24] UK Government (2019) NHS basic pay. Ethnicity facts and figures.

[25] Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England - December 2020 (publishing.service.gov.uk)

[26] See endnote reference 1

[27] Public Health England (2015) Local action on health inequalities: Promoting good quality jobs to reduce health inequalities https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/460700/2a_Promoting_good_quality_jobs-Full.pdf

[28] Ten Ways businesses can help to reduce inequalities. Infographic. NHS England. https://www.england.nhs.uk/wp-content/uploads/2022/01/10-ways-businesses-can-reduce-health-inequalities-infographic-1.pdf

[29] https://www.gov.uk/government/publications/levelling-up-the-united-kingdom

[30] https://www.england.nhs.uk/wp-content/uploads/2021/11/Reducing-healthcare-inequalities-Core20PLUS-infographic.pdf

[31] The CIPD (2019) describes good work as follows: Good work is fairly rewarded. Good work gives people the means to securely make a living. Good work gives opportunities to develop skills and a career and ideally gives a sense of fulfilment. Good work provides a supportive environment with constructive relationships. Accessed 05.12.22: https://www.cipd.co.uk/Images/uk-working-lives-summary-2019-v1_tcm18-58584.pdf

[32] Statistics » NHS Staff Survey in England

[33] Statistics » NHS Staff Survey in England

[34] Edmondson A (2018) The fearless organisation: creating psychological safety in the workplace for learning, innovation and growth. Harvard Business School: Whiley

[34] https://www.england.nhs.uk/about/equality/objectives-for-22-23-and-23-24/

[35] (2021) Good Recruitment for Older Workers: An Employers Guide. https://ageing-better.org.uk/sites/default/files/2021-10/GROW-a-guide-for-employers.pdf

[36] NHS Digital. NHS Workforce statistics March 2022: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2022

[37] Héliot YF (2020). Religious identity and working in the NHS. NHS Employers.

[38] King's Fund (2015) Making a difference to diversity and inclusion in the NHS.

[39] https://commonslibrary.parliament.uk/research-briefings/cbp-8537/

[40] Government Equalities Office (2019) Gender Equality at Work: Research on the Barriers to Women's Progression

[41] (Pregnancy and maternity-related discrimination and disadvantage: summary of findings (publishing.service.gov.uk))

[42] LGBT Foundation - Revealed: Improving Trans and Non-binary Experiences of Maternity Services (ITEMS) report

[43] https://www.cqc.org.uk/publication/surveys/maternity-survey-2022

[44] Statistics » NHS Staff Survey in England

[45] https://www.kingsfund.org.uk/blog/2021/04/supporting-lgbtq-nhs-staff

[46] Details on the Calibre Disabled Leadership Programme as at December 2022: https://www.ossiesway.com

[47] Details on the Disability Rights UK Leadership Programme as at December 2022 https://www.disabilityrightsuk.org/how-we-can-help/leadership

[48] Equality and Human Rights Commission inquiry

[49] General Medical Council

[50] Kline R, Somra G (2021) Difference matters: The impact of ethnicity on speaking up (National Guardian Office)

[51] Kline R, Somra G (2021) Difference matters: The impact of ethnicity on speaking up (National Guardian Office)

Wellington House
135-155 Waterloo Road
London SE1 8UG

england.nationalediteam@nhs.net

@nhsengland

@NHSE_WTE

Other formats of this document are available on request.
Please send your request to: england.nationalediteam@nhs.net

NORTH WEST
Black, Asian and Minority
Ethnic Assembly

NORTH WEST BLACK, ASIAN, AND MINORITY ETHNIC ASSEMBLY

Anti-racist Framework

NHS
England
North West

Contents

Foreword

As partners in championing this ambition, the North West Black, Asian and Minority Ethnic Assembly (the Assembly) and NHS England (NHSE) North West believe that the NHS in our region should be unapologetically anti-racist. We also believe that the NHS should take positive action to eliminate racism in our organisations, stand with our colleagues when they experience racism, and eradicate the inequalities in access, outcomes and experience of health care that some of our communities face.

This document provides a framework for all NHS organisations across the North West to work towards the ambition of becoming actively anti-racist organisations. It aims to embrace both the spirit of our commitments and provide NHS organisations with guidance to put into action quickly, the steps needed to reduce the inequalities we still see every day across our workforce and to become intentionally anti-racist.

We all recognise the history and impact of institutional racism across our organisations and the harm caused to both our colleagues and communities through the continued inequalities that we still see across our society. From higher rates of bullying and harassment, disproportionate referrals into disciplinary processes, recruitment and selection where ethnicity still impacts your chance of appointment after shortlisting, all of these issues and many more needed to be tackled intentionally and as a priority by all our organisations.

We are asking our NHS partners across the North West to make a commitment to embrace the intentionally inclusive language and the approach of becoming actively anti-racist organisations. As intentionally inclusive leaders it is vital that we all look at each of the areas set out in this anti-racist framework and seek to embed the change needed to transform our own departments and teams into places where this activity is not seen as just a nice to do, but is seen as mission critical to all that we stand for; and that messaging is backed up by senior colleagues across the region, being clear that actions to tackle inequalities are a priority in all that we do.

Leaders should use the practical steps and suggested actions to support existing change activity, to add focus to future equality action plans and to build on any long-term inclusion strategies you may have. While there is not a one size fits all solution to advancing equity within any one organisation, we hope that the guidance and structure provided will help with the task of co-creating the solutions that will work for your organisation easier.

This document has been produced by The Assembly, the Northern Care Alliance's Inclusion Centre of Excellence, and NHSE North West.

Richard Barker
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Regional Director for the North East and Yorkshire & North West regions

Evelyn Asante-Mensah OBE
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Pennine Care NHS Foundation Trust

Why does an intentionally anti-racist approach matter?

Racism is very real, both in society and across our NHS organisations. Yet, despite a large number of reports and pledges over the years we have seen inequalities persist and some areas even get worse.

- The NHS is built on a founding principle of equality and social justice. That the service is free at the point of need anchors the NHS in social egalitarianism and makes equal rights part of our core business.
- We have seen a growth of hate incidents and racism across our communities in the UK despite existing equality and human rights legislation. It is more important than ever that as public sector organisations, we contribute to ensuring racism has no place in our society and is addressed across the communities we serve.
- Racism and discrimination are major drivers behind the health inequalities we still see today. It is our role as a health care system to be intentional in tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not further contributing to the problems.

Our anti-racism journey

Becoming an intentionally anti-racist organisation is a continuous journey that involves leaders and organisations continually reviewing their progress and being intentional about their actions for change.

The Fear, Learning, Growth Zone tool can help you both as an individual and as an organisation to consider honestly where you are on the path to become more anti-racist.

Approaches to move through the zones

FEAR ····· LEARNING ····· GROWTH

Provide clear factual information that challenges and supports the overcoming of any fears that individuals and teams may have with talking about racism and what is needed to address this issue.

Consider more development building on any existing learning; steps and opportunities that increase confidence with existing learning.

Empower inclusive leaders through allyship programmes and activities.

1. Prioritise anti-racism

As the NHS we have always been instinctively supportive of equality as social justice is the bedrock and foundation of our creation as an institution back in 1948. However, prioritising anti-racism work is more than simply caring about equality or stating support for inclusion; it is about ensuring we are giving it the same attention and response as other mission critical work we manage across the NHS.

The two main commodities we give to a task or area of work when we prioritise it are both time and resources. When equality activity is seen as an add-on or a nice to do, other mission critical work is seen as more important; time and resources are directed elsewhere and progress around tackling inequalities slows and stops.

Organisations need to commit to the principle that anti-racism work matters and their leaders need to see it as a priority for them as well. There will always be competing time and resource pressures when it comes to managing any large organisation, but anti-racist organisations understand that investing the time and resources needed to tackle the inequalities that exist across their workforce and services is more effective in the long term and will support them in meeting their other long-term goals.

What does this look like?

Leading from the front

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Dedicated EDI Resource

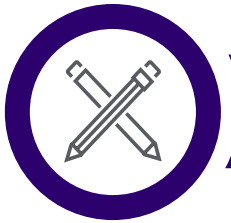
The amount of dedicated resource we have allocated to focus on an area of work is a key indicator of how much it has been prioritised. Equality, diversity and inclusion (EDI) professionals are experienced experts who can support leaders with this work. They must, however, be considered an important part of the organisation's leadership for their activity to be impactful and transformational over the longer term.

Mission Critical

Anti-racism activity needs to be at the heart of all work across an organisation, not simply a central equality action plan. Organisations that have got this right can clearly demonstrate how anti-racist practice is considered mission critical in plans around service delivery and the development of their workforce.

