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)

13 SEPTEMBER 2023, 12.30pm

BOARDROOM, TRUST HQ / MS TEAMS

AGENDA

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

OPENING MATTERS				
TB/2023/101	**Chairman's Welcome**	Chairman	v	
TB/2023/102	**Apologies** To note apologies.	Chairman	v	
TB/2023/103	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	
TB/2023/104	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 12 July 2023.	Chairman	d✓	Approval
TB/2023/105	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2023/106	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2023/107	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2023/108	**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/2023/109	**Patient Story** To receive and consider the learning from a patient story.	Chief Nurse	p	Information/ Assurance
TB/2023/110	**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/ Assurance/ Approval
TB/2023/111	**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/ Assurance/ Approval

Agenda

TB/2023/112	**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/2023/113	**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 (Deputy Chief Operating Officer) f) Well-Led (Deputy Director of People and Culture and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2023/114	**Staff Safety and Welfare Update**	Executive Director of Integrated care, Partnerships and Resilience/ Deputy Director of People and Culture	p	Information/ Assurance
TB/2023/115	**Response to NHSE Letter Regarding Internal Review of Processes in Relation to Lucy Letby Case**	Chief Executive	d✓	Information/ Assurance/
STRATEGIC ISSUES				
TB/2023/116	**Overarching Strategic Framework and Refresh of Trust Strategies**	Chief Executive / Executive Director of Service Development and Improvement	d✓	Assurance/ Approval
TB/2023/117	**Maternity and Neonatal Service Update**	Chief Nurse	d✓	Information/ Assurance
TB/2023/118	**New Hospitals Programme Quarter 1 Board Report**	Chief Executive	d✓	Information
GOVERNANCE				

TB/2023/119	**NHS Improvement Annual Board Self-Certification**	Director of Corporate Governance	d✓	Information/ Approval
TB/2023/120	**Emergency Preparedness, Resilience and Response (EPRR) Annual Statement**	Executive Director of Integrated Care, Partnerships and Resilience	d✓	Information/ Assurance
TB/2023/121	**Ratification of Board Sub-Committee Terms of Reference** a) Finance and Performance Committee b) Audit Committee c) People and Culture Committee	Director of Corporate Governance	d✓ d✓ d✓	Approval Approval Approval
TB/2023/122	**Finance and Performance Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/123	**Quality Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/124	**Audit Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/125	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2023/126	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2023/127	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2023/128	**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/2023/129	**Date and Time of Next Meeting** Wednesday 8 November 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** **104**

13 September 2023 **Purpose** Approval

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

Summary: The minutes of the previous Trust Board meeting held on 12 July 2023 are presented for approval or amendment as appropriate.

Report linkages

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

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

(104) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 1.00PM, 12 JULY 2023
MINUTES

PRESENT

Mr S Sarwar	Chairman	Chair
Mr M Hodgson	Chief Executive / Accountable Officer	
Mrs P Anderson	Non-Executive Director	
Mr S Barnes	Non-Executive Director	
Mrs M Brown	Executive Director of Finance	
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 P Murphy	Chief Nurse	
Mr K Rehman	Non-Executive Director	
Mr R Smyth	Non-Executive Director	

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience
Mrs K Quinn	Executive Director of People and Culture
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary	
Mr D Byrne	Corporate Governance Officer	Minutes
Miss K Ingham	Corporate Governance Manager	
Mr M Pugh	Corporate Governance Officer	
Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council	
Miss T Thompson	Head of Midwifery	Item: TB/2023/090

APOLOGIES

Professor G Baldwin Non-Executive Director

TB/2023/077 CHAIRMAN'S WELCOME

Mr Sarwar welcomed Directors to the meeting. He extended his thanks to the Executive team and to all colleagues in the Trust for their exemplary work in ensuring the recent successful implementation of the new Electronic Patient Record (EPR) system.

Mr Sarwar also emphasised the need to recognise the significant pressures being placed on colleagues elsewhere in the Trust, particularly in emergency care pathways where patient numbers had remained consistently high. He went on to refer to a number of recent incidents that had taken place in the Trust's Emergency Department and reiterated that the Trust maintained a zero-tolerance policy regarding abuse of any kind towards its staff, adding that, if necessary, the Trust could refuse to provide treatment to individuals who were abusive to staff.

TB/2023/078 APOLOGIES

Apologies were received as recorded above.

TB/2023/079 DECLARATIONS OF INTEREST

Mr Sarwar referred Directors to the Directors Register of Interests (DROI) report. There were no changes to the DROI, and no declarations of interest made in relation to any agenda items.

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

TB/2023/080 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 10 May 2023 were approved as a true and accurate record.

TB/2023/081 MATTERS ARISING

There were no matters arising.

TB/2023/082 ACTION MATRIX

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

RESOLVED: Directors noted the position of the action matrix.

TB/2023/083 CHAIRMAN'S REPORT

Mr Sarwar provided a summary of his activities to Directors since the previous meeting. He confirmed that he continued to attend meetings of the Provider Collaboration Board (PCB) and that there was currently a significant amount of focus on corporate collaboration, financial challenges and the clinical configuration programme. Mr Sarwar stated that a substantial amount of effort was being made to drive these various items forward but explained that progress was heavily dependent on the clinical commissioning element of the Integrated Care Board (ICB). He confirmed that he continued to meet with his fellow Integrated Care System (ICS) Chairs and that there was a good understanding between them of the operational and financial challenges over the coming months.

Mr Sarwar went on to inform Directors that he had been involved in a significant amount of activity at Trust level. He advised that he, alongside Mr Hodgson, had recently attended an event hosted by the Trust's Charity, ELHT&Me, and stated that this had been a good opportunity to meet with and acknowledge the various fundraisers who devoted their free time to raising money for the benefit of patients and staff.

Mr Sarwar highlighted that he and Mr Hodgson had also met with the Rt Hon. Antony Higginbotham MP during his recent visit to the Endoscopy Unit at Burnley General Teaching Hospital (BGTH) and explained that this was an opportunity for the Trust to clearly demonstrate its commitment to investing at the site and improve services for the local community.

Directors noted that Mr Sarwar had spent a significant amount of time engaging with applicants for the recently advertised Non-Executive and Associate Non-Executive Director posts and that a further update on the outcomes from this process would be provided in due course. Mr Sarwar concluded his update by reporting that he had recently met with the Chief Executive of Blackburn with Darwen Borough Council, Denise Park, and the ICB Director of Health and

Care Integration, Claire Richardson, to discuss place-based aspects and the planned transfer of community services to the Trust.

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

An update on the outcomes of the Non-Executive Director and Associate Non-Executive Director recruitment process will be provided in due course.

TB/2023/084 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 fed back on the recent celebrations for the 75th anniversary of the NHS and highlighted that there had been a clear focus not only on past successes and innovations but also on future developments. He commended the Trust's Communications Team for their efforts in promoting the event across the organisation.

Mr Hodgson reminded Directors of the recent publication of the NHS Long Term Workforce Plan and noted that it had been universally well received. He clarified that the Plan focused on how the NHS could address existing as well as future workforce challenges through training, retention and reforming. Mr Hodgson confirmed that there would be a significant increase in the numbers of available training places and an aspiration to retain 130,000 staff to continue to work in the NHS. Directors noted that training would be delivered in new and innovative ways, including the use of new apprenticeships.

Mr Hodgson also referred to the recent publication of the NHS England (NHSE) Equality, Diversity and Inclusion (EDI) Improvement Plan and explained that this would play a pivotal role in the further development of a positive and welcoming culture in the Trust. He added that work would continue with the Trust's Staff Networks to embed improvements across the organisation. Mr Hodgson concluded his summary of national headlines by making reference to the impact from the industrial action taken by junior doctors in June 2023. He reiterated that the Trust would always recognise the right of individuals to take action in this manner but stressed that it had clearly impacted on patient care and patient experience.

Mr Hodgson informed Directors that several developments had taken place at a Lancashire and South Cumbria (LSC) system level, including the feedback provided in response to the 2023-24 planning submission to the ICS. He confirmed that there was a strong focus on national priorities such as elective recovery, cancer, diagnostics and the workforce, and

advised that a new regional Recovery and Transformation Board was due to be established soon, to co-ordinate the work taking place around this. Mr Hodgson referred to the most recent meeting of the PCB and highlighted that a Target Operating Model had been agreed for the central services collaboration programme. He clarified that this would take the form of a Host Trust Model and that the process to select which Trust would take on this responsibility would commence shortly. Directors noted that a significant amount of work was also taking place to progress the Lancashire and South Cumbria Pathology Service.

Mr Hodgson went on to provide a summary of the developments taking place at Trust level. He echoed the praise given by Mr Sarwar at the start of the meeting for colleagues who had been involved with the 'go live' of the Trust's EPR project and reported that it had been widely regarded as a very successful launch. Mr Hodgson acknowledged that there were a number of outstanding 'teething' issues that would likely take several months to fully address but stressed that this had been expected and was reflective of 'go live' events at other organisations. He stated that the EPR was just the start of the Trust's digital journey and what it would provide in terms of better and more integrated care for the Trust's local communities. Mr Hodgson noted that the EPR 'go live', as well as the ongoing demand on the Trust's emergency pathways, had placed a significant amount of pressure on staff and confirmed that a substantial amount of effort had been made by the Wellbeing Team to provide additional support over recent weeks. He added that this made the recent national and regional plaudits awarded to the Trust, including a winner of the Nursing and Midwifery category at the NHS Parliamentary Awards, all the more impressive.

Mr Hodgson highlighted that the Trust had also received visits from several eminent colleagues over recent weeks and reported that they had come away impressed with the positive working culture at the Trust.

Mr Hodgson concluded his update by requesting confirmation from Directors that they were content to approve the latest round of submissions for Safe, Person and Effective Care (SPEC) awards for the Children's Medical Unit, the High Dependency Unit, Lancashire Women's and Newborn Centre Theatre, the Coronary Care Unit and Wards 15 and C10. Directors confirmed that they were content for these awards to be given.

Mr Sarwar commented that although the NHS Long Term Workforce Plan was a welcome development, there were still lingering questions about the availability of resources needed to support the aspirations that it set out. He stated that he welcomed Mr Hodgson's comments

regarding the publication of the NHSE EDI Improvement Plan, adding that the Trust' role as a key anchor institution in the area made getting its values right even more important.

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

Board members agreed to award SPEC status to the Children's Medical Unit, the High Dependency Unit, Lancashire Women's and Newborn Centre Theatre, the Coronary Care Unit and Wards 15 and C10.

TB/2023/085 PATIENT STORY

Mr Murphy reiterated that patient stories would be presented in a video format going forward. He advised that the story being presented was from a patient who had recently given birth to their second child and was a summary of her experiences at Blackburn Birth Centre, as well as those of her relatives. Mr Murphy stated that while the story was an uplifting and positive one, it also emphasised the importance of ensuring the safety of maternity services, particularly in light of the significant amount of national attention currently being given to this area.

Mr Sarwar commented that the patient's story had been a clear reflection of the Trust's values of Safe, Personal and Effective.

Mr Hodgson reiterated that significant issues relating to maternity services had been found at a number of other organisations over recent years and stated that the story presented was tangible evidence and assurance that the Trust's maternity services continued to provide an excellent patient experience. In addition to the positive outcome from the inspection of maternity services recently carried out by the Care Quality Commission (CQC) and in the previous year.

Mrs Anderson advised that the Trust's maternity services were routinely monitored through the Quality Committee and that significant assurance had always been gained through these updates. She informed Directors that she had recently attended the BGTH Birth Centre alongside Mr Murphy and that the calmness and positive attitude of the staff working there had been clear.

Mr Rehman reminded Directors that he had recently taken on the role as NED Maternity Champion and that he was already clearly seeing the commitment of Trust staff to ensuring

the quality of their services, whilst also acknowledging any areas that still required improvement.

Mr Murphy stated that he agreed with many of the comments already made. He made reference to the midwife mentioned in the patient story and extended his thanks to them for the attention that they had paid to the patient which had allowed them to have such a positive experience.

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

TB/2023/086 **CORPORATE RISK REGISTER (CRR)**

Mr Husain referred Directors to the previously circulated report and provided a summary of key highlights. He advised that the total number of risks on the CRR had now been reduced to 18, following the removal of two since the previous meeting, specifically risk ID 9439 (failure to meet internal and external financial targets for the 2022-23 financial year) and risk ID 8960 (risk of undetected foetal growth restriction and preventable stillbirth and compliance with pulsatility index ultrasound guidance).

Mr Husain added that risk ID 9439 had been replaced with a new finance risk for the current year and explained that risk ID 8126 (risk of compromising patient care due to lack of an advanced EPR system) would also be replaced by a new risk now that the EPR was in place.

Directors noted that risks 9296 (inability to provide routine or urgent tests for biochemistry requests), 8941 (potential delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology) and 8257 (loss of transfusion service) were likely to be downgraded as tolerated risks in the near future.

Mr Husain concluded his update by highlighting that the number of open risks had reduced by 58% since the previous meeting and that work continued to profile and map strategic risks.

Mr Smyth commented that there had been a clear and steady improvement in the reviews of the highest scoring risks over recent months and that it was good to see that they were now being reviewed more consistently and regularly.

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

TB/2023/087 **BOARD ASSURANCE FRAMEWORK**

Mrs Bosnjak-Szekeres confirmed that the annual review process of the BAF was now complete and highlighted that the total number of strategic risks had been reduced from 12 to 5. She also advised that the score assigned to BAF Risk 5 (Financial Sustainability) had been increased to 25 to reflect the current financial climate across the region and the wider NHS. Mrs Bosnjak-Szekeres confirmed that the revised BAF now incorporated all strategic objectives and was more closely linked with the strategic programmes in place at the Trust and at a system level. She confirmed that work would continue on aligning the BAF and the CRR.

Mrs Bosnjak-Szekeres requested confirmation from Directors that they were content to approve the revised BAF and the revised risk appetite statement included in appendix 1 of the report.

Mr Barnes suggested that more granular detail could be added to the system risks linked to BAF Risk 1 (Integrated Care / Partnerships / System Working), particularly in relation to the changes taking place at PCB level and the ongoing development of place-based partnerships. Mr Sarwar agreed and noted that it was important for the Trust to understand these risks and what it was doing to mitigate them.

Mr Smyth referred to the 'heat map' included in the report and confirmed that he felt it properly encapsulated the difficulties that the Trust was currently facing in relation to quality and finance.

Mr Sarwar agreed that there would be a need to properly recognise the tension between these two areas as the year progressed, adding that some of this was already being reflected through the pressures being seen in the Trust's emergency care pathways.

Directors confirmed that they were content to accept the revised BAF and approve the risks included on it. They also confirmed that they were content to approve the revised risk appetite statement.

RESOLVED: **Directors received, noted and approved the revised BAF for 2023-24 and the proposed risk appetite statement.**

TB/2023/088 **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 confirmed that the Trust continued to maintain a positive reporting culture, with a low number of moderate and severe harms despite a recent increase in the overall numbers of incidents being reported. Mr Husain advised that slips, trips and falls have remained the most regularly reported category of incident and that the situation was being closely monitored through the Trust's Falls Steering Group.

Mr Husain reminded Directors that a total of five Never Events had been reported since January 2023 and that confirmation had recently been received that one of these would be downgraded after being investigated.

Mr Husain went on to inform Directors that an internal Patient Safety Summit had taken place a few weeks earlier and that there had been a substantial amount of good learning form the event that would be widely disseminated. He confirmed that the Trust continued to engage with its external stakeholders, including the CQC and the ICB, and that they were satisfied with the work being done in the organisation to address and learn from Never Events.

He concluded his update by reporting that compliance rates for the new Patient Safety Incident Response Framework (PSIRF) mandatory training continued to rise and that the Trust was on track to achieve its target of 100% by the end of March 2024.

Mrs Atkinson informed Directors that, following the successful implementation of the EPR, work would now be taking place in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders and Emergency Department (ED) transfers to understand how the system could be used to support clinical colleagues to deliver the best care possible. She went on to highlight that the recent reductions seen in cancer waiting times was testament to the improvement work undertaken in the background.

RESOLVED: **Directors noted the report and received assurances about the learning from Never Events and the dissemination of it across the organisation to improve clinical practice and patient care.**

TB/2023/089 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 May 2023. He highlighted that the Trust continued to perform well in several key metrics but acknowledged that there were areas of challenge, including the high numbers of patients currently spending 12 hours or more in the ED. Mr Hodgson reported that

patient experience surveys remained largely positive and noted that this was another important barometer of how the Trust was performing.

b) Safe

Mr Husain referred Directors to the Safe section of the report. He reiterated that it had been a particularly challenging time for the Trust over recent months due to the high numbers of patients coming through the emergency care pathways and the increased levels of acuity.

Mr Husain reported that there had been one confirmed case of Methicillin-Resistant Staphylococcus Aureus (MRSA) since the previous meeting but provided assurances that, following a 'deep dive' exercise undertaken by Infection Prevention and Control (IPC) colleagues, no lapses of care had been identified. He explained that some learning around hand hygiene had been identified as part of this process and confirmed that this had been shared with colleagues.

Mr Husain went on to inform Directors that the Trust had reported 11 cases of Clostridium difficile (C. diff) for the year to date, against its annual trajectory of 53. He explained that higher incidences of C. diff infections were being seen across the country due in part to overcrowding and the other pressures facing NHS organisations. Mr Husain highlighted that blood culture contamination rates had continued to fall despite these pressures and that Venous Thromboembolism (VTE) assessments remained above trajectory at 97%. Directors noted that there were no COVID-19 positive patients currently in the Trust, or any recent outbreaks on its premises.

Mr Murphy drew Directors' attention to the safe staffing information provided in the report and pointed out that clear improvements could be seen in overarching fill rates. He advised that work was taking place to assess how the Trust was managing its nursing resources and that a significant reduction in spend had been forecast if it was able to keep to its trajectories.

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. He explained that a review of the Trust's complaints processes had recently taken place and that a range of improvements,

including new monitoring arrangements and stricter deadlines for responses to be provided, would be launched from September 2023 onwards.

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

d) Effective

Mr Husain confirmed that the Trust's Summary Hospital-level Mortality Indicator (SHMI) remained within expected ranges but reported that its Hospital Standardised Mortality Ratio (HSMR) continued to flag outside of its expected tolerances. He reiterated that work was taking place with colleagues from Dr Foster to address this and advised that a number of challenges had recently been put to them around how the Trust's HSMR was being calculated. Directors noted that the Trust's crude mortality levels remained the lowest in the North West. Mr Husain confirmed that all elements of mortality, as well as alerting groups, continued to be regularly addressed via the Trust's Mortality Steering Group with reporting via the Quality Committee.

Responding to a request from Mr Rehman for additional clarity regarding the expected timeframes for substantive improvements to be made to the Trust's mortality performance, Mr Husain explained that it would be difficult to state for certain, due to the way that Dr Foster carried out their calculations and due to other factors, such as the coding issues referred to during previous meetings. He confirmed that measures were being taken to address these and other issues and explained that, in time, the EPR system would help to facilitate these improvements. Regular updates on progress will be reported to the Board and to the Quality Committee.

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

e) Responsive

Mrs Gilligan informed Directors that due to the recent introduction of the EPR, she did not have access to all of the latest performance figures that she typically would have. She reported that the Trust's emergency care pathways remained extremely busy, with a total of 963 patients waiting 12 hours or more to be admitted to a bed in May 2023. Mrs Gilligan highlighted that this had improved slightly in June, with a total of 797 patients waiting 12 hours or more. She reported that the longest wait experienced by a patient in May had been 160 hours.

Directors noted that 30 new escalation beds had now been put in place in the Trust to help alleviate these pressures and that a clear Standard Operating Procedure (SOP) was in place to determine when these should be used.

Mrs Gilligan went on to report the Trust's overall performance against the four-hour Accident and Emergency target had been 76.4% in May and highlighted that it was on track to achieve the required trajectory target of 76% by the end of March 2024. She added that the Trust was also still ahead of its trajectory for patients waiting 62 days or more for cancer treatment and for the faster diagnosis standard.

Responding to a query raised by Mrs Anderson as to whether the rise in the number of patients coming through the Trust's emergency care pathways was due to gaps in other services, Mrs Gilligan confirmed that this was a contributing factor and was being seen across the country. She explained that the Trust's EPR system would help to source much more granular information around this and advised that Mr Murphy and Mr McDonald were already looking at new ways to direct appropriate patients towards community-based services rather than acute settings. Mrs Gilligan added that an ICB event had been arranged for the end of the month to look at a future of urgent and emergency care pathways across LSC.

Mr Husain pointed out that the significant health inequalities in the LSC region were also playing a role in the higher numbers and acuity of patients. He also stressed that it would take a substantial amount of time for these issues to be addressed.

Mr McDonald noted that the Trust was a victim of its own success to an extent as people were able to come to one of its hospitals to receive high quality treatment in a matter of hours rather than potentially having to wait days to be seen in a primary care setting. He informed Directors that a national recovery plan for primary care access was already in progress to facilitate easier access to appointments with GPs and other primary care professionals, but agreed with Mr Husain's assessment that there would be no quick fix to the issues currently being seen. Mr McDonald added that there were a number of additional local challenges in Blackburn with Darwen and East Lancashire facing the Trust, including the fact that it had the lowest number of GPs per head of population in comparison with other areas in the country.

Mrs Atkinson noted that the activities taking place referred to by Mr McDonald would act as the building blocks for other longer-term work that was taking place to support the earlier identification of frailty.

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

f) Well-led

Mrs Quinn reported that sickness and absence rates had continued to fall steadily over recent weeks, dropping to under 5% during June 2023, but were still not at the level that the Trust would want. She added that work was taking place to develop and implement an attendance management tool across the system to look at whether attendance was being managed in the right way. Mrs Quinn also reported that the numbers of vacancies in the Trust had continued to fall and that she was working with Mr Murphy to consider how to reduce them further.

Mrs Quinn went on to inform Directors that a new programme aimed at reducing agency rates had been implemented across the ICS, which had resulted in a saving of around £700,000. She noted that this had been offset to a degree by a recent surge in demand for a contingency workforce but explained that the current focus on a substantive workforce and filling vacancies would help to reduce this. Mrs Quinn confirmed that an agreement had also been reached regarding a Collaborative Bank across the ICS and advised that a suitable model for this was currently being developed.

Mrs Quinn referred to the information provided in the report regarding staff appraisal rates and acknowledged that they had still not fully recovered to the levels seen prior to the COVID-19 pandemic. She confirmed that work was continuing with the clinical divisions to improve compliance rates and that it had been agreed to tie pay progressions to appraisal completion from October 2023 onwards to encourage staff to ensure that they were up to date. Directors noted that core skills compliance would also be micromanaged through divisions and that newly implemented divisional performance meetings would help to maintain oversight around this.

Mrs Bosnjak-Szekeres commented that it was concerning that the Trust was falling behind in some areas of core skills compliance, such as safeguarding adults and children. She suggested setting a firm deadline for senior leaders and relevant staff to ensure that they were

compliant with their mandatory training and monitoring this through the new People and Culture Committee, once it was in place.

Mrs Brown informed Directors that the audit of the Trust's financial accounts for 2022-23 had now been completed and submitted to the regulator following their approval at the most recent meeting of the Audit Committee. She confirmed that the Trust had received a complimentary audit from its external auditors and had been determined to have achieved its financial duties as planned. Mrs Brown added that the Trust's final financial for 2022-23 position had included a technical deficit of £4.3m, which reflected the uncertainty around the national pay award at the time. She advised that work was continuing to draw up its savings plan for 2023-24, with £38,000,000 of schemes currently identified, but pointed out that there was significant risk to achieving this.

RESOLVED: **Directors noted the information provided under the Well-Led section of the Integrated Performance Report.**
Monitoring of the Trust's Core Skills compliance will be carried out by the People and Culture Committee and reported to the Board as part of the Integrated Performance Report.

TB/2023/090 MATERNITY AND NEONATAL SERVICE UPDATE

Miss Thompson provided a summary of the activities for the Trust's maternity services as well as a summary of the progress made against the ten safety actions for the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5. She highlighted that the Trust had already achieved all eligibility criteria in relation to safety action 1 (are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?) and reminded Directors that this was the only safety action that the Trust had not been able to demonstrate compliance against the Year 4 objectives. Miss Thompson confirmed that good progress was being made with the remaining safety actions but advised that more work was still required in relation to safety action seven (Listen to women, parents and families using maternity and neonatal services and coproduce services with users). She added that further updates would be provided in future.

Mr Hodgson commented that it was clear how much work was taking place in the Trust's maternity service to ensure that it was compliant with CNST requirements. He noted that a key finding of the Ockenden Review had been that more work was needed in relation to

listening to women, parents and families and requested more assurance around the Trust's response to safety action seven.

Miss Thompson clarified that more work was still required to enable better triangulation with neonatology areas and to ensure that any changes were co-produced with users. She explained that neonatology had not been covered by safety action seven in previous years but confirmed that work was well underway to ensure that the Trust was compliant.

In response to a request from Mr Rehman for assurance around appropriate representation from minority communities, Miss Thompson confirmed that work was taking place with neonatology colleagues to ensure diverse representation. She added that the Trust had also been able to demonstrate evidence to the CQC that every effort was being made to connect with 'harder to reach' groups. Miss Thompson advised that she would welcome any additional support from Board members to make initial contact with groups that were proving more difficult to engage with.

Mr Sarwar stated that he would look to arranging a further meeting with Miss Thompson and Mr Rehman after the meeting to discuss this further.

RESOLVED: **Directors noted the progress and approved the Trust's CNST submission.**

A meeting will be arranged between Mr Sarwar, Mr Rehman and Miss Thompson at a later date to discuss any additional support that may be required to make contact with local community groups.

TB/2023/091 NHS EDI IMPROVEMENT PLAN AND ANTI-RACISM FRAMEWORK

Mrs Quinn referred Directors to the previously circulated documents and provided a summary of key areas.

Mrs Quinn explained that the EDI Improvement Plan covered all aspects of inclusion and belonging, with six high impact actions (measurable objectives on EDI for Chairs, Chief Executives and Board members, overhaul recruitment processes and embed talent management processes, eliminate total pay gaps with respect to race, disability and gender, address health inequalities within the workforce, comprehensive induction and onboarding programmes for internationally recruited staff and eliminate conditions and environment in which bullying, harassment and physical harassment occurs) to be prioritised over the coming years. She reiterated the commitment of the Board to achieving these actions and to ensuring that its ambitions were reflected by the experiences of the Trust's staff.

Mrs Quinn went on to advise that the Anti-racist Framework had been developed by the North West Black, Asian, and Minority Ethnic (BAME) Assembly and detailed five anti-racist principles (prioritise anti-racism, understand lived experience, grow inclusive leaders, act to tackle inequalities and review progress regularly) for NHS organisations across the region to commit to. She confirmed that the Trust was fully committed to ensuring that it was an anti-racist organisation and explained that the accompanying self-assessment tool and accreditation process would form a key part of its efforts to be recognised as such. Mrs Quinn informed Directors that a formal launch of the Framework was planned to coincide with the Trust's Festival of Inclusion event later in the year. She noted that the Framework also had strong links to the NHS Long Term Workforce Plan and would provide a significant opportunity for the Trust to work with its local communities to address its ongoing workforce challenges.

Mrs Anderson agreed that it would be crucial for the Trust to ensure that it took the actions and principles laid out in each document seriously. She noted that capacity was already proving to be an issue for many areas in the Trust and suggested that further consideration would be needed to make sure that this did not impede progress.

Mr McDonald stated that the importance of EDI and anti-racism could not be underestimated. He advised that a culture programme had recently been taking place in the Trust's Estates and Facilities Team and that some very valuable learning, some of which played into the high impact actions described in the EDI Improvement Plan, had come from this, particularly in relation to middle management.

Mr Rehman commented that both documents were very welcome and timely and agreed with the need to ensure that good progress was made in relation to both over the coming months and years.

Mr Sarwar pointed out that there was nothing stopping the Trust from going even further than the actions and principles outlined in the documents and stressed that any work done would have to result in real positive change for staff. He urged the Board to consider how it could respond and suggested that consideration could be given to maintaining oversight through the People and Culture Committee and Staff Networks. Mr Sarwar agreed that the Trust would

need to ensure that time was made available to the Chairs of the Staff Networks and that the organisation sets itself goals that were measurable and achievable.

Mrs Quinn acknowledged that some momentum had been lost around EDI over recent years due mainly to capacity issues but agreed that it was everyone's responsibility in the Trust. She stated that the point made by Mr McDonald in relation to middle managers was key, as the aspirations of the Board had not always historically been translated down through the Trust in all cases. Mrs Quinn confirmed that a substantial number of measures had already been put in place to start to address this and that it was being made clear that all senior staff would need to be aligned with the EDI Improvement Plan, Anti-racist Framework and the Trust's wider Behavioural Framework.

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

TB/2023/092 **RATIFICATION OF BOARD SUB-COMMITTEE TERMS OF REFERENCE**

The revised terms of reference for the Quality Committee were presented to the Board for ratification. Directors confirmed that they were content with the revisions made.

RESOLVED: **The revised terms of reference for the Quality Committee were ratified.**

TB/2023/093 **FINANCE AND PERFORMANCE COMMITTEE SUMMARY REPORT**

The report was presented to the Board for information.

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

TB/2023/094 **QUALITY COMMITTEE SUMMARY REPORT**

The report was presented to the Board for information.

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

TB/2023/095 **AUDIT COMMITTEE SUMMARY REPORT**

The report was presented to the Board for information.

TB/2023/096 **TRUST BOARD (CLOSED SESSION) INFORMATION REPORT**

The report was presented to the Board for information.

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

TB/2022/097 **ANY OTHER BUSINESS**

Mr Sarwar noted that the meeting would be Miss Malik's last in her role as a Non-Executive Director. He extended his thanks to her on behalf of the Board for her significant contributions to the Trust during her tenure and for the insight she had provided into some of the challenges facing communities across Lancashire.

TB/2023/098 **OPEN FORUM**

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

TB/2023/099 **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. Members agreed that he felt that the Board had fulfilled its obligations and had clearly recognised the effect of health inequalities in the area.

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

TB/2023/100 **DATE AND TIME OF NEXT MEETING**

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

Mr D Byrne, Corporate Governance Officer

TRUST BOARD REPORT **Item** **106**

13 September 2023 **Purpose** Information

Title	Action Matrix
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mr S Sarwar, Chairman

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

Report linkages

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

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

(106) Action Matrix

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2022/064: Behaviour Framework Implementation Update	A further progress report on the implementation of the Trust's Behavioural Framework will be provided to the Board in 12 months' time.	Executive Director of People and Culture	November 2023	Agenda Item: November 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	TBC	The business case will be presented at a future meeting once it has progressed through the appropriate business case process.
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
TB/2023/083: Chairman's Report	An update on the outcomes of the Non-Executive Director and Associate Non-Executive Director recruitment process will be provided in due course.	Chairman	September 2023	Complete

Item Number	Action	Assigned To	Deadline	Status
TB/2023/089: Integrated Performance Report – Well-led	Monitoring of the Trust's Core Skills compliance will be carried out by the People and Culture Committee.	Executive Director of People and Culture	Complete	Complete: This has been added to the workplan for the People and Culture Committee which was agreed by members on the 4 September 2023.
TB/2023/090: Maternity and Neonatal Service Update	A meeting will be arranged between Mr Sarwar, Mr Rehman and Miss Thompson at a later date to discuss any additional support that may be required to make contact with local community groups.	Chairman	September 2023	Update: Due to annual leave this meeting has not yet taken place, it will be arranged before the next meeting.

Mr D Byrne, Corporate Governance Officer

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **108**

13 September 2023 **Purpose** Information
Approval

Title	Chief Executive's Report
Report Author	Mrs Emma Cooke, Joint Deputy Director of Communications
Executive sponsor	Mr M Hodgson, Chief Executive

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

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

Report linkages

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

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

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 data on strike action

Industrial action by consultants, over the 48 hours between 20 and 21 July, saw 65,557 rescheduled appointments and procedures.

More action is planned for 24-25 August, 19-20 September and 2-4 October, as they commit to long term protests over the government's failure to enter pay talks. Consultants will provide "Christmas Day" cover during the strikes, with emergency services running as normal.

The five days of industrial action by junior doctors from 11 – 15 August saw 61,200 rescheduled acute inpatient and outpatient appointments and procedures. The number of staff absent from work due to strikes peaked on 11 August with 23,682.

The ballot to extend the mandate for further junior doctor strike action closed at noon on 31 August.

The cumulative total of acute rescheduled inpatient and outpatient appointments and procedures over eight months of industrial action across the NHS now stands at 839,327.

NHS expands hospital 'matching' platform to bring down longest waits

Thousands of patients who need NHS treatment could be quickly and easily allocated to hospitals that can take on their care. The easy-to-use tool allows NHS colleagues to view and add available surgery slots in hospitals across the country, including independent sector capacity. Clinical teams can upload details of patients on their waiting list who are willing to travel, with other NHS and independent sector providers able to log on and 'match' people up to treatment.

Initially introduced for patients needing a hospital admission, the platform will now expand to include cancer, diagnostic checks, and outpatient appointments. Around four in five patients on an

NHS waiting list won't need a hospital admission. Since its launch in January, more than 1,700 offers of support have been made with thousands of patients set to benefit as the platform grows. Mutual aid is a key part of the NHS Elective Recovery Plan, with joined up working and shared support helping to reduce waits.

NHS to speed up diagnosis and treatment of respiratory and heart conditions

The NHS introduced new measures last month to improve the detection of major health issues, enabling GP practices to directly request diagnostic checks for a wide array of conditions, including COPD, asthma, cardiovascular disease, and heart failure.

Approximately one million patients could benefit from this accelerated access, reducing the need for specialist consultations and speeding up potentially life-saving interventions and medications. This approach, already successful in cancer cases, has provided quicker access to tests for nearly 80,000 individuals who might not meet the urgency criteria for a cancer referral set by NICE guidelines.

GPs will be able to refer patients with symptoms of heart and respiratory problems for various checks at their local hospital or local community diagnostic centre, which provides a one stop shop for scans and tests.

New standards for NHS board members to strengthen leadership and governance

The NHS has published a framework and supporting resources to help senior board members to strengthen board governance, boost leadership and improve patient safety.

Resources have been shared with leaders to support current and aspiring board members to further develop their skills and careers. The resources including information on development programmes and peer support networks to develop and share good practice.

A Fit and Proper Person Test (FPPT) framework for board members has also been published, which will help prevent directors who have been involved in or enabled serious misconduct or mismanagement from joining a new NHS organisation.

NHS England was commissioned to update the framework as part of five recommendations from the Kark review of the Fit and Proper Person Test.