Actions Not Words

Organisations that are committed to anti-racism do more than the minimum ask; their work is driven by a desire to transform and have a big impact on the inequalities they see. This should be clearly visible in the activity and actions of any anti-racist organisation.



2. Understand lived experience

It is everyone's responsibility to tackle racism not just Black, Asian and Minority Ethnic colleagues, but meaningful involvement of people who experience racism and inequalities across your organisation will ensure decisions on how to tackle it are informed by real insights that reflect the different challenges people may face.

Meaningful involvement of people you would like to share their lived experiences involves committing to acting on what you hear and embedding their voices into change focused activity and decision making. Leaders need to be intentional in seeking out lived experience perspectives and considering what may be preventing some people feeling able to be involved.

When reaching out to seek the lived experiences of Black, Asian and Minority Ethnic communities it is important that leaders acknowledge and value intersectionality and understand the need to get more than a single person's perspective. When engaging others to hear their lived experiences, we should be intentional in ensuring we are hearing from a diverse range of voices rather than simply identifying a single individual to invite into a space.

Sharing lived experiences can have a weathering effect on people's wellbeing. Any activity that looks to involve and encourage others to share their lived experiences to support leaders and an organisation make better decisions should also include a clear and intentional focus around the wellbeing of those involved.

What does this look like?

Listen and Learn

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Empowering Your Talent

As well as hearing the lived experiences of staff, it is important that the underutilised potential of talented leaders from ethnic minorities is considered and empowered to support decision making. A key consideration is where you can diversify the decision makers in a space and how you can ensure the full talent potential of your diverse workforce is used.

Growing Cultural Competency

Connecting a diverse range of lived experiences with leaders is vital to improving the cultural competency of an organisation over a longer period of time. Leaders who understand their colleagues, service users and local communities are better placed to make decisions that are fair for all.

Data Plus

Organisations need to be intentional about understanding the experiences of Black, Asian and Minority Ethnic staff and service users.

3. Grow inclusive leaders

Inclusive leadership is vital if an organisation aims to be anti-racist in all that it does and aims to tackle the inequalities it sees across its workforce and services.

Where an organisation has a mature, inclusive leadership culture you will see diversity clearly represented at all levels across the workforce and colleagues will feel they belong and are included at work. On that journey to growing an inclusive leadership culture it is vital that there is an approach and strategy for reducing inequalities, not just at the top of the hierarchy, but also a commitment to increase diversity and reduce inequalities across middle leadership.

Too often the focus around developing Black, Asian and Minority ethnic leaders has been on providing them with more skills and academic development to help them move up to the next level in the leadership ladder; this reinforces a deficit stereotype rather than tackling the institutional racism that has been holding them back. Positive action measures should be targeted on the bias and prejudice that has led to ethnic minority colleagues not being given the opportunities to demonstrate the skills they have.

Inclusive leadership is not a destination. It is a continuous journey to look at how you can do more to reflect and own your own privilege, understand others more, act to tackle bias in the decisions you make, and ensure that change is seen as a positive step to tackle inequalities and injustice rather than simply a threat to the status quo.

What does this look like?

Visibility matters

Our most senior public sector leaders should come from a wider diverse range of backgrounds and should broadly represent the communities they serve. This diversity and visibility help to build communities' trust in our institutions and also lead to better decision-making overall.

Where is your talent?

Understanding your talent trajectory in respect to Black, Asian and Minority Ethnic colleagues helps an organisation know where actions need to be to increase diversity and tackle departmental or structural inequalities. Diversity should be visible across all levels of an organisation.

Levelling up middle leadership and inclusion

If we only focus development on our most senior leaders, commitment to change is often not followed through by those leaders tasked with implementing decisions across the organisation.

Real opportunities

For some time we have seen sending colleagues on dedicated learning programmes as the solution to under representation in leadership roles. However, it is often the case that development does not lead to an opportunity for promotion and reinforces the idea that Black, Asian and Minority Ethnic colleagues need to work harder and earn more to achieve the same as their white peers.

4. Act to tackle inequalities

"Let my actions speak for themselves" is a famous saying that represents the mantra by which an organisation truly committed to anti-racism needs to run.. Words alone can often become a shield through which organisations are able to justify, consciously or unconsciously, their inaction over time, and determine whether they have followed through with meaningful actions to tackle an inequality.

Initiatives like the Workforce Race Equality Standards (WRES), Model Employer plans and others are not a solution in themselves, but can be a positive tool to measure existing inequalities and target actions to have the biggest impact. These tools need to be used actively to support equality activity across an organisation rather than simply as an assurance framework completed once a year and not looked at again.

The inequalities we see across our communities today will only be addressed when organisations use their resources collectively in partnership to tackle their main causes. Building a critical mass of activity around neighbourhoods, localities and our region as a whole is key to the numerous health inequalities and social injustices that harm so many being relegated to history, instead of being a painful reality of today that many are forced to live with.

The amount of action needed to tackle inequalities is large. It reflects the generations of institutional racism and injustice developed over decades in this country. However, when viewed as mission critical and delivered through embedded priorities across all areas of an organisation's structure, the task is not insurmountable and the outcomes will be transformational for our communities as a whole.

What does this look like?

More than a tick box

While assurance frameworks have at times been labelled as just a tick box for an organisation to deliver against, this does not have to be the case. Tools like the WRES and others can be used to prioritise, leverage and monitor real change. Anti-racist organisations use all the resources and tools available to them to achieve their goals of reducing inequalities and tackling discrimination.

Zero tolerance matters

Being anti-racist is an active stance and means more than simply not acting to do harm, but actively tackling the harm we see. Organisations that are on the journey to getting this right are clear in the zero tolerance they have for racism from anyone, including colleagues and service users. It is vital that organisations consider how they handle these types of incidents and constantly learn to do more to tackle racist abuse.

We do this together

Many inequalities are too big to tackle on your own as a single organisation. It is vital that organisations work in partnership to tackle the racial inequalities we see across our communities. When looking at health inequalities, NHS organisations should work with their local community and other statutory sector bodies to tackle these collectively rather than them staying in the too hard to do pile.

Fair and just

The processes that exist across an organisation to look at grievances and disciplinaries for staff should feel fair and equitable for all. Where this is not the case, the outcomes experienced by colleagues lead to mistrust and a clear weathering effect on the wellbeing of Black, Asian and Minority Ethnic staff.

5. Review progress regularly

The NHS is no stranger to performance measures and the need to be intentional about tracking progress with a clear and detailed approach.

However, when it comes to anti-racism and wider equality, diversity and inclusion activity, this often lacks the same rigour in monitoring performance as other areas of our organisations.

Research from the USA has shown us that one of the most important aspects to diversity and equality activity is grounding this work in social accountability and taking time to measure and be clear about whether progress is being made.

While an organisation may have implemented actions elsewhere to tackle and reduce the impact on bias within decision processes and decision making, it is vital that the same consideration is taken when reviewing an organisation's overall performance around anti-racism and equality as a whole. What this means in practice is ensuring progress is reviewed by not just the people who have led or commissioned any activity, and that there is intentional consideration to the diversity of those involved in the reviewing and monitoring progress.

The NHS is the biggest employer in the country. However, as we are split up into hundreds of separate organisations we often look inward for ideas and feedback around change. Through the work of the BAME Assembly, we in the North West have an opportunity to collaborate and ensure reviewing organisational progress is a task that we are able to support each other with; this can be done through ideas and the sharing in equal measure of success and failure to support our anti-racism journey.

What does this look like?

How are we performing?

It is vital that organisations consider the management of performance around inclusion as seriously as they monitor performance of other areas of work. Leaders at all levels should understand how their area is doing in relation to key targets.

What is our approach?

Becoming an anti-racist organisation takes a clear intention to deliver a range of actions and measures consistently over a prolonged period of time. Understanding where the organisation is on its journey to become anti-racist is vital.

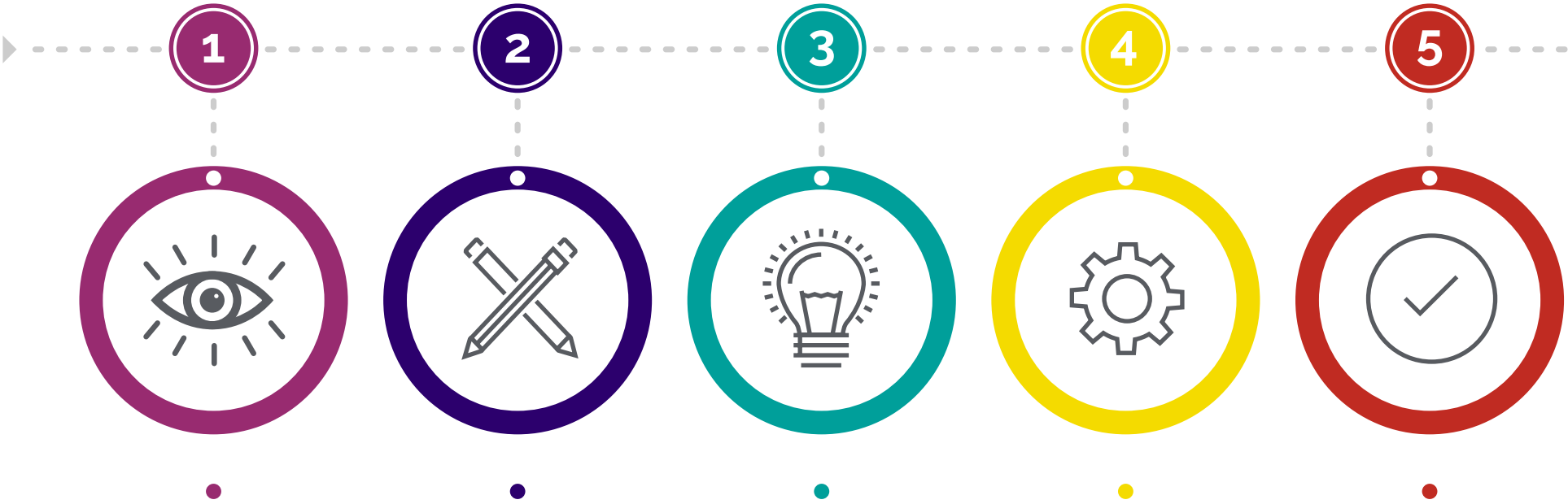
Our voices matter

The voices of Black, Asian and Minority Ethnic people should be at the heart of an organisation considering where they are on their journey to become anti-racist. This helps ensure actions that have been meaningful and impactful are prioritised, and where progress has not been made, this is not hidden.

Open and transparent

To have credibility around a statement that an organisation is anti-racist, it is vital the label is not just coming from the organisation itself but that the statement is supported by the community it serves.

The 5 anti-racist principles - Reflection questions



PRIORITISE ANTI-RACISM

How much of my time have I actually spent on anti-racism work in the last month?

UNDERSTAND LIVED EXPERIENCE

Whose voice and experience is not present, what have I done to address this, and how have I supported others to share their lived experience?

GROW INCLUSIVE LEADERS

What does the diversity of my organisation look like and how have I created opportunities for colleagues from ethnic minority backgrounds to grow and be included?

ACT TO TACKLE INEQUALITIES

What actions have I taken towards addressing racial inequalities and what impact has been made?

REVIEW PROGRESS REGULARLY

How has my organisation built anti-racism into their EDI targets and how is progress being measured?

Framework overview

This framework aims to support organisations on the journey to becoming intentionally and unapologetically anti-racist. The framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. Through the embedding of the themes, deliverables and actions outlined into structures, processes, policies and culture, organisations will create meaningful and measurable change within their workforce and service delivery.

The framework is organised into three levels of achievement: Bronze, Silver and Gold. Each level builds on the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination in their organisations.

Bronze status

Bronze status signifies that an organisation has taken initial steps towards becoming an intentionally anti-racist organisation. These deliverables are those that embed structures and accountability for the delivery of racial equity in an organisation.

Key Drivers	Direct Deliverables	Supporting Actions
Leading from the front	The appointment of an executive or director level EDI sponsor with a commitment to advancing anti-racism within the organisation.	• This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism. • Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.
Anti-racism as Mission Critical	Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.	• An anti-racism statement to be produced and published detailing organisational commitment to racial equity.
Actions Not Words	An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	• Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.
We do this together	The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.	• The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report.
Zero Tolerance	The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.	• Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures.

Silver status

The silver status shows that organisations have embedded structures to ensure commitment and accountability towards achieving anti-racism and have also developed actions to nurture and empower Black, Asian and Minority Ethnic talent, encourage culture change, and improve data collection, quality and reporting.

Key Drivers	Direct Deliverables	Supporting Actions
Empowering Your Talent	Set up a local Black, Asian and Minority Ethnic leadership council within your organisation.	• Ensure Black, Asian and Minority Ethnic talent is intentionally included across organisational talent programmes. Numbers should reflect the need for positive action to increase diversity within leadership roles. • Must have set targets and a published talent trajectory for Black, Asian and Minority Ethnic representation across every level of the organisation. • An organisation should have a dedicated positive action secondment or stretch projects programme in place to give Black, Asian and Minority Ethnic colleagues the chance to gain experience to support with career progression.
Levelling Up Middle Leadership & Inclusion	All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion, and a process to report annually the percentage of these goals that have been met.	• Leaders / managers to identify actions and create plans within their work to advance anti-racism.
Growing Cultural Competency	Evidence of inclusive leadership education for all executive directors.	• Further education for leaders, including inclusive recruitment, cultural awareness / competency, inclusive leadership, equality strategy and direction. • 75% of executive and non-executive directors and their direct reports have been part of a racial equality reverse mentoring programme over the past three years.
Listen and Learn	An executive director must attend Black, Asian and Minority Ethnic staff network meetings at least four times a year.	• A reciprocal arrangement with Black, Asian and Minority Ethnic staff network chair to attend and contribute to committee / board meetings.
Data Plus	WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.	• A detailed breakdown by ethnicity of the staff survey report should be presented to the board annually, including the involvement of Black, Asian and Minority Ethnic staff network members to ensure more than just data is presented. • Quarterly monitoring and review of WRES data, workforce data and action plans by executive EDI lead and presented to board and staff networks.

Gold status

To obtain Gold status, the organisation must demonstrate that anti-racism has been embedded throughout all levels of the organisation, with diverse representation at the most senior levels and parity in staff experience, as well as ensuring anti-racism is seen as everyone's business through performance and engagement.

Key Drivers	Direct Deliverables	Supporting Actions
Visibility Matters	An organisation's board of directors diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (which ever figure is higher).	• Creation and implementation of talent development and pipeline plan for Black, Asian or Minority Ethnic directors or associate non-executive director programme. • Partner with the North West Black Asian and Minority Ethnic Assembly to create a mentorship programme for Black, Asian or Minority Ethnic talent within the organisation.
How are we performing	An organisation must use an EDI performance dashboard that is presented quarterly to board and include performance against the race disparity ratio, WRES, and other race specific targets as appropriate.	• Organisation should record and publish their ethnicity pay gap annually • Intersectional data collection and analysis (by ethnicity, sex, gender, disability and sexual orientation) to be published and presented annually. • Chairs and non-executive directors to be updated annually on the progress on anti-racism plans.
More than a tick box	The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.	• Creation of a cross-departmental WRES actions working group to support and challenge progress on WRES data.
Fair and Just	The organisation can evidence diverse representation within their disciplinary and grievance processes.	• Freedom to Speak Up Champions within the organisation to support in incidents involving racial discrimination.
Our Voices Matter	The organisation should bring together annually Black, Asian and Minority Ethnic staff to review EDI progress and any learning be built into the following year's plans.	• WRES and anti-racism action plans to be co-produced with staff networks.

Regular review

Key Drivers	Deliverables	Supporting Actions
What's our approach	Organisations should review progress against each of the key drivers and direct deliverables within the NHS North-West Anti-Racism Framework at least annually.	Draft an annual action plan to attain initial or next accreditation that is reported on at board to ensure delivery and commitment.
Open and Transparent	The organisation should apply to the North West Black, Asian and Minority Ethnic Assembly to receive feedback against their anti-racism framework at least every two years.	Organisations should liaise with the Assembly / their Assembly member regarding progress and support in attaining recognition.

Support

The North-West BAME Assembly is here to support you in the implementation of this framework in your organisations.

We have a dedicated resource who can assist with strategy, queries, and troubleshooting any issues you may come across on your journey.

Please contact **england.nwbame_assembly@nhs.net** to discuss further.

Recognition

1. Assess your organisation's current progress using the self-assessment tool.
2. Draft action plan towards achieving either Bronze, Silver or Gold status, and implement necessary strategies to achieve the deliverables.
3. Apply to the North West Assembly for recognition. A small panel of Assembly members will review applications, make assessments and recognise successful organisations.

Self-assessment tool

The self-assessment tool has been designed as an assurance checklist. The checklist should be used by organisations as they begin to implement the Anti-Racist Framework to identify which of the key deliverables from the framework are already in place and which are the development areas for the organisation.

When an organisation has identified their gaps using the checklist, actions can then be developed to support the implementation of the framework fully prior to moving towards requesting recognition.

Anti-racist framework checklist

Summary of direct deliverables

Bronze

- [ ] The appointment of a senior director level EDI lead with a commitment to advancing anti-racism within the organisation.
- [ ] Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.
- [ ] An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.
- [ ] The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.
- [ ] The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.