NHS delivers another record year of lifesaving cancer checks for patients

Record numbers of cancer checks over the last year means that almost three million people have received care that could save their lives. In June alone, over a quarter of a million people (261,000) were seen for urgent cancer checks, which is well over double the number of people checked in the same month a decade ago (101,592).

A record 335,000 people have also started treatment for cancer in the last year (July 2022 – June 2023), up by over 20,000 on same period before the pandemic (July 2018 – June 2019).

Ensuring people are diagnosed with cancer at an early stage is a key priority for the NHS as treatments are more likely to be successful, giving people a greater chance of surviving the disease.

NHS cancer standards reformed to speed up diagnosis for patients

Thousands of people referred for urgent cancer checks every month are set to be diagnosed and treated sooner, as cancer standards are reformed to reflect what matters most to patients and to align with modern clinical practice.

The NHS currently has ten performance standards for cancer. Following rigorous consultation and engagement, the government has agreed these targets will be consolidated into three key standards:

- **28-Day Faster Diagnosis Standard** (FDS) which means patients with suspected cancer who are referred for urgent cancer checks from a GP, screening programme or other route should be diagnosed or have cancer ruled out within 28 days.
- **62-day referral to treatment standard** which means patients who have been referred for suspected cancer from any source and go on to receive a diagnosis should start treatment within 62 days of their referral.
- **31-day decision to treat to treatment standard** which means patients who have a cancer diagnosis, and who have had a decision made on their first or subsequent treatment, should then start that treatment within 31 days.

The three agreed standards, which will come into effect from October, have been identified as the best measures to ensure patients are being seen and treated as quickly as possible, and to provide a clear focus for NHS Trusts delivering vital care.

3. Regional Updates

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

Members of the Lancashire and South Cumbria Integrated Care Board (ICB) met on 5 July 2023. A recording of the meeting is available to watch online here: LSC ICB: 5 July Board Meeting.

The Chief Executive's Report, submitted by Kevin Lavery as part of the meeting's papers, provides a wider update. The report in full is included as *Appendix 1*.

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

PCB meeting – 20 July 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.

The overview of the July meeting is at the end of this report as *Appendix 2*. The August meeting was cancelled.

Provider Collaborative colleague briefing

A colleague briefing took place on 4 September 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 and will provide updates on collaboration, working together through significant challenges, our clinical strategy, central services collaboration, and our people strategy.

The dates of next briefings are:

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

New Hospitals Programme update

A summer series of national New Hospital Programme roadshow events visited Preston last month, as Government representatives arrived to discuss the next steps for building two new hospitals in the region.

Lancashire and South Cumbria NHS welcomed Health Minister Lord Nick Markham CBE following on from the Government's commitment to replace both Royal Preston Hospital and Royal Lancaster Infirmary with new builds on new sites.

The roadshow event was an opportunity for Lord Markham to hear first-hand from staff and patients of Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust, as well as local NHS leaders, members of parliament and local councils, health and social care colleagues.

Lord Markham saw first-hand the challenges of working in and being cared for in some of the current buildings. Conversations also explored what the rebuilds of Royal Preston Hospital and Royal Lancaster Infirmary could mean for those who access these facilities, including improving the working lives of staff and enabling patients to access outstanding care in new state-of-the-art hospital facilities.

Replacements for Royal Preston Hospital and Royal Lancaster Infirmary are part of a rolling programme of national investment in capital infrastructure beyond 2030. In addition, Furness General Hospital in Barrow will benefit from investment in improvements.

The existing Preston and Lancaster sites will remain in place and deliver services to the population until new hospital facilities are opened. The local NHS will continue to keep communities involved and provide further updates as more information becomes available.

Further detailed work is underway to assess the viability of potential locations for both new hospital builds and to develop the required business cases. For the latest news, visit the Lancashire and South Cumbria New Hospitals Programme website.

Collaborative UEC strategic redesign day

Organisations involved in urgent and emergency care (UEC) across Lancashire and South Cumbria have met ensure that our services are fit for the future.

Colleagues from provider Trusts, ICB, primary care, out of hours providers, NWAS, Lancashire and South Cumbria NHS Foundation Trust (LSCft), social care, community services, Public Health,

NHS England and voluntary, community, faith and social enterprise along with patient representatives, discussed what we can start to do now to adapt and develop over the next few years.

The meeting looked at what has worked well in other systems, with help from the emergency care improvement support national team, and what we could focus on locally and across our footprint.

This was just the start of a journey of collaborative design with colleagues and patients across the system, to ensure all services in Lancashire and South Cumbria provide the best experience and outcomes for communities, starting with how people are supported in their own home before they even need UEC, and are workplaces where staff want to work, thrive and feel empowered.

Collaborative clinical strategy update

ELHT, in collaboration with other NHS Trusts and the Lancashire and South Cumbria Integrated Care Board, is jointly pursuing a vision aimed at enhancing clinical services through collaboration – a joint clinical strategy. The shared objective is to establish sustainable healthcare services that contribute to improved health outcomes, reduced disparities in health access, and a positive work environment.

The collective aspiration includes equitable access to high-quality care for all patients across Lancashire and South Cumbria, with a targeted goal of achieving a Care Quality Commission rating of at least 'good' within three years for all five trusts. Addressing existing challenges such as workforce management, accessibility, waiting times, service excellence, operational resilience, financial stability, and health inequalities requires a reimagined approach to collaboration, ensuring patients receive the care they both need and deserve.

The best way to achieve these aims is for the five provider NHS Trusts to work collaboratively as a connected network of service providers. One size will not fit all – different clinical services would work together in different ways, from sharing clinical standards and best practice to a specialist team of health professionals working at a centre of excellence. Most services would continue to be delivered across all hospitals.

Delivering services as close to home as possible remains a priority for patients and the public. Access to services already in the community would continue to improve access and consideration would be made on which other services could be safely and effectively delivered in community settings.

Some specialised services are already working on a network basis (such as trauma, renal services, and most cancer surgery). Some of other specialised services, such as complex surgery for vascular, urology and head and neck cancers, could also benefit from this approach to ensure the best possible patient outcomes.

Underpinning this is the Lancashire and South Cumbria NHS Joint Forward Plan (2023-2028). The plan describes how the NHS will meet the health needs of our population by working jointly with partners on prevention and by working with all organisations within the NHS family to transform the way healthcare services are provided. The plan also includes a joint vision and values and several key priorities.

Young people in Lancashire and South Cumbria urged to speak out and seek help

LSC ICB has launched a new campaign aimed specifically at 11 to 18-year-olds. The campaign, which will mainly been seen on Snapchat, TikTok and Instagram, encourages young people who may be feeling anxious about school or exams, finding it hard to fit in, or having negative thoughts about how they look, to find help and support on the Healthy Young Minds website.

The campaign concept – which shows teenagers feeling alone and consumed by their own thoughts, before realising it's good to talk – has been brought to life by young people from the Blackburn Youth Zone. The campaign also encourages parents and carers to talk more to their children about mental health concerns.

Pathology Service Update

An update has been shared by Kevin McGee, Lead Chief Executive of the Provider Collaborative on the future of the Lancashire and South Cumbria Pathology service.

In the message, which has been shared directly with Pathology Leads at all Trusts, Mr McGee highlighted the great work being carried out including cancer restoration and genomic profiling, Laboratory Information Management System (LIMS) and digital pathology.

He also provided an update on the change from the Pathology Collaboration Board to the new Pathology Network Board.

Work has also begun to compile a robust business case for the funding on offer from the Department of Health and Social Care. More than £30 million of funding will be used to support Pathology Services in the Lancashire and South Cumbria System, ringfenced for infrastructure work that will be completed by March 2025.

Changeology, the company who completed an extensive engagement exercise on the pathology network, will also be helping to facilitate the development of the delivery model which will form part of the business case.

Colleagues across the network will be updated on a regular basis through a special Pathology Service Colleague Briefing, hosted by several leaders from across the system.

Place Update

The 'Place Integration Deal' was agreed by the ICB on 5 July 2023 meaning that some future NHS services will be delivered locally via the four Place Based partnerships this will enable good quality, joined up health care to be delivered locally.

This decision, welcomed by Lancashire County Councils Cabinet, means that decisions can be taken closer to the point where services are delivered and accessed, supporting more integrated working over time between the council and NHS and reducing duplication and hand offs between the two. This is a significant decision given that over time this will see around £1 billion of non-hospital services transfer to Places.

The Clinical and Care Professional Leads have been appointed for Lancashire, one for each locality (Central, East and North Lancashire), who will be providing overall leadership to the clinical and care professional networks within the Lancashire 'Place'. These are:

- **Dr Santhosh Davis** for the East Lancashire Locality
- **Dr Elizabeth MacPhie** (Consultant Rheumatologist) for the Central Locality
- **Dr Anthony Naughton** for the North Lancashire Locality

Executive Oversight Groups (EOGs) are now meeting monthly within each locality area. These meetings bring together chief executives and senior leaders on a regular basis to further build relationships, trust, share opportunities and accelerate place delivery.

4. Local and Trust specific updates

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

Use of the Trust Seal

The seal has not been used.

Changes to the Trust Board

The Trust has appointed two new Non-Executive Directors (NEDs) to the Board, Catherine Randal and Liz Sedgley.

Catherine will chair the Trust's quality committee with immediate effect and Liz will chair the Trust's finance committee from December.

Catherine and Liz replace Non-Executive Directors Naseem Malik and Stephen Barnes. Naseem stepped down from her role in August and Stephen will be stepping down in December, after completing their terms of office. The Board remains grateful for their contribution to the success of ELHT and is thankful for their service and support during their time at the Trust.

On the appointment of Catherine and Liz, there will be seven voting Non-Executive Directors who, together with the Chair, form a majority on the Board of Directors (voting members).

Non-Executive Directors do not have responsibility for the day-to-day management of the Trust but share the Board's corporate responsibility for ensuring it is run efficiently, economically and effectively. To be effective, they must be well-informed about the Trust and have a good grasp of the relevant issues.

Catherine has an impressive career spanning over 37 years, with a wealth of leadership experience in national safeguarding for NHS England, as a former Chief Nurse and through providing important support at East Lancashire Hospitals Trust in the response to COVID-19.
In addition to her career, Catherine holds the title of Honorary Professor at the University of Central Lancashire (UCLan) and was awarded the honoured of Queen's Nurse in 2022.

Catherine's extensive qualifications encompass a diverse range of healthcare roles, including registered nurse, midwife, family planning nurse, health visitor, and Nye Bevan graduate and brings her expertise from working within the NHS at local, regional and national levels.

Her areas of particular focus include transformation, safeguarding, and a commitment to incorporating the lived experiences of individuals into healthcare decision-making.

In her new role, Catherine will undertake the position of Chair of the Trust's quality committee, further advancing her mission to enhance healthcare quality and patient experiences.

Liz is a Fellow of the Chartered Association of Certified Accountants in England and Wales and has a remarkable career spanning two decades.

During this time, she has operated a highly successful management consultancy firm, offering expert accountancy and strategic finance support to a wide array of public sector organisations and businesses, spanning sectors such as construction, chemical sales, communications, and web-based retail.

For the past six years, Liz has held the position of a Non-Executive Director and the Deputy Chair at the University Hospitals of Morecambe Bay NHS Foundation Trust.

Her journey with the Trust is not new, as she previously served as a non-Executive Director and the Audit Committee Chair for an eight-year tenure. In her new capacity, Liz will assume the role of Chair of the Finance Committee.

Liz has a keen interest in understanding and improving the patient's experience and helping to develop seamless care between hospital and community settings for the benefit of patients.

Industrial action

The Trust continues to manage ongoing industrial action by professional groups and trade unions over a pay dispute with the Government. There have been multiple periods of industrial action since the last report, which proved particularly challenging as they coincided with school summer holidays.

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 Thursday, 13 July until Tuesday, 18 July and Friday, 11 August to Tuesday, 15 August.

Consultants have staged four days of industrial action so far and have planned at least five more in the coming weeks, on 19 and 20 September and 2, 3 and 4 October. Following the reballot result on 31 August, junior doctors announced six further days of strike action on 20, 21, 22 September, and 2, 3, 4 October.

The four joint days of action on 20 September and 2-4 October will see ‘Christmas Day’ levels of cover from both groups.

Joint Junior and Consultant strike action dates:

September

Date	Consultants	Juniors
19 September	Christmas day cover from 7am	Non strike day
20 September	Christmas day cover	Christmas day cover from 7am
21 September	Non strike day from 7am	Full walkout from 7am
22 September	Non strike day	Full walkout
23 September	Non strike day	Non strike day from 7am

October

Date	Consultants and Juniors
2 October	Christmas day cover from 7am
3 October	Christmas day cover
4 October	Christmas day cover
5 October	Non strike day from 7am

A joint Consultant and Junior Doctor rally will take place on Tuesday 3 October at St Peter's Square, Manchester.

Careful planning has and will continue to take place to minimise the impact on patients, families, and colleagues.

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 and signposting to appropriate pathways for treatment.

This communication aims to reduce disruptions and maintain quality care during these challenging times.

Lucy Letby Trial Conclusion

The lengthy trial of nurse Lucy Letby for crimes at the Countess of Chester Hospital concluded in August with significant media coverage of the guilty verdicts and her sentencing. The Department of Health and Social Care has subsequently announced that there will be an independent inquiry into the events, which was upgraded following public debate to a statutory inquiry which can compel people to provide evidence.

Within the Trust, A letter from Amanda Pritchard, Sir David Sloman, Dame Ruth May and Professor Sir Stephen Powis, which was issued to NHS Integrated Care Boards, NHS Trust and Primary Care Network leaders has been shared with colleagues.

The outcome of the trial was also mentioned in our standard communications channels with a refreshed message about speaking up and raising concerns. This will continue to be a focus across ELHT, particularly in October which is the official Freedom to Speak Up month nationally and will provide a platform to amplify our commitment to hearing and acting upon concerns from colleagues and patients.

Reinforced autoclaved aerated concrete (RAAC)

The Trust has been proactive in surveying it's buildings for reinforced autoclaved aerated concrete (RAAC) at the beginning of the year. The survey identified two areas at Royal Blackburn Teaching Hospital with RAAC and a full programme of work was put into place to safely remove the panels.

A full inspection was carried out by a qualified surveyor to confirm there was no deterioration in the structure. This was logged and recorded on our risk register to provide assurance that patients, visitors and colleagues are safe.

The majority of the RAAC has now been removed from the main area of the hospital roof. A further inspection to check the condition and deterioration in the second area – an administration block – is to be completed before removal work can begin.

EPR Update

The Trust continues to focus on embedding the new Electronic Patient Record (EPR) system which was implemented in June. The key focus continues to be listening to the experiences of colleagues and supporting them to embrace a new way of working which will deliver a great number of benefits for the Trust, patients and partners across the system.

A range of support continues to be provided as we move through the optimisation phase and this includes ensuring feedback is captured and considered openly with teams and improvement support provided in a timely fashion. It is expected this work will be ongoing for some time before the system is operating as expected across all areas of the Trust.

To support colleagues, the Clinical Informatics team began a series of post go-live walkabouts mid-August with the aim to visit all Trust sites and departments over the course of four weeks. The team have been engaging in discussions to uncover any challenges or obstacles and to gather further feedback. This is critical to ensure the EPR is improved further.

The feedback has also led to various technical issues being resolved based on change requests. The Trust is now preparing to roll out almost 1,000 hours of one-to-one coaching from Cerner Oracle to provide further support and guidance.

The Trust announced Clare-Marie Owen as the new Chief Nursing/AHP Information Officer following the retirement of Amanda Claeys. Clare-Marie started in the role in August to lead the clinical informatics team within the Data and Digital Service.

Clare brings a wealth of improvement and clinical experience to the role and will be working closely with our AHP and nursing teams to take forward the Trust's Data and Digital ambitions.

An image of success for new community diagnostics centres

Patients in Rossendale and Burnley are benefiting from two new community diagnostic centres (CDC), which are exceeding all expectations on trajectory for the number of scans being performed.

Burnley CDC also delivered 1,678 non-pregnancy-related ultrasounds between 1 April and 30 July - a 194% increase against their planned activity. The CDC in Rossendale delivered 4,479 MRI scans and non-pregnancy-related ultrasounds in the same period - 11% over the predicted number. The new Rossendale CDC became operational in October 2022 following a £1.2m investment from national funding allocated to reduce scan waiting times and bring services closer to patients' homes.

The Lancashire and South Cumbria diagnostic programme has overseen the mobilisation of the CDCs across the system area, including Burnley and Rossendale, and is a great example of collaboration.

Community health services - working in partnership for our patients

Community health services play a pivotal role in prevention and improving health outcomes. Many of these services involve partnership working across health and social care teams, made up of a wide variety of hard-working professionals including GPs, community nurses, allied health professionals, district nurses, mental health nurses, therapists and social care workers. Currently however there are gaps in service provision across the region which need addressing.

An immediate and significant piece of work is taking place to provide a resilient, sustainable, strengthened and integrated model of community services within Blackburn with Darwen (BwD).

It has now been agreed that:

1. The 0-19 Service (health visitor and school nursing) in Blackburn with Darwen currently provided by LSCft, will be provided by ELHT from April 2024 following a formal tender process. Meetings are being set up between the two organisations to work through the detail and arrange for colleagues involved to transfer to ELHT.

2. NHS commissioned adult physical health community services in Blackburn with Darwen will transfer from LSCft to ELHT over the next 12 months. Physical health services are already integrated well in BwD and this is an exciting opportunity to further develop quality and opportunities as well as address some the current difficulty in recruitment.

Investment in our services

Paediatric outpatients at Royal Blackburn Teaching Hospital have expanded with three new clinical rooms and additional child-friendly waiting areas. The additional space will mean extra clinics and activity can run from the site, helping improve patient experience by increasing the offer of location-based services.

The Trust also has replaced its Speech and Language Therapy equipment – a FEES Stack system, as part of wider £3.1 million programme of investment and improvements in technology across ELHT sites.

FEES is flexible endoscopic evaluation of swallowing carried out by Speech and Language Therapists which involves us passing a nasendoscope through the nose and into the throat to assess a patient's swallow function. It also enables the team to investigate their secretions, sensation, structures and voice.

They see both inpatients and outpatients for FEES, working in clinic and taking the stacker to the patient's bedside on the ward.

Welcome to our newest Foundation Year trainee doctors

The Trust has welcomed its latest cohort of Foundation Year trainee doctors. The Foundation Year doctors will be starting their two-year foundation training at ELHT after recently graduating from medical school.

Following the first few days of local induction, the FY1 doctors will begin their shadowing programme to provide a direct insight of working on the wards alongside clinical staff, doctors and medical leads on hand to support.

Alfie passes therapy dog assessment

Trainee therapy dog Alfie, the apricot cockapoo, has graduated with flying colours to become ‘Head of Happiness’ at ELHT. He completed home and work assessment to be officially recognised as a fully trained therapy dog.

The Trust’s Charity ELHT&Me used a grant from NHS Charities Together to introduce Alfie, who offers unique wellbeing support to patients, visitors and colleagues and ensure he was properly trained.

As a fully trained therapy dog Alfie will now be able to visit patients and colleagues anywhere, including the children’s wards, and provide comfort and companionship in a clinical setting. He will also be able to attend bed visits for patients facing end of life to help give comfort to both the patient and their family and friends to make the situation more bearable.

Remembering Jasper

A number of actions have been taken to honour Jasper, the 6 year old therapy dog at ELHT who sadly died in April this year.

Jasper joined the Trust in 2019 and made an unforgettable impact. In those four short years he touched the lives of many people – patients and colleagues. Walking the wards every week, not many people could pass by without a smile or saying hello.

He made a huge impression on everyone who was lucky enough to meet him. He was instrumental in providing care and support to colleagues and patients who needed it, bringing a playful energy wherever he went.

He was a constant comfort during Covid at the most challenging of times. Over 1,000 people joined his Conversations with Jasper sessions and that brave support led to him receiving a national award at the House of Lords in 2021.

Jasper's enduring presence has been beautifully commemorated through the placement of a plaque and a plant in the tranquil sanctuary of the Memories Garden on the Royal Blackburn site. A painting of Jasper can also be found on the wall of the quiet room in the spiritual centre, capturing the comfort and the solace he provided to so many there.

Outside the General Office a dedicated bench, donated by Unison, has been positioned, offering a moment of respite and reflection to those he supported.

And in recognition of the profound impact Jasper had on the community, a painting has been commissioned by the Trust's Charity, ELHT&Me, as an enduring testament to his legacy.

These gestures stand as a tribute to a remarkable companion for David Anderson, Hospital Chaplain and Counsellor, and Jasper's dad, ensuring that Jasper's memory remains alive and well, a source of comfort and inspiration for all who knew him.

Neonatal coffee mornings set up

Families who have received care at the Trust's neonatal intensive care unit (NICU) are being invited to a new monthly coffee morning.

They have been organised by the Trust's Neonatal Community Team to provide a safe space for families to meet others who have been through similar experiences, as well as a chance to take part in crafts, sensory play, singing and story time. Older children are also welcome to attend alongside a parent or carer.

Many families whose babies were born poorly, premature or sick value the chance to meet other parents and babies who have been on a similar journey to them and the coffee mornings also provide an opportunity to receive peer support and signposting.

Remembering those who lost their lives to Hep C

As part of World Hepatitis Day in July, trees were planted at RBTH and Accrington Victoria Community Hospital in memory of those who have lost their lives to the disease.

Survivors of Hep C joined the events and shared their stories to help raise awareness about viral hepatitis, including Shaun Denny who was homeless for 15 years and as a result of his living conditions contracted hepatitis C. He eventually needed two liver transplants which have helped him change his life.

Improving the use of advance care plans

An improvement project is taking place at ELHT to improve both colleague and public awareness of advance care plans, develop education provision for colleagues and to simplify the documentation used to ensure the medical care our patients receive is aligned with their wishes.

Advance care planning offers people the opportunity to plan their future care and support, including medical treatment, while they have capacity to do so.

The project, utilising the SPE+ improvement methodology, will look to implement improvement ideas that are co-designed with patients and colleagues.

Clinical Quality Academy launched

A new SPE+ Clinical Quality Academy is being launched at ELHT, in collaboration with Blackpool Teaching Hospitals. The 12 month programme is designed to support colleagues to understand, design, test and implement changes that lead to improvement and the delivery of safe, personal and effective care.

The Clinical Quality Academy is an opportunity for medical leaders and their multi-disciplinary team to learn what is needed to make improvements that drive better patient outcomes, experience and system performance. The academy creates the conditions to stimulate critical thinking, teach the very latest in improvement science and inspire the next generation of improvement leaders.

Delivering an intensive programme of teaching, action learning and coaching in the science of improvement, facilitated by eminent leaders from both the UK and USA.

Teams are asked to identify projects that lends themselves to a quality improvement approach to achieve the Trust's aspiration of delivering Safe, Personal and Effective (SPE+) Care. Projects should support the delivery of the Trust clinical and quality strategies with a patient focussed outcome.

NHS Staff survey

The 2023 National NHS Staff Survey will be launched in September with all colleagues invited to provide feedback and input about how they feel about and experience their working lives.

The annual survey is gathered across the whole NHS at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling a range of organisations to understand what it is like for colleagues across different parts of the NHS and work to make improvements.

The survey is aligned to the NHS People Promise to track progress against its ambition to make the NHS the workplace we all want it to be by 2024. The survey is coordinated for the Trust by Picker Institute ensuring all answers remain anonymised. The results are expected in quarter four and will enable the Trust to track progress and create priorities for 2024-25 in line with the colleague feedback received.

Star Awards

The highlight of the Trust's colleague recognition calendar is the STAR Awards, which will take place in October 2023. A record number of entries have been received this year – over 600! A reconfiguration of the award this year has created new categories, including Volunteer of the Year, Safe, Personal and Effective Champion and Jasper's Colleague Kindness Award

Following the promotion of the Public Health Hero award, in the local media and on the Trust's social media channels, we have received over 60 nominations. The nominations hold some amazing stories shared by the local community about the care and support they have received from ELHT.

Judging panels, which include Executive Directors, Non-Executive Directors and senior managers, will select three finalists, and a winner, in each of the categories, celebrating Trust values, innovation and team members who have gone the extra mile.

For the first time this year, following colleagues' feedback, everyone who was nominated for an award, has received a congratulations letter from Chief Executive Martin Hodgson to recognise the great work they are doing.

On Thursday 5 October at 7pm, the ceremony will be live streamed from a professional broadcast studio, where Executive and Non-Executive Directors will announce the winners alongside host and BBC Radio presenter Graham Liver. The benefit of this virtual format is that as many colleagues as wish to attend will be able to join live and enjoy the event. And for those who can't join live, the event can be viewed later via catch-up.

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

New breastfeeding and expressing room

Colleagues at Burnley who need to express milk during their working day can now benefit from a new private room. It is hoped the quiet private room will help to reduced stress levels for nursing mums and support their continuation of breastfeeding.

The colleague expressing room, in the Paediatric Outpatients department at BGH Area 6 Level 1, is open from 8am to 5pm Monday to Friday.

Celebrating 75 years of the NHS

The planned activities, as outlined in the July CEO Board Report, marking the 75th anniversary of the NHS on 5 July, were carried out with great success. In the run up to the celebration week, a 75-day countdown of 75 human stories were published across our social media platforms. These stories were compiled into a 75-page online magazine which was launched on the final day of the celebrations.

Below is a brief synopsis of some of the activities:

- **NHS 75 Give Aways**
  Nominations for teams or individuals who deserved 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.

- **NHS75 birthday on Radio Lancashire**
  Radio Lancashire's Graham Liver interviewed Martin Hodgson for the Breakfast Show on Tuesday 4 July, followed on Wednesday 5 July, with live interviews with colleagues from various locations on the RBTH and BGTH sites.

- **NHS75 thank you video**
  Colleagues from across Lancashire and South Cumbria worked together on a NHS75 thank you video. It includes people from every Trust in the area including ELHT.

Awareness days and events

The Trust has celebrated a range of awareness days and events over the last two months, shining a light on the work of a variety of colleagues and services.

These have included:

- South Asian Heritage Month
- Employee of the month
- Genomics Conversation Week
- World Hepatitis Day
- World Breastfeeding Week
- Annual Cancer Conference
- Rainbow Baby Day

Awards and recognition

National NHS Parliamentary Awards

Vicki Stevenson-Hornby, a pancreas specialist nurse at the Trust has been crowned the national winner of the Nursing and Midwifery category at the NHS Parliamentary Awards.

Vicki's passion about improving awareness and outcomes, 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 Rt Hon Sir Jake Berry MP, Rt Hon Nigel Evans MP, Rt Hon Andrew Stephenson CBE MP and Antony Higginbotham MP.

Armed Forces team shortlisted for multiple awards

The Armed Forces and Veterans' team at the Trust has been shortlisted in a collection of highly recognised national awards this year.

1. Nursing times finalist for 2023, in Team of the Year category
   Ceremony to be held on 25 October
2. HSJ 2023 finalist, second year running for the "Military and Civilian Partnership" award
   Ceremony to be held on 16 November
3. Nominated in Best of Lancashire "Armed Forces Award"
   Ceremony to be held on 28 September
4. Nominated in English Veteran awards "Health and Wellbeing award"
   Ceremony to be held on 6 September

Since being set up last year, the team have supported over 1,600 patients. Their achievements have been acknowledged nationally through the participation in a national workshop held by the Office of Veteran Affairs in Whitehall London. The team have also been invited to present to the Veterans National Conference in Barbican London later this year.

Quality award for support to international healthcare professionals

The Trust has been awarded the prestigious NHS Pastoral Care Quality Award for its support to international nurses and midwives.

The national award scheme was launched last year to recognise organisations with high-quality care and wellbeing support for new people joining the NHS from overseas.

The Trust has a dedicated recruitment and induction programme helping healthcare professionals from around the world start their career with the NHS in East Lancashire. The wrap-around care starts from the moment of interest and continues for as long as people need it, including personalised educational support as they complete professional UK assessments.

The in-depth support is a key reason why the Trust attracts around 600 overseas nurse applicants every year, with 20 recruited every month.

ENDS

Emma Cooke
Joint Deputy Director of Communications
August 2023

Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	5 July 2023
Title of paper	Report of the Chief Executive
Presented by	Kevin Lavery, Chief Executive
Author	Hannah Brooks, communications and engagement manager and executive team lead contributors
Agenda item	5
Confidential	No

Executive summary

This report provides an opportunity to reflect on a year since the establishment of the ICB, focusing on the importance of strong leadership that will be required to lead the organisation through a challenging recovery and transformation programme.

A key part of ensuring the ICB's success is to achieve the right balance between what happens at place and what happens across the system, and this report introduces the proposal for a place integration deal and the opportunities that are opened up by delegating to our places. The report also provides an update on the Integrated Care Strategy and specialised commissioning.

Recommendations

The Lancashire and South Cumbria Integrated Care Board are requested to note the updates provided.

Which Strategic Objective/s does the report contribute to		**Tick**
1	Improve quality, including safety, clinical outcomes, and patient experience	✓
2	To equalise opportunities and clinical outcomes across the area	✓
3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	✓
4	Meet financial targets and deliver improved productivity	✓
5	Meet national and locally determined performance standards and targets	✓
6	To develop and implement ambitious, deliverable strategies	✓

Implications

	Yes	**No**	**N/A**	**Comments**
Associated risks			✓	
Are associated risks detailed on the ICB Risk Register?			✓	
Financial Implications			✓	

Where paper has been discussed (list other committees/forums that have discussed this paper)

Meeting	Date	Outcomes
n/a	n/a	n/a

Conflicts of interest associated with this report
Not applicable

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			✓	
Equality impact assessment completed			✓	
Data privacy impact assessment completed			✓	

Report authorised by:	Kevin Lavery, Chief Executive

Integrated Care Board – 5 July 2023

Report of the Chief Executive

1. Introduction

"Rough waters are truer tests of leadership. In calm water, every ship has a good captain." - Swedish proverb

1.1 As we reflect on one year since the establishment of the ICB, there are three key areas to focus on:

1. Leadership is about facing up to challenges.
2. Improvement is a constant process.
3. Delivery is key.

1.2 Being a leader is not easy. Of course, working within a challenged health organisation, decision making comes with the territory. However, it goes beyond that; it should not be easy to be a good leader. It is about facing up to challenges, getting out of your comfort zone, recognising that something is not working and having the courage to change it.

1.3 It is too easy to avoid the difficult decisions and just enjoy the trappings of power. I saw that clearly in local government during the austerity crisis. Some leaders stood up and faced up to the issues, whilst others did not – and instead hoped they would go away. This had real impact on local communities and some suffered more than they needed to as a result of a lack of leadership.

1.4 We face major challenges in health and care on a similar scale to those faced by local government in austerity. The challenge is not going to go away, and as leaders we will need to be brave in the difficult decisions that we will face over the coming years. It will be an uncomfortable experience if we are going to achieve a real step change across the system.

1.5 We also cannot take our eye off the ball. Focusing on a small number of priorities and getting them right is vital to our success but we also have to be on a continuous journey of making sure that what we are doing is making a difference.

1.6 To make progress, as leaders we have to make the most of the opportunities we have now and in doing so, we will reach a point where we can go even further.

1.7 We need to continually review the good, the bad and the ugly; reset and identify the opportunities to improve. An essential part of leadership is setting and managing expectations. Transformation programmes can often be oversold and do not meet the original expectations which can lead to a perception of failure, despite the improvements that have been made. In this context it is important

that we under-promise and over-deliver.

1.8 Which brings me to the final point that delivering improvements, consistently, is the real goal in all of this. As an organisation that enables change and supports system-thinking, our ICB must still focus on the delivery. As a board we have a duty to make sure that our priorities are met and our communities are served.

2. Integration at place

2.1 If there is one difficult decision that we made in the last year that we should commend, it was the decision that we took as a board in our first business meeting to realign the place boundaries.

2.2 Before our ICB was established, we had eight Clinical Commissioning Groups (CCGs) working across five places based on hospital catchments, and those places were not coterminous with our principle local authorities, so it would have been nigh impossible to integrate health and care. Lancashire County Council for example were in five place-based partnerships. Integration would have been too hard.

2.3 It was a tough decision to make so early in the establishment of a new organisation with a newly-formed board, but recognising the need and having the courage to make the change has built a strong foundation for much of the integration work that has taken place since.

2.4 We knew it was the right thing to do and that we would never be able to truly integrate without this step. But it was not easy. We knew it would affect our ability to make fast progress with the places. We had challenges from our colleagues in primary care. Those that had been working in the former place footprints felt a connection to those places that was hard to shift away from.

2.5 It did slow us down initially; it took until December to get our full leadership team in place. Since then, we have begun to move forward and we are now really gathering pace.

2.6 It is because of the brave decision that we made in July last year that we have been able to make two other significant decisions already at our board meetings; the transaction between Lancashire and South Cumbria NHS Foundation Trust (LSCFT) and East Lancashire Hospitals NHS Trust (ELHT) for community services in Blackburn with Darwen; and the roll out of integrated neighbourhood teams over the next two years.

2.7 As part of today's papers, there is another big decision around the place integration deal. We are presented with a major delegation programme over a two-to-three-year period, and the decision opens up the opportunity to go even further.

2.8 This moves us towards the idea of a small, slim, strategic centre with most of the action happening in place and with our providers, and most people working in the ICB at those more local levels. As the delegation programme develops,

we will need to revisit that vision of a small, slim, strategic centre and make sure that what remains at the centre of the ICB is fit for purpose.

2.9 As a board, we need to appreciate that this is a huge change for the ICB. It will be a major challenge in terms of financial delegation, and in terms of leadership and culture for our staff. The other challenge is that we have a number of services that are fragile and fragmented, with significant variation in delivery arrangements, funding levels and service standards across Lancashire and South Cumbria. This is not going to be for the faint hearted and it certainly will not be plain sailing.

2.10 The place integration deal is one of the enablers for us to achieve greater integration with our local authority partners and has the full support of our local authority chief executives, who we brought together for a half day workshop in early June to look at the proposed arrangements for place integration and the opportunities to go further and faster.

2.11 The workshop was a great opportunity to reset our intentions to integrate further and for me there are three big things to consider here.

2.12 Firstly, how we can remotely monitor patients, in ‘virtual’ beds. We have done well as a system in this, and we have plans in place for rapid expansion of our virtual wards. The important part about this is not the expansion of beds. It is how we make sure that the people in those beds are the ones that need it the most. We must carefully target patients who are at risk of going into hospital, or those that are currently in hospital with moderate health needs that could be managed at home. We also have a low technology offer across the four hospital virtual ward systems. Increasing the level of technology, for example with wearable technology, could help us to move further and faster on this too.