Silver

- [ ] Set up a local BAME leadership council within your organisation.
- [ ] Evidence of inclusive leadership education for all executive directors.
- [ ] All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion and a process to report annually the percentage of these goals that have been met.
- [ ] An executive director must attend Black, Asian and Minority Ethnic staff network meeting at least four times a year.
- [ ] WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.

Gold

- [ ] An organisation's board of directors' diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (whichever figure is higher).
- [ ] An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub-group of the board and include performance against the race disparity ratio, WRES and other race specific targets.
- [ ] The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.
- [ ] The organisation can evidence diverse representation within their disciplinary and grievance processes.
- [ ] The organisation should bring together annually Black, Asian and Minority ethnic staff to review EDI progress and any learning be built into the following year's plans.

Sample action plan

Once the self-assessment is complete, an action plan to address the gaps should be developed. The action plan should identify a responsible person or team, a target completion date, and progress updates.

Level	Action	Person/ Team	Timescale	Target completion date	Progress	Comments
Bronze	The appointment of an executive / director level EDI sponsor.	HR	6 months		Ongoing	Proposal taken to board; nominated sponsor to be appointed at next meeting.
	Senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism.	HR	12 months		Ongoing	HR to explore the addition on an anti-racism PDP goal to role descriptions; meeting to discuss progress and next steps scheduled for 07/08.
	Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.	HR	6 months		Ongoing	Once senior sponsor appointed, meetings with Exec directors and chief executive to be scheduled on a six monthly basis to provide updates.

Resources

To support your journey towards becoming an unapologetically anti-racist organisation, we have compiled a list of resources to assist in the development of your strategies, plans and actions.

NHS North West Black, Asian and Minority Ethnic Strategic Advisory Group

National Education Union Anti Racism Framework

NHS Leadership Academy Allyship Toolkit

NHS Leadership Academy Resources on Racism

NHS Employers Resources to Tackle Racism

NHS England WRES 2022 Data Analysis Report

NHS England Patient Carer Race Equality Framework

NHS Race and Health Observatory

NHS Confederation BME Leadership Network

Change the Race Ratio Guidance - KPMG

Board Diversity More Action Less Talk

Why companies Need a Chief Diversity Officer

Competency Framework for Equality and Diversity Leadership

Diversity Management That Works - CIPD

Embed Anti-Racism in the NHS

Guide to Establishing Staff Networks - CIPD

WRES Board Briefing BAME Leadership Council Case Study - NHS England

Building Narrative Power for Racial Justice and Health Equity

Lived Experiences of Ethnic Minority Staff in the NHS - The Kings Fund

A Case for Diverse Boards - NHS England

Taskforce on Increasing Non-Executive Director Diversity in the NHS - NHS Confederation

Develop a Strong Talent Pipeline from Entry Level to Executive Roles - CBI

Practical Guide Bridging the Gap - CBI

Six Traits of Inclusive Leadership - Deloitte

Northern Care Alliance NHS Foundation Trust Intentional Inclusion Model

Black Jobs Matter - Personnel Today

Health Inequalities Hub Case Studies - NHS England

BMA Charter for Medical Schools to Prevent and Address Racial Harassment

Hospital CEO on Zero Tolerance - BBC News

Addressing Race Inequalities Needs Engagement - The Kings Fund

A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce - NHS England and NHS Improvement

Health Education England Diversity Performance Dashboard

Civil Service Diversity and Inclusion Dashboard
The Value of Lived Experience - HPMA Newsletter

Diversity and the Case for Transparency - PWC

Shattered hopes: Black and minority ethnic leaders' experiences of breaking the glass ceiling in the NHS - BME Leadership Network NHS Confederation

No more tick boxes: a review on the evidence on how to make recruitment and career progression fairer - NHS England

If your face fits: exploring common mistakes to addressing equality and equity in recruitment- NHS England

Ref RB HH 20230626

Richard Barker
North West Region
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

richardbarker.nwrd@nhs.net

Chairs and Chief Executives
NHS Trusts and Integrated Care Boards
North West region

By email

26 June 2023

Dear all

Antiracist Framework

Further to our statement sent on 28th March 2023 highlighting the most recent tribunal case of racism and discrimination against a Black nurse, we would like to support the system to address longstanding racial inequalities within the NHS.

In the statement, we called on NHS leaders across the North West to:

- Commit to taking sustained action and demonstrate visible leadership on addressing racism in all its forms – interpersonal, structural, and institutional
- To prioritise addressing race inequalities in health and care both as a system and within their own organisations
- For Integrated Care Boards to demonstrate strong competence in the understanding of causes of racism and the impact this has on people's lives
- Connect with their staff by talking openly, creating an environment of compassion, respect, and safety, and to share experiences and learning from each other.

The recently published NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan supports the NHS Long Term Workforce Plan in the achieving of strategic EDI outcomes of addressing discrimination, increasing the accountability of all leaders, supporting the levelling up agenda, and making progression opportunities equitable.

As an Assembly we are keen to work with NHS leaders from across the North West to achieve these strategic EDI goals by:

- Providing support to the system
- Sharing insights and lived experiences of racism and inequality
- Creating good practice in the realms of EDI and antiracism

- Contributing the collective expertise of the Assembly to EDI strategies and plans

We have developed an Antiracist Framework to support NHS organisations on their journey towards becoming intentionally antiracist. The framework outlines the actions to change racial inequality within your workforce, services, and organisational cultures. The framework will support the improvement of Workforce Race Equality Standard (WRES) data, support Equality Delivery System 2022 reporting, achieve EDI outcomes outlined in the NHS EDI Improvement Plan, and assist with achievement of Model Employer status.

The framework is a step-by-step plan to review the current status of your organisation, assess inequalities, celebrate successes, and encourage continuous improvement. There are 3 levels of achievement to guide organisations from building strong antiracist foundations in their policies and processes to the ultimate goals of diverse representation in leadership, parity in staff experience, and antiracism being business as usual with your organisation. We know several boards have publicly committed to the Antiracist Framework and this is an important signal for staff within these organisations.

The framework is enclosed with this letter for your reference.

We do hope that you join us in creating an equitable NHS for all staff and service users by engaging meaningfully with the Assembly and adopting and implementing the framework.

Yours faithfully

Evelyn Asante-Mensah OBE

Chair
North West, Black Asian and Minority Ethnic Assembly and

Pennine Care Foundation Trust

Richard Barker CBE

Co-Chair
North West, Black Asian and Minority Ethnic Assembly

Regional Director (North West)

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 92

12 July 2023

Purpose Discussion
Approval

Title	Ratification of Board Sub-Committee Terms of Reference a) Quality Committee
Director Sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance

Summary: The terms of reference for the Quality Committee have been reviewed in line with their current work plans and best practice. They have been reviewed by the Committee during the month of May 2023 and are presented to the Board for ratification.

Members are asked to note that items highlighted in yellow in the terms of reference will be moving under the remit of the newly formed People and Culture Committee from September 2023 onwards.

Recommendation: The Board is asked to consider and ratify the revised terms of reference for the Quality Committee and the changes which will be enacted from September 2023.

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

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

TERMS OF REFERENCE: QUALITY COMMITTEE

Constitution

The Trust Board has established a Committee with delegated authority to act on its behalf in matters relating to patient and staff safety and governance to be known as the Quality Committee.

The Committee will provide assurance to the Board and to the Audit Committee which is the high-level risk Committee of the Board, on all matters that it considers and scrutinises on behalf of the Board.

Purpose

The purpose of this Committee is to provide assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board.

Duties and Responsibilities

The Committee will:

- Review and approve the Trust's Risk Management Strategy (and supporting documents) under the delegated authority from the Board and assuring the Board that it contains the information necessary to support good governance and risk management throughout the Trust. Including that the Trust meets the requirements of all mandatory and best practice guidance issued in relation to clinical and corporate governance.
- Have the responsibility for scrutinising the Trust's (Corporate) Risk Assurance Framework on a regular basis and satisfying itself that the identified risks are being managed appropriately within the divisions, departments and at executive level.
- Be responsible for ensuring that those risks, within its remit, which are escalated to the Corporate Risk Register and Board Assurance Framework (BAF) are appropriate and proportionate, seeking further assurance from the executive team and escalating to the Board, concerns relating to unresolved risks that may require executive action or pose significant threats to the operation, resources or reputation of the Trust.
- Assure itself that adequate and appropriate integrated governance structures, processes and controls (including Risk Assurance Frameworks at all levels) are in

place across the Trust.