2.13 Secondly, the Jean Bishop Integrated Care Centre in Hull is a great model of admission avoidance, providing a central hub for NHS, social care, voluntary, fire and rescue services to work collaboratively to keep thousands of frail and elderly people fit, out of hospital and living independently at home or in their care setting.

2.14 Following an initial assessment in their own home or care setting, each patient is seen at the Jean Bishop centre by a clinician (either a GP with an extended role in frailty, a consultant community geriatrician or an advanced nurse practitioner), a physiotherapist, social worker, voluntary services worker and other specialists. There are also diagnostics facilities, which enable healthcare staff to carry out blood tests, x-rays and in the near future CT scans as required.

2.15 At the end of their visit, each patient receives their care plan, knowing they have been listened to by healthcare professionals who have the time to listen and identify what is important to each patient, and reassured their plan will be implemented and monitored.

2.16 Between April 2019 and September 2022, the Jean Bishop Integrated Care Centre contributed to a 13.6% reduction in emergency hospital attendances for patients aged over 80. Over the same period there was a 17.6% reduction in emergency department attendances for patients in care homes. Following its success, the service has now been rolled out to cover the East Riding of Yorkshire.

2.17 It is a fully integrated centre and, rightly so, has received national attention as an example of good practice, not least from the Secretary of State for Health and Social Care in his keynote speech at the NHS ConfedExpo. We are just starting to look at whether we can do something similar in our patch, and one area in particular that we are looking at is Cumbria.

2.18 The third area was the opportunity to use NHS and local authority resources better between us. We already have the Better Care Fund, so why do we not utilise that more to target the right priorities within that fund, to receive a maximum return for minimum investment? Using our shared resources as efficiently as possible gives us the opportunity to free up some of our capital spend to be used on frontline services. The possibilities are impressive, and exciting if we get this right.

3. System transformation and recovery

3.1 We are one of 14 systems in England that has confirmed that we will end the year with a budget deficit, having been one of the original five ICBs that had forecasted this outcome. We are grateful to NHS England for recognising our circumstances and the work that we have been doing, with the approval of a multi-year approach to tackling our financial deficit.

3.2 However, we know that finance is just the symptom of an underlying issue; in this case it is how we are configured and how we do things round here. As I have said before, we are in a crisis, but there are some amazing opportunities that we need to take advantage of.

3.3 If we had a blank sheet of paper, we would not plan to have seven elective care centres, six A&Es, five separate and expensive sets of support services. We would not plan to spend over £300 million on temporary staff at premium rates and spend two thirds of our money on treating illness, and one third on care and community.

3.4 The solutions are pretty obvious; we need a major clinical productivity and reconfiguration programme with single clinical networks, increasingly moving to single sites so that ultimately we have two or three elective sites. We need major non-clinical reconfiguration with a single platform for shared services and the collaboration bank.

3.5 Although the answers are obvious, they are not easy to do. Again, this links back to strong leadership and making difficult decisions. In recognition of the importance and enormity of the system recovery and transformation work,

Maggie Oldham is taking the lead on this portfolio.

3.6 To free Maggie up to focus fully on recovery and transformation, we have made some changes to the portfolios of other members of our executive team. Chief nurse, Sarah O'Brien, and medical director, David Levy, will also be freed up to support as clinical leads, which will be a vital part of the clinical productivity and reconfiguration.

3.7 Most of Maggie's functions, along with some of David's and Sarah's, will move to Craig Harris, who will be responsible for urgent and emergency care, mental health, primary care and emergency preparedness, resilience and response (EPRR). The expectation is that with these new functions, Craig will play a much bigger role in consolidating commissioning, which has been fragmented due to legacy arrangements from the eight CCGs.

3.8 We have embarked on a month of intensive work to kickstart the recovery and transformation programme and the paper in part two of the board meeting presents the results of this intense review and provides a baseline for the programme.

3.9 We also launched a second mutually agreed resignation scheme for ICB staff. Feedback from staff side representatives has identified a small number of staff that did not feel they were well enough informed of the future of the organisation to make a decision about the scheme during the first round. We are not expecting large numbers of applications and the approvals process will be carefully managed to ensure that we retain the stability of our teams.

3.10 We need to recognise that we have a very challenging agenda here, reconfiguration is not for faint hearted and will be high risk, which again links back to the need for robust leadership. That is why we need a dedicated team for this. We are going to keep this at the forefront of our decision-making; it is going to be biggest issue that dominates our agenda in the coming years.

4. Lancashire and South Cumbria Integrated Care Partnership (ICP)

4.1 The ICP continues to support the development and maturity of our place-based partnerships, which are often best placed to act on the wider determinants of health. The ICP has made good progress in building a shared purpose across the whole system; to support people to live healthier and more independent lives longer, through our Integrated Care Strategy.

4.2 We must tackle the most complicated issues affecting people's health and wellbeing together, we know that many of these problems can only be solved through better integration and working together with our communities. ICB board members endorsed the draft strategy at the 29 March meeting and can now find the full strategy document on the ICP's website.

4.3 It is intended for use by the public, partners, our places and wider organisations within the Lancashire and South Cumbria system. Both the full strategy and summary version were approved by the Lancashire and South Cumbria

Integrated Care Partnership on 17 April 2023 and can now be formally adopted by the ICB board.

4.4 The partnership itself also continues to develop, since it formed in the summer of 2022, so the Terms of Reference (ToR) have also been updated to reflect the move to a more formal and established stage in the partnership's existence. Board members are also asked to endorse the updated ToR, which can be found on the Lancashire County Council website.

5. Specialised commissioning transfer

5.1 NHS England will be delegating a major portion of specialised commissioning to ICBs from next year. The new arrangements will be set up in shadow form during 2023-24, scheduled to go live on 1 April 2024.

5.2 It has been agreed that Lancashire and South Cumbria ICB will host the North West specialist commissioning hub.

5.3 The inaugural meeting of the North West Specialised Services Committee (NWSSC) met on 1 June 2023. The purpose of this committee is to provide a forum for NHS England and the three North West ICBs (Greater Manchester, Cheshire and Merseyside and Lancashire and South Cumbria) to collaboratively make decisions on the planning and delivery of the joint specialised services, to improve health and care outcomes and reduce health inequalities. The draft ToR for the committee were received and endorsed by the board in May and the final version can now be found on the ICB website.

5.4 This joint committee will support ICBs taking on full delegated commissioning responsibility and will provide Lancashire and South Cumbria ICB a greater level of involvement in the commissioning of specialised services to better align and transform pathways of care around the needs of local populations. Future meetings will focus on the identified transformation priorities as well as the financial plan.

5.5 It is important to note here that we do not want to simply devolve the hub to the three ICBs and then do everything in the same way it had been done by NHS England. The rationale behind this transfer is to do things differently and better. One of the big opportunities will be further devolution of specialised commissioning and integration with the work of the ICBs. There will be opportunities to move work upstream and reduce the demand for specialised commissioning and this is best done at ICB level, rather than at a national level.

5.6 There are also substantial risks in making this change, looking at the transformation agenda. We must recognise that this is a significant change; funding is currently directed to specialist institutions, for example Liverpool University Hospitals NHS Foundation Trust (LUHFT) and Manchester University NHS Foundation Trust (MFT).

5.7 From 2024, funding will be population-based through ICBs. A careful balance will therefore need to be struck between progressing the transformation agenda

and transitioning safely from the current arrangements. Further work will need to take place to understand the full financial risks and opportunities.

5.8 The added complication in the North West is that we have a number of specialist institutions in Greater Manchester and Merseyside that provide services to patients well beyond the North West. That is another significant risk that we will need to keep an eye on.

6. Hewitt review: government response

6.1 Following on from the Hewitt report published in April 2023, the government provided a response to the report within their response to the House of Commons Health and Social Care Committee's report on 'Integrated care systems: autonomy and accountability'.

6.2 The response is generally supportive of Hewitt, and there is a lot of overlap between Hewitt's report and that of the Health and Social Care Committee's, with regards to ICS oversight, national targets and the role of the Care Quality Commission (CQC).

6.3 One of the areas that was perhaps not responded to as fulsomely as I might have expected was prevention. The budget for prevention is one of the things that has been left to ICB discretion. Hewitt had recommended a one per cent real terms increase annually, but this does not feel like it goes far enough.

6.4 We need to go further and invest more, whilst recognising that this will be challenging with the financial constraints within which we are working.

6.5 Prevention is a local priority, for us as an ICB and as an Integrated Care Partnership, and we are one of a small number of ICBs that commissioned Professor Sir Michael Marmot to do a report on the issue of inequalities, who called for an increase in public health funding and increased focus on prevention from the NHS.

6.6 However, not everything requires significant extra investment. One simple area is the campaign to reduce smoking. I have agreed with the chair that we will commit to the NHS Smokefree Pledge. In signing the NHS Smokefree Pledge, organisations commit to reduce the harm caused by tobacco through implementing comprehensive smokefree policies.

6.7 To support our work in this area, the ICB is working with key partners to develop a refreshed Tobacco Free strategy for Lancashire and South Cumbria which will be presented to the board during the autumn.

6.8 The pledge document will be signed by the chair, chief executive and medical director of the ICB.

7. New Hospitals Programme

7.1 At the end of May, there was a national funding announcement which confirmed that Lancashire and South Cumbria will receive funding for two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary.

7.2 We are in the second tranche of funding, which on the face of it seems like a delay from 2030 to 2035. However, if we are realistic about the delivery, this involves two huge and complex projects, and there will be a lot of groundwork to complete between now and then, which we would have been unlikely to achieve within six or seven years.

7.3 The timescales will allow the necessary time for securing the land, getting the consent, carrying out a comprehensive consultation and engagement process with our staff, patients and communities, undertaking significant enabling works, working closely with local authority partners, as well as undertaking the construction of the project. This is a huge project that will take eight to ten years from start to finish. There is a long way to go; the critical issue is to secure the land. We are not in a position to be able to discuss sites as that is commercially sensitive, but we do need to secure the land as a priority.

7.4 We have also had confirmation of the budget envelopes, and that both hospitals will be new builds. This is significant as it really does allow us to build hospitals of the future, which will be premised on transforming our community services to result in a community centric health and care system, rather than being set up purely to tackle illness.

7.5 Our prime objective is that most people get care living independently at home and only go into hospital when they really have to. One of the differences we might therefore expect to see would be fewer beds.

8. NHS Parliamentary Awards

8.1 We have been shortlisted for three NHS Parliamentary Awards; improving the care and detection of oesophageal cancer in patients with Barrett's oesophagus (cytoprime); Lancashire and South Cumbria Reproductive Trauma Service (our maternal mental health service) and tackling COVID-19 vaccination hesitancy and health inequalities in underserved and seldomly heard communities. The awards ceremony take place on the same day as board, Wednesday 5 July.

8.2 The recognition that we received from 11 MPs across our patch helps to highlight the work of our staff and partners and shows appreciation from our MPs for a number of projects that are making a difference to the lives of our communities. Being nominated for awards such as these helps to demonstrate the impact that colleagues working in the ICB have for our patients and communities on a daily basis and I am keen to see more recognition for our organisation as we develop.

9. Recommendations

9.1 The Lancashire and South Cumbria Integrated Care Board is requested to note the updates provided.

Kevin Lavery

26 June 2023

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 | **Item** | **110**

13 September 2023 | **Purpose** | Information / Assurance / Approval

Title	Corporate Risk Register Report
Report Author	Mr J Houlihan, Assistant Director of Health, Safety and Risk
Executive sponsor	Mr J Husain, Executive Medical Director

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

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

Report linkages

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

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptors on Board Assurance Framework. 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. 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. 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. 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.
Related to recommendations from audit reports	Mersey Internal Audit Agency (MIAA) Risk Management Audit Report 2022-23
Related to Key Delivery Programmes	Clinical Strategy, Quality Strategy, People Strategy, Corporate Governance Model and Trust Wide Quality Improvement Programmes.
Related to ICB Strategic Objective	1. Improve quality, safety, clinical outcomes and patient experience. 2. To equalise opportunities and clinical outcomes across the area. 3. Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees. 4. Meet financial targets and deliver improved productivity. 5. Meet national and locally determined performance standards and targets. 6. To develop and implement ambitious, deliverable strategies.

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by:

Executive Summary

1. A summary of key points to note.
   a) 18 risks are currently held on the corporate risk register. 5 are new risks, 13 risks have no movement or change in risk scores. 6 risks have been removed.
   b) Numbers of open risks held continue to reduce from 1,709 risks in Q4 2021-22 to 833 in Q2 2023-24 to date, a reduction of 69%.
   c) The profiling and mapping of strategic and operational risks in line with organisational strategy, objectives, targets and of strengthening links with the board assurance framework is now complete.

Risk management and the impact of taking / not taking action

2. Risk management is the process of identifying, assessing, managing, controlling and reviewing risks in order to minimise harm, improve safety and performance.
3. It is a health and safety legislative requirement and key line of enquiry of inspection used by regulatory bodies e.g. the Care Quality Commission (CQC) etc. when monitoring healthcare service provision.
4. The benefits of good risk management are that it;
   a) Minimises loss.
   b) Enhances decision making.
   c) Improves organisational resilience.
   d) Supports legislative and regulatory compliance and license to operate requirements.
   e) Enhances stakeholder confidence.
   f) Facilitates strategic and operational planning.
   g) Improves organisational efficiency.
   h) Promotes innovation.
   i) Reduces financial, legal and insurance costs.
   j) Improves credibility, reputation and commercial viability.

Corporate Risk Register (CRR) Performance Activity

5. A summary of key points to note.
   a) 18 risks are currently held on the CRR. 5 are new risks, 13 risks have no movement or change in risk scores. 6 risks have been removed. A more detailed summary and breakdown is included within the appendices.

Risk Management Performance Activity (Trust Wide)

6. Work remains ongoing to avoid duplication, improve standardisation and the quantity and quality of risks held on the risk register. A summary of key points to note.
   a) Numbers of open risks held on the risk register are down from 1,709 risks in Q4 2021-22 to 833 in Q2 2023-24 to date, a decrease of 69%.
   b) Risks identified as being significant or moderate are down from 1,386 risks in Q4 2021-22 to 718 in Q2 2023-24 to date, a 62% decrease.
   c) Risks remaining open over 3 years old are down from 1,035 risks in Q4 2021-22 to 543 in Q2 2023-24 to date, a 62% decrease.
   d) Overdue risks are down from 230 in Q4 2021-22 to 99 in Q2 2023-24 to date, an 80% decrease.
   e) Tolerated risks surpassing their review date continue to remain well below 5%.
   f) Clinical risks (62%) remain the highest risk type category followed by health and safety risks (20%).
   g) A breakdown of clinical risks shows the highest risk sub types relate to patient safety (33%) followed by medical devices (15%).
   h) A breakdown of health and safety risks shows the highest risk sub types relate to manual handling (31%) followed by radiation risks (16%).
   i) Highest numbers of open risks on the risk register are held within Diagnostic and Clinical Services (DCS) (29%).

Mitigations for risks and timelines

7. A summary of recent mitigations for risks and timelines to note.
   a) The profiling and mapping of strategic and operational risks before end Q2 2023-24 has been completed.
   b) The development and roll out of a new proforma for risks held on the CRR and for use within reports that strengthen links to the board assurance framework, improve the quality and management of risks, in particular, actions required to mitigate the risk before end Q2 2023-24 has been completed. The introduction of CERNER has delayed implementation. Expectations have been communicated to risk handlers regarding their use within the next reporting period.

c) The development of risk management key performance indicators (KPI) against CQC key lines of enquiry (KLOE) for use within the Quality Strategy Priorities Metrics before end Q2 2023-24 period has been completed.

d) The profiling, mapping and transfer of risks on the risk register to lead specialisms and or subject matter experts within their own areas of responsibility and control before end Q2 2023-24. This action remains on course for completion within the target date.

e) Work to address a steady rise in risks held across divisions scoring 15+ not on the CRR remain a key area of focus. A number of wide ranging measures have been put in place to help address growing concerns and drive improvement. These include increased awareness of the risk management framework and process of escalation, improved scrutiny of risk controls and assurances including validity of risk scores, more detailed assurance within divisional reporting at the Risk Assurance Meeting (RAM), specific inclusion of KPI as part of the Quality Strategy Priorities Metrics and increased scrutiny and review of performance by the Executive Risk Assurance Group (ERAG). In addition, work is being undertaken to help address increasing challenges of risk handlers or leads being unable to present risks at RAM due to conflicting clinical priorities or urgent work activity.

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

8. Effective leaders and managers should know the risks its organisation faces, prioritise them in order of importance and take action to control them.

9. The profiling and mapping of strategic and operational risks and its link to the board assurance framework remains crucial to its success and will help strengthen corporate governance arrangements in seeking quality assurances of the robustness of management systems and processes, ensure consistency in approach as to how risks are being suitably managed, by whom and where and help prevent the risk register from being inappropriately used.

10. Open risks on the risk register are expected to significantly decrease across divisions as more focused attention is given to the better utilisation of lead specialists and or subject matter experts regarding the management of risks within their own areas of responsibility and control, leaving clinical services to focus more on their operational risks.

Resource implications and how they will be met

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

Benchmarking Intelligence

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

Conclusion of Report

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

Recommendations

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

Next Actions

15. A summary of key focused activity.

a) The continuation of reaffirming the risk management framework and process of escalation to all risk handlers and or leads.

b) The continuation of improvement works to avoid unnecessary duplication, improve standardisation and the quantity and quality of risks held on the risk register.

c) The revisiting of all open risks whereby current risk scores continue to meet target scores.

d) The profiling, mapping and standardisation of workforce staffing risks in line with the NHS workforce plan and people strategy.

e) The profiling, mapping and standardisation of clinical management risks associated with discharge, delayed transfers, missed diagnosis and sub-optimal care in line with clinical best practice, professional and regulatory bodies, NHS organisations and NICE guidance.

f) The targeted review of risk profiles across estates and facilities, radiology and security management services.

g) Supporting services in addressing the 542 foreseeable risks due for review over the next three months.

h) The submission of a formal training evaluation report for approval at the Health and Safety Committee and escalation outlining the identification, review and or development of health and safety training needs, including risk management and risk assessment, training plans, resources and roll out required for delivery and of monitoring competencies and training compliance of staff.

i) The review and implementation of actions from the updated Mersey Internal Audit Agency (MIAA) Risk Management Audit.

j) The profiling, mapping and integration of risks held within PWE Healthcare.

k) Assimilation of new risk approval statuses, risk type and sub type categories both within DATIX and in preparation of migration to RADAR.

l) The removal of the risk sub type category of ‘other’ which does not add any value to the risk identification or assessment process. This will be remedied as part of risk profiling and mapping and upon the introduction of RADAR.

m) To review and simplify the risk management framework and its integration within the health and safety strategy.

How the decision will be communicated internally and externally

16. Decisions regarding the review and approval of risks and the validity of risk scores are made via Divisional Quality and Safety Board meetings, at Committees and or Groups and escalated through the approved governance framework.

How progress will be monitored

17. Progress in monitoring the quality and integrity of risks held on the risk register, in particular, those with a current risk score of 15+, is undertaken at monthly Risk Assurance Meeting (RAM) and Executive Risk Assurance Group (ERAG) meetings.
18. A senior executive lead is nominated by the ERAG to monitor and review risks scoring 15+ that have been approved onto the CRR and ensure they are being managed and mitigated in accordance with the risk management framework.

Appendices

Summary of the CRR

Risks removed from the CRR

Detailed CRR

Mr J Houlihan, Assistant Director of Health, Safety and Risk, 24 August 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	Inadequate	⇧
2	9570	Family Care	No capacity for the storage of legacy ECHO images	20	Inadequate	⇧
3	9557	Trust Wide	Patient, staff and reputational harm as a result of the Trust not being registered for mental health provision	20	Limited	⇔
4	9336	MEC	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery	20	Limited	⇔
5	8061	Trust Wide	Management of Holding List	20	Limited	⇔
6	9705	SAS	Inability to provide a robust hepatobiliary (HPB) on call service	16	Limited	⇧
7	9367	Family Care	ECHO Images Transfer	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	8725	CIC	Lack of senior clinical decision making and inconsistent medical cover	15	Inadequate	⇧
14	8808	Corporate	BGTH - breaches to fire stopping and compartmentalisation in walls and fire door surrounds	15	Adequate	⇔
15	7764	Corporate	RBTH - breaches to fire stopping and compartmentalisation in walls and fire door surrounds	15	Adequate	⇔
16	7008	Trust Wide	Failure to comply with 62 day cancer waiting time target	15	Limited	⇔
17	5791	Corporate	Failure to recruit and retain to substantive nursing and midwifery posts	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

No	ID	Where is the risk being managed	Title	Risk Score (current)	Effectiveness of Controls (taken from Datix)	Changes since last report
1	9296	DCS	Unable to provide routine / urgent test for biochemistry requests	12	Limited	⇩
2	9222	Trust Wide	Failure to implement NHS Green Plan	12	Limited	⇩
3	8257	DCS	Loss of Transfusion Service	10	Limited	⇩
4	8126	Corporate	Risk of compromising patient care due to lack of an advance Electronic Patient Record system	8	Adequate	⇩
5	9439	Trust Wide	Failure to meet internal and external financial targets for the 2022-23 financial year	5	Adequate	⇩
6	8960	Family Care	Risk of undetected foetal growth restriction, 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**	⇧
Description		Failure to meet the Trusts financial plan and obligations together with the failure to meet the wider Lancashire and South Cumbria ICB system financial plan. Failure to meet the plan and obligations is likely to lead to the imposition of special measures and limit the ability of the Trust to invest in the services that it provides. The financial risk is made up of: 1. 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. 2. A 7.4% efficiency target of £54.6million for the Trust, a level that has never been achieved previously. 3. A system financial gap of £12m within ELHTs financial plan that is within the 7.4% 4. A system financial deficit that still needs closing. 5. Unknown additional consequences of the impact of the electronic patient record system, extent of inflation rates, pay awards and industrial action.	**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 assurances** 1. Poor monitoring of the system risk. 2. Lack of understanding of the full system risks 3. Lack of airtime for discussion of the full system financial risk		
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				
Update since the last report		**Update 17/08/2023** **New Risk** At M4 the Trust is reporting a £16.4m deficit against a plan of £10.8m, £5.5m (movement of £1.9m) off plan. The variance to plan is due to unidentified WRP and additional staffing costs related to industrial action. An additional £0.4m WRP has been identified, equating to £39m. Whilst there is a healthy cash balance at present this may present more of a risk in the future. **Next Review Date 15/09/2023**	**Date last reviewed**	**17/08/2023**		
			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	9570	No capacity for the storage of legacy ECHO images				
Lead		Risk Lead: Helen Campbell Exec Lead: Peter Murphy	**Current score**	**20**	**Score Movement**	⇧
Description		The current ultrasound machines within Chronic Obstructive Pulmonary Disease (COPD) and Neonatal Intensive Care Unit (NICU) services have no storage options for ultrasound images and are currently stored on scanning machines with limited memory. Once storage reaches capacity ECHO machines will stop functioning and images will be lost if images cannot be offloaded. This is crucial in diagnosing lifesaving cardiac abnormalities and pulmonary pathologies.	**Gaps and potential actions to further mitigate risk**		**Gaps / weaknesses in controls** 1. Scanning machines have limited memory. 2. Cost implications for software storage solution. 3. Staff training in use of the system. 4. Benchmarking of compliance against Royal College of Radiologists Standards for the provision of ultrasound service. **Gaps / weaknesses in assurances** 1. Unwell cardiac children and neonates may not have appropriate investigation to aid diagnosis and management.
Controls and Assurances in place		Controls 1. The current ultrasound images are stored on scanning machines with limited capacity. No other effective controls in place to mitigate risk. Assurances 1. Work underway with McKesson software for storage of images which is not adding to current storage capacity.				
Update since the last report		**New Risk LINK TO DATIX ID 9367** **Update 17/08/2023** IT solution (Medi-Connect) is currently being explored to resolve this issue leading to risk being suitably mitigated and potential reduction in risk scoring. **Next Review Date 15/09/2023**	**Date last reviewed**	**17/08/2023**		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					20		
			8-week score projection	**20**			
			Current issues	System wide external influences			

No	ID	Title
3	9557	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.

Controls and Assurances in place

Controls

1. Pathway for the management of mental health patients is within the Emergency Department (ED).
2. A functioning Mental Health Unit Assessment Centre (MHUAC) is in place.
3. Mental Health Liaison Nurse support based within the Emergency Department (ED).
4. Enhanced care assessments undertaken.
5. Protocols in place for more challenging patients.
6. Assessments for the management of ligature risks completed by services in high risk areas.
7. Wellbeing support mechanisms in place for staff.
8. In-house transfer of security management services to within ELHT and recruitment of a security manager completed.
9. Training of security management staff completed end Jun-23.
10. Security staff on site to support clinical management of higher risk patients.
11. A more robust process is in place for the reporting of incidents involving control and restraint of patients.

Assurances

1. Care Quality Commission (CQC) and Integrated Care Board (ICB) supporting ELHT regarding registration for the provision and treatment under the MHA.
2. Safeguarding Team available for advice regarding the management of at risk patients.
3. Collaborative working arrangements in place between ELHT and Lancashire and South Cumbria NHS Foundation Trust (LSCFT).
4. Gold calls escalate cases of concern at system level.
5. Monitoring and review of environmental incidents including self-harm being undertaken by the health and safety team.
6. Visibility of inquest closure forms within Quality Strategy KPI Metrics Pack for senior management overview.
7. The staff safety group oversees the management of violence and aggression to staff.

Gaps and potential actions to further mitigate risk

Gaps / weaknesses in controls

1. ELHT require suitable resources, estates and building infrastructure and capital funding to be able to fully and safely enable detention of patients under the MHA.
2. A more formal service level agreement is required between ELHT and LSCFT that details staff support mechanisms, escalation pathways, management of psychiatric medications, mental health care plan documentation and training.
3. Training of medical staff and supervision required to effectively utilise 5.2 of the MHA.
4. Significant and ongoing training required for clinical and identified non-clinical staff in de-escalation / control and restraint techniques, dementia and mental health awareness, drug and alcohol dependency etc. to develop workforce competence and confidence.
5. Assessments regarding the management of ligatures only completed within high risk clinical areas.
6. Additional resource may be required to administer and oversee implementation of the MHA in line with Approved Codes of Practice.
7. A matron post specifically for mental health awaiting approval and recruitment.
8. System wide review of governance systems and processes regarding patient self-harm and absconds require review.

Gaps / weaknesses in assurances

1. Awaiting review of registration by the CQC.
2. A staff safety dashboard is currently in its primary stages of development.
3. Increasing numbers of inquests containing issues of relevance to this risk, with inquest closure forms retrospective.
4. Mental Health Liaison Nurse support to wider clinical areas remains unclear.
5. A review of clinical and non-clinical related policies and procedures is required to ensure they remain robust.

Update since the last report

Update 28/07/2023
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 29/08/2023

Date last reviewed	28/07/2023			
Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	20	20		
8-week score projection	20			
Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

No	ID	Title
4	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: Jawad Husain	Current score	20	Score Movement	⇔

Description

A lack of capacity is leading to extreme pressure resulting in delayed delivery of optimal standard of care. At times of extreme pressure, increasing patient numbers across the emergency pathway makes the provision of care difficult, impacts on clinical flow, increases the risk of nosocomial infection spread as a result of overcrowding and poor patient experience leading to complaints.

Staffing requirements are not calculated as standard to be able to care for increased patient numbers and complexity, with inadequate capacity within specialist areas such as cardiology, stroke etc. to ensure adequate clinical flow and optimum care.

Controls and Assurances in place

Controls

1. Robust ambulance handover and triage escalation processes to reduce delays.
2. Operational Pressure Escalation Levels (OPEL) triggers and actions completed for ED and Acute Medical Units (AMU).
3. Established 111 / GP direct bookings to Urgent Care Centre (UCC).
4. 111 pathways from GP / North West Ambulance Service (NWAS) directly to Ambulatory Emergency Care Unit (AECU).
5. Pathways in place from NWAS to Surgical Ambulatory Emergency Care Unit (SAECU), Children's Observation and Assessment Unit (COAU), Mental Health, Gynaecology and Obstetrics and the Community.
6. ED streamer tool in place to redirect patients to an appointment or alternative service where required.
7. Daily staff capacity assessments completed and staff flexed as required.
8. Divisional Flow Facilitators established across all divisions to assist with clear escalation and 'pull through'.
9. Escalation pathway and use of trolleys in place for extreme pressures.
10. Zoning of departments to enable better and clearer oversight, staffing and ownership and isolation of infected patients, in particular, those with influenza and risks of cross contamination.
11. Corridor care standard operating procedure embedded.
12. Workforce redesign aligned to demands in ED.
13. Safe Care Tool designed for ED.
14. Full recruitment of established consultants.
15. Matrons undergone coaching and development on board rounds.
16. Reduced thresholds within critical care to support patient admissions.
17. Patient champions in post to support patients on corridors and volunteers utilised to support with non-clinical tasks.

Assurances

1. Support provided by IHSS Ltd. in regularly reviewing admission avoidance.
2. Gold command in place to provide support.
3. Bed meetings held x4 daily with Divisional Flow Facilitators.
4. Hourly rounding by nursing staff embedded in ED.
5. Daily consultant ward rounds done at cubicles so review of care plans are undertaken.

Gaps and Potential actions to further mitigate risk

Gaps / weaknesses in controls and assurances

1. Ambulance handover and triage escalation processes only effective if patients are transferred elsewhere and interventions are carried out.
2. OPEL triggers consistently remain at Level 4 with no escalation strategy should triggers be continuously met.
3. Clinical pathways are not being effectively utilised.
4. Patients not always keen to follow 111 / GP direct booking pathways to UCC.
5. Daily staff assessments are completed but there is still not enough staff to send support.
6. Limitations of 'pull through' and what can be achieved are due to challenges regarding patient discharge.
7. Extreme escalation highly dependent on flow. It does not always decrease pressures due to same sex / side room requirements.
8. Zoning of departments is only effective where severe overcrowding does not take place.
9. The corridor care standard operating procedure, hourly rounding by nursing staff and processes across acute and emergency medicine cannot be safely followed at times of severe overcrowding.
10. Workforce redesign undertaken twice yearly and despite a clear recruitment strategy and positive campaign, gaps in vacancies continue to remain high locally and nationally.
11. Safe Care Tool is completed twice yearly and has highlighted gaps between need and decision making.
12. Departmental board and walk rounds can take several hours due to severe overcrowding.
13. Reduced thresholds for support result in pushback from clinical areas vs a pull model.
14. Delays in the HR onboarding process is resulting in slow recruitment of volunteers and not enough to support demand.
15. Bed meeting actions can be person dependent e.g. consultants to discharge patients etc.
16. Further in reach to department support does not always occur due to staffing levels and space constraints, creating further delays.
17. Staff are not always available to redeploy to support at times of increased pressure.
18. Compliance with UK guidance for isolation of infectious patients creates further risks e.g. availability of side rooms etc.
19. Not all patients or staff follow infection prevention control policy requirements.
20. Not enough side rooms to support clinical requirements, in particular, patients identified as being not for corridor when severely overcrowded.
21. Reports not always accessed and meetings can be stood down due to operational pressures meaning data is not always enacted upon.
22. Added demand 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.

	6. Daily 'every day matters' meetings held with Head of Clinical Flow and Patient Flow Facilitators. 7. Daily visit by Infection Control Nurse to ED with patients identified as being not for corridor. 8. Increased bed capacity within cardiology**.** 9. High observation beds in place on AMU to support patients who require high levels of care. 10. Further in reach to departments in place to help decrease admissions. 11. Discussions ongoing with commissioners in providing health economy solutions via A&E delivery board. 12. Continuous review of processes across Acute and Emergency medicine in line with incidents and coronial process.		24. A patient experience strategy is in place to support patients within ED but is heavily reliant on demand vs capacity so complaints continue to increase yearly despite interventions being put in place. 25. Friends and family results highlighting increasing concerns of waiting times. 26. System partners ability to flex and meet demands of local health population compounded with offer of mutual aid, with support with hospital diverts increasing risk.
Update since the last report	**Update 03/08/2023.** 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 04/09/2023**	**Date last reviewed**	**03/08/2023**
		Risk by quarter 2023-24	**Q1**: 20 / **Q2**: 20 / **Q3**: / **Q4**:
		8 week score projection	**20**
		Current Issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title
5	8061	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**	**Gaps / weaknesses in controls** 1. Holding list remains high due to backlog from COVID-19. 2. General lack of capacity across specialties impacting on reducing holding list numbers. 3. Not all staff are following standard operating procedures for RAG rating of patients, leaving some patients without a rating. **Gaps / weaknesses in assurances** 1. Automated reporting system in development that will ensure oversight of risk stratified lists by specialty. 2. Current level of patients without a RAG rating classed as uncoded and unknown. 3. Patient appointments not RAG rated will drop onto the holding list if appointments are cancelled. 4. Patients added onto the holding list from other sources such as theatres, wards etc will not have a RAG identified.
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 made to all Directorates that all patients on holding list are initially assessed for potential harm due to delays being seen, with suitable RAG ratings applied to these patients. 5. Specialties continue to review patients waiting over 6 months and those rated as red to ensure they are prioritised. 6. Audit outcomes highlighted no patient harm due to delays. 7. Meetings held with Directorate Managers from all Divisions to understand position of all holding lists. 8. Individual specialities undertaking own review of the holding list to identify if patients can be managed in alternative ways. 9. Updates provided weekly to Executive Team. .		
Update since the last report	**Update 02/08/2023** Risk reviewed. No change in risk score. Delays incurred to backlog figures due to CERNER implementation. **Next Review Date 01/09//2023**	**Date last reviewed**	**02/08/2023**
		Risk by quarter 2023-24	Q1: 20 | Q2: 20 | Q3: | Q4:
		8 week score projection	**20**
		Current issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title				
6	9705	**Inability to provide a robust hepatobiliary and pancreatic (HPB) on call service**				
Lead		Risk Lead: Susan Anderson Exec Lead: Jawad Husain	**Current score**	**16**	**Score Movement**	⇧
Description		Inability to provide a tertiary HPB on call service in and out of hours to inpatients from other hospitals including the major trauma centre in a timely manner. This may result in a deleterious effect on the standard and timeliness of care and clinical outcomes, particularly in an emergency situation. The inability to provide HPB care in line with specialist commissioning guidance may result in ELHT losing the service resulting in financial and reputational impact.	**Gaps and potential actions to further mitigate risk**		**Gaps / weaknesses in controls** 1. HPB consultants form part of general surgery rota expected to cover Lancashire Teaching Hospital Trust (LTHT) out of hours. 2. Additional activity not provided within job design or plans leading to gaps. 3. Not enough surgeons willing to volunteer to cover the HPB on call rota. 4. Clashes with other clinical commitments e.g. elective surgery, CAT 1 cases etc. 5. Incorrect transfers / admissions from other NHS organisations to the wrong specialities may delay assessment and treatment. 6. Routine cancer surgery cancellations if HPB on call service requires surgeons in the night. 7. Additional travel costs and time impacting on emergency theatre at ELHT should HPB on call be required to attend LTHT. 8. Potential impact on compliance with National Confidential Enquiry into Patient Outcomes (NCEPOD) Guidance 9. High frequency of on call rota leading to stress, burn out and fatigue as two different rotas may need to be covered. This may further impact clinical decision making at periods of high intensity and demand and conflicting emergency priorities. **Gaps / weaknesses in assurances** 1. Micro management of HPB rota dependent on goodwill of surgeons leading to potential gaps in HPB on call service provision. 2. Awareness of incidents and reporting may not take place if there is no suitable cover. 3. Lack of consultation and involvement does not always take place within Directorate.
r		Controls 1. HPB consultants providing an on call HPB service in addition to general surgical commitments. 2. Process in place regarding acceptance of HPB patients from other NHS organisations. 3. Rota plan ensures HPB surgeons covering on call are not listed for elective activity the following day. Assurances 1. Micro management of the HPB rota. 2. Monitoring of incidents. 3. Regular meetings and discussions held at Directorate and Divisional level.				
Update since the last report		**New Risk** **Update 01/08/2023** Agency / locum consultants are currently being used to backfill increasing gaps in on call HPB rota. **Next Review Date 01/09/2023**	**Date last reviewed**		**01/08/2023**	
			Risk by quarter 2023-24		Q1	Q2: 16	Q3	Q4
			8-week score projection		**16**			
			Current issues		System wide external influences			

No	ID	Title				
7	9367	ECHO images transfer				
Lead		Risk Lead: Savi Sivashankar Exec Lead: Peter Murphy	**Current score**	**20**	**Score Movement**	
Description		Babies on NICU and within children's outpatient clinic get ECHO images completed for various cardiac concerns and is undertaken by neonatologists trained in ECHO on NICU and OPD. Sometimes, neonatal consultants need expert advice from the Alder Hey Children's Hospital Cardiology Team regarding ECHO findings which requires the transfer of ECHO images in providing clinical opinion. Whilst this provides a safety net for the neonatal team the transfer of ECHO images is challenging and made difficult due to capacity issues regarding storage and the subsequent transfer at PACS end. The lack of adequate storage availability increases the risk of missed diagnosis from the ECHO machine becoming non-functional.	**Gaps and potential actions to further mitigate risk**		**Gaps / weaknesses in controls** 1. Scanning machines have limited memory. 2. Cost implications for software storage solution. 3. Staff training in use of the system. 4. Benchmarking of compliance against Royal College of Radiologists Standards for the provision of ultrasound service. 5. Development of VPN not fully embedded as a process. **Gaps / weaknesses in assurances** 1. Unwell cardiac children and neonates may not have appropriate investigation to aid diagnosis and management. 2. Incidents regarding echo image transfer, delays in diagnosis, discharge without tertiary review of scan and clear management plan and of machine malfunction. 3. Transfer images to desktop and screen sharing through MS Teams ineffective as there is a reliance on the availability of consultants attendance from Alder Hey Children's Hospital.	
Controls and Assurances in place		Controls 1. The current ultrasound images are stored on scanning machines with limited capacity. No other effective controls in place to mitigate risk. The only option is to transfer babies, even if they are sick, to Alder Hey Children's Hospital for review. 2. Development of Virtual Private Network (VPN) tunnel to Alder Hey Children's Hospital currently under trial. Assurances 1. Work underway with McKesson software for storage of images which is not adding to current storage capacity. 2. Transfer of images to desktop and screen sharing through MS Teams meetings.					
Update since the last report		**New Risk LINK TO DATIX ID 9570** **Update 10/08/2023** IT solution (Medi-Connect) is currently being explored to resolve this issue leading to risk being suitably mitigated and potential reduction in risk scoring. **Next Review Date 10/09/2023**	**Date last reviewed**	**10/08/2023**		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					20		
			8-week score projection	**20**			
			Current issues	System wide external influences			

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**	**Gaps / weaknesses in controls** 1. A WTE histopathologist has been recruited awaiting commencement of employment. 2. Lack of equipment being partially addressed by capital funding. **Gaps / weaknesses in assurances** 1. Some breaches in compliance fall outside the control of ELHT e.g. patients breaching targets due to complexities in pathways, comorbidities or patient choice.
Controls and Assurances in place	Controls 1. A 5 year workforce plan in place to support recruitment and retention. 2. Successful recruitment of laboratory staff consisting of 1 x WTE Senior BMS, 3 x WTE BMS, 2 x WTE MLA's 3. Performance manager in post since Jun-23 whose role is to ensure right cases go to laboratory services at the right time and to work closely with cancer services. 4. Sample tracking software now installed. 5. New external reporting supplier in use (DIAGNEXIA) offering quicker TAT and use of digital images preventing slides being sent off site. 6. Triaging of cases by consultants to maximise resources based on clinical urgency. 7. Escalation process for priority cases is well established. Assurances 1. Monitoring at Directorate and Departmental meetings. 2. Monthly monitoring of TAT against targets. 3. Increased focus on backlog reduction to support performance recovery showing signs of improvement. 4. Attendance at weekly cancer performance meetings. 5. Collaborative working established with Lancashire and South Cumbria Foundation Trust (LSCFT) to implement digital pathology to aid recruitment and retention. 6. Multiple external reporting services being used to help mitigate the risk. 7. Annual assessment of pathology performance undertaken by the UK Accreditation Service (UKAS), the accrediting body.		
Update since the last report	**Update 28/07/2023** Potential for review of risk score to reflect additional recruitment and additional controls. **Next Review Date 28/08/2023**	**Date last reviewed**	**28/07/2023**
		Risk by quarter 2023-24	Q1: **16** | Q2: **16** | Q3: | Q4:
		8 week score projection	**12**
		Current issues	External influences regarding mitigation of risk beyond the control of the Trust. 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**	**Gaps / weaknesses in controls** 1. Non adherence to policy and procedural controls. 2. Inconsistent, inaccurate assessments and recording of malnutrition risk. 3. Lack of appropriate use of safeguarding processes. 4. Limited capacity of speech and language therapists, dietetics, endoscopy and nursing, including bank and agency, delaying assessments and impacting on feeding routes. 5. Limited capacity of nutrition support team undertaking ward rounds. 6. Lack of available housekeepers at weekends. 7. Training gap regarding nutrition and hydration training identified within doctors curriculum. 8. No process in place for the recording and review of non-mandatory training compliance. **Gaps / weaknesses in assurances** 1. Staff knowledge and confidence questionable in use of safeguarding processes in these cases. 2. No review of nutrition and hydration at ward rounds or timely best interest decisions. 3. Not all patients are weighed, with an over reliance on estimation of weight, not actual. 4. Recording of information in multiple places. 5. Current electronic 'MUST' toolkit insufficiently used to gather compliance reports and prevents healthcare assistants inputting weights. 6. Access to the nutrition support team is limited and instigated by dieticians and nutrition nurses rather than referral from ward. 7. Insufficient information provided in referrals to dieticians and speech and language therapists. 8. Timely review of blood results relating to parenteral feeding. 9. No medical representation at the Nutrition and Hydration Steering Group.
Controls and Assurances in place	Controls 1. Regulatory requirements and guidance written into nutrition and hydration provision to inpatients, parental nutrition, enteral feeding, refeeding, mental capacity and safeguarding adults policies and procedures. 2. Standard operating procedures and tools in place i.e. ward swallow screen, electronic malnutrition screening tool, food record charts and fluid balance, nasogastric tube care bundle, food for fingers and snack menus and nutrition and hydration prompts on ward round sheets. 3. Inclusion within Nursing Assessment and Performance Framework (NAPF) and ward managers audits 4. Training provided to staff that includes malnutrition screening, nasogastric tube replacement, nasogastric x-ray interpretation and nasogastric bridle, mouthcare, malnutrition identification and management, fluid balance, Percutaneous Endoscopic Gastronomy (PEG) management and food hygiene. Assurances 1. Nutrition and hydration prompt on ward round sheets 2. Inclusion within ward manager audits. 3. Monitoring of incidents and levels of harm, complaints, patient experience outcomes etc. as part of divisional reports. 4. Outcome results form part of the work plan of the Nutrition and Hydration Steering Group. 5. Inclusion via Nursing Assessment and Performance Framework (NAPF).		
Update since the last report	**Update 14/08/2023** Risk reviewed. No change in risk score. Additional nutritional nurse now in post and internal recruitment of pharmacist, speech and language therapist and dietician is awaiting backfill. The plan for medical and surgical input remains ongoing. Expectation that by end Q3 nutrition support team will be receiving referrals via CERNER and to conduct regular ward rounds. As a result score expected to reduce **Next Review Date 14/09/2023**	**Date last reviewed**	**14/08/2023**

Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	16	16		

8 week score projection	**12**
Current issues	Recovery and restoration pressures, recruitment and retention

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**	**Gaps / weaknesses in controls** 1. Impact of the new Patient Safety Incident Response Framework on RIDDOR reporting timescales. 2. Improvements in compliance heavily reliant on major changes to the incident management and triage processes and limited capacity and resource within the health and safety team. 3. Investigations to determine RIDDOR reportable incidents highlighting gaps in quality management systems or processes and of policy and or procedural controls not being followed by managers or staff. 4. 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. **Gaps / weaknesses in assurance** 1. Increase in numbers of RIDDOR reportable incidents when comparing previous Q1 and Q2 year periods. 2. Threshold target of achieving 95% compliance remains very challenging and is heavily reliant on one person. 3. The health and safety team currently review and investigate c.30% of all incidents reportable in DATIX which is not sustainable. 4. There is no standardised quality management system for capturing total numbers of days lost off work as a result of a workplace accident or injury. 5. No evidence of assurance return to work processes are being completed by managers or reviewed. 6. RIDDOR performance increasing attracting the interest of the HSE and CQC.
Controls and Assurances in place	Controls 1. RIDDOR reporting requirements contained within scope of incident management policy and procedures. 2. Improved data capture and utilisation of incident management module of DATIX. 3. Centralised process firmly established for the health and safety team to review and submit RIDDOR reportable incidents externally to the HSE. 4. 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. 5. 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 etc. with further ad hoc training across divisional groups available, where necessary. 6. Increased senior management awareness of RIDDOR to help drive and reinforce the importance of ensuring legislative compliance. Assurances 1. Specialist advice, support and guidance readily available from the Health and Safety Team. 2. 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. 3. Thematic review of RIDDOR performance against legislative requirements included as a standalone agenda item of the Health and Safety Committee, with escalation by exception. 4. Occupational disease more explicitly included within performance reports. 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. RIDDOR performance now included as part of Quality and Safety KPI performance for senior management review. 7. Continuous reduction in numbers of RIDDOR reportable incidents following investigation from 54 in 2020-21, 45 in 2021-22 to 38 in 2022-23.		
Update since the last report	**Update 16/08/2023** Risk reviewed. No change in risk scoring. Improvements remain heavily reliant on major review of the incident management system and processes of investigation, the triaging of incidents to improve quality and avoid multiple review and capacity and resources within the health and safety team. **Next Review Date 15/09/2023**	**Date last reviewed**	**16/08/2023**

Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	16	16		
8 week score projection	16			
Current issues	Capacity and workforce pressures			

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 unbooked new patients and a very large holding list of overdue patients. In some cases, there is significant delay and therefore a risk to patients. Demand far outweighs capacity, and this has been exacerbated since the COVID-19 pandemic. All patients are risk stratified (red, amber, green) but still cannot be seen within timescales with additional risk that amber patients could be become red over time etc.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Funding and insufficient staff numbers, competencies and skills mix to provide capacity. 2. Limited estates capacity and outpatient space to provide required clinics. 3. Limited opportunity to flex theatre to outpatient departments and vice versa. 4. Use of locums to support capacity sessions no longer in place due to lack of available space, gaps in competency, expertise and skills and challenges in practice regarding discharge, adding to holding list concerns. **Gaps / weakness in assurance** 1. Getting It Right First Time (GIRFT) report not yet created for patient waiting times above 25% within recommended timescales for review.
Controls and Assurances in place	Controls 1. An integrated eye care service is in place for specific pathways to help steer patients away from out of hospital eye care services. 2. New glaucoma virtual monitoring service in place to manage reviews and support the service. 3. Use of capacify sessions where doctors are willing and available. 4. Use of clinical virtual pathways where appropriate. 5. Action plan and ongoing service improvements identified to reduce demand. 6. A failsafe officer has been recruited to validate the holding list and focus on appointing red rated patients and those longest waiting. 7. Expanded non-medical roles e.g. orthoptists, optometrists, specialised nurses etc. 8. Additional ST's rotated for use one day per week from Aug-23 with 1 ST able to operate independent clinics. Assurances 1. Capacity sessions held where doctors are willing and available. 2. Increased flexibility of staff and constant review and micro-management of each sub specialty. 3. All holding list patients reviewed weekly by administrative staff with patients highlighted where required to clinical teams. 4. Weekly operational meetings challenge outpatient activity and recovery. 5. Arrangements made with college to support a further two ST's one day per week each.		
Update since the last report	**Update 14/08/2023** Risk Reviewed. No change in risk scoring. Whilst the new glaucoma virtual monitoring service is supporting the service, numbers of urgent glaucoma patients are still being received. An empty ST slot has been filled with a MCH awaiting a start date. The triage process is being reviewed and improved. The holding list still remains a major concern with numbers of patients awaiting review of appointments unable to be accommodated. **Next Review Date 14/09/2023**	**Date last reviewed**	**14/08/2023**
		Risk by quarter 2023-24	Q1: 16 · Q2: 16 · Q3: · Q4:
		8 week score projection	16
		Current Issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title
12	8839	Failure to achieve performance targets

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 coronavirus 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**	**Gaps / weaknesses in controls** 1. Balancing cancer performance targets and achievement of RTT performance remains challenging. 2. Pension rules and workforce challenges have reduced consultant numbers offering additional capacity sessions to manage demand. 3. Inability to recruit to some clinical specialties impacting on performance and targets. 4. Gaps between demand and capacity still remain high impacting on overall performance. **Gaps / weaknesses in assurance** 1. Internal and external influences may impact on recovery and performance e.g. clinical delays, winter pressure, industrial action, patient attendance or cancellations etc. 2. Target plans for next recovery milestone to remove all patients waiting >65 weeks remains on course to be achieved by end Dec-23.
Controls and Assurances in place	Controls 1. Revised clinical harms process implemented to ensure patient safety. 2. Micromanagement of all 65 and 52 week breaches. 3. Patients continue to been in order of clinical priority. 4. Addition of priority code monitoring to enable all clinically urgent patients to be tracked for dates. 5. Outpatient Transformation Group tracking outpatient redesign. 6. Recovery plans updated weekly by Directorate Managers. 7. Additional waiting list initiatives for theatres and clinical to close gaps and maximise capacity. Assurances 1. Close monitoring of elective recovery milestones, with no >184 week or >78 week waiters achieved. 2. Weekly patient treatment list (PTL) meetings held within division of awareness of current position and ensure suitable controls remain in place to focus on achievement of targets. 3. Bi weekly meetings held with Directorate Managers led by the Director of Operations to monitor and review performance and trajectories. 4. Attendance of Divisional Information Manager (DIM) at Directorate meetings to provide updates on current position. 5. Exception reports provided by DIM where standards are not being met. 6. Regular performance monitoring and challenge at Divisional Management Board (DMB) and Senior Management Team. 7. 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 01/08/2023** Risk reviewed. No change in risk scoring. Active RTT pathways = 36,672. >18 weeks = 13.323 of which 1,009 are >52 weeks, 202 are >65 weeks, 0 are >78 weeks and 6,005 at risk of breaching 65 weeks by end of Mar-24 **Next Review Date 01/09/2023**	**Date last reviewed**	**01/08/2023**

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

No	ID	Title
13	8725	Lack of Senior Clinical Decision Making and Inconsistent Medical Cover for Community Intermediate Care Services

Lead	Risk Handler: Sharon Sidworthy Exec Lead: Jawad Husain	**Current score**	**15**	**Score Movement**	⇧

Description	The Community and Intermediate Care Division (CIC) manage a range of Intermediate Tier services across both bed based and domiciliary settings which have developed significantly over the past few years with the expansion of the Intensive Home Support Service Team (IHSS) and Intermediate Care Allocation Team (ICAT). Mixed cover is in place across all sites, with medical staffing remaining inconsistent, leading to limited assurance that the current model of service and interventions provided remains robust and is meeting the needs of patients and staff.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weakness in controls** 1. Contractual cover arrangements at Clitheroe Community Hospital are held with the ICB. 2. Budgetary controls for peripheral site medical cover sit within MEC Division with costs of covers remaining unclear making affordability of any new model difficult. 3. Lack of coordinated medical oversight with gaps between senior decision maker support and wards contributing to lack of forward effective medical plans. 4. No robust 24 hour cover arrangements across peripheral sites. 5. Interface consultant role managed by Acute Medicine adding further complexity in managerial and professional arrangements. 6. Gaps in cover presented due to locum junior clinical fellow posts and priority of peripheral sites. 7. Difficulty of junior medics receiving support they need due to geographical isolation of community hospitals. 8. Existing systems and processes do not allow flexibility of clinical fellow posts to cover rotas spanning all intermediate tier services. 9. No succession planning. 10. Shortages in other clinical professions e.g. speech and language therapy, dietetics and pharmacy. **Gaps / weaknesses in assurances** 1. Division has little control over resource. 2. Governance arrangements are not robust and split between Divisions. 3. Limited control in relation to the transfer of care into community wards. 4. No presence or influence of senior management team or senior clinicians working within CIC. 5. Limited autonomy of intermediate care inpatient wards in relation to intake of patients. 6. Poor collaboration across MEC and CIC Divisions in progressing joint working arrangements.
Controls and Assurances in place	Controls 1. Staff rosters managed by medical staffing team and sent out in advance so gaps and inconsistencies are known. 2. Senior roster completed and overseen by the Clinical Director for Medicines and Older People. 3. Ward Managers, Sisters, Charge Nurses in place who can oversee patient care and provide interventions and actions within skills set. 4. Consultants allocated for each ward. 5. Directorate Manager awareness of staffing levels and escalation process in place. Assurances 1. Cross divisional escalation regarding poor medical cover. 2. Daily senior nurse meetings held with operational site team to highlight and address ward concerns. 3. Consultant meetings held with Clinical Director to highlight and address concerns. 4. Lessons learned from two coroner reports regarding inconsistency of medical cover. 5. Review and management of incidents in place.		
Update since the last report	**New Risk** **Update 18/08/2023** Paper presented to senior leadership team outlining current issues and proposed resolution. No major incidents have been reported to date. **Next Review Date 18/09/2023**	**Date last reviewed**	**18/08/2023**

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
14	8808	BGTH - breaches to fire stopping and compartmentalisation in walls and fire door surrounds

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

Description	Phase 5 breaches to fire stopping compartmentalisation in fire walls and fire door frame surrounds due to poor workmanship or incorrect product usage may result in faster spread of smoke or fire between compartments within a timescale <1 hr or 30 mins that compartments and doors are designed to provide.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Refurbishment of Renal Unit including fire compartmentalisation and fire doors completed and review undertaken by Lancashire Fire and Rescue Service. Minor snagging remains ongoing with fire doors installed but not signed off by third party accreditor. **Gaps / weaknesses in assurances** 1. Assurances required regarding integrity of fire stopping in compartment walls throughout Phase 5. A sequence programme of ward closures to be agreed with an estimated duration of 20 weeks for completion of remedial works.
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 alarm systems and planned preventative maintenance programme. 2. Upgrade of suitable building fire detection systems in place to provide early warning of fire. 3. Fire 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. 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 between the Trust, Albany and third parties to identify / prioritise higher risk areas, address remedial works and defect corrections 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. Fire wardens in place and additional fire wardens provided by Albany 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. External monitoring, servicing and maintenance of fire safety alert system and suitable fire safety signage in place. 9. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England. 10. Independent consultant employed to review and oversee project.		
Update since the last report	**Update 16/08/2023** No change to risk scoring. LFRS have issued enforcement action. Improvement works being monitored and reviewed by the Fire Safety Committee. **Next Review Date 15/09/2023**	**Date last reviewed**	**16/08/2023**

Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	15	15		

8 week score projection	15
Current issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title				
15	7764	RBTH - breaches to fire stopping and compartmentalisation in walls and fire door surrounds				
Lead		Risk Lead: John Houlihan Exec Lead: Tony McDonald	**Current score**	**15**	**Score Movement**	⟺
Description		Phases 1 to 4 and Phase 5 breaches to fire stopping compartmentalisation in fire walls and fire door frame surrounds due to poor workmanship or incorrect product usage may result in faster spread of smoke or fire between compartments within a timescale <1 hr or 30 mins that compartments and doors are designed to provide.		**Gaps and Potential actions to further mitigate risk**		
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 alarm systems and planned preventative maintenance programme. 2. Upgrade of suitable building fire detection systems in place to provide early warning of fire. 3. Fire 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 between the Trust, Consort Healthcare and third parties to identify / prioritise higher risk areas, address remedial works and defect corrections 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. Fire wardens in place 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.			**Gaps / weaknesses in controls** 1. 60 minute fire door installation completed, awaiting final survey and third party accreditation. 2. 30 minute fire door installation still in planning and early implementation stage. 3. Fire stopping works remain ongoing with contractors working on a 'find and fix' basis. 4. Fire detection installation in void areas currently 80% complete. 5. Putty pad works in Phase 5 remains ongoing. In Phases 1 to 4 work continues in corridor areas. No bedded areas have been completed to date. **Gaps / weaknesses in assurances** 1. Fire stopping works within riser areas may affect multiple areas. Passive fire protection stakeholders to determine level of work required against the impact on patient care.	
Update since the last report		**Update 16/08/2023** No change to risk scoring. LFRS have issued enforcement action. Improvement works being monitored and reviewed by the Fire Safety Committee. **Next Review Date 15/09/2023**		**Date last reviewed**	**16/08/2023**	
				Risk by quarter 2023-24	**Q1**: 15	**Q2**: 15	**Q3**	**Q4**
				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		The Trust will fail to achieve the operational standard of 85% for the 62 day GP referred (classic) cancer waiting time target resulting in potential harm to patients and organisational reputational damage should treatment be delayed.				
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. NHS England and the Lancashire and South Cumbria Cancer Alliance provide investment and funding into problematic areas. 4. 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. 5. A 5 year workforce plan in place to support recruitment and retention. 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. 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.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Medical vacancies. Many areas suffering with excessive waiting times resulting from vacancies to key posts in particular posts difficult to recruit into due to national shortages. **Gaps / weaknesses in assurances** 1. Unavoidable breaches. Some breaches are outside of the control of ELHT e.g. patients breaching targets because of complexities in their pathway, comorbidities or patient choice		
Update since the last report		**Update 01/08/2023** Risk reviewed. No change in risk scoring. Service improvement plans including 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 etc. are being regularly monitored by the ICB. Backlog reduction continues to improve with further progress delayed due to CERNER implementation. Risk score to be reviewed following data analysis. **Next review date 01/09/2023**	**Date last reviewed**	**01/08/2023**		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
				15	**15**		
			8 week score projection	**15**			
			Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
17	5791	**Failure to adequately recruit and retain to substantive nursing and midwifery posts may adversely impact on patient care**				
Lead		Risk Handler: Jane Pemberton Exec Lead: Kate Quinn	**Current score**	**15**	**Score Movement**	⟺
Description		Difficulties in the recruitment and retention of substantive nursing and midwifery posts is resulting in continued use of agency and or bank staff, which, in turn, is financially challenging and does not support continuity of patient care.				
Controls and Assurances in place		Controls 1. A 5 year workforce plan in place to support recruitment and retention. 2. Use of e-rostering, both actual and planned, staffing numbers recorded daily and reported monthly as part of quality assurance processes. 3. 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. 4. 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. 5. 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. 7. Progression of next cohort of international nurses to support recruitment and retention and recruitment to aid newly registered staff.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Non elective activity impacting on staffing. 2. Individuals acting outside controlled environment. 3. Pressures within the system e.g. emergency pathways etc. leading to overcrowding and patients requiring corridor care with more nurses required to facilitate this. **Gaps / weaknesses in assurances** 1. May not be able to staff to agreed staffing levels due to gaps created by vacancies, sickness absence, maternity leave, unfilled bank or agency shifts, recovery and restoration stages of the coronavirus pandemic and excessive demand within the emergency department.	
Update since the last report		**Update 24/08/2023** 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 22/09/2023**		**Date last reviewed**	**24/08/2023**	
				Risk by quarter 2023-24	Q1: **15**	Q2: **15**	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		Current score	15	Score Movement	⟺
	Risk Lead: Lyndsay Parsons Exec Lead: Peter Murphy				

Description	Patients referred to Lancashire County Council and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DoLS) authorisation are not being assessed by these agencies within the statutory timescales, or at all, which means the DoLS is in effect unauthorised.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Inability of supervisory body to process assessments within set statutory provision. 2. In the absence of assessments the inability of ELHT to extend urgent authorisations beyond required timescales set at 14 days. 3. In the absence of assessments patients will not have a DoLS authorised and will not have had relevant checks undertaken to ensure they are legally detained, leading to patients being detained without authorisation as not doing so would present an even greater risk. 4. Plans to change DoLS to Liberty Protection Safeguards (LPS) remains ongoing, with no date set for their implementation or subsequent publication of new National Approved Codes of Practice. **Gaps / weaknesses in assurances** 1. Continuous increase in numbers of DoLS applications
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 17/08/2023** Risk reviewed. No change in risk score. The mitigation of this risk is outside the control of the Trust and is the responsibility of the local authority as the nominated supervisory body. This has a secondary impact on the Trust who has reduced the risk within its control to its lowest level practicable. As a result this risk has been approved as being a tolerated risk. **Next review date 13/09/2023**	**Date last reviewed**	**17/08/2023**

Risk by quarter 2023/24	Q1	Q2	Q3	Q4
	15	15		

8-week score projection	**15**
Current issues	External influences regarding mitigation of risk beyond the control of the Trust

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **111**

13 September 2023 **Purpose** Approval
Assurance
Information

Title	Board Assurance Framework (BAF)
Report Author	Mrs A Bosnjak-Szekeres, Director of Corporate Governance Miss K Ingham, Corporate Governance Manager
Director Sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance

Summary: The Executive Directors and their deputies have reviewed and revised the BAF during the course of August 2023. In addition, the Quality Committee has reviewed and discussed the revised document at its most recent meeting and agreed to recommend the revisions to the Board for ratification. The Finance and Performance Committee will consider the BAF at its meeting on 11 September 2023.

The risk scoring and risk appetite for each of the risks have been reviewed, including updates to the actions due in this reporting cycle and remain unchanged.

The cover report sets out an overview of the changes made to the document, including updates on actions and the addition of assurances where actions have been completed. The timelines for some of the actions have been revised and explanations are provided in the detailed BAF sheets. There are no proposed changes to risk scores in this round of reviews.

The Executive have also discussed the tolerated risk scores and target risk scores and there is an agreement to revise these at the next meeting of the Executive Risk Assurance Group (ERAG) in light of the current challenges. The proposed changes to these risk scores will be presented to the next Committees and Board round in October/November 2023.

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

Report linkages

Related Trust Goal	Deliver safe, high-quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.

	3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register (CRR)	Please refer to the BAF report for relevant CRR risks
Related to recommendations from audit reports	Assurance Framework Key Financial Controls Risk Management Core Controls
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement People Plan Priorities Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by:

Executive Directors, August 2023

Quality Committee, August 2023

Finance and Performance Committee, September 2023

Introduction

1. The Executive Directors and their deputies with BAF risks assigned to them have met with the Corporate Governance Manager and the Director of Corporate Governance to review and revise the individual risks.
2. This document sets out an overview of the changes that have been made to the BAF since the Board meeting that took place in July 2023, including any updates to the actions, assurances and controls.
3. The full BAF is presented to the Finance and Performance Committee and Quality Committee and will also be presented to the People and Culture Committee from November 2023 onwards. The BAF will also be presented to the Audit Committee twice per year for completeness. However, the Committees are only asked to discuss the risk scores, mitigations and actions for the risks that are within their remits as follows:
   a) **Finance & Performance Committee:** BAF 1, BAF 3 and BAF 5.
   b) **Quality Committee**: BAF 2.
   c) **People and Culture Committee**: BAF 4.
4. The BAF includes, where appropriate, references to the 8 steps for increasing capacity and operational resilience in urgent and emergency care ahead of winter.
5. For ease of reference, we have produced the following heat map of the BAF risks for 2023-24 below.

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

1. There have been minor updates to the controls section of the risk, these are detailed via tracked changes in the BAF risk sheet.
2. With regard to the actions section of this risk, there have been a number of updates, including changes to the due dates for 6 of the actions (1, 3, 4, 6, 8 and 9), the details of which are also included in the document via tracked changes.

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. The section detailing the links to the Corporate Risk Register (CRR) has been updated to reflect the revised CRR risks. For clarity, there have been 4 new additions to the CRR which relate to this risk (ID's 9570, 9705, 9367 and 4932) and 3 risks have been removed which relate to quality and safety (ID's 8125, 9296 and 8960).

4. There has been 1 new addition to the controls section of the risk, which is shown via tracked changes.
5. With regard to the actions section of the risk, all but one action has been updated. There have been changes to the due date of 2 of the actions (3 and 6). Furthermore, it is proposed that actions 4 and 5 are merged together in future versions of the BAF risk due to the similarities between them.

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.

6. The section detailing the links to the CRR has been updated to reflect the revised CRR risks. For clarity, there has been 1 risk removed from the CRR section of this risk (ID 8257).
7. There have been no revisions made to the controls or assurances section in this review round.
8. In relation to the actions section of the BAF risk, there have been updates provided for every risk. It is proposed that action 7 is removed as it is covered elsewhere on the BAF.
9. There have also been a number of revisions to the action due dates (4, 5, 6, 8, 10, 11 and 12). The rationale for the revised dates is included within each update, however it is worth noting that the majority of the revisions are as a result of the implementation of the Trust's new Electronic Patient Record (EPR) system and the impact of the ongoing industrial action.

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.

10. There have been minor updates to the controls and assurances sections of the risk, which are shown via tracked changes in the document.
11. There have been updates to all of the actions and there have been extensions to the due dates on 2 actions (5 and 7), the reasons why are also detailed in the BAF sheet.

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.

12. The section detailing the links to the CRR has been updated to reflect the revised CRR risks. For clarity, there has been 1 risk removed from this section (ID 9222).
13. There have been a number of updates to the controls and assurances section of the BAF risk, all of which are shown in tracked changes in the detailed BAF sheet.
14. All 5 actions have been updated and all bar one has had revised due dates. The rationale for the changes to the due dates are as a result of external factors, which the Trust has no control over.

Recommendation

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

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

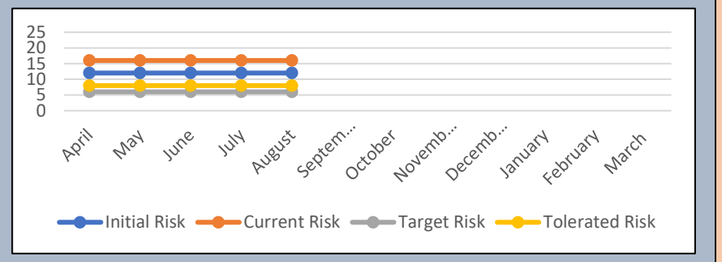
Date of last review: Executive Director: August 2023
ERAG:

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
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)

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

- 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.
- System Corporate Collaboration group oversees potential savings and other benefits of corporate collaboration opportunities including strengthening fragile services.

Provider Collaborative Board (PCB):

- 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.

Place-Based Partnership (PBP):

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

ELHT:

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

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

- ICS/PCB/PBP Updates are a standing agenda item at Executive meeting and Senior Leadership Group.
- Reports from PCB SROs. Programme Update reports to the PCB Co-ordination Group and PCB Board.
- 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.

Specialist support, policy and procedure setting, oversight responsibility:

- Standing agenda item at Trust Board where approvals will be established, and permissions are provided by the Board to let Executives progress the generation of ideas and options with external stakeholders.
- Board Chief Executive Officers (CEO) report including updates on system developments and engagement.
- System delivery plans are reflected in updates on Trust Key Delivery Programmes. 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

Independent challenge on levels of assurance, risk and control:

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

BAF Risk 1 – Integrated Care / Partnerships / System Working

- Central Services Collaboration internal group

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 Revised date of October 2023 for final actions.	L&SC ICP Strategy and Joint Plan has been finalised in July.~~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 and still outstanding and this is the reason for moving the due date out to October 2023..	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. This is an agenda item for the September Board meeting.	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~~ October 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. Awaiting feedback from PCB workstreams to finalise actions. Update will be provided and due date extended.	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 October/November 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. Due to the timings of the PCB meetings, this has now moved to October/November 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. Work on track for completion by the end of September and will be presented to the Board for information in November 2023.	A
6.	Community service alignment~~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	April 2024 ~~No date yet agreed – ongoing review underway~~	Review of options ongoing and proposals in development. Proposals now developed and letter of intent and plans being jointly agreed by ICB and providers. Anticipated transfer date phase 1 – April 24 / phase 2 – mid 2024. Next update to the Board in September 2023. This is an agenda item for the September Board meeting.	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~~ October 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. Update Sept 23 – ELHT plans in place and 24/25 planning starts Autumn 2023. PMO delayed due to funding which is still being explored.	R

BAF Risk 1 – Integrated Care / Partnerships / System Working

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Update to be provided October 2023 – due date extended.	
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~~ October 2023	Final review of framework completed~~underway~~, sharing with Trust Board and Senior Leadership Group planned during Autumn 2023 (due date extended)~~.~~ Quarterly review meetings commenced in July for Q1. ~~to commence in July for Q1~~	A

BAF Risk 2 – Quality and Safety

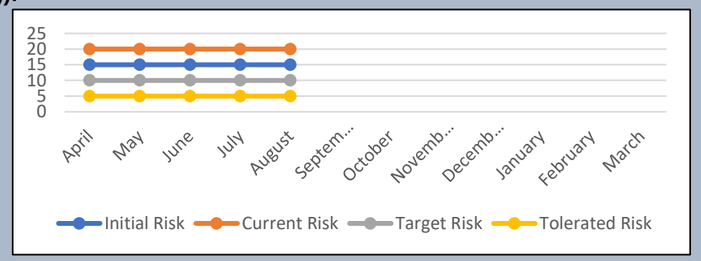
Risk Description: The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.		**Executive Director Lead:** Executive Medical Director and Executive Director of Nursing	
Strategy: Quality Strategy	**Links to Key Delivery Programmes:** Quality and Safety Improvement Priorities	**Date of last review:** Executive Director: August 2023 ERAG:	**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
9570	No capacity for the storage of legacy ECHO images	20
~~8126~~	~~Risk of compromising patient care due to lack of electronic patient record (EPR) system.~~	~~20~~
9705	Inability to provide a robust hepatobiliary (HPB) on call service	20
9367	ECHO image transfer	16
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
4932	Patients who lack capacity to consent to placements in hospital may be unlawfully detained	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
Target Risk Rating: C5 x L1 = 5



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Minimal

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

Strategy and Planning:

- The Quality Strategy contains 14 core priorities which are routinely reported and monitored through the Quality Committee. These will be reviewed and updated annually through workshops with key partners.
- The Quality Strategy priorities for 2023-24 have been confirmed, with associated KPIs. Progress against the 2022-23 priorities was reviewed by the Executive team on 30 November and a progress update is planned for presentation a minimum of quarterly via a presentation and update of the Executive Improvement Wall.
- The Patient Safety Incident Reporting Plan identified 5 priorities for investigation during 2022-23, the investigations now complete are moving to thematic review for organisational learning. New priorities for 2023-24 have been proposed following engagement with key stakeholders, including the PPP and Healthwatch.