- Receive reports from its sub-committees at which the patient safety and quality issues and risk management processes in the Divisions are debated and monitored collectively.
- Receive and oversee the production of the Trust's Quality Account and, review and endorse them for approval by the Trust Board.
- Oversee the development and implementation of the Trust's Quality Strategy.
- Receive professional staffing reviews relating to both nursing and midwifery services.
- Scrutinise the effective and efficient use of resources through evidence based clinical practice and assure itself that there is an appropriate process in place to monitor and promote compliance across the Trust with all standards and guidelines issued by the regulators, NHS England/Improvement, NHS Resolution, the Royal Colleges and other professional and national bodies.
- Promote a culture of open and honest reporting of any situation that may threaten the quality of patient care and oversee the process within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, complaints and litigation.
- Satisfy itself that examples of good practice are disseminated within the Trust, ensuring that its sub-committees have adequately scrutinised the investigation of incidents and that there is evidence that learning is identified and disseminated across the Trust.
- Satisfy itself that Safeguarding Children and Vulnerable Adults is at the heart of everything we do, ensuring that the Trust meets all of its obligations in respect of safeguarding at all times. This includes satisfying itself that all staff have training to the standard and frequency required. It will also satisfy itself that the Trust captures the learning from nationally published reports and that the learning is embedded in the practices, policies and procedures of the Trust.
- Satisfy itself that the appropriate actions in respect of patient safety and governance have been taken following recommendations by any relevant external body. This includes monitoring the Trust's compliance with the Care Quality Commission registration requirements and any reports resulting from visits.
- Receive a detailed annual report on the activity of the PALs service and complaints and litigation.
- Consider matters referred to it by other committees and groups across the Trust

provided they are within the Committee's remit.

Reflection

- The Committee shall allocate a short amount of time at the end of each meeting to reflect on the discussions that have taken place, assurances gained and, where appropriate, challenge the purpose, focus and length of the papers presented. Specific areas of focus will be whether the papers have been aligned to these terms of reference and the clarity and assurances that they provide as well as issues escalated from sub-committees.
- The Committee will have a specific agenda item for matters escalated to them from other Committees, for matters to be escalated to the Board and actions to be delegated to other Board Committees. This item will be clearly captured in the minutes of the meeting and will feature in reports from the Committee to the Board.

System Working

There is an increasing expectation for the Trust, and others within the Lancashire and South Cumbria Integrated Care System, to work together as a system for the betterment of the health of the population. With this in mind, the provider Boards and their sub-committees, within the Lancashire and South Cumbria (LSC) Integrated Care System (ICS), have, following the Board agreement, supported the delegation of the following functions to the PCB Joint Committee, where such matters affect the Trusts and can benefit the population of LSC.

a) service transformation priorities as defined by the ICS and commissioners
b) priorities for provider productivity improvement
c) opportunities for developing standardised approaches to service change and delivery
d) Shared clinical services for community services
e) Shared corporate services for: bank and agency workers procurement
f) Pathology Collaboration Network strategic decisions
g) And other matters as determined from time to time

In exercising these delegated functions, the PCB shall provide a single, collective view of the Provider Trusts and agree an annual work programme, each year, relating to the delegated functions, that promotes the best interests of the whole population.

The Trust Board and its sub-committees will ensure that they are fully involved in the decision making and engagement process in relation to the strategic collaborative items

and this will be enacted through an Executive function with representation from the Non-Executive contingent of directors.

Membership

Three Non-Executive Directors/Associate Non-Executive Directors (a Non-Executive Director will be the Chair of the Committee)
Executive Medical Director
Chief Nurse
Executive Director of People and Culture
Executive Director of Integrated Care, Partnerships and Resilience

The Executive Director of Service Development and Improvement will attend the Committee meeting on a quarterly basis to provide an update on the Trust's Improvement Programme. Other officers of the Trust may be invited to attend the Committee to report on items within their remit.

Attendance

The Director of Corporate Governance/Company Secretary and the Associate Director of Quality and Safety will be in attendance at meetings. A representative of the Trust's Internal Audit function will be invited to attend and observe each meeting. The Committee may direct the attendance of others at meetings as the Chair of the Committee deems appropriate

Frequency

The Committee will meet at least 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee as provided for in the Trust Standing Orders and Standing Financial Instructions.

Quorum

Two Non-Executive Directors/Associate Non-Executive Directors and two Executive Directors, one of whom must be either the Executive Medical Director or Chief Nurse.
A quorum must be maintained at all meetings. Members are expected to attend all meetings but will attend at least 75% of meetings. Members who are unable to attend will arrange for the attendance of a nominated deputy, whose attendance will be recorded in the minutes,

making clear on whose behalf they attend but they will not count towards the quorum.

Regular Reports

Monthly Items

Patient Safety Incident Response Framework Report

Quality Dashboard/Integrated Performance Report (including Infection Prevention and Control)

Trust-Wide Quality Group Report

Focused GIRFT Report

Cancer Update

Alternate Months

Clinical Harms Review Management Report

Board Assurance Framework

Corporate Risk Register

Records Management Report

Nursing Assessment Performance Framework

Head of Midwifery/Maternity Floor to Board Report (to be received in the months where there is no Trust Board)

Quarterly

Workforce Strategy Update

Mortality

Inquests/Claims

Doctors and Dentists in Training Safe Working Hours

PHSO Complaints Standards

DERI Update

Improvement Update

Twice per year

Freedom to Speak Up/Guardian of Safe Woking

Patient Participation Panel

Annually

Annual Safeguarding

Medicines Management

Annual Transfusion

Annual Infection Prevention and Control

Learning from Deaths

Health, Safety and Security

Nurse and Midwifery Staffing (Professional Judgement)

Organ Donation

National Cancer Patient Survey

End of Life Care

National Staff Survey

Annual Workforce Race and Disability Equality Standards (WRES and WDES) Reports

Annual Complaints

Nurse and Doctors Revalidation Reports

Risk Management Strategy

Quality Account

Trust Education Board

Authority

The Committee has no executive powers other than those specified in these Terms of Reference and by the Trust Board in its Scheme of Delegation.

The Committee is able to summon reports (and individuals) to enable the Committee to discharge its duties.

The Committee forms the high-level Committee for quality and safety reporting.

The Committee is authorised to investigate any issue within the scope of its Terms of Reference.

The Committee is authorised, with the support of the Director of Corporate Governance/Company Secretary, to obtain any independent professional advice it considers necessary to enable it to fulfil these Terms of Reference.

Reporting

The Committee will report to the Trust Board.

In addition, the Committee will report any specific risks or matters identified for escalation to the Audit Committee.

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board business cycle and reported to the Board. The Committee will provide regular reports on its activities to the Trust Board. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

Committee Support

Lead Director: Executive Medical Director and Chief Nurse

Secretarial Support: Corporate Governance Team

TRUST BOARD REPORT

Item 93

12 July 2023

Purpose Information

Title	Finance and Performance Committee Summary Report
Executive sponsor	Mr S Barnes, Committee Chair

Summary: The report sets out the summary of the papers considered, and discussions held at the Finance and Performance Committee meeting held on 24 April 2023.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal

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

Related to key risks identified on assurance framework

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

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

Meeting: **Finance and Performance Committee**

Date of Meeting: **24 April 2023**

Committee Chair: **Stephen Barnes, Non-Executive Director**

ITEMS APPROVED

- The minutes of the previous meeting held on 28 March 2023 were approved as a true record of the meeting pending a minor update to clarity for item FP/2023/045 – Finance Reporting.

ASSURANCE RECEIVED

1. Action Matrix

Members received a brief update on the Better Care Fund (BCF), with members being advised that there had been agreement from Integrated Care Board (ICB) colleagues to share information on all investment decisions that had been through the BCF.

2. Finance Reporting

The Committee were informed that the Trust had managed to achieve the breakeven target for the 2022/23 financial year and had ended the year with a small surplus of £23,000. Members were informed that pressure to achieve the 2023/24 targets would be high and that work had taken place to strike a balance between recognising the financial position of the Integrated Care System (ICS) that the Trust contributes to, as well as finding a realistic and credible position for what could be delivered.

The Committee were informed that the Trust currently had a cash balance of £45 million and had managed to meet its Waste Reduction Programme (WRP) targets, however the majority of savings being non-recurrent. Members were informed that deferred income had fallen to £7 million with the majority being attributed to hosted services. Furthermore, the estate had been revalued resulting in an increase of £14 million. Members were advised that this had been due to inflation and recommissioning areas that had been out of use.

An update was provided on the Better Payment Practice Code (BPPC) showing that the Trust had achieved 3 of the 4 targets, however although the target for Non-NHS payables had improved significantly during quarter 4, it had only achieved 94% against the target of 95%. Members were informed that a new process had been introduced to pay agency invoices which had improved the position.

Members were informed that the draft income and expenditure plan for 2023/24 was showing a £37 million deficit, noting that this was inclusive of a £42.3 million WRP, of which, £30.3 million had been identified. Members were advised that sessions would be taking place with the Division in

order to find the remainder. It was raised that the time and capacity needed to undertake all the planning work was having an impact on the ability to undertake work to meet targets.