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.

BAF Risk 2 – Quality and Safety

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. <u>Patient safety specialists are working with Deputy Director of HR to integrate staff safety metrics alongside patient safety.</u> <u>PSS Summit held in June 2023 following a number of Never Events and focused on -receiving staff feedback on ELHT safety culture and</u>	~~G~~ A

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					psychological safety of staff. Learning from this is being rolled out in partnership with the Quality and Safety Team. Despite systems working the fragility of the workforce across LSC doesn't enable sufficient mutual support for fragile services. New Clinical Lead for Retention, Resilience and Experience in post from 1 August 2023 for nursing and AHP workforce. Work is being undertaken with ward managers and team leaders to review and learn from observations of patient care. It is anticipated that this work will positively impact patient care, outcomes and experience. Tests of change are planned to be rolled out in September 2023.	
2	Provision of histopathology within the Trust (medical and healthcare scientists)	Work is taking place across providers via mutual aid and exploration of outsourcing and open recruitment. Ongoing improvement work to identify internal efficiency opportunities. Continued effort to appoint consultant to current gaps in the department	Executive Medical Director/ 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. Early evidence of improvement work having impact on Histopathology turnaround times. Ongoing limited 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 ongoing to implement digital pathology, this has an oversight from the pathology board, diagnostic board and ICB digital strategy board.	G
3	Lack of electronic governance management system	Implement RADAR as new governance system	Executive Medical Director	September 2022 start date met. Staged approach now in place to support full implementation by October ~~September~~ 2023 IT have suggested a date of the end of October~~July~~ 23 for implementation of Radar as a result of the new EPR rollout.	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.~~ The Trust continues to pay for both the Datix and Radar licences which is a continued cost pressure for the Trust. ~~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 continue to require clarification from the Chief Information Officer ~~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 – this issue is ongoing as of 14 August 2023. ~~-~~ Programme Manager has been identified from the existing IT team and is working with the Datix manager to progress the system. Additional risks have been identified due to the temporary trainer post recruited in line with the original roll-out date, the funding for this post is due to end in December 2023.	R

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
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 4)	Executive Director of Nursing/ Executive Medical Director/ Executive Director of Integrated Care, Partnerships and Resilience	End 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. Following multiple discussions with CQC registration team it has been agreed that registration for mental health patients will be assessed in relation to patient subject to section 136 initially. CQC registration assessment visit planned for 6 September 2023 to consider the ED and Urgent Care mental health pathway. This is being co-ordinated in partnership with LSCFT. Only one registration updated following this visit will any further work towards the 5 (2)/wider sections being used across wards be considered.	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). It is proposed that this action be merged with action 4 above.	~~G~~ A~~mber~~
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 via the BAF.	Terms of Reference now confirmed nationally. Meetings with Hempsons indicate likely significant focus on ELHT and likely significant assurance evidence required to be co-ordinated and checked prior to submission. Formal NHS focus may be later than initially anticipated. Task and Finish group established internally with evidence gathering commenced in preparation. The system rather than individual Trusts will be assessed. The webinar from Hempsons, the expectation is for a system level response and not from individual Trusts. Module 3 of the Inquiry has now begun and no request for information has yet been made to the Trust. Updates are regularly circulated internally. ~~recently begun recruiting core participants, however no contact has yet been made with ELHT.~~ Our panel solicitors have not yet suggested we put ourselves forward. Information gathering is being co-ordinated through our EPRR/Governance teams No target date yet – preparation started at Trust level.	G

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
		b) Introduction of Liberty Protection Safeguards. (LPS)	Executive Director of Nursing/ Executive Medical Director	~~Before October 2023~~ This date has been removed and there is no further date for implementation confirmed.	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 New Head of Safeguarding now in place who will co-ordinate the Trust's response.	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~~ The Trust has recruited 5 PSPs from the local community via exploring links through Healthwatch etc. they are due to commence in post in September 2023. It is recognised that those recruited are not fully representative of the diversity in the local community however Healthwatch are assisting with redressing this balance. Core functions of the PSP to be agreed with the Executive Directors/Board members PSPs currently to be launched across the Trust at the planned patient experience summit in early October 2023.	~~G~~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. Recruitment and retention campaign being undertaken as well as work to improve recruitment from overseas.	A
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 Executive Director of People and Culture 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 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Impact on the Trust's financial trajectory, patient and staff wellbeing, cancer waiting times, 65 week waits training of junior doctors.	

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: August 2023
ERAG:

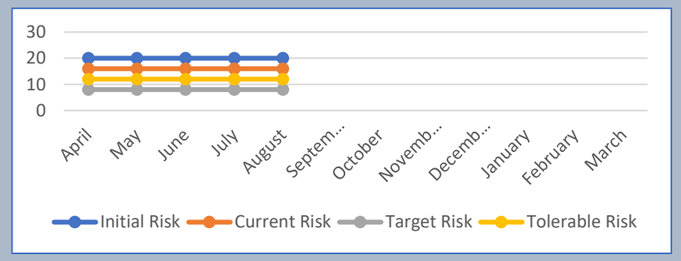
Lead Committee: Finance and Performance Committee

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
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).

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

- 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.
- 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.

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 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.

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

- 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.

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

• 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. • 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.	• 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

- 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 month 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. Target revised to 107% by the regulator to recognise the impact of the first industrial action	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. Activity levels not being achieved as a result of the industrial action (primary cause) and EPR roll-out. All controls are being applied, but a lack of workforce due to industrial action is impacting the performance.	A
2	Diagnostic clearance to 95% of patients receiving a diagnostic test within ~~<~~6 weeks of referral ~~at 95%~~ by March 2025.	Implementation of Modality level delivery plans.	Chief Operating Officer	March 2025	ICS wide modelling completed, and discussion are ongoing around mutual aid to across the Lancashire and South Cumbria area ensuring patients have equity of access. The Trust has an internal recovery plan and, in the main we currently carry out all diagnostic testing within the 6-weeks of referral for 95% of patients, with the exception of endoscopy. Endoscopy is a key area of risk due to demand volumes. Investment in endoscopy to increase capacity. The Key Performance Indicators of the business case will be monitored through the Finance and Performance Committee (next report to the October 2023 meeting).	A

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
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. On trajectory for 62-day cancer backlog clearance and the 28-day faster diagnosis standard.	A
4	Low Outpatient (OP) utilisation (booking appointments 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~~ December 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. Issues with embedding our electronic patient record (EPR) are affecting our ability to demonstrate meeting this target. The delivery timeline has been revised to allow the embedding of the system.	A
5	Maintain ~~Increase and sustain~~ capped theatre utilisation at a minimum of 85% ~~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~~December 2023 ~~2023~~	Currently, aggregate position at 86% (March 2023). Risks to sustain continue. Issues with embedding our electronic patient record (EPR) are affecting our ability to demonstrate meeting this target. The delivery timeline has been revised to allow the embedding of the system. Report back in November 2023 to the Board.	**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~~March 2024	Nil >78-week breaches between ~~in~~ March and July 20~~-~~23. ~~April 23 has 15 at risk and all dated in month~~. This is being monitored daily under the Deputy COO leadership with the operational ~~DDoP~~ team. We are currently off-trajectory as activity levels are not being achieved as a result of the industrial action (primary cause) and EPR roll-out. All controls are being applied, but a lack of workforce due to industrial action is impacting the performance. Regular updates are provided to the Executive Team and Senior Leadership Group.	~~AR~~
~~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 mental health 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~~December 2023	Revised operating model by LSCFT to support timely mental health assessment treatment and/or intervention. Improved responses to delayed admissions of patients with mental health needs requiring admission to LSCFT facilities/Out of Area mental health provider. However, delays still experienced and will require close monitoring in combination with LSCFT colleagues with escalation process.	A

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Timeline moved to December as a result of LSCFT winter planning review for capacity.	
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). We have set up a regular Executive led meeting to ensure exec oversight.	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 Potential for a new deadline to be set due to the ongoing implementation and learning from Cerner.	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. Bed Manager post recruited to, and they are due to commence in post in September 2023.	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 BGTH and RBTH sites resulting in a 53-bed reduction from 17th April 23.	Monitor impact of 53 bed reduction. Increased efforts around pathway 0 discharges with the discharge matron team. Continued admission avoidance via ED and SDEC pathways as well as IHSS team. Home including rehab as a default for pathways 2. Increased use of pathway 1.	Executive Director of Integrated Care Partnerships and Resilience/ Chief Operating Officer	End of October 2023 End December 2023 due to impact of Heart Centre works being completed.	Bed model in place. Further work around non-elective LoS at specialty level in progress although overall LoS is within national average. ~~Discharge matrons to re-focus on pathway 0 from 17th April 23.~~ Further plans in place for winter bed capacity within MEC.	**A**
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~~ End September 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. Average handover times have improved; however the 50% reduction has not been achieved, this is partially as a result of reporting issues associated with the implementation of the EPR system. The Associate Director of Service Development and Improvement is scheduled to meet with the ED team and NWAS representatives to revisit the plan and agree the next steps for improvement in September 2023, hence the revised timeline.	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: August 2023
ERAG:

Lead Committee: Quality Committee

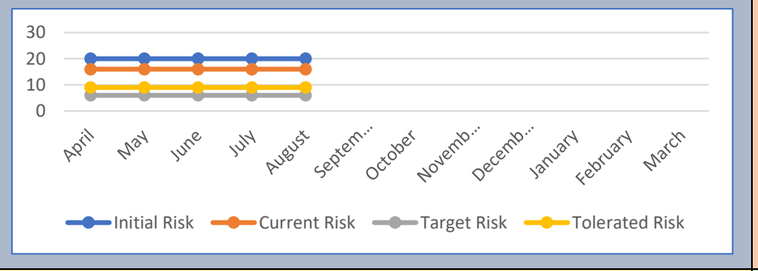
From September 2023 this will be People and Culture Committee

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
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.
- 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.

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.

- 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
- Culture dashboard being developed for inclusion in divisional performance review meetings and for presentation at P&C Committee

Specialist support, policy and procedure setting, oversight responsibility:

- 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.

Independent challenge on levels of assurance, risk and control:

BAF Risk 4 – Culture Workforce Planning & Redesign

	• 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. This will be an agenda item for the People and Culture Committee in September 2023.	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~~ was presented to Executive Team ~~s~~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.~~Due to financial constraints, only the protected time element was agreed and there is no external funding available. There is exploration of opportunities to work across providers to support this area of work as part of the central services work. ~~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.	AG

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					The task relating to exploring protected time for the Networks has been completed but there remain outstanding actions with regard to exploring funding.	
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. No further update is available for this reporting period.	G
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 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. A number of pilots have been undertaken regarding team-based rostering which have gone well.	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~~ December 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. The timeline for this work has been extended due to external factors affecting progress. 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

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Across the ICS work is taking place to arrange placements for overseas doctors to achieve CESR qualification, enabling them to progress to consultant level. There is also a piece of work taking place regarding overseas nurse recruitment, there are around 20 nurses per month recruited and commencing in post, from April 2023 to date there have been 100 nurses commenced at the Trust from overseas.	
6	Risk of staff leaving the NHS due to burnout.	Delivery of the Enhanced Health & Wellbeing offer to the ICS. Next steps are to revise 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 Occupational Health and Wellbeing (OHWB) The OD and Well team are continuing to explore how staff can be further supported during this ongoing period of unprecedented demand. The LSC occupational health and wellbeing collaborative programme has been identified as one of the early functions to move across to the Central Services platform once the host Trust has been agreed on 19 September 2023. PCB OH and Wellbeing services are currently scoping a future service specification in readiness for the future model.	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 September ~~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. This continues to be an ongoing issue and is likely to remain so for a number of months.	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: August 2023
ERAG:

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~~

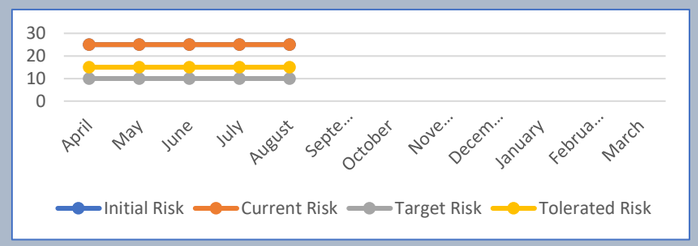
Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: C5 x L5 = 25

Initial Risk Rating: C5 x L4 = 25

Tolerated Risk Rating: C5 x L3 = 15

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 Trust level controls ~~that the Trust has imposed and further controls imposed by the ICB for external review~~
- Financial plans for 2023-24 developed via annual planning process, ~~not currently~~ signed off at the Trust Board in July 2023~~or agreed~~.
- Divisional financial revoery plans in place and overseen by the Executive Director of Finance.
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations. The last review was completed in April 2023.
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Waste Reduction Programme (WRP) are reported and scrutinised through the monthly Finance Assurance Board with Executive and cross-Divisional team representation, Capital Planning Board chaired by the Director of Finance, and Finance and Performance Committee, sub-committee of the Board.

System

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

- System financial controls implemented from August 2023 (central services recruitment, general recruitment and non-pay controls/thresholds).

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

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

- 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
- Divisiona~~l~~, Trust wide and system 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 has been presented to the Finance and Performance Committee March 2023, not yet approved nationally. Stretch target being requested.~~ *Removed as covered in point 2 under organisation*.
- 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. ICS additional controls currently applied

Specialist support, policy and procedure setting, oversight responsibility:

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

Independent challenge on levels of assurance, risk and control:

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

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.~~ One NHS Finance Towards Excellence Accreditation shows that the finance team's processes and procedures are working. It proves that we have developed a culture where staff feel appreciated, and successes are celebrated. ELHT Finance Team are accredited at the highest level (Level 3). High level of qualified staff in department (53%) with a further 35% in training.

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	No signed contract nor agreed financial plan for 2023-24	Continue to develop plans for system, region and national sign off, and documenting all risks of reducing expenditure in line with expectations.	Executive Director of Finance	End of ~~July~~ September 2023	System plan agreed internally but with significant financial risk. Awaiting national sign off. Financial plan signed off by Trust Board July 2023, with full documentation of risks associated with achievement of said plan. Contract work continuing for the year – not currently signed due to continued work on income plans Work has begun on the LSC system financial plan for the next 3 financial years.	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~~ September 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.~~ £39m is identified and is being worked up. (72% of the WRP and system gap at £54m) Finance Assurance Board is now chaired by the Chief Executive with full Executive Team presence. Divisional Improvement boards are in place.	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 J~~uly~~September 2023	ICB proposals being reviewed by provider governance. ICB proposals remain under review by Executive teams. Diaries being aligned to ensure attendance by ELHT at all committees	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. Work is ongoing to achieve full transparency	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~~ September2023	2 system meetings to identify specifics. Joint meeting CFOs/Operational colleagues to take place. Work on the system roadmap to be continued with new PCB finance lead	R

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **112**

13 September 2023 **Purpose** Information Assurance

Title	Patient Safety Incident Response Assurance Report
Report Author	Mrs J Hardacre, Assistant Director of Patient Safety and Effectiveness Mr L Wilkinson, Incident and Policy Manager
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 Trust Goal	Deliver safe, high quality care Secure COVID recovery and resilience Improve health and tackle inequalities in our community	
Related to key risks identified on Board Assurance Framework	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.
Related to key risks identified on Corporate Risk Register	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. 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. ID 6190: Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales. ID 8839: Failure to achieve performance targets. ID 8257: Loss of transfusion service. ID 7008: Failure to comply with 62-day cancer waiting time target.
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	Clinical Strategy, Quality Strategy, People Strategy, Corporate Governance Model and Trust Wide Quality Improvement Programmes.
Related to ICB Strategic Objective	1. Improve quality, safety, clinical outcomes and patient experience. 2. Meet national and locally determined performance standards and targets

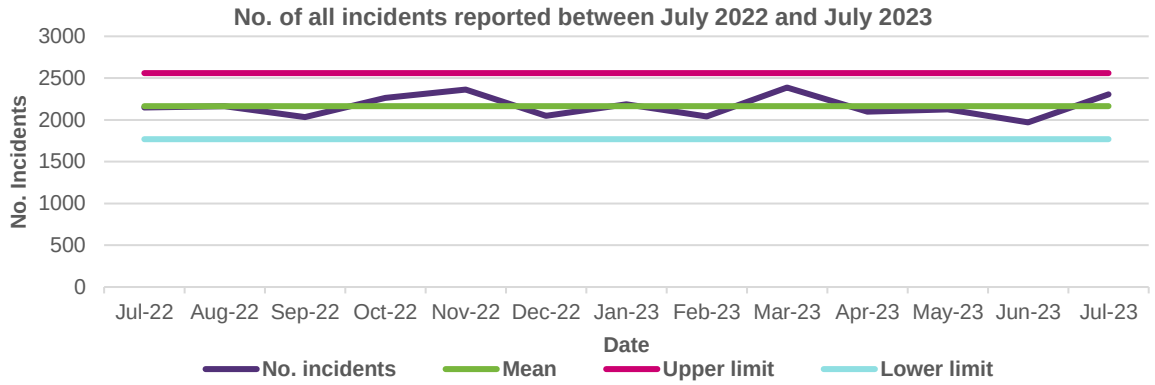
Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: No formal Committee

1. Incident Reporting

1.1 The Trust reports and manages incidents in line with the New National Patient Safety Incident Response Framework. Over the last year, 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 Following a reduction in incident reporting levels in June 2023, the position has now recovered in July 2023. This reduction was mainly due to the impact of Cerner being launched.

1.3 The number of moderate incidents reported remains at an increased level, however there was slight reduction in July 2023 (15) compared to June 2013 (18), see appendix A. However, there is no single category of incident causing the increased number in July 2023.

1.4 There has been another spike in severe harm incidents in July 2023, this is not related to any single category of incident. (see appendix A)

1.5 There has now been a consistent increase for 3 months in the number of incidents where a patient safety incident may have contributed to the death of a patient. This equates to a total of 5, 2 occurred within Emergency Department. All the incidents are subject to a Patient Safety Incident Investigation. (see appendix A)

2. Duty of Candour

2.1 There have been 40 reported incidents of moderate and above harm in June and July 2023, of which Duty of Candour applies, as set out in CQC Regulation 20. The Trust has continued to demonstrate 100% with not breaches reported in June and July.

Duty of Candour	KPI	Apr	May	Jun	Jul
No. of breaches	0	0	0	0	0

3. Safety Incident Responses (IR2s)

3.1 In line with the New Patient Safety Incident Response Framework all incidents not being investigated as a Patients Safety Response, or a full Patient Safety Incident Investigation should be reviewed and actioned within 30 days of reporting. A KPI of 95% has been set and appendix B provides an overview by division.

3.2 None of the Divisions are achieving the 95% KPI target. However, there has been an overall improvement in June 2023. The KPI dashboard has been shared with Divisions who are all currently monitoring and putting actions in place to reduce the number outstanding.

4. Patient Safety Responses (PSR)

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

4.2 Each Division have taken actions to reduce the number of overdue PSRs which include weekly monitoring review meetings to update progress. Divisions have stated that several PSRs have been completed but not updated on DATIX, Divisions have been asked to ensure timely updates are provided on DATIX once a PSR has been approved at DPSIRG.

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

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

5.1 In June and July 2023, the Complex Case meeting reviewed 42 incidents of which 7 met the PSIRF National Priorities for reporting and require a full PSII, these have been allocated to lead investigators within the Patient Safety Team. All PSII reports and safety improvement plans are presented at the Trusts Patient Safety Incidents Requiring Investigation (PSIRI) Panel for Trust approval and signoff.

5.2 A KPI dashboard of PSIIs is provided in appendix D. At the end of July the Trust had 29 open PSII incidents of which 4 were being investigated by HSIB.

5.3 There are currently 4 PSIIs which have been open longer than 6 months and 2 HSIB reports.

5.3.1 The Trust has no control on timescales for HSIB reports.

5.3.2 The 4 PSII delays are due to several factors including families wishing to delay the first meeting to discuss TOR, availability of staff to interview and safety improvement plans outstanding from Divisions.

5.3.3 3 of the PSIIs are currently being reviewed by either Divisional Patient Safety Incident Response Groups (DPSIRG) or awaiting approval at PSIRI.

5.3.4 1 PSII is relates to a complex complaint and the lead investigator is currently meeting with family to ensure all areas of their concerns have been covered within the TOR and timescale for final response.

5.4 In June and July 2 PSII reports, 2 HSIB reports, and 2 overdue safety improvements plans have been approved by PSIRI and closed.

6. Never Events PSIIs

6.1 There has been no new Never Events reported within the Trust since the last report. The Trust have reported 4 Never Events for this financial year (April 2023 to March 24) and 1 further Never Event is under investigation from February 2023.

- *Wrong site Surgery (Nerve Block) – report in draft with Division for approval before presenting at PSIRI in early September.*
- *Transfusion of ABO incompatible blood component – report in draft with Division for approval before presenting at PSIRI*
- *Wrong site surgery (injection) – report currently being drafted*
- *Wrong Implant – Currently under investigations*
- *Misplaced NG Tube – Currently under investigations*

7. PSIRI Panel Approval and Learning from Reports

7.1 During June and July 2023, 4 new PSII / HSIB reports were presented at the Trusts PSIRI panel. All reports were approved by the panel with some minor amendments required, however two of the reports safety improvement plans are still required to be submitted to the panel by the Divisions.

7.1.1 Incident resulting in death: (eIR1234124) – The report highlighted opportunities to develop a formal resus step down process, wider access to the NWAS One Response system, whom patients with history of aortic aneurysm and symptoms compatible with dissection or rupture are reviewed, strengthen education and training for patients attending with chest pain, and a review of the streaming pathway to OPRA for patients transferred from the Emergency Department without an Emergency Department medic assessment.

7.1.2 Vulnerable adult nil by mouth: (eIR1241826) – The report highlighted opportunities to improve the processes for referral forms to the speech and language therapy, and dietetics teams for nil by mouth patients, to ensure regarded information is shared. Clearer guidance on when to refer. Improve the guidance on what actions staff need to take when patients fail ward swallow screens and consideration for the development of a nil by mouth care bundle.

7.1.3 Intrapartum Stillbirth (eIR1240208) – The HSIB report highlighted no safety recommendations as the findings from the analysis of the information shared with HSIB during the investigation did not contribute to the outcome.

7.1.4 Maternal Death (eIR1232314) – The HISB outcome of the report made two safety recommendations which the division are currently developing safety improvement actions which will be presented at the next PSIRI panel. The recommendations stated that Primary care services and the Trust to ensure that when a mother presents with a headache during pregnancy or in the postnatal period, the threshold for further exploration of her systems is lowered and red flag symptoms are explored. The Trust to ensure that local processes for laboratory testing, when there are not established national protocols for the test, are robust to support the safe provision of care.

7.2 Two outstanding PSII divisional safety improvements plans that were not available when the reports were presented have been approved by the panel.

8. Patient Safety Incident Response Plan (PSIRP) - New Local Priorities update

8.1 In July 2023 two PSIRP workshop took place. The aim of the workshop was to identify potential new Local Priorities for investigation and improvement for the next 12-18 months in line with the National Patient Safety Incident Response Framework and the Trusts Patient Safety Incident Response Plan (PSIRP).

8.2 Two years data was analysed from several key sources and crossed referenced with current improvement programmes these included:

- Incidents reporting and learning
- Complaints / Concerns raised by key stakeholders
- Themes from Divisions
- Health and Safety (RIDDOR)
- High scoring risks across the Trust
- National Safety Alerts
- Mortality Data alerting groups including SJRs
- Learning from Autism and Learning Disability Deaths reviews

8.3 A list of the top 25 themes was presented at the workshops, the groups identified a short list of 6 for further consideration. Further discussions have taken place with key leads and a potential shortlist of 3 have been identified.

- Safeguarding patients with Learning Difficulties where issues with Mental Capacity Act has been identified.
- Medication Errors
- Discharge planning issues/problems from Acute hospital beds to Care Homes and IHSS

8.4 Work is currently on going to ensure these categories meet the requirements of PSIRF. A paper will be presented to the next Trust Board to review the final proposed Local Priority categories for approval.

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. KPIs have been set for each quarter:

9.2.1 Qtr 1 50% - achieved.

9.2.2 Qtr 2 70% - on target to achieve.

9.2.3 Qtr 3 85%

9.2.4 Qtr 4 95%

Table 3: Patient Safety Syllabus Training (as of 31st July 2023)

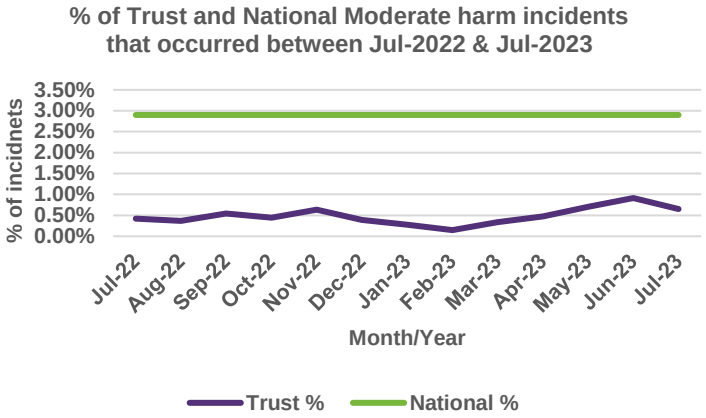
Patient Safety Training Modules	KPI Target Q1	% of staff completed training
Patient Safety Level 1a – all staff	50%	78.3%
Patient Safety Level 1b – Boards and senior leadership	50%	60.3%
Patient Safety Level 2 – Essential to role	50%	68.9%

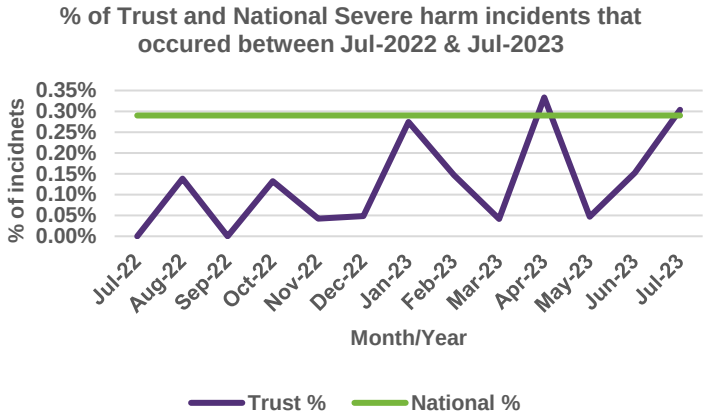
10. Maternity specific serious incident reporting in line with Ockenden recommendations

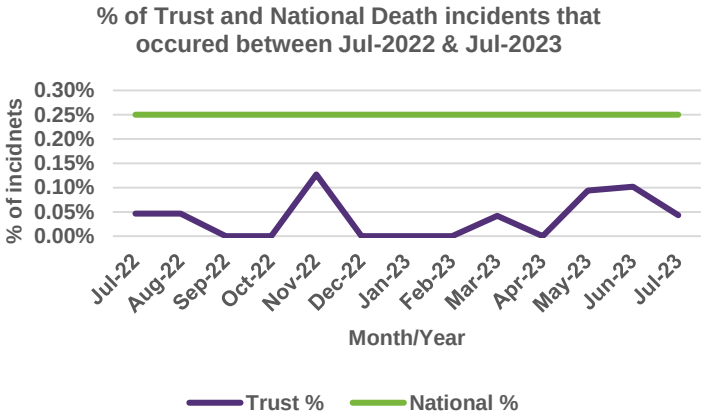
10.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 52 maternity related incidents have been reported on StEIS of which:

- 30 have been closed by the ICB with learning.
- 14 have been agreed for de-escalation from StEIS
- 4 are currently being investigated by HSIB
- 3 are currently under investigation by the Trust
- 1 is awaiting closure by PSIRI

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







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

Division	Number of SIRs (IR2s) by Month Target 95%	Apr	May	June	Trend	Total Number IR2s requiring action Datix (over 30 days)
CIC	No. open by month	303	328	336	↑	32
	No/Percentage open >30 calendar days	(245) 80.86%	(267) 81.40%	(284) 84.52%		
DCS	No. open by month	153	143	122	↑	139
	No/Percentage open >30 calendar days	(91) 59.48%	(81) 56.64%	(77) 63.11%		
FC	No. open by month	185	199	238	↓	148
	No/Percentage open >30 calendar days	(119) 64.32%	(131) 65.83%	(154) 64.71%		
MEC	No. open by month	998	959	796	↑	376
	No/Percentage open >30 calendar days	(751) 75.25%	(642) 66.94%	(578) 72.61%		
SAS	No. open by month	367	374	386	↑	289
	No/Percentage open >30 calendar days	(207) 56.40%	(213) 56.95%	(252) 65.28%		
Corp	No .Open by month	48	68	40	↓	93
	No/Percentage open >30 calendar days	(13) 27.08%	(28) 41.18%	(16) 40.00%		

Appendix B: KPI Dashboards for PSRs

Division	Number of PSRs open	Jun	Jul	Trend >90
CIC	No. open	41	41	↓
	No. open more than 90 calendar days	15	5	
DCS	No. open	6	8	→
	No. open more than 90 calendar days	1	1	
FC	No. open	28	35	→
	No. open more than 90 calendar days	13*	13*	
MEC	No. open	83	118	→
	No. open more than 90 calendar days	25	25	
SAS	No. open	44	49	↑
	No. open more than 90 calendar days	1	9	

**Outstanding PSRs for Family Care include PMRTs and ATAIN reviews which can take up to six months due to external multi-agency meetings.*

Appendix B: KPI Dashboards for PSIIs

PSII reports (including HSIB/PMRT)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total / Trend
No. incidents at Complex case	32	21	22	20						93
No. incidents agreed as PSII including (HSIB/PMRT)	5 (1)	4 (0)	5 (2)	2 (0)						16 (3)
No. over 6 mths	N/A	N/A	3	6 (2)						↑
Total No. of PSIIs Open	N/A	N/A	30 (6)	29 (4)						↓
No. approved/closed by PSIRI	0	4 (1)	3 (1)	3 (1)						10 (3)

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **113**

13 September 2023 | **Purpose** | Information / Assurance

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

Summary: This paper presents the corporate performance data at July 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 Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	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. 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. ID 6190: Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales. ID 8839: Failure to achieve performance targets. ID 8257: Loss of transfusion service. ID 7008: Failure to comply with 62-day cancer waiting time target. ID 5791: Failure to recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance. ID 9771: Failure to meet internal and external financial targets for the 2023-24 financial year. ID 9222: Failure to implement the NHS Green Plan
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	Urgent and emergency care improvement, elective pathway improvement, People Plan priorities, quality and safety improvement priorities, Electronic Patient Record, care closer to home/place-based partnerships, Provider Collaborative, tackling health and care inequalities, R&D, education and innovation, Waste Reduction Programme, Sustainability.
Related to ICB Strategic Objective	1. Improve quality, safety, clinical outcomes and patient experience. 2. To equalise opportunities and clinical outcomes across the area.

3. Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees.
4. Meet financial targets and deliver improved productivity.
5. Meet national and locally determined performance standards and targets.
6. To develop and implement ambitious, deliverable strategies.

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: Quality Committee, Finance & Performance Committee.

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- There were 0 MRSA infections detected in month
- The Cancer 28 day faster diagnosis standard was achieved in June at 76.9%.
- Average fill rates for registered nurses/midwives and care staff remain above threshold.
- 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.
- The Trust turnover rate is showing a significant reduction this month at 6.4%
- Compliance against the Information Governance Toolkit has achieved the 95% threshold.
- Friends & family scores in A&E are above threshold, although low number of responses must be noted.

Areas of Challenge

- There were 2 Steis reportable incidents in July. 0 of these were never events
- There were 4 healthcare associated clostridium difficile infections, 8 post 2 day E.coli bacteraemia and 5 Klebsiellas detected in month.
- There was 1 P.aeruginosa bacteraemia identified in July, bringing the year to date total to 6 vs the annual trajectory of 7.
- Venous Thromboembolism (VTE) risk assessment performance has dropped, however remains above 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 July at 75.8%, but was above the 70% improvement trajectory.
- There were 1073 breaches of the 12 hour trolley wait standard (46 mental health and 1027 physical health).
- There were 515 ambulance handovers > 30 minutes and 34 > 60 minutes. Following validation, 10 were due to ED delays and 24 were due to non-compliance with the handover screen.
- There were 84 Delayed discharges at the end of July, above trajectory (79).
- Performance against the cancer 62 day standard remains below threshold in June at 56.0%.
- There were 15.5 breaches of the 104 day cancer wait standard.

- The 6wk diagnostic target was not met at 11.1% in July.
- In July, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 63,291, which is above the trajectory.
- The number of RTT pathways over 65 weeks has increased to 435, which is above the trajectory.
- In July, there were 2506 breaches of the RTT >52 weeks standard.
- There were 80 operations cancelled on the day (non-clinical). This has returned to pre-covid levels.
- In July, there were 6 breaches of the 28 day standard for operations cancelled on the day.
- Length of stay - non-elective continues to be above baseline and has moved into quartile 2, just below national average (Model Health data)
- Sickness rates are above threshold at 6.1%
- The Trust vacancy rate is above threshold at 6.0%
- Compliance against the Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 14%.
- The Trust is reporting a breakeven duty deficit of £12.8m for the 2023-24 financial year to date, £3.6m behind plan, largely due to a £5.2m underachievement of the Waste Reduction Programme.

No Change

- The Summary Hospital-level Mortality Indicator (SHMI) has remained as expected at 1.09.
- The complaints rate remains below threshold and is showing no significant variation.
- 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.

Safe

	Indicator	Target	Actual	Variation	Assurance
M65	MRSA	0	0		
M64	Clostriduim difficile (C.diff) - 'Hospital onset healthcare associated (HOHA)'	n/a	4		
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	0		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	53	17		
M124	E-Coli (HOHA)	n/a	4		
M124.ii	E-Coli (COHA)	n/a	4		
M124.iv	E-Coli cumulative from April (HOHA & COHA)	129	46		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	1		
M155.ii	P. aeruginosa bacteraemia (COHA)	n/a	0		
M155.3	P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)	7	6		
M157	Klebsiella species bacteraemia (HOHA)	n/a	4		
M157.ii	Klebsiella species bacteraemia (COHA)	n/a	1		
M157.3	Klebsiella species bacteraemia cumulative from April (HOHA& COHA)	41	13		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	13.4		
M69	Serious Incidents (Steis)	No Threshold Set	2		
M70	Central Alerting System (CAS) Alerts - non compliance	0	0		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	#N/A		

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	96%		
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	21%		
C40	Maternity Friends and Family - % who would recommend	90%	96%		
C42	A&E Friends and Family - % who would recommend	90%	98%		
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	1%		
C44	Community Friends and Family - % who would recommend	90%	95%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	95%		
C15	Complaints – rate per 1000 contacts	0.40	0.28		
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.09		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at Mar-23)	Within Expected Levels	110.2		
M74	Hospital Standardised Mortality Ratio - Weekday (as at Mar-23)	Within Expected Levels	109.5		
M75	Hospital Standardised Mortality Ratio - Weekend (as at Mar-23)	Within Expected Levels	112.2		
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

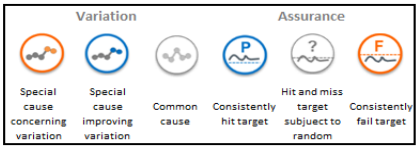
	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	76.0%	74.6%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	76.0%	75.8%		
M62	12 hour trolley waits in A&E	0	1073		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	515		
M84	Handovers > 60 mins (Arrival to handover)	0	34		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	59.8%		
C3	Referral to Treatment (RTT) non admitted pathways: percentage within 18 weeks	No Threshold Set	73.1%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	59,399	63,291		
C37.4	Referral to Treatment (RTT) 65 Weeks (Ongoing)	159	435		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	1571	2506		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	5.0%	11.1%		
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	56.0%		
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	93.2%		
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	89.1%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	99.1%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	82.4%		
C36	Cancer 62 Day Consultant Upgrade	85.0%	72.7%		
C25.1	Cancer - Patients treated > day 104	0	15.5		
C47	Cancer - % Waiting over 62 day (Urgent GP Referral)	N/A	7.51%		
C46	Cancer - 28 Day faster diagnosis standard	75.0%	76.9%		
M9	Urgent operations cancelled for 2nd time	0	0		
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	6		
M138	No.Cancelled operations on day	No Threshold Set	80		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re admissions within 30 days				
M90	Average length of stay elective (excl daycase)				
M91	Average length of stay non-elective				

Well Led

	Indicator	Target	Actual	Variation	Assurance
M77	Trust turnover rate	12.0%	6.4%		
M78	Trust level total sickness rate	4.5%	6.1%		
M79	Total Trust vacancy rate	5.0%	6.0%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	73.0%		
M80.35	Appraisal (Consultant)	90.0%	94.0%		
M80.4	Appraisal (Other Medical)	90.0%	99.0%		
M80.2	Safeguarding Children	90.0%	96.0%		
M80.21	Information Governance Toolkit Compliance	95.0%	95.0%		
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	-£5.5		
F2	WRP achieved YTD - variance to plan (£m)	£0.0	(£5.1)		
F3	Liquidity days	-25.8	-23.9		
F4	Capital spend v plan	85.0%	89%		
F18a	Capital service capacity	0.6	-0.2		
F19a	Income & Expenditure margin	-3.5%	-7.1%		
F21d	Agency spend as a proportion of total pay bill (£m)	3.7%	3.8%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	94.5%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	98.9%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	95.5%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	97.5%		

NB: Finance Metrics are reported year to date.

KEY

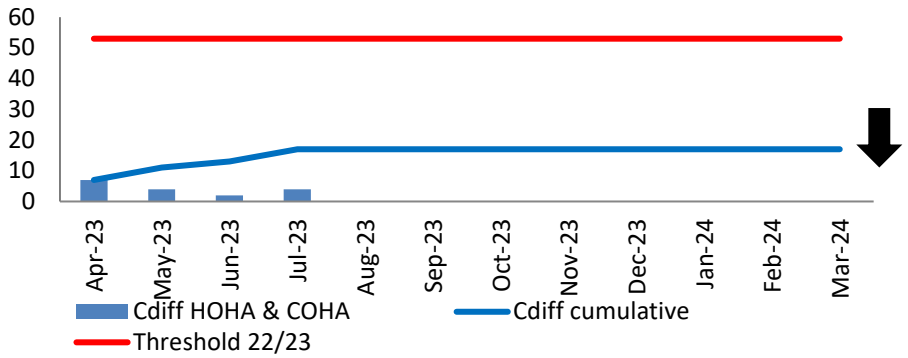


SPC Control Limits

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

SAFE

C Difficile (HOHA &



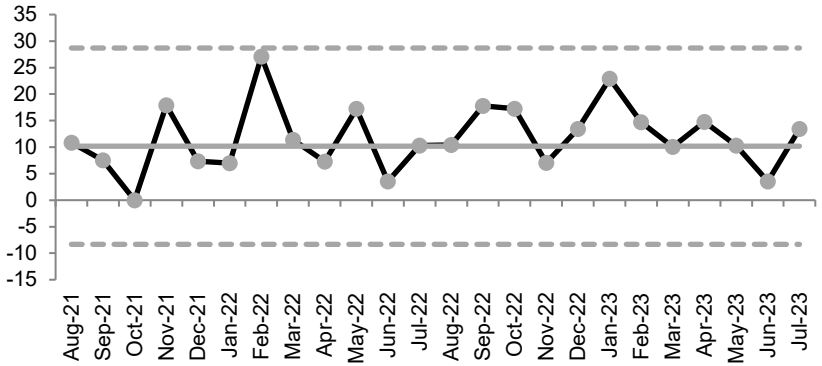
There were 0 post 2 day MRSA infection reported in July. So far this year there have been 3 cases attributed to the Trust.

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 July; All 4 cases were HOHA.

The year to date cumulative figure is 17 (HOHA & COHA). The detailed infection control report will be reviewed through the Quality Committee.

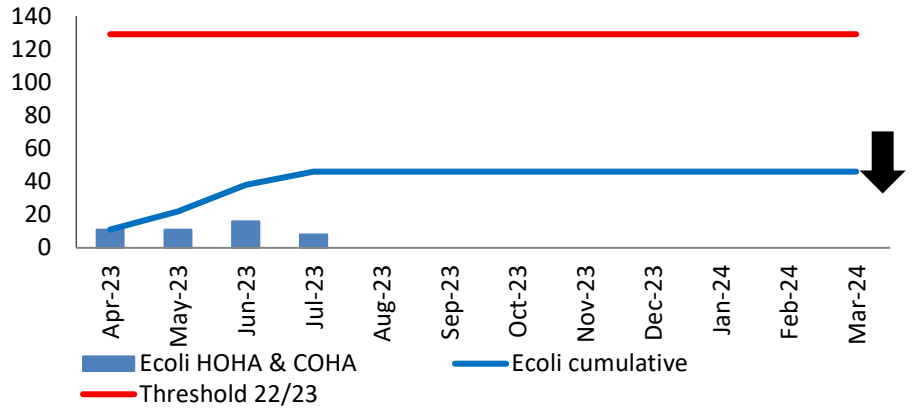
C Diff per 100,000 Occupied Bed Days (HOHA)



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

SAFE

E. Coli (HOHA & COHA)

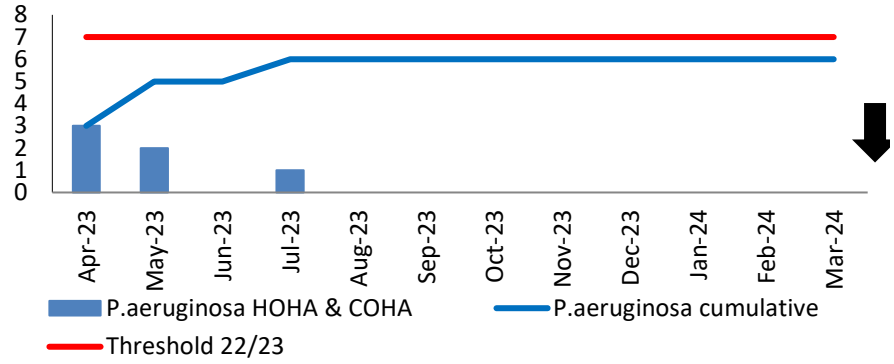


The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

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

There were 8 reportable cases of E.coli bacteraemia identified in July;4 HOHA and 4 COHA. The year to date total is 46.

P.aeruginosa

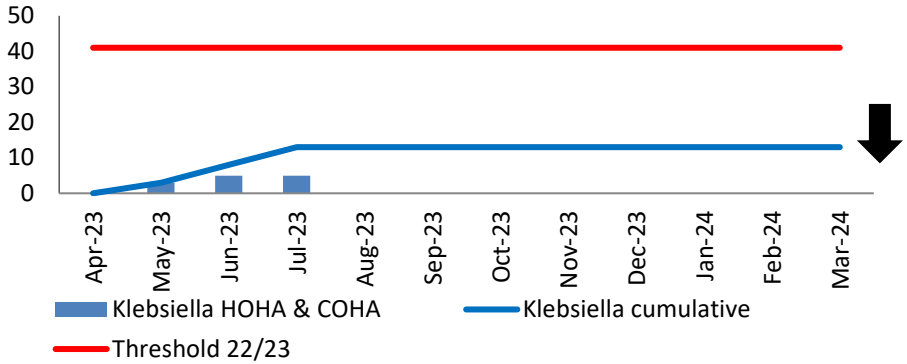


From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England.

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 was 1 reportable cases of Pseudomonas identified in July (HOHA).

Klebsiella



There were 5 reportable cases of Klebsiella identified in July. 1 COHA and 4 HOHA

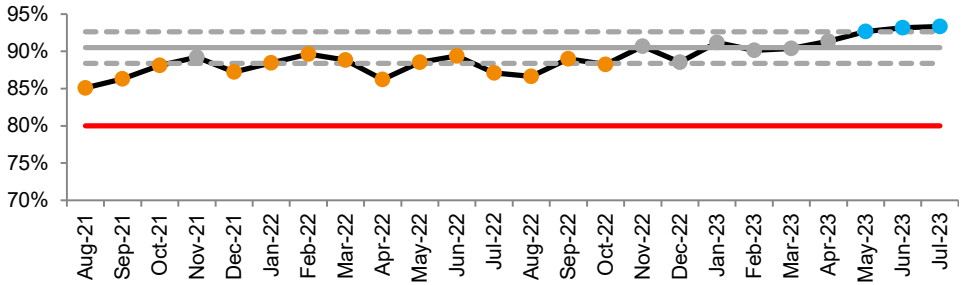
Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

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

SAFE

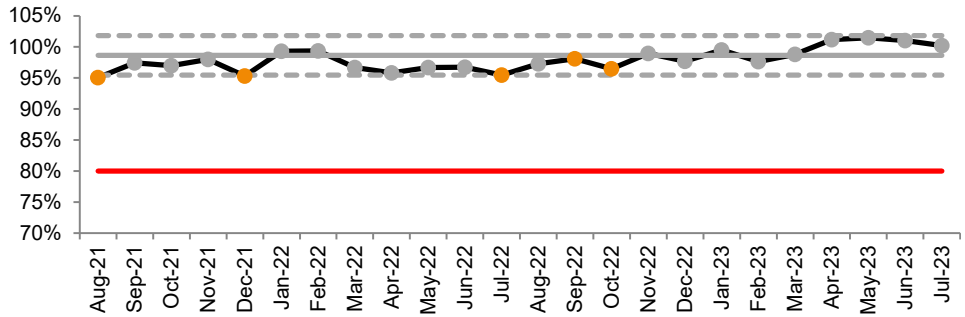
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



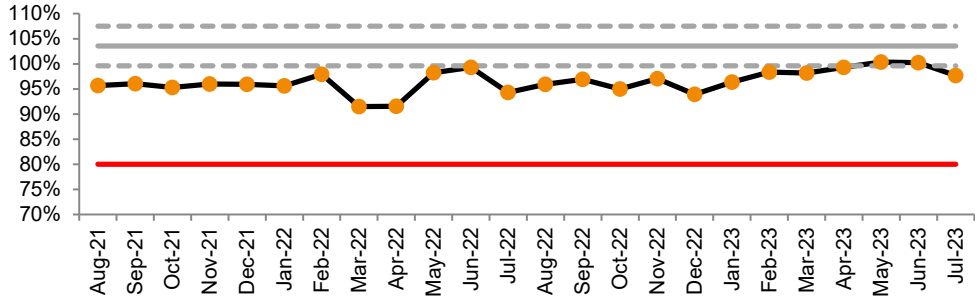
The average fill rate for registered nurses/ midwives during the day has shown an increase when compared to the pre covid levels. Based on current variation will consistently be above threshold.

Registered Nurses/ Midwives - Night



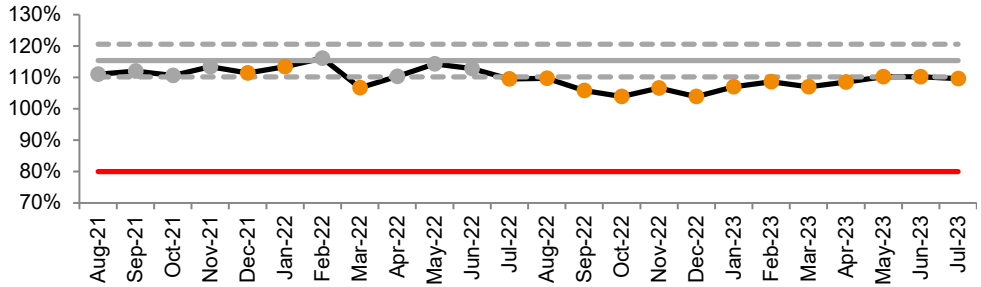
The average fill rate for registered nurses/ midwives at night is similar to pre-covid levels and based on current variation will consistently be above threshold.

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.

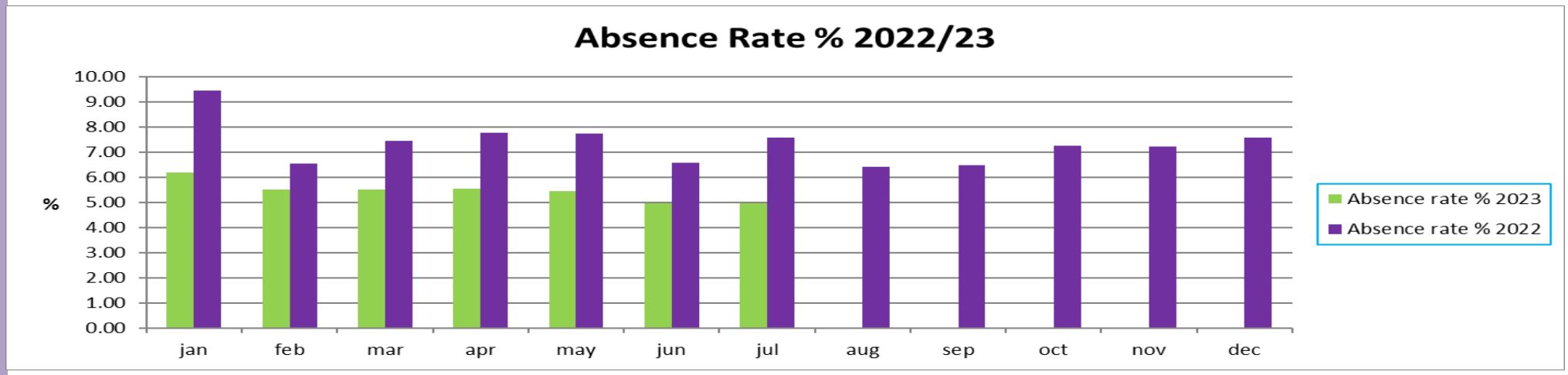
Care Staff - Night



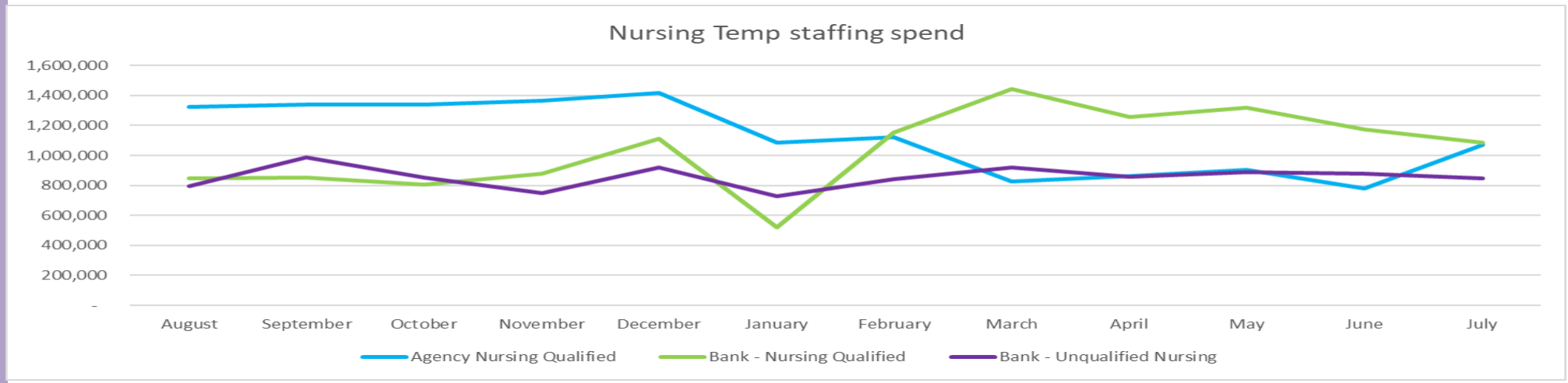
The average fill rate for care staff at night remains above threshold, however is showing a reduction on pre covid levels. Based on current variation will consistently be above threshold.

SAFE

Staffing in July 2023 remains challenging. Overall Nursing and Midwifery sickness and absence rates have reduced whilst maternity absence remains static., the data below shows the trends for 2023.



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. The chart below demonstrates cost of nursing bank and agency per month.



In July 2023, no areas fell below the 80% for Registered Nurses/Midwives for the day shifts. It should be noted that actual and planned staffing does not denote acuity, dependency, the number of women in labour or bed occupancy. The divisions consistently risk assess and flex staffing resources to support staffing. Every option is explored throughout the day and night to support staffing.

SAFE

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
Jul-23	93.3%	97.7%	100.2%	109.6%	29,766	8.61	0	2	0	0

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 (%)
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
Jun-23	93.2%	100.2%	101.1%	110.2%	28,056	8.95	1	1	1	0
Jul-23	93.3%	97.7%	100.2%	109.6%	29,766	8.61	0	2	0	0

SAFE

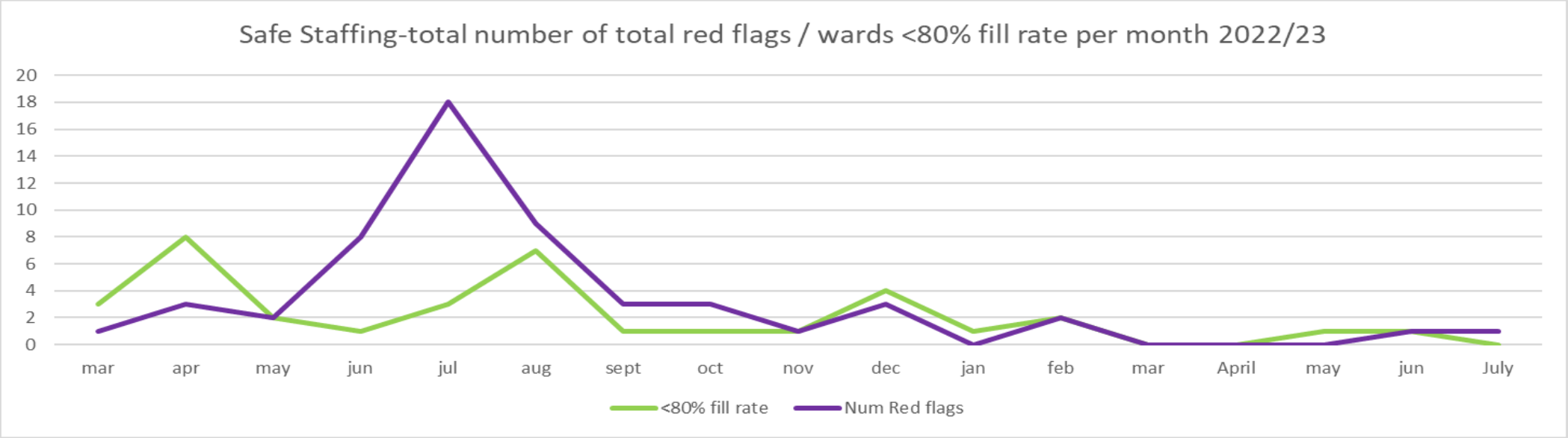
National Nursing Red Flags

On reviewing July 2023 data there was 1 Nursing Red Flag reported.

CIC, ward 19 – Medication delays and delays in personal care on one night shift in July. Increased number of patients to the bed base for this ward, care and activity is being monitored with support from the Acute Care Team. No harm to any patients.

In July, 0 areas fell below the 80% fill rate.

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.

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SAFE

Actions taken to mitigate risk

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

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

* Recruitment Strategy, this continues as an internal QI project, with a further workshop focusing on the nurse recruitment / vacancy data being planned.

* 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
    * 20 in April
    * 18 in May
    * 20 in June
    * 20 in July
    *20 planned for August

* ELHT has agreed to recruit 8 international midwives. 6 have passed their OSCEs and working as qualified midwives. 3 more will arrive before December 2023

* We have recruited, and now in post a second WTE band 6 Pastoral Nurse for our International Nurses.

Family Care Staffing Summary – July 2023

On reviewing Datix for July 2023 there were 0 National Midwifery Red Flags reported

Maternity (Midwife to Birth Ratio)

Month	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Staffed to full Establishment	01:28	01:27	01:28	01:28	01:27	01:27	0.060856	01:27:31	01:27	1:26	1:27:64	1:27
Excluding mat leave	01:28	01:27	01:29	01:27	01:27	01:27	01:27	0.061435	01:27	1:26	1:27	1:27
Maternity leave	-	-	-	-	-	-	03:50	4.52	3.40	3.40	3.40	3.40
With gaps filled through ELHT Midwife staff bank	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage
Per week	16.10	20.75	30.56	21.74	17.99	25.73	25.73	25.71	18.25	16.77	21.58	17.50
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)	26 wte (15) 11 VRs for mat	25 wte (14)

Maternity- June bank filled hours filled 17.50 wte.
Safe midwifery staffing levels also continue to be reviewed with the appropriate risk assessments 4 times a day at each safety huddles. Additional staffing/ leadership huddles will take place in periods of extreme staffing pressures to mitigate throughout maternity services; midwives are redeployed to other areas to support acuity and activity as and when required. Bank filled duties remain stable as reflected above and monitored in monthly figures. Local midwifery red flags noted at each handover and reviewed by the local governance team on a weekly basis.
An unusual number of maternity diverts for the month of July. This is due to changes in activity and therefore the reallocation of staff (implementation of national guidance has seen an increase in induced labours hence a reduction of natural labours, this is being monitored locally), a spike in sickness in midwives (4.56% to 5.02%) and vacancies. 27 new starter midwives are scheduled to start at the end of September 2023.

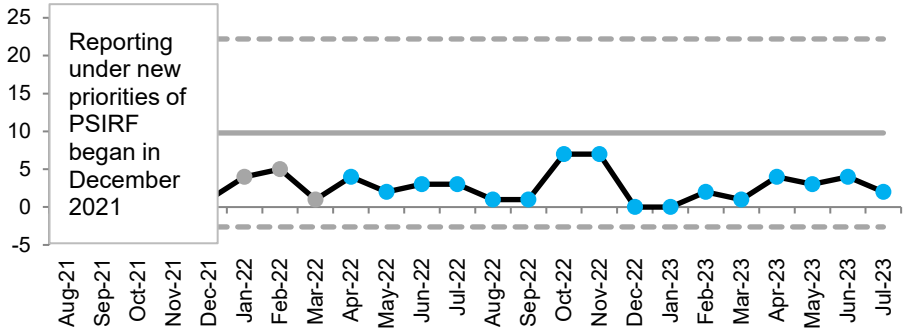
Neonatology – Median number of internal/ external closures in the month of July, this is due to acuity/ dependency and activity. Daily maternity/ neonatology safety huddles inclusive of safe staffing tool are completed four hourly to support QIS cover as acuity has been high for intensive and special care infants. A risk assessment is available for agency nurse cover if escalation permits in the occurrence of bank duties with the enhanced pay rate. Minimal agency requests in the month of July as bank uptake has met the shortfall.

Paediatrics – No staffing exceptions. Reduced beds and activity at periods in the month of July – shortfalls reflect acuity and dependency.

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, this is being monitored to ensure staffing numbers on the ward always remain at safe levels. Risk assessment, cross divisional in draft at

SAFE

Serious Incidents



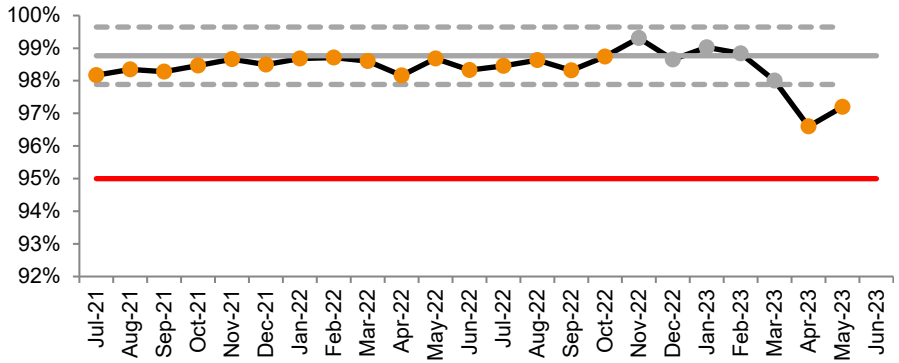
PSIRF Category	No. Incidents
PSIRF Early Adopter - Incident resulting in death	2

There were no never events reported in July.

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

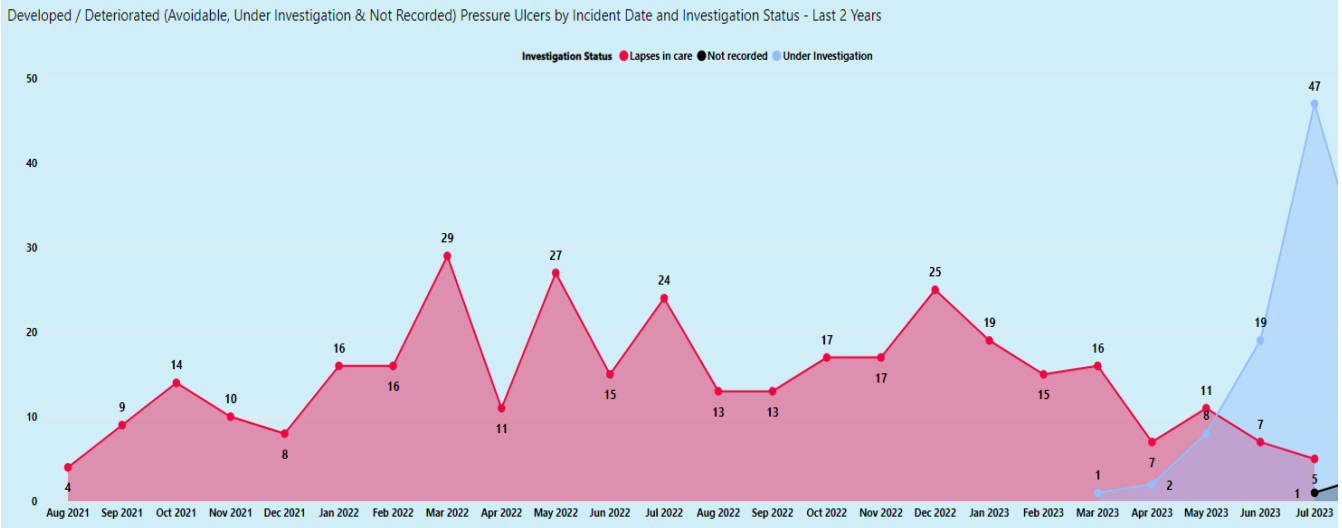


The Venous Thromboembolism (VTE) assessment trend has dropped below the normal run rate, however is still above the threshold.

SAFE

Pressure Ulcers

For July 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-July)
2	32	44	73	9
3	14	14	6	1
4	0	3	9	2
Unstageable	15	25	33	9
Deep Tissue Damage	9	53	91	18
TOTAL	70	139	212	39

The 39 lapses in care during 2023 is a concern, themes identified are incomplete risk assessments, lack of appropriate skin assessments being undertaken and record keeping. A 'live' improvement plan is in place, owned by the Pressure Ulcer Steering Group with Quality Improvement Team involvement; current actions include the requirement of the uploading of clinical photography of the wound at the time of reporting the incident, a strong focus on the appropriate use of continence pads and DERI presenting to the Exec Board the recommendation to request that all patient facing staff are equipped with the right knowledge with regards to both the prevention and management of skin damage.

The National Wound Care Strategy Programme on 'Pressure Ulcer Clinical Recommendations and Clinical Pathway' is now finalised and due for release in August 2023 – this will require the Trust to make changes to the current Pressure Ulcer Policy

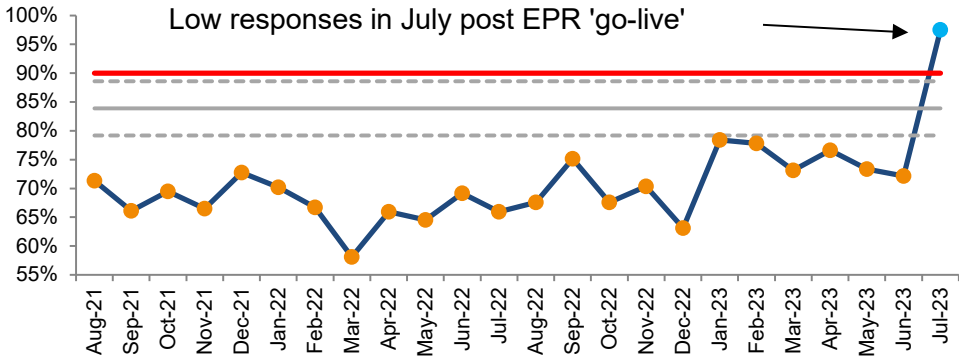
Ongoing work continues with our North West colleagues to establish a benchmarking position.

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.

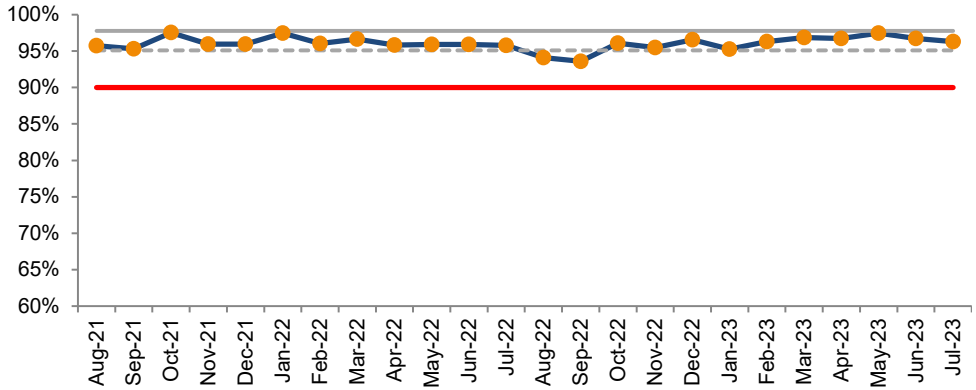
Baseline period for SPC comparison is Apr 18 - Mar 20

Friends & Family A&E



A&E scores are showing a significant Improvement from the baseline (Apr 18 - Mar 20) in July, however the number of responses was lower than previous months as the text survey has not yet recommenced following Cerner go-live. Based on current variation this indicator is not capable of hitting the target routinely.