Members were informed about the consequences of the Trust not reaching breakeven in 2023/24, including the potential for regulatory action, the removal of delegated authority, including the removal of unfunded capacity, and access to further capital being prohibited.

3. National Planning Guidance

Members received an update on the National Planning Guidance, being informed that the Trust had committed to meeting the 76% target for patients to be seen within 4-hours by the end of March 2024. They were advised that that the bed occupancy rate had not been forecast to be met due to extensive activity taking place across the Trust due to the fire mitigation works and the implementation of the Electronic Patient Record (EPR) system. Members were informed that the out of hospital targets were expected to be achieved.

The Committee were advised that a plan had been submitted to meet the 109% elective care ask, however achieving the target had many technical difficulties due to coding, counting and what was allowed to be submitted. Members were informed that there would need to be some investment requirements in order to deliver the 109% target and that if the investment was unable to be made, there would be a risk to meeting them. Furthermore, essential estate and EPR work over the summer would impact targets.

Members were informed that the productivity plan assumes the Trust will hit 85% in all areas, however at present, this was not being achieved. The Committee were advised that detailed work was being undertaken in order that this target would be reached. Furthermore, the plan did not take into account the impact from any industrial action with 943 patients having already been cancelled due to action.

4. Improvement Update

Members received a Non-Elective improvement update, with the Trust's performance plan showing what was needed to be achieved for the coming year. Members noted that to the date of the meeting, the Trust was exceeding trajectory and reporting 76.13%, however the rest of the month needed to be accounted for.

Members were informed that a 53-bed reduction had been enacted during March in order to allow fire prevention works to progress. They noted that the impact of this was being monitored closely. Members were informed that some reduction in emergency admissions had been noted during the second week of April 2023, and that additional preparations had been implemented during the Junior Doctors strike action around front-end senior decision making for admission avoidance.

Members were shown the draft Urgent Care plan, noting that key improvement targets had been linked to the plan. Members were informed that teams across the Trust were working on developing a detailed delivery plan and that this would form a significant part of the mitigation against the loss of 53 beds

Members were informed that a number of flow weeks looking at education and capacity had been held over Winter and 22 bitesize education modules had been delivered to staff. Over 17 sessions, 57 members of staff had been updated on improvement methodology and approaches

5. Integrated Performance Report (IPR)

The Committee were informed that the Trust was on trajectory to meet the 4-hour for Urgent and Emergency Care. Members were advised that the Trust was trying to move away from having patients residing on trollies whilst on wards. Members were informed that having patients on trollies was having an adverse impact on staff morale and if a patient has been on a trolley for 24 hours, an email is sent to the Executive tam advising them of the situation. Members noted that over the previous week, several patients had said they were content to stay on the trolley rather than be moved around until a bed was found.

Members were advised that the Trust was one of only a few in the country, and the only acute Trust in Lancashire and South Cumbria to have met the requirement for all patients having waited 78 weeks or longer to have been seen by the end of March 2023. Members were informed that the Trust was ahead of trajectory for all patients waiting 65 weeks or more to have been seen by March 2024.

The Committee were advised that work continued to increase theatre utilisation, including the implementation of a new system where should an area not be meeting trajectory, they would be supported to realign with expectations. Members noted that Ear, Nose and Throat had been through the process and were now back on trajectory.

Members were updated on the Trust's Cancer performance, noting that it was currently in the bottom 22 nationally and work was taking place to improve the position. Furthermore, the cancer backlog had decreased significantly.

Members were informed that the Trust had achieved weighted activity around 99% for 2022/23, however there would be a decrease in activity for April due to industrial action taking place.

6. Covid-19 and Restoration Update

This item was covered as part of the Integrated Performance Report.

7. Update on Meeting Agency Targets

Members were updated on the procurement exercise taking place across Lancashire and South Cumbria to create a collaborative staff bank. It was explained that the original plan had been to award the contract at the end of March 2023, however due to receiving questions from the suppliers

and the Easter Bank Holiday period, requests had been received for an extension to the process. Members noted that this had been granted and the contract was now expected to be awarded on 19 May 2023. Members were informed that all provider Trusts and partners were involved with the procurement process and evaluation.

The Committee received an update on the work to reduce agency rates across the system in a unified way, noting that this had resulted in savings of £1 million pre-covid. Work had now recommenced in this area and a number of agency staff had already migrated to the staff bank due to bank conditions being more attractive than agency working. Members were advised that there were potential savings of around £5 million across the system, however this was caveated that this would only be achieved if clinical risk could be managed. Furthermore, market management for medical spend had the potential to release between £9 million and £15 million.

8. Private Finance Initiative (PFI) Update

Members were updated on the work progressing at Royal Blackburn Teaching Hospital (RBTH) and Burnley General Teaching Hospital (BGTH) sites with the relevant PFI partners. Members were advised that the handover for the front door work at BGTH had been delayed and the expected date would now be during March 2023.

9. Corporate Risk Register and Board Assurance Framework Update

The Committee were informed that work would be taking place to create a new format for the Corporate Risk Register (CRR) in order to align it to the Board Assurance Framework (BAF).

Members were updated on the BAF, noting that work to improve the BAF was ongoing and a forthcoming BAF workshop was to be held which would involve reviewing all risks to ensure they were still correct, as well as looking to reduce the number of risks on the BAF.

ITEMS TO ESCALATE TO THE AUDIT COMMITTEE AND TO THE TRUST BOARD

ITEMS FOR ESCALATION

No items were escalated to either the Audit Committee or Trust Board but the Committee remained concerned for the financial challenges for the current financial year which continue to be discussed at Committee and Trust Board level.

ITEMS RECEIVED FOR INFORMATION

Any Other Business

There was no further business raised.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

Item 94

10 May 2023

Purpose Information

Title	Quality Committee Summary 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 26 April and 24 May 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: NA

(94) Quality Committee Summary Report

MEETING: **Quality Committee**

DATE OF MEETING: **26.04.2023**

CHAIR OF MEETING: **Naseem Malik, Non-Executive Director**

ITEMS APPROVED

- The minutes of the previous meeting held on the 29 March 2023 were approved as a true and accurate record.

ASSURANCE RECEIVED

1. Patient / Staff Safety

The Committee was informed that the Trust had recently declared its third Never Event since January 2023. It was confirmed that senior leadership colleagues had been briefed and that a 'deep dive' exercise would be done on these incidents to determine what could be learned. Members were advised that regulatory colleagues were being kept fully informed and that the Trust would be providing assurance to them regarding these incidents and what actions were being taken to avoid them happening again.

2. Floor to Board Report for Maternity Services

Members were updated on recent activity in relation to the Trust's maternity services. It was reported that the Trust had been able to demonstrate compliance against nine of the ten Clinical Negligence Scheme for Trusts safety standards for 2022-23 and that this was a significant achievement in the light of the wider pressures across the healthcare sector. The Committee was also informed that there had been a recent visit to the Trust from Local Maternity and Neonatal Systems colleagues to assess its response to the Ockenden Review and that they had received significant assurance regarding the actions taken thus far.

3. Patient Safety Incident Assurance Report

A summary of highlights from the Trust's Patient Safety Incident Response Framework was presented to the Committee. It was noted that a substantial amount of work was taking place to prepare the Trust for the imminent implementation of its new Electronic Patient Record system, as well as any risks or issues that may come about as a result.

4. Infection Prevention and Control Report

A summary of highlights from the Trust's Infection Prevention and Control team was presented to the Committee. Members noted that the Trust was currently above trajectory for clostridium difficile infections but had remained below trajectory for klebsiella infections. It was also reported that themes around cleanliness in stairwells and corridors had been picked up on the Royal Blackburn Teaching Hospital site and that a walk round

had been arranged with colleagues from estates and facilities to carry out a detailed review at a later date.

5. Corporate Risk Register

Members were informed that the Corporate Risk Register, alongside the Board Assurance Framework, was currently being revised as part of their annual review process. It was agreed that more work was still needed on the Corporate Risk Register to ensure that it properly summarised risks and the mitigations in pace around them, particularly in light of the financial challenges expected in 2023-24.

6. Board Assurance Framework

The Committee received a brief summary of the annual review process of the Board Assurance Framework. Members noted that all risks were being extensively reviewed by individual Executive leads and that a session had been arranged for all Board members for the following week to discuss any potential changes in more detail.