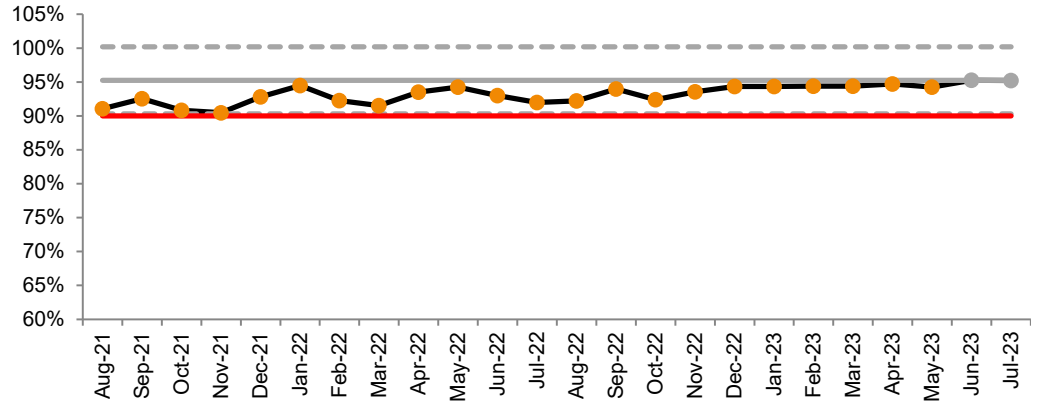
Friends & Family Inpatient



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

CARING

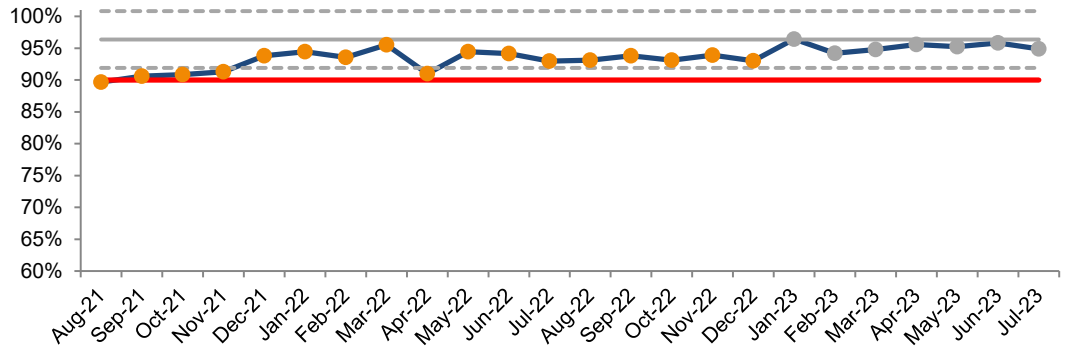
Friends & Family Outpatients



Outpatient scores continue to be above target and are within the normal range when compared to the pre-covid baseline.

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

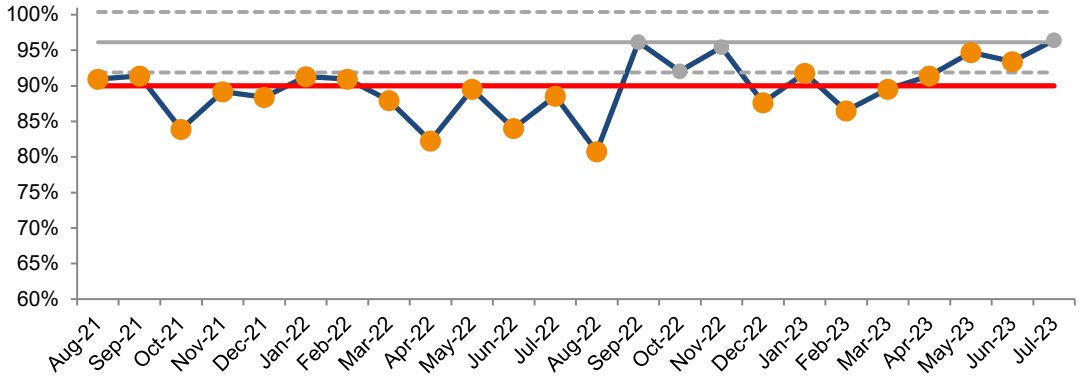
Friends & Family Community



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

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

Friends & Family Maternity

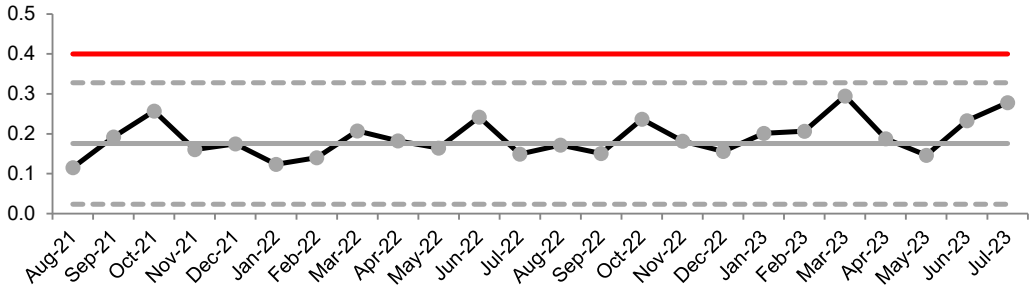


Maternity scores are above target this month and are within the normal range when compared with pre-covid levels

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

CARING

Complaints per 1000 contacts



The Trust opened 23 new formal complaints in July.

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 July the number of complaints received was 0.28 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	100	100
Community	Community and Intermediate Care Services	96.28	90.83	93.93	94.44	94.09
Community	Diagnostic and Clinical Support	99.04	96.53	99.09	91.67	97.34
Community	Family Care	100	-	-	100	100
Community	Surgery	99.83	95.97	-	-	97.07
Delivery	Family Care	100	-	100	100	100
Inpatients	Community and Intermediate Care Services	88.49	84.66	87.63	87.5	87.09
Inpatients	Diagnostic and Clinical Support	100	93.9	89.84	98.25	95
Inpatients	Family Care	92.71	86.49	88.1	86.29	88.69
Inpatients	Medicine and Emergency Care	88.93	77.22	78.42	82.69	80.19
Inpatients	Surgery	94.04	85.38	90.43	89.51	90.01
OPD	Diagnostic and Clinical Support	98.58	95.15	99.65	97.18	97.08
OPD	Family Care	99.36	91.51	94.12	93.42	94.67
OPD	Medicine and Emergency Care	98.8	88.66	98.61	98.33	95.34
OPD	Surgery	100	93.15	96.85	100	97.38
Other	Surgery	88.41	91.57	90.7	68.89	86.25
Postnatal	Family Care	100	100	100	100	100
SDCU	Family Care	94.17	94.17	93.75	93.75	93.96
	Total	**95.02**	**90.24**	**91.78**	**92.38**	**92.18**

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

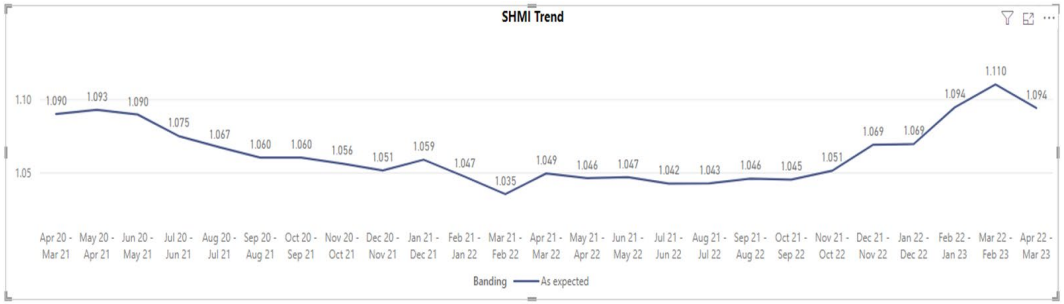
The threshold is a positive score of 90% or above for each of the 4 competencies.

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

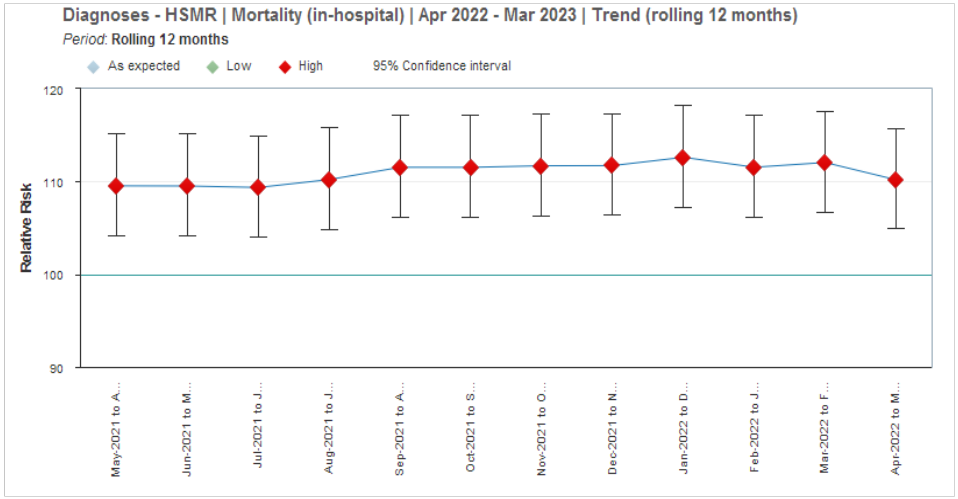
SHMI Published Trend



Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month Apr 22 – Mar 23
	ALL
TOTAL	110.2
Weekday	109.5
Weekend	112.2

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 Apr 22 to Mar 23 has decreased from last month, however remains within expected levels at 1.09, as published in Aug 23.

The latest indicative 12 month rolling Hospital Standardised Mortality Ratio (HSMR), (Apr 22 – Mar 23) has reduced from last month but remains 'above expected levels' at 110.2 against the monthly rebased risk model.

The benchmark model has been adjusted this month to account for data up to Dec 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, Acute cerebrovascular disease, Repiratory failure and Secondary malignancies.

Pneumonia 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

	Month of Death																			
Stage 1	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar 20	Apr 20 - Mar 21	Apr 21 - Mar 22	Apr 22 - Mar 23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	TOTAL
Deaths requiring SJR (Stage 1)	46	212	250	262	214	163	230	18	5	9	7									39
Allocated for review	46	212	250	262	214	163	230	18	5	9	7									39
SJR Complete	46	212	250	262	214	162	212	7	1	2	0									10
1 - Very Poor Care	1	1	0	0	1	1	1	1	0	0	0									1
2 - Poor Care	8	19	22	34	35	22	38	3	0	1	0									4
3 - Adequate Care	14	68	70	70	65	49	70	1	1	0	0									2
4 - Good Care	20	106	133	129	103	78	98	2	0	1	0									3
5 - Excellent Care	3	18	25	29	10	12	5	0	0	0	0									0
Stage 2																				
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	39	4	0	1	0									5
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	4	1	0	0	0									1
Allocated for review	6	18	21	30	35	22	35	3	0	1	0									4
SJR-2 Complete	6	18	21	30	35	22	33	1	0	0	0									1
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0	0									0
2 - Poor Care	3	6	7	13	13	10	18	1	0	0	0									1
3 - Adequate Care	2	10	13	13	21	10	11	0	0	0	0									0
4 - Good Care	0	1	0	2	1	1	3	0	0	0	0									0
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0	0									0

	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar 20	Apr 20 - Mar 21	Apr 21 - Mar 22	Apr 22 - Mar 23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
stage 1 requiring allocation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
stage 1 requiring completion	0	0	0	0	0	1	18	11	4	7	7	0	0	0	0	0	0	0	0	29
Stage 1 Backlog	0	0	0	0	0	1	18	11	4	7	7	0	0	0	0	0	0	0	0	29
stage 2 requiring allocation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
stage 2 requiring completion	0	0	0	0	0	0	10	4	5	6	7	8	9	10	11	12	13	14	15	114
Stage 2 Backlog	0	0	0	0	0	0	10	4	5	6	7	8	9	10	11	12	13	14	15	114

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

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

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

Learning Disability Mortality Reviews

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)

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.

CCG10 had been added to the list of relevant CQUIN schemes for ELHT following discussion with the relevant services. Outcome data has been added for CCG3 and CCG12

The deadline for the quarter 1 submision is 27th August

Ref:	Title of Scheme	Indicator	Lead/s	CQUIN Value	Period Calculation	Min (%)	Max (%)	Percentage Compliance (%)				Scheme performance (%)	Travel
								Q1	Q2	Q3	Q4		
CCG1	Staff Flu Vaccinations	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact	S Brewer	NA	All Quarters Quarterly average %	75	80						
*CCG2	Supporting patients to drink, eat and mobilise after surgery	Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	Prof A Krige C Aherne	1,100k	All Quarters Quarterly average %	70	80	91					
*CCG3	Prompt switching of intravenous to oral antibiotic	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria	Dr H Ziglam K Robinson	1,100k	All Quarters Quarterly average %	60	40	21					
CCG4	Compliance with timed diagnostic pathways for cancer services	Achieving 55% of referrals for suspected prostate, colorectal, lung, oesophago-gastric, head & neck and gynaecological cancers meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	S Hechter V Cole A Casey	N/A	All Quarters Quarterly average %	35	55	8.9					
*CCG5	Identification and response to frailty in emergency departments	Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.	C Finney P McManaman	NA	All Quarters Quarterly average %	10	30						
*CCG6	Timely communication of changes to medicines to community pharmacists via the discharge medicines service	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.	E Watson	1,100k	All Quarters Quarterly average %	0.5	1.5	15.3					
*CCG7	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.	A Catterall	1,100k	All Quarters Quarterly average %	10	30	85					
**CCG8	Achievement of revascularisation standards for lower limb ischaemia	Percentage of patients that have a diagnosis of CLTI that undergo revascularisation, either open, endovascular or combined within 5 days of a non-elective admission to vascular provider units.	Mrs J Buxton L Taylor	NA	All Quarters Quarterly average %	45	65						

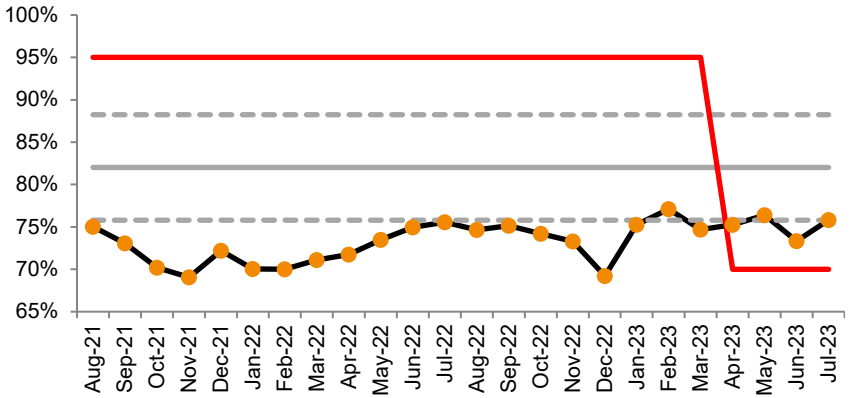
EFFECTIVE

**CCG9	Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	The percentage of patients commencing treatment within 4 weeks of referral to ODN	J Grassham	TBC	Quarters 1 to 4	40	75						
**CCG10	CCG10: Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-1) referred for treatment with curative intent, as per the NICE QS17 recommendation	Dr F M Zaman V Cole	TBC	Whole period %	80	85						
**CCG11	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	The level of patient satisfaction with shared decision-making conversations – as measured by patient scores on internationally validated patient questionnaires – at key decision points in specified pathways that are priority areas for recovery around managing /reducing waiting lists, unplanned admissions and keeping vulnerable people out of hospital.	S Hechter J Lishman	TBC	Quarter 2 and 4	65	75						
CCG12	Assessment and documentation of pressure ulcer risk	Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.	C Forrest A King	NA	All Quarters Quarterly average %	70	85	34					
CCG13	Assessment, diagnosis, and treatment of lower leg wounds	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.	C Forrest	NA	All Quarters Quarterly average %	25	50	62					
CCG14	Malnutrition screening for community hospital inpatients	Achieving 90% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks	J Wilding	NA	All Quarters Quarterly average %	70	90						
*CCG15a	Routine outcome monitoring in community mental health services	Achieving 50% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice. Separately, achieving 10% of adults and older adults accessing select Community Mental Health Services, having their patient-reported outcomes measure (PROM) recorded at least twice.	J Weller	1,100k	Whole period; 50% weighting on each type of measure	20 2	50 10						

*Incentivised Schemes in Green, **Specialist Service Schemes in Blue

RESPONSIVE

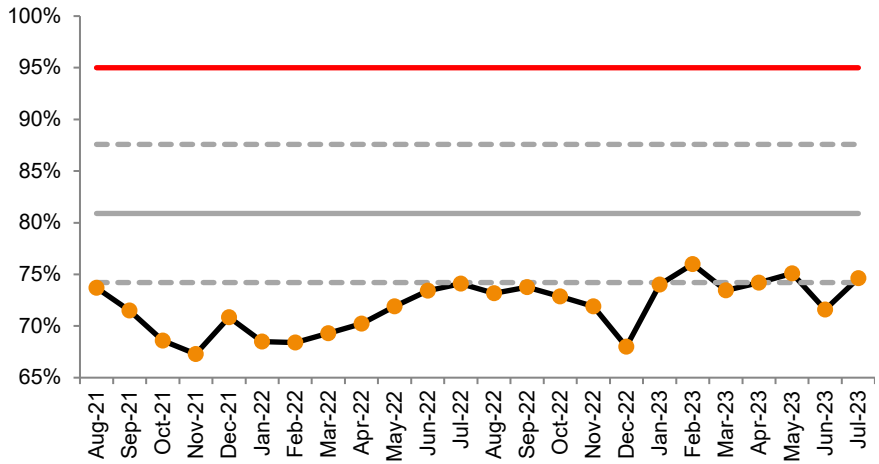
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 75.82% in July, which is below the 76% threshold, however above the improvement trajectory (70%).

The trend continues to show a deterioration on previous performance however the Trust is on track to deliver the 76% target.

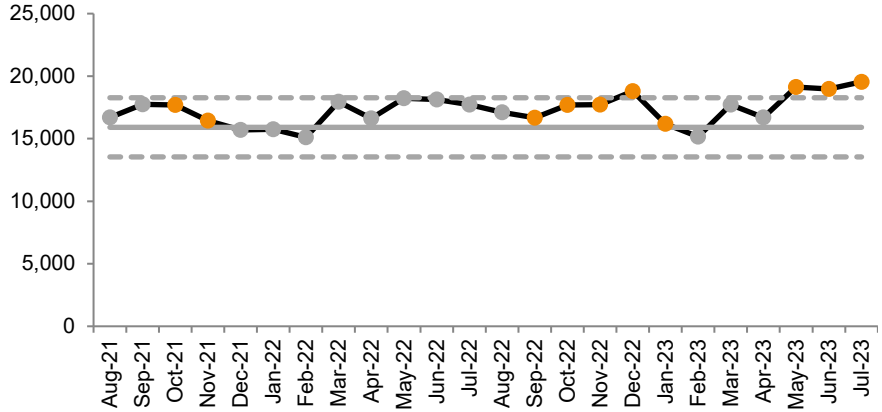
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 74.62% in July.

The national performance was 74.0% in July (All types).

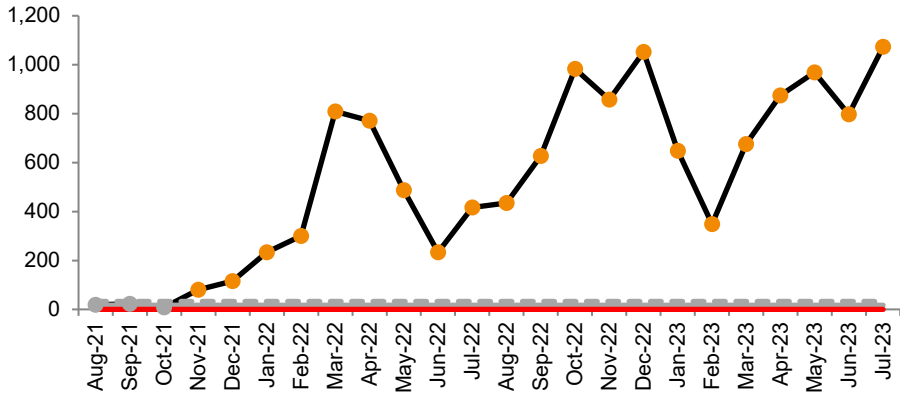
A&E Attendances - Trust



The number of attendances during July was 19,547, which is above the nornal range when compared to the pre-covid baseline.

RESPONSIVE

12 Hr Trolley Waits

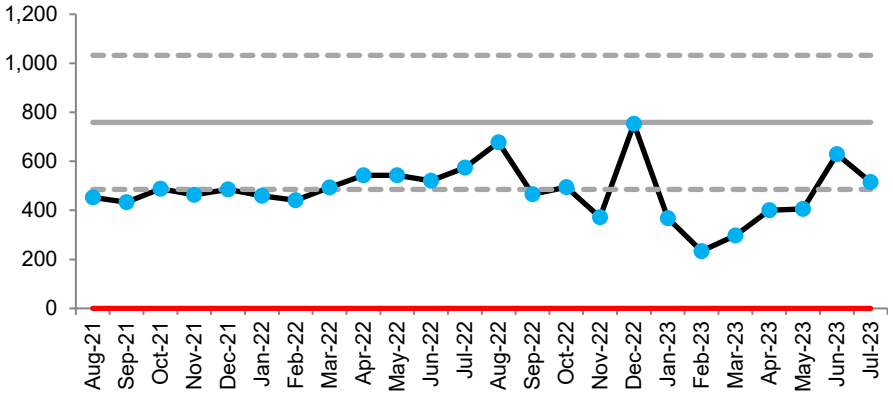


There were 1073 reported breaches of the 12 hour trolley wait standard from decision to admit during July, which is higher than the normal range. 46 were mental health breaches and 1027 were physical health.

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

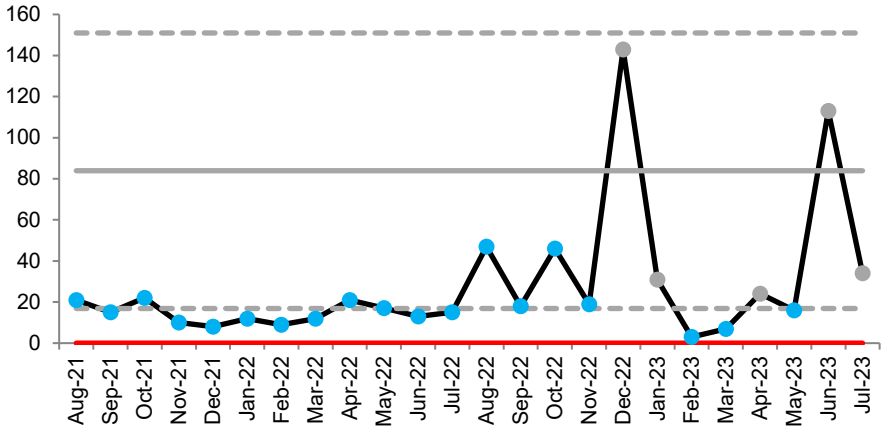
	Mental Health	Physical Health
No. 12 Hr Trolley Waits	46	1027
Average Wait from Decision to Admit	49hr 42 min	21hr 54 min
Longest Wait from Decision to Admit	168hr 09 min	44hr 03 min

Ambulance Handovers - >30Minutes



There were 515 ambulance handovers > 30 minutes in July. 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 34 ambulance handovers > 60 minutes in July.

Following validation, 10 were due to delays in ED and 24 were due to non-compliance with the handover screen.

The average handover time was 23 minutes in July and the longest handover has been reported by NWAS as 4hr 06 and was an NWAS delay.

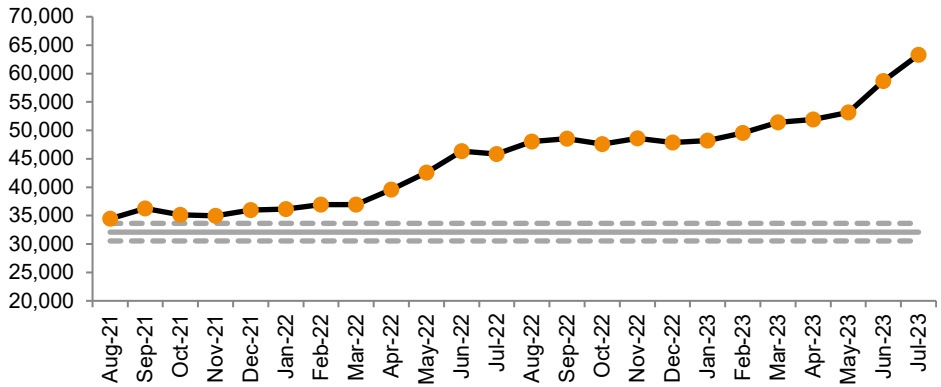
RESPONSIVE

At the end of July, there were 63,291 ongoing pathways, which has increased on last month and is above pre-COVID levels.

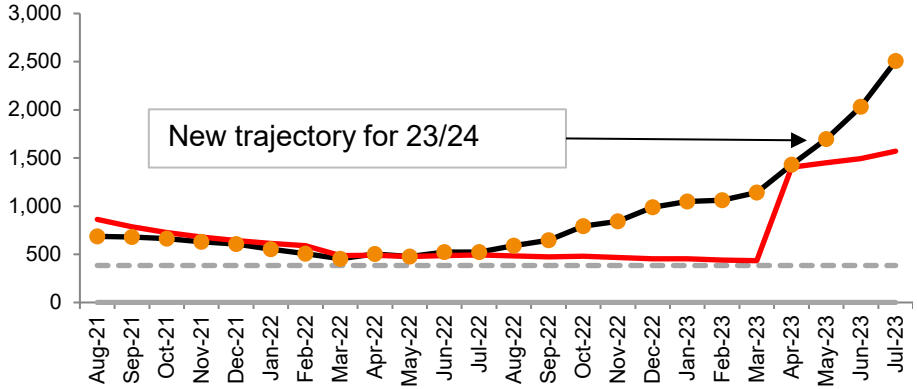
There were 2506 patients waiting over 52 weeks at the end of July which has increased on last month and is above trajectory.
There were 435 patients waiting over 65 weeks at the end of July which has increased on last month and is above trajectory.

There were no patients waiting over 78 weeks.

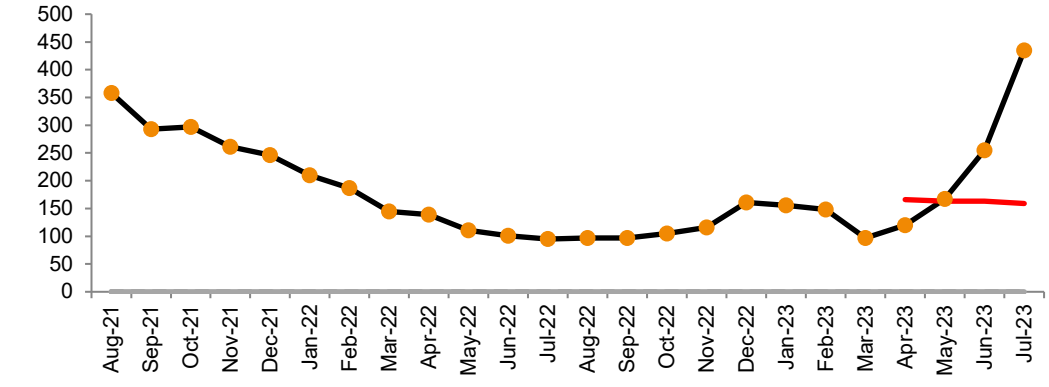
Referral to Treatment (RTT) Total Ongoing



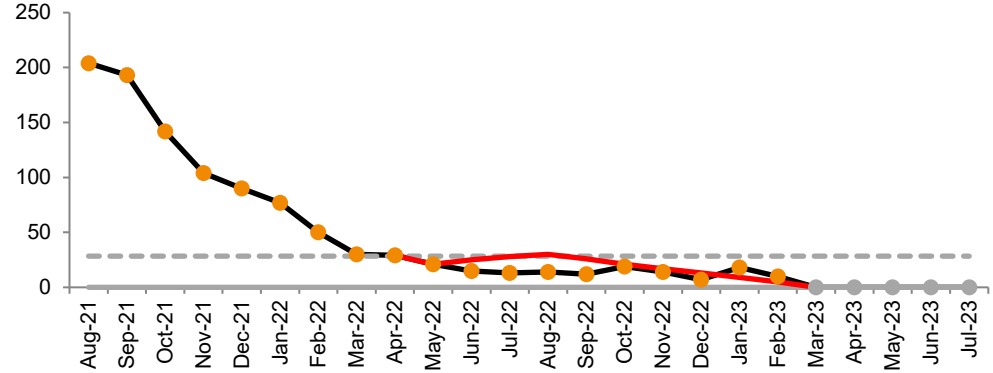
RTT Total Over 52 wks



RTT Total Over 65 wks



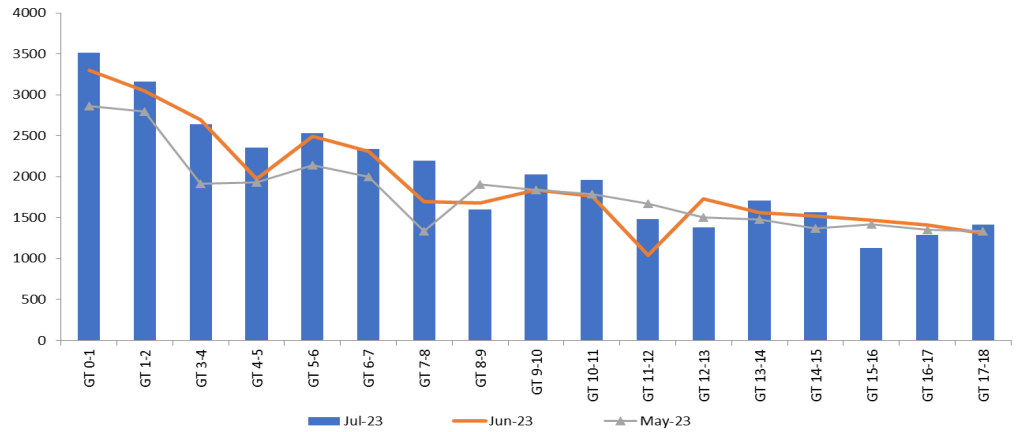
RTT Total Over 78 wks



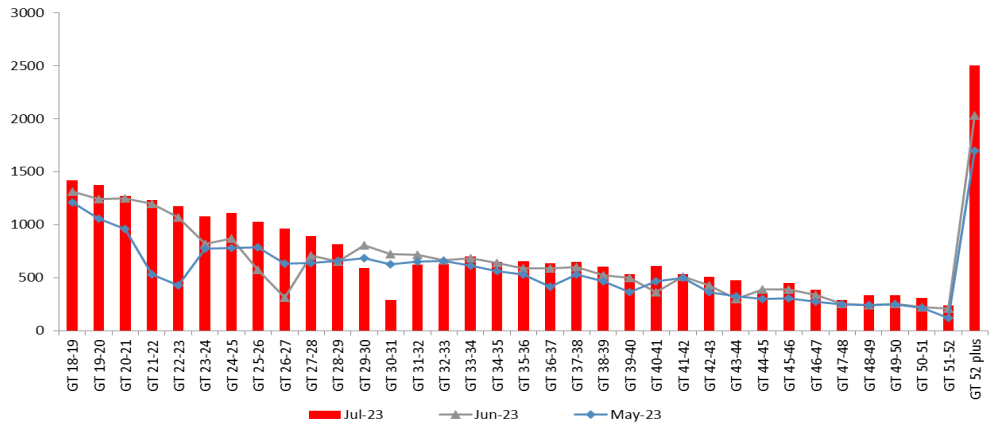
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

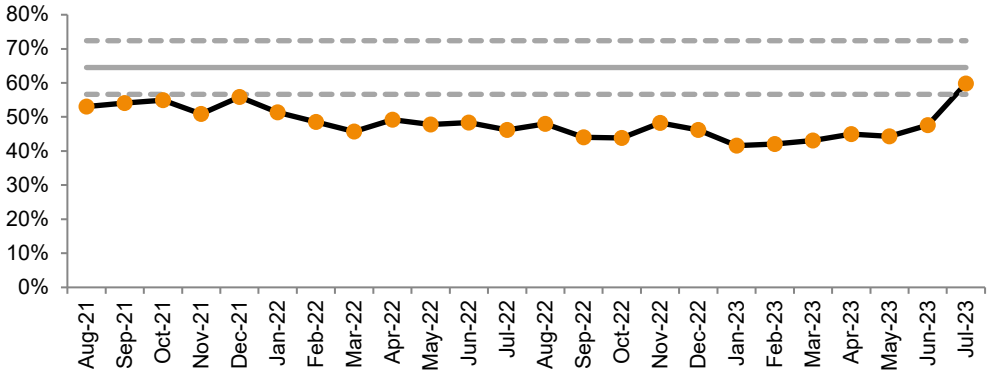


RTT Over 18 weeks

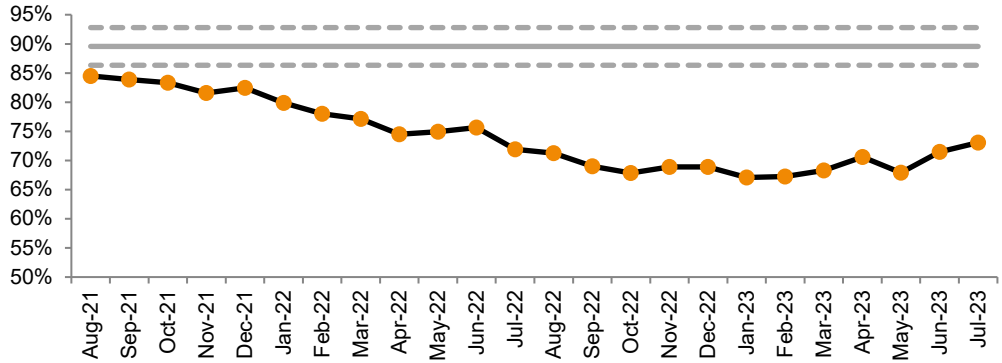


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted

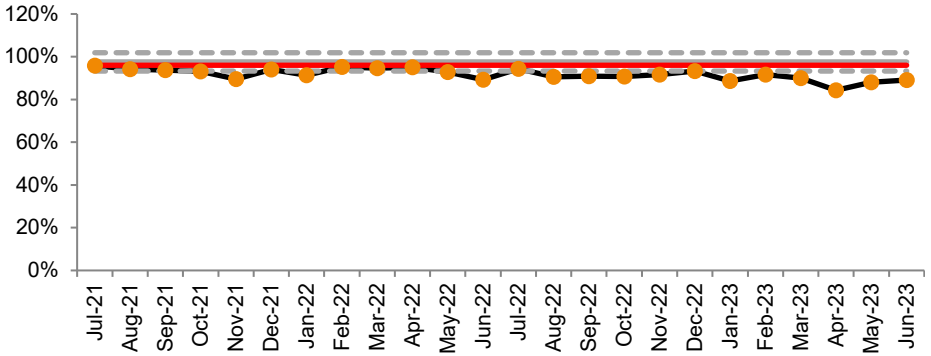


RTT Non-Admitted



RESPONSIVE

Cancer 31 day



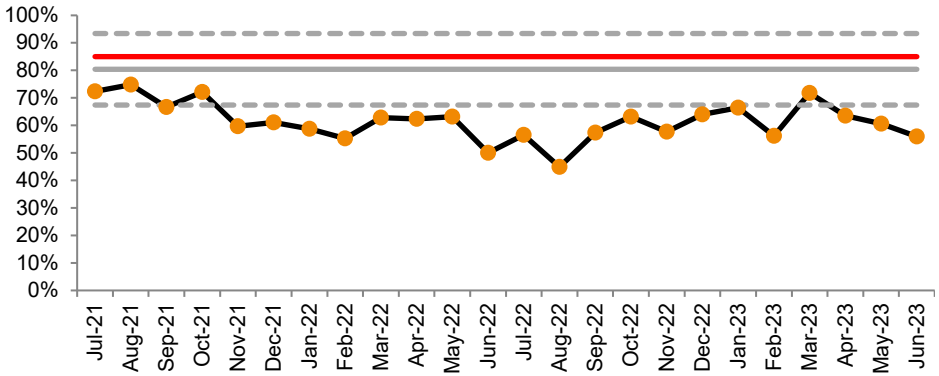
The 31 day standard was not achieved in June at 89.1%, below the 96% threshold.