7. Allied Health Professionals Workforce Strategy

A series of slides were presented to members to update them on the recent challenges, achievements, and next steps in relation to the Trust's Allied Health Professional (AHP) workforce. It was explained that the first iteration of the Trust's AHP workforce strategy had been produced in 2022, which had forecast a potential shortfall of 2016 vacancies if no action was taken. Members noted that this had been followed up by a second three-year version of the strategy, which was focused on retention, recruitment and returning retired colleagues to the workforce. It was reported that a revised 12-month forecast had been produced which had shown improvements in many areas but also indicated that more work was still required in others.

8. 2022 National Staff Survey Summary Report

The Committee received a report summarising the results from the most recent staff survey. It was noted that the response rate for the 2022 survey had been lower than the rate seen in 2021 but that the Trust had scored above average for all themes. Members were informed that work was already underway to further triangulate the results of the survey with other sources, such as the Trust's Staff Guardian service, to determine if there were any particular areas of concern, or best practice, that it could learn from.

9. Draft Quality Account Report 2022-23

The Draft Quality Account Report for 2022-23 was presented to members for comments and feedback. It was confirmed that a number of additional sections around medical and dental staffing gaps and data quality assurance had been added to comply with new regulations and that the document would be circulated to key stakeholders, including colleagues from the ICB and Healthwatch, for them to provide feedback after the meeting.

The Committee:

1. Confirmed that they were content to recommend the Quality Account to members of the Audit Committee for approval, via delegated authority from the Trust Board.

10. Integrated Performance Report

The Committee received a summary of key performance metrics for March 2023. It was noted that the Trust's Hospital Standardised Mortality Ratio (HSMR) performance had slightly improved but was still above expected levels. Members were also informed that work was taking place to address safer staffing levels, including a recent decision to move the Trust away from using off framework agencies.

ITEMS TO ESCALATE TO THE AUDIT COMMITTEE AND TRUST BOARD
ITEMS FOR ESCALATION
None

ITEMS RECEIVED FOR INFORMATION
None

MEETING: **Quality Committee**

DATE OF MEETING: **24.05.2023**

CHAIR OF MEETING: **Naseem Malik, Non-Executive Director**

ITEMS APPROVED

- The minutes of the previous meeting held on the 26 April 2023 were approved as a true and accurate record.

ASSURANCE RECEIVED

1. Patient / Staff Safety

The Committee was informed that confirmation had been given by the British Medical Association that further industrial action would be taking place from the 14 to the 16 April. It was noted that this would coincide with the planned 'go live' date for the Trust's Electronic Patient Record system and that significant disruption would likely be caused as a result, particularly with regard to training programmes. Members also noted it was likely that elective activity would need to be reduced to ease the pressure on colleagues and to reduce the risk of additional complications.

2. End of Life and Bereavement Care Improvement Project Update

The Committee received a presentation from the Trust's End of Life Care and Bereavement team summarising their activities and progress since their previous update as well as their priorities going forward. Members noted that the establishment of a seven-day palliative care service was imminent and that there had been significant improvements in a number of areas on the Trust's bereavement surveys. It was also noted that there were several areas that still required improvement, particularly around timely recognition of dying and communication with patients and their families. The Committee was informed that work was underway to establish a dedicated Bereavement Suite within the Trust in the near future and that this would provide a safe space for any patients or staff members that required it.

3. Learning and Disability Improvement Plan Update

An update on the progress made with the Trust's Learning and Disability Improvement plan was provided to members. It was noted that a new Learning Disability and Autism Improvement Plan and Strategy was due to be finalised over the coming weeks and presented at the next meeting of the Trust's Safeguarding Assurance Committee for ratification.

4. Patient Safety Incident Assurance Report

A summary of highlights from the Trust's Patient Safety Incident Response Framework was presented to the Committee. Members were informed that a total of four Never Events had been declared since January 2023 and that the learning from these incidents would be widely shared not only in the Trust, but also with its partner organisations and with national colleagues.

5. Infection Prevention and Control Report

The Committee was informed that a new trajectory of 53 clostridium difficile (c. diff) infections had been set for the Trust for 2023-24 but explained that this was currently being challenged, as it was substantially lower than other organisations in the region. Members noted that blood culture contamination rates had remained low and stated that this clearly showed the careful attention that was still being paid to infection prevention and control principles despite the significant pressures on the Trust.

6. Organ Donation Annual Report

A series of slides were presented to members summarising the activities of the Trust's Organ Donation team through 2022-23. It was reported that the consent rate for donations had dropped to 50% over 2022-23, compared to 78% the previous year. The Committee noted that the Trust had achieved 100% in several key metrics for donation after brain death (DBD) patients in 2022-23, including testing, referrals and Specialist Nurse Organ Donation (SNOD) presence and that work was taking place to increase organ donation consent rates.

7. Patient Participation Panel Update

The Committee received an update on the activities of the Trust's Patient Participation Panel, including its ongoing involvement with the Trust's End of Life Care Strategy & Operational Group. Members were informed that the main challenges facing the PPP were securing involvement and ensuring longer commitments from its members and that this had been particularly difficult since the onset of the COVID-19 pandemic.

<u>The Committee:</u>

1. Requested that a further update on the Patient Participation Panel's activities was provided in another six months' time.

8. Quality Improvement Update

A presentation was provided to the Committee summarising the work undertaken by the Trust's Quality Improvement (QI) team over the previous three-month period. Members noted that the QI team had been involved in a wide range of projects, including ambulance handover times, chronic pain pathways, the PSIRF, Institute for Healthcare Improvement collaborative training, nutrition and hydration and frailty. Members were also informed that that the Improvement Hub was working with colleagues from the Department of Education, Research and Innovation (DERI) and University of Central Lancashire (UCLan) to support a range of new trainees and other newly qualified staff to develop their improvement skills and take part in improvement projects.

9. Review of Committee Terms of Reference

The Committee Terms of Reference, revised for 2023-24, were presented to the Committee for approval.

<u>The Committee:</u>

1. Approved the Committee Terms of Reference for presentation to the Trust Board in July 2023 pending some minor amendments.

10. Integrated Performance Report

Members received a summary of key performance metrics for April 2023. They were informed that the Trust had now been taken our of tier two monitoring arrangements for its 62-day cancer performance after the significant improvements made in reducing its backlog.

ITEMS TO ESCALATE TO THE AUDIT COMMITTEE AND TRUST BOARD

ITEMS FOR ESCALATION

None

ITEMS RECEIVED FOR INFORMATION

None

TRUST BOARD REPORT

Item 95

12 July 2023

Purpose Information

Title	Audit Committee Summary Report
Executive sponsor	Mr R Smyth, Committee Chair

Summary: The report sets out the summary of the papers considered, and discussions held at the Audit Committee meeting held on 17 April 2023.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal

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

Related to key risks identified on assurance framework

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

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

Meeting: **Audit Committee**

Date of Meeting: **17 April 2023**

Committee Chair: **Richard Smyth, Non-Executive Director**

ITEMS APPROVED

- The minutes of the previous meeting held on 16 January 2023 were approved as a true record of the meeting
- Members approved the draft Internal Audit plan for 2023/24
- Members approved the Anti-Fraud workplan for 2023/24
- Members approved the adoption for the Going Concern statement for the 2022/23 financial year
- Members approved the draft response from those charged with governance
- Members approved the Standing Orders and Standing Financial Instructions
- Members approved the draft accounting policies

ASSURANCE RECEIVED

1. Management Response to Fit and Proper Persons Test Audit

The Committee were informed that following the audit undertaken by Mersey Internal Audit Agency (MIAA) in September 2022, limited assurance had been received. It was explained that the audit had highlighted a number of areas for improvement and listed key actions to undertake. Members were informed that the Trust was working through the list of actions and updated on the progress made to date.

2. Current Financial Position

Members were informed that the Finance team was working on finalising the annual accounts and had identified that the Trust had finished the year with a small surplus of £23,000. Members were informed that negotiations continued to establish the contractual position for 2023/24, noting that there had been the request for a minimum of a 55% savings programme, equating to approximately £40 million. Members were informed that the system had previously reported a deficit of £300 million, however this had now reduced to £167 million. Members were informed that the Integrated Care Board (ICB) had previously reported a £130 million funding gap, however this had now changed to a breakeven position.

Members were informed that contractual negotiations were still taking place with the ICB, and that there was a push to understand the income and expenditure within the ICB and wider system as a whole. The Committee were updated on the work to meet the savings programme with £30 million

of savings having been identified. Members were advised that the Trust would be aiming to achieve more recurrent savings, however work was still needed to achieve the 5.5% target.

Members discussed the potential for a system redesign of fragile services and the potential for unfunded services to be stopped in order to in order to help alleviate pressures. Members noted that the Trust had the best theatre utilisation in the system at 85% and were on par for where organisations should be for efficiency.

3. Private Finance Initiative (PFI) Update

Members were informed that fire prevention works continued at Royal Blackburn Teaching Hospital (RBTH), furthermore, internally a new PFI team was now in place and working through issues on the site.

Members were updated on PFI issues at Burnley General Teaching Hospital (BGTH), noting that there had been further delays on the handover of the retail unit at the hospital entrance. Members were informed that a request had been made for a meeting between the PFI partners and Trust legal team to understand the plans for the future.

4. Correct Consultant Audit Report Update

The Committee were updated on the progress made across the Trust following the initial audit in 2020. Members were informed that the initial five non-compliant areas had been re-reviewed and now had 100% compliance. Furthermore, the intention is for all inpatient areas to now be reviewed monthly. Members were informed that the audit had now been built and was ready for use, with all related policies having been completed and sent to the Policy Council.

5. NHS Green Plan

Members were informed that the full NHS Green Plan report would be brought to the July meeting of the Audit Committee. Members were updated on the draft report, noting that there had been a reduction in carbon dioxide equivalent gases (CO2e), however this had been lower than was expected and data was being reviewed for accuracy.

6. Whistleblowing Update

The Committee were updated on the activity and action undertaken as a result of the whistleblowing report received in September 2021. The Committee were informed that the Trust had immediately responded to say that although they were disappointed to receive this claim, they would undertake a full external investigation.

The Committee were informed that it had been agreed that an organisation with legal privilege should be commissioned, and following the agreement of the terms of reference, a full investigation was undertaken over several months. It was noted that of the 15 allegations made, 14 were not supported with one upheld in part. It was explained that this was on the basis that the complaint had been made by the individual and in an effort

to deal with this informally, the Trust had not formally followed the Trust resolution policy. Members were informed that the recommendation was that should further complaints be received, the resolution policy should be followed.

Members were informed that the Trust was satisfied there was no underlying racist or sexist issues within the related directorate, and that lessons had been learned over the use of the policy. Furthermore, ongoing work to monitor the type and concern of allegations raised was taking place, with the Staff Guardian now having data to show any areas of concern for racist or sexist issues.

7. Internal Audit Progress Report

Members were referred to the progress report, noting that the internal audit plan for 2022/23 was nearing completion. Members were informed that some of the reviews were at draft stage, including the patient communications audit and the data protection security toolkit. Members were informed that the review into salary overpayments was now complete and had received moderate assurance.

Members were informed that the assurance framework meets the requirements and was well used by the Board. Internal auditors advised that some suggestions had been made for improvements, including making sure that the quality of content is concise and accurately describes the controls and assurance.

A change was proposed to the audit plan, deferring the review into escalating deteriorating patients until quarter three after the Electronic Patient Record (EPR) implementation. It was explained that following the EPR go-live, the way deteriorating patients is managed would change and it would be beneficial to have the response based on the new way of working. Members approved the decision to move the escalating deteriorating patient review until quarter three.

8. Internal Audit Follow Up Report – April 2023

The Committee were referred to the previously distributed report, being advised that an update on the PFI recommendations would be required following the introduction of the new PFI team.

9. Draft Internal Audit Plan 2023/24

Members were referred to the report, being informed that this had previously been shared with the Trust Board and that no changes had been made to the draft plan that had previously been shared with the exception of a table now being included that covered all work undertaken for the past 5 years.

Members were informed that this was a risk-based plan based on the Trust's assurance framework, and was flexible, allowing movement following in year reviews. Members were informed that the proposed audits were set out in the plan. The Audit Committee were asked to consider the plan and provided approval so that work could commence. Members approved the draft internal audit plan for 2023/24.
10. Internal Audit Charter Members were presented with the Internal Audit Charter, noting that it provided confirmation that Mersey Internal Audit Agency (MIAA) comply with public sector and internal audit standards.
11. Head of Internal Audit Opinion 2022/23 Members informed that reasonable progress had been made with the audit plan and that MIAA were on track to supply the Head of Internal Audit Opinion in early April 2023.
12. External Audit Strategy Memorandum Members were presented the external audit strategy memorandum for financial year 2022/23. Members were informed that the memorandum sets out the timetable Mazars would be working to enable sign off of the accounts prior to 30 June 2023.
13. Anti-Fraud Service Annual Report Members were presented the Anti-Fraud service annual report, noting that the Trust had been rated green against 10 of the 12 components of the anti-fraud standards. It was explained that standard 11 related to fraud awareness training and this could potentially be changed to green if this could be agreed prior to submission. Furthermore, standard 12 related to declarations of interest with members being informed that work was underway to improve this area which should be seen in the new financial year.
14. Anti-Fraud Workplan 2023/24 Members were presented the Anti-Fraud workplan for the upcoming financial year. Members were advised about the areas to be reviewed and the uplift in fees. Members provided their approval to the draft workplan.
15. Draft Annual Governance Statement Members were presented with the draft Annual Governance Statement, noting that this was the first draft and was being shared for comments and feedback.
16. Review of Going Concern for 2022/23 Financial Year Members were advised that report covered the management assessment of the appropriateness to adopt a going concern for the 2022/23 financial year. It was explained that since there was no awareness of the prospect for disillusionment within the next 12 months, the Committee were being asked to approve the adoption of the going concern assumption for the purpose of preparing the accounts.

Members approved the adoption of the going concern statement for the purposes of the 2022/23 financial accounts.
17. Draft Response from Those Charged with Governance Members were presented with the draft response from those charged with governance, noting that the report would require minor updates once final figures were available. Members were informed that the response was being presented for approval. Members provided approval to the draft response.
18. Corporate Risk Register The Committee were presented the Corporate Risk Register (CRR), noting that a new risk relating to nutrition and hydration had been added. Members were advised that significant quality improvement had taken place in this area, however the complexity of this meant there was an ongoing risk. Members noted that there was an overall reduction in the number of open risks on the risk system.
19. Board Assurance Framework Members were presented with the Board Assurance Framework (BAF). It was explained that work continued on the creation of a system wide BAF with the intention that this could be linked with the Trust specific BAF and CRR. Members noted that work would continue to keep refining the BAF to ensure that it is a useful tool for the Board to run the Trust effectively.
20. Waivers Report Members were informed that the report covered up to the end of February 2023 with the next report to cover the remainder of the financial year. Members were advised that although several waivers had been included, this was in keeping with previous financial years.
21. Standing Orders and Standing Financial Instructions Members were advised that the policies had been discussed during the January Audit Committee meeting and had been reviewed to enable delegative authority to be given to the Provider Collaboration Board. It was explained that the Standing Orders and Standing Financial Instructions had been reviewed and aligned to remove and inconsistencies between the policies and were being presented for approval. Members provided their approval to the policies.
22. Review of Accounting Policies Members were informed that the main change to the accounting policies was the application of International Finance Reporting Standard (IFRS) 16 and the change to how leases were recorded. Members confirmed they were content to approve the draft policy, subject to finalisation.

23. Update from the Lancashire and South Cumbria Audit Chairs Network Members were updated on the discussions taking place within the Lancashire and South Cumbria Audit Chairs Network. Members were informed that this included collaboration and system working.
24. MIAA – The Internal Audit Network Monthly Insight Report – March 2023 This item was presented for information only.
25. Quality Committee Minutes This item was presented for information only.
26. Finance and Performance Committee Minutes This item was presented for information only.
27. Information Governance Steering Group Minutes This item was presented for information only. Members were informed that work to improve compliance for Information Governance training continued.
ITEMS TO ESCALATE TO THE TRUST BOARD
ITEMS FOR ESCALATION
No items were raised for escalation the Trust Board but the Committee remained concerned for the challenges for the current financial year which continue to be discussed at Committee and Trust Board level.
ITEMS RECEIVED FOR INFORMATION
Any Other Business There was no further business raised.

TRUST BOARD REPORT

Item 96

12 July 2023

Purpose Information

Title	Trust Board (Closed Session) Summary Report
Executive sponsor	Mr S Sarwar, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 10 May 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 strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
2. The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
3. A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
4. The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
5. The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system

and deliver the additional benefits that working within the wider system should bring.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

MEETING: **Trust Board – Closed Session**

DATE OF MEETING: **10.05.2023**

CHAIR OF MEETING: **Shazad Sarwar, Chairman**

ITEMS APPROVED
• The minutes of the previous meeting held on the 8 March 2023 were approved as a true and accurate record.
ITEMS DISCUSSED
At the meeting of the Trust Board on 8 March 2023, the following matters were discussed in private: a) Summary from April Board Strategy Session b) Round Table Discussion – National ICB / PCB and Pennine Lancashire Update c) ELHT 2023-24 Planning Submission Summary d) Never Events Update e) BAME Assembly Statement f) Fire Remediation Programme Update g) Electronic Patient Record Progress Update h) Responsible Officer's Report to Trust Board Regarding Doctors with Restrictions
ITEMS RECEIVED FOR INFORMATION
None