Q1 was not achieved at 87.2%

National position Q1 - 90.7%

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

Cancer 62 Day



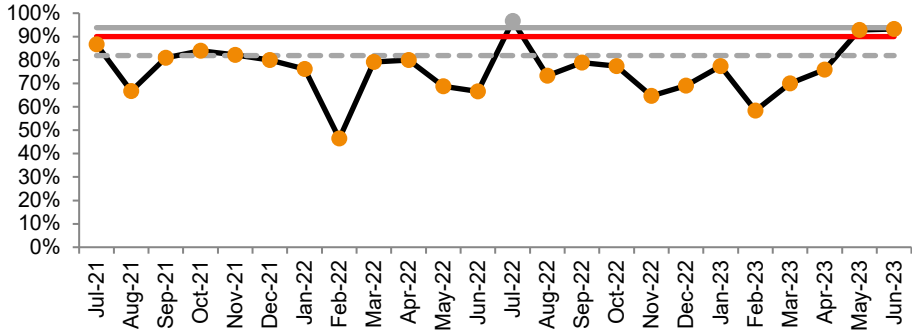
The 62 day cancer standard was not achieved in June at 56.0% below the 85% threshold.

Q1 was not achieved at 62.4%

National position Q1- 59.6%

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

Cancer 62 Day Screening



The 62 day screening standard was achieved in June at 93.2%, above the 90% threshold.

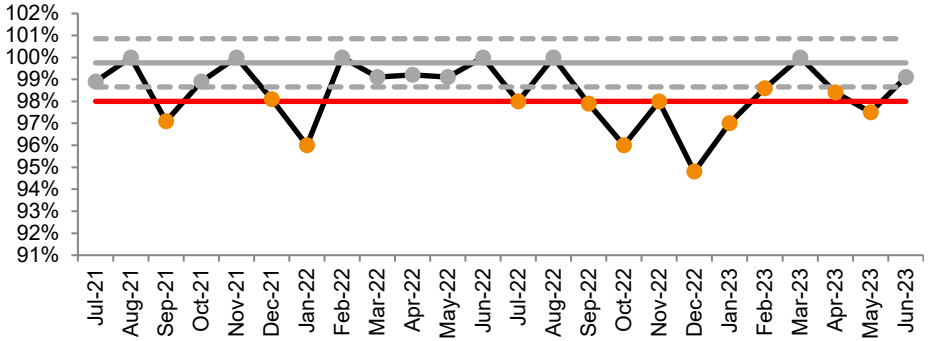
Q1 was achieved at 90.6%

National position Q1 - 63.8%

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

RESPONSIVE

Cancer - Subsequent treatment within 31 days (Drug)



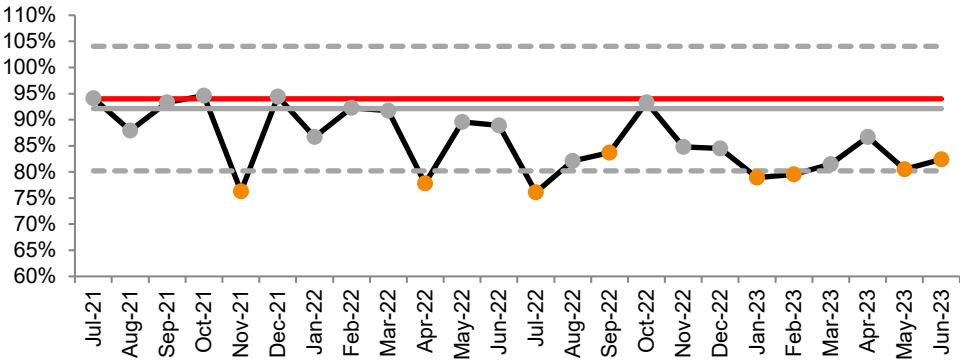
The subsequent treatment - drug standard was above target in June at 99.1%

Q1 was achieved at 98.4%

National position Q1 - 97.6%

The trend is within normal range when compared to the pre-covid baseline and based on the normal variation, the indicator should consistently achieve the standard.

Cancer - Subsequent treatment within 31 days (Surgery)



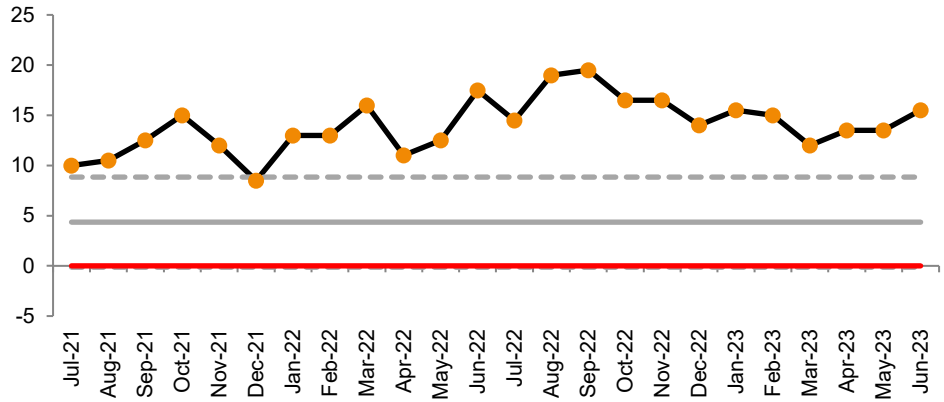
The subsequent treatment - surgery standard was not met in June at 82.4%, below the 94% standard.

Q1 was not achieved at 82.9%

National position Q1 - 77.5%

The trend is showing deterioration 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

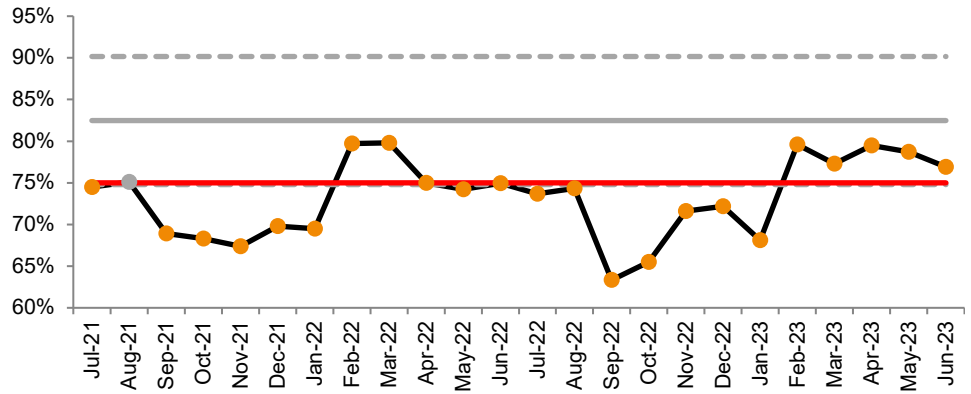


There were 15.5 breaches allocated to the Trust, treated after day 104 in June and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the consultants involved in the pathway as required.

The trend is showing a significant increase on the baseline.

RESPONSIVE

Cancer 28 Day faster diagnosis



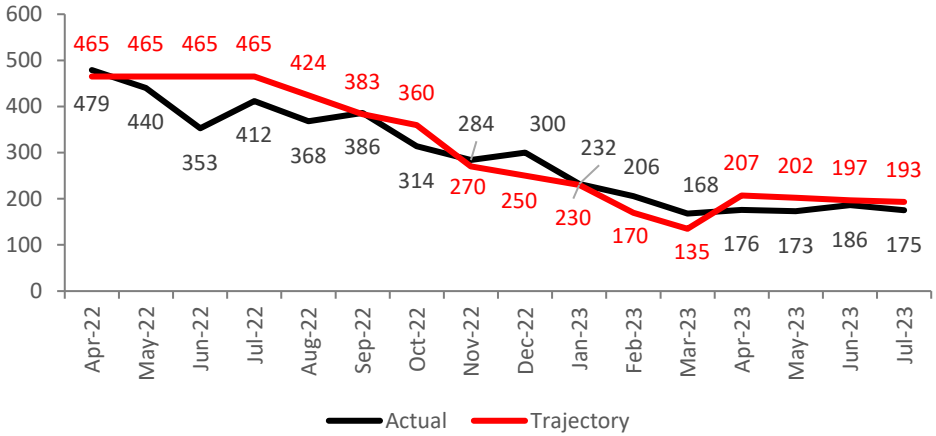
The 28 day faster diagnosis standard acheived the target in June at 76.9%

Q1 was achieved at 79.5%

National position Q1 - 72.0%

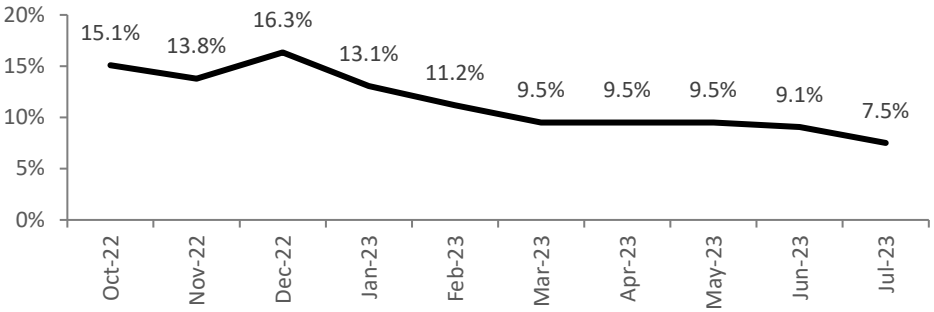
The trend is showing significant deterioration when compared to the pre-covid baseline.

Cancer >62 day vs trajectory



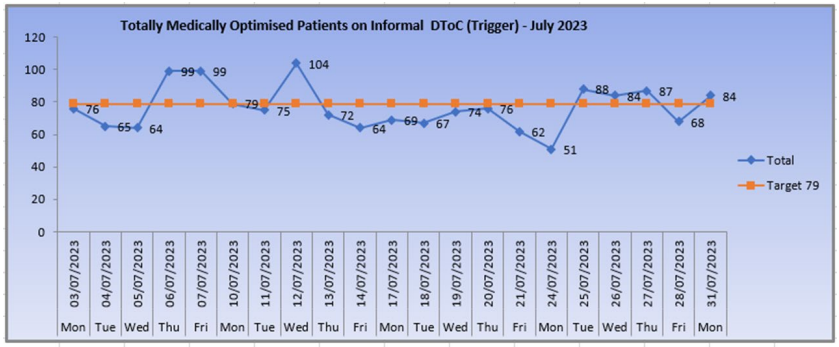
At the end of July the number of patients >62 days was 175 vs 193 trajectory. This was 7.5% of the total wait list.

Cancer % Waiting >62days (Urgent GP Referral)



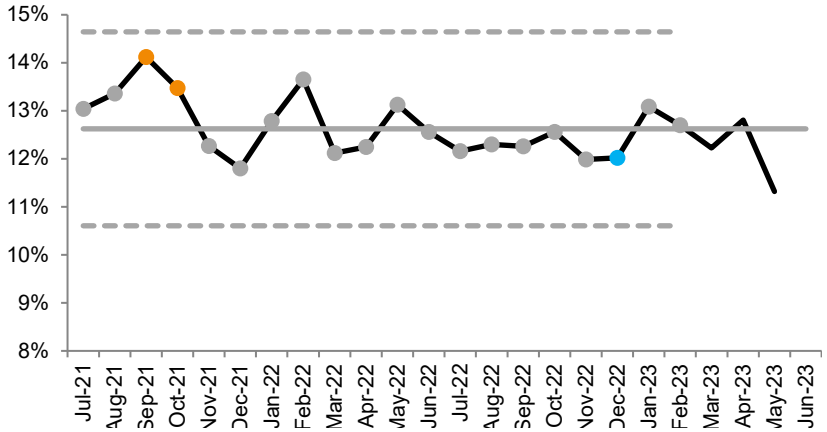
RESPONSIVE

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.

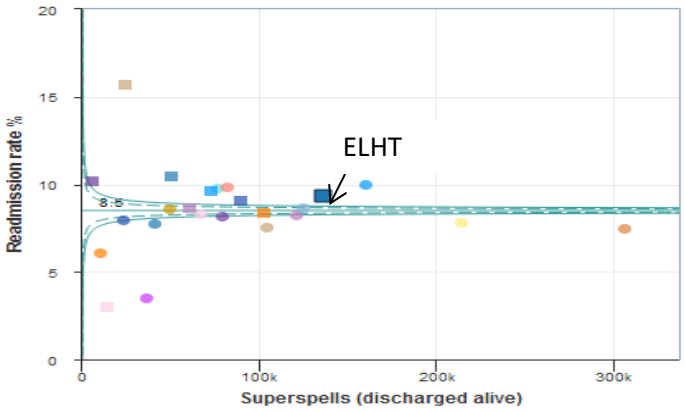
Emergency Readmissions



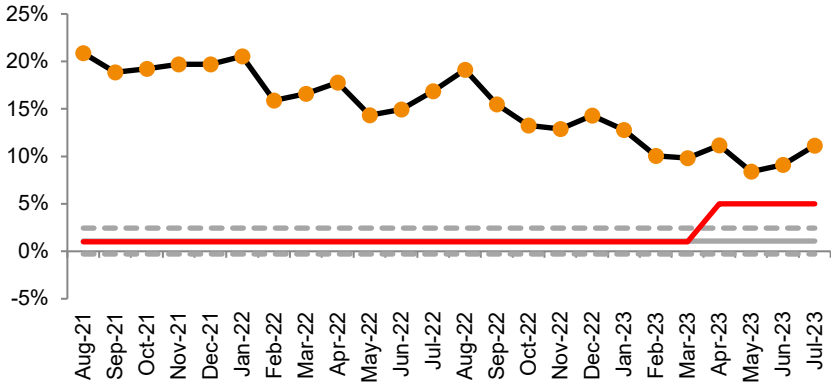
The emergency readmission rate is showing normal variation this month.

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 July, 11.1% 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 5% target at 25.2% in June.

RESPONSIVE

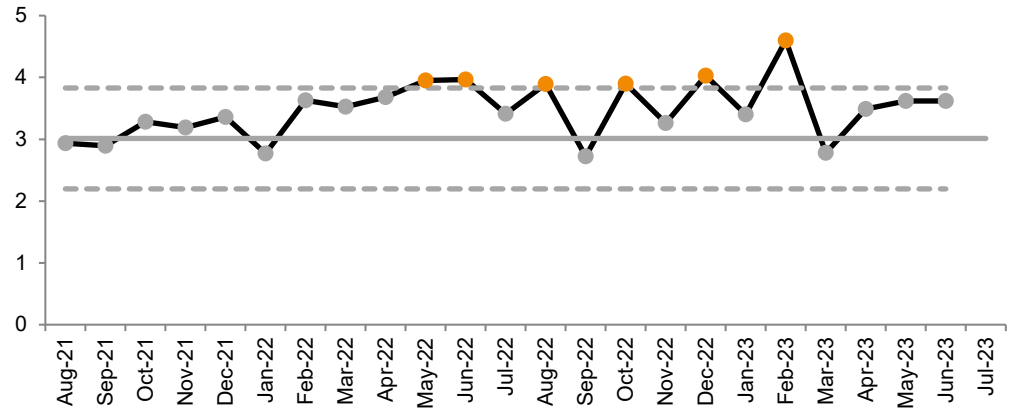
Average length of stay benchmarking

Dr Foster Benchmarking Apr 22 - Mar 23

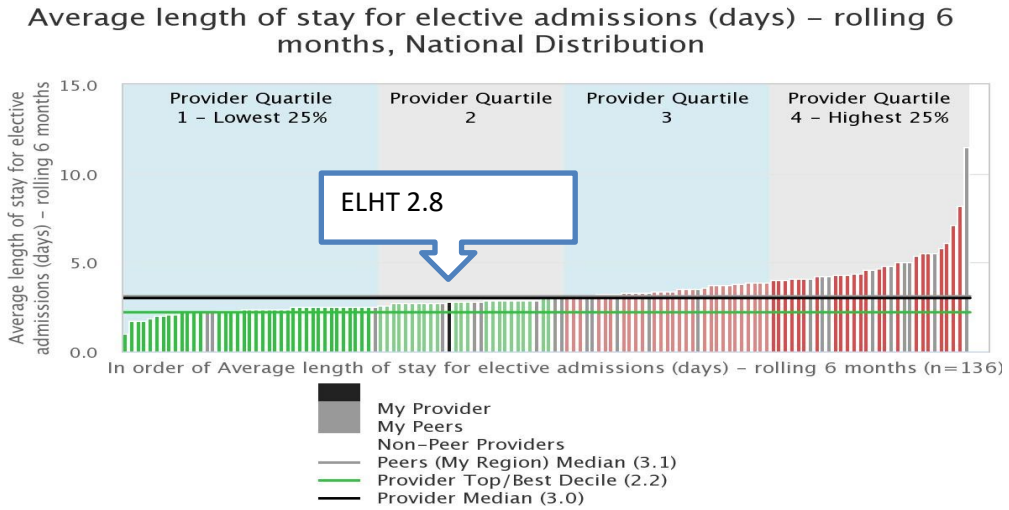
	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	62,164	10,266	51,898	3.3	2.7	-0.5
Emergency	62,691	62,691	0	4.1	4.5	0.5
Maternity/ Birth	12,826	12,826	0	2.4	2.2	-0.1
Transfer	223	223	0	7.9	23.5	15.6

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

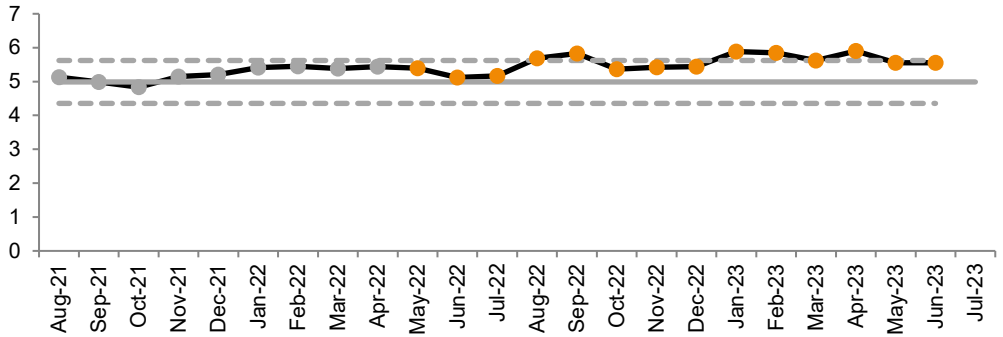


The Trust elective average length of stay is within normal range this month.

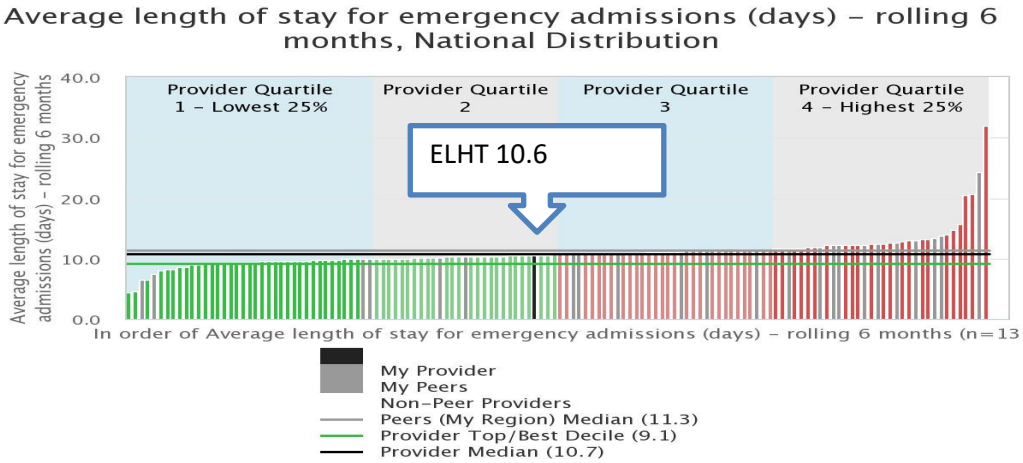


Data up to Mar 23 from the model health system shows ELHT in the second quartile for elective length of stay. Excludes day case.

Average length of stay - non elective

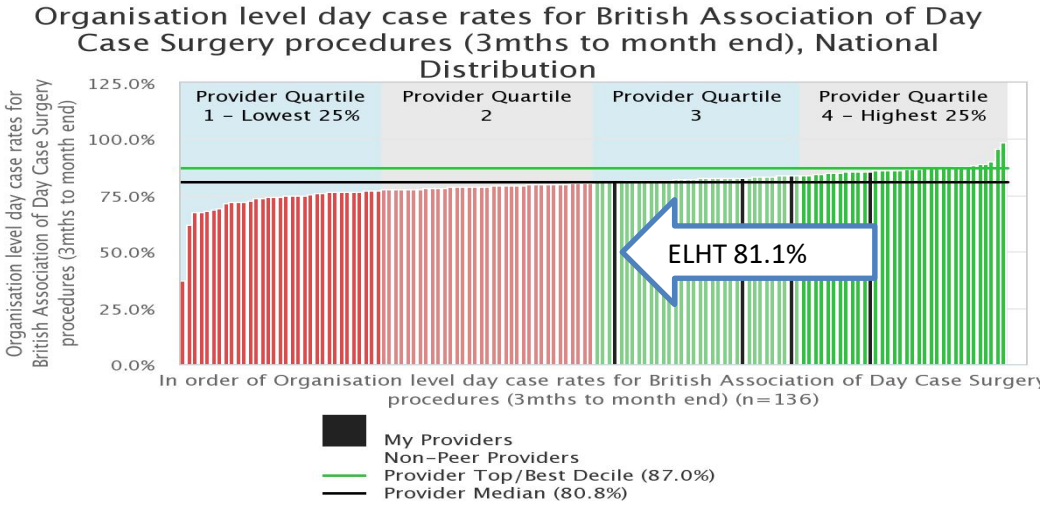


The Trust non-elective average length of stay is showing deteriorating performance this month, when compared to the pre-covid baseline.



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

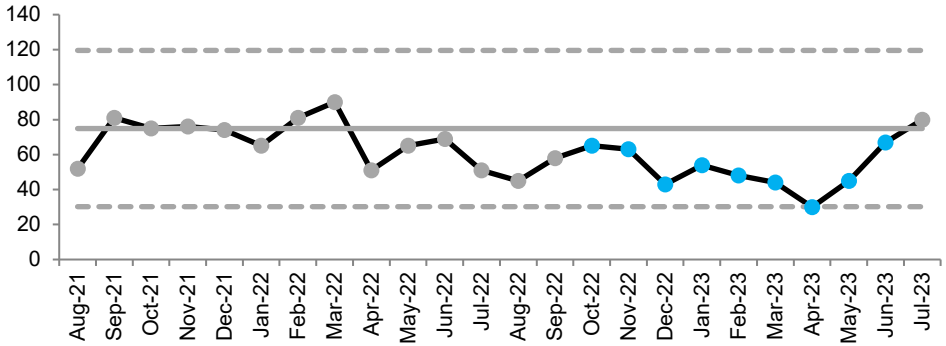
Daycase Rate



Model health system data based on latest 3 months up to Mar 23, shows ELHT in the third quartile for daycase rates at 81.1%. Data is for adults only

RESPONSIVE

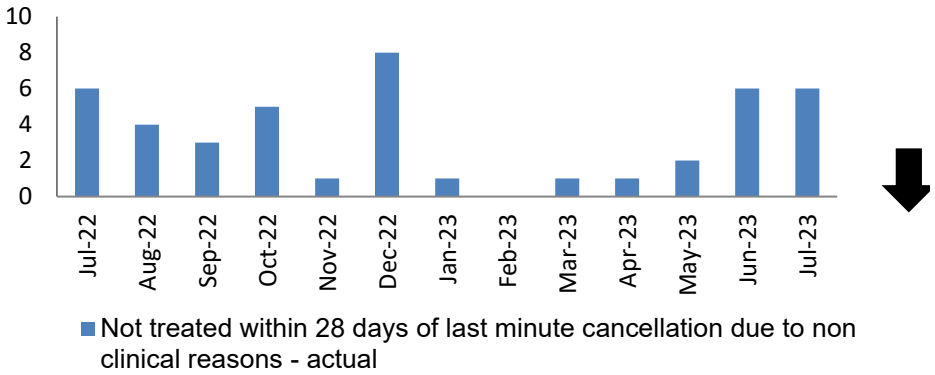
Operations cancelled on day



There were 80 operations cancelled on the day of operation - non clinical reasons, in July.

The trend is within the normal range compared to pre-covid levels.

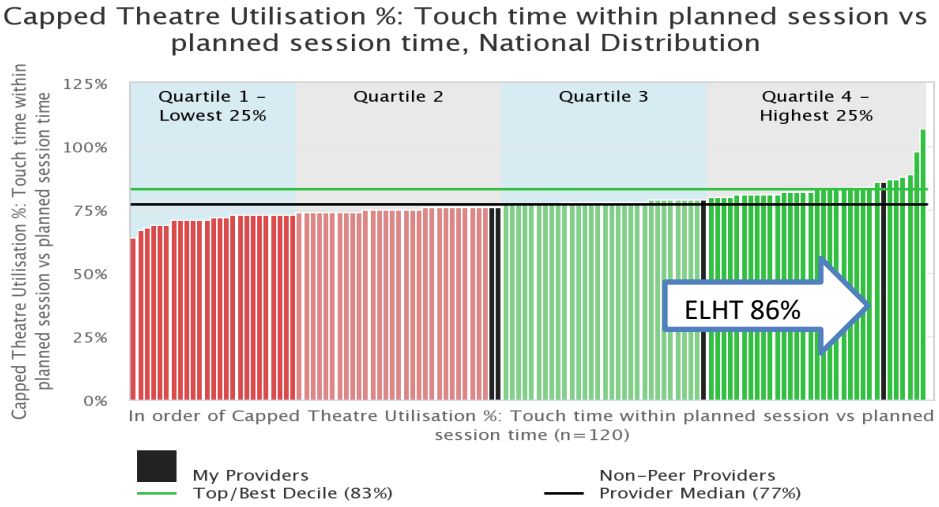
Operations cancelled on day - breaches of 28 day



There were 6 'on the day' cancelled operations not rebooked within 28 days in July.

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.

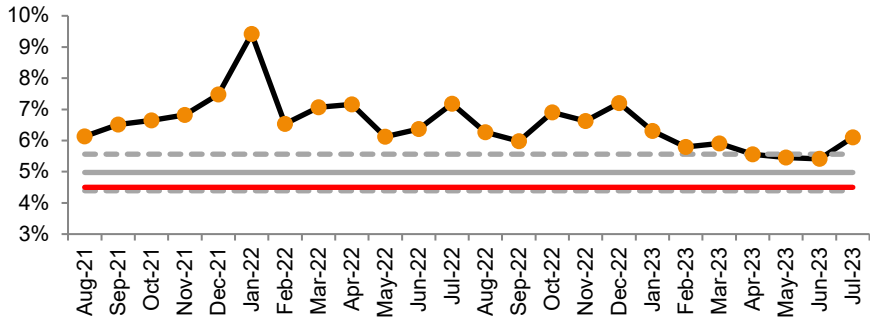
Theatre Utilisation



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.

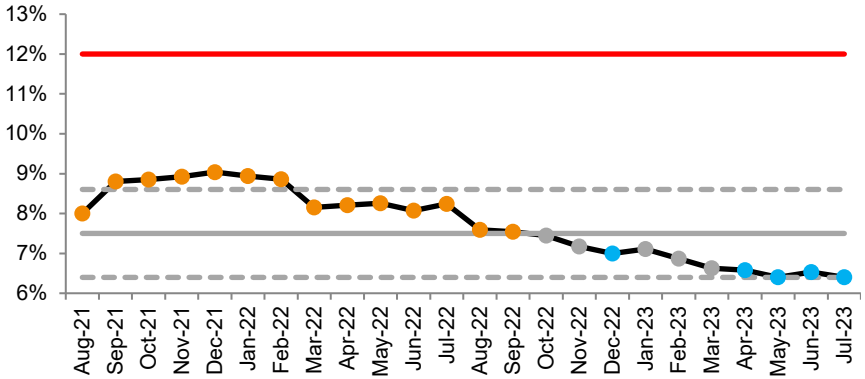
WELL LED

Sickness



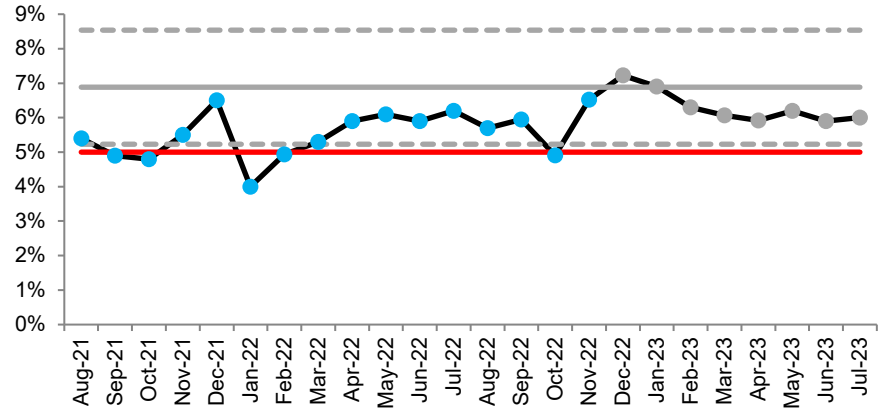
The sickness absence rate was 6.1% for July which is above the threshold of 4.5%. The trend is significantly higher than the pre covid baseline and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 6.4% in July 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



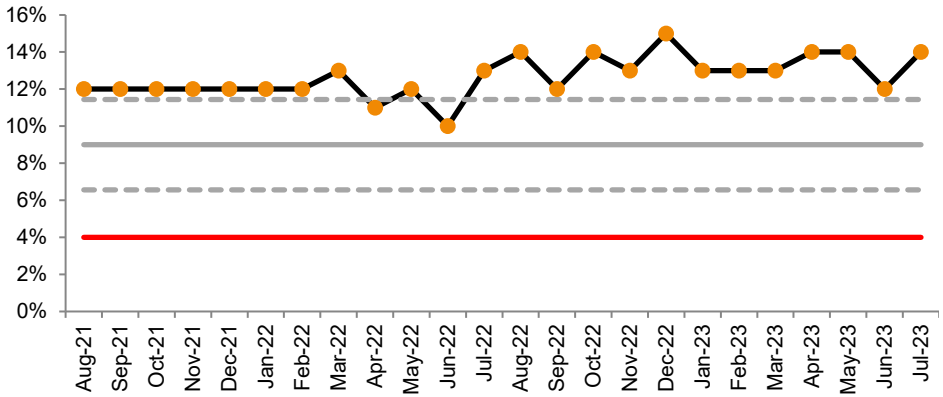
The vacancy rate is 6.0% for July which is above the 5% threshold.

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 July 2023, £6.2 million was spent on temporary staff, consisting of £1.8 million on agency staff and £4.4 million on bank staff.

WTE staff worked (9,988 WTE) was 59 WTE more than is funded substantively (9,929 WTE).

Pay costs are £865k more than budgeted establishment in July.

At the end of July 23 there were 568 vacancies

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

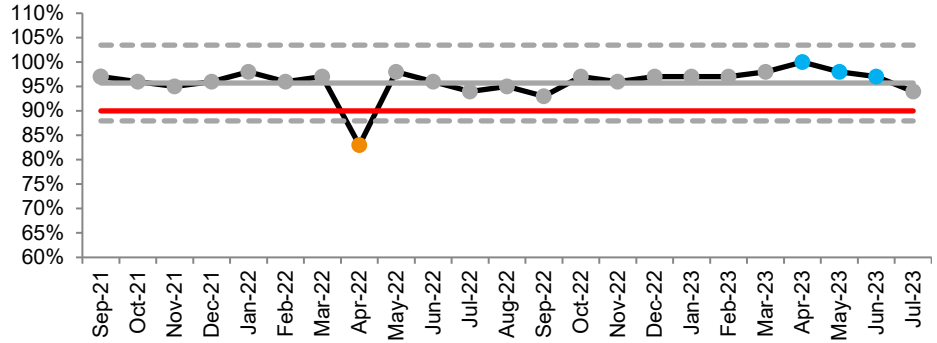
Job Plans

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	48	17
Signed off	16	6
Locked Down	0	0

As at July 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

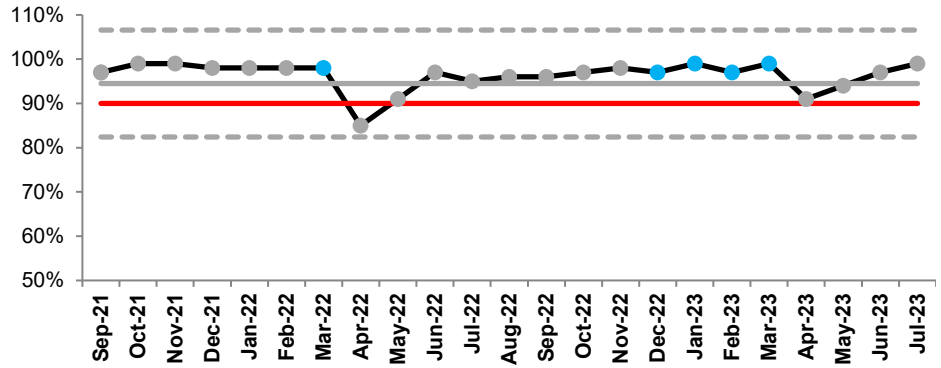
Appraisals, Consultant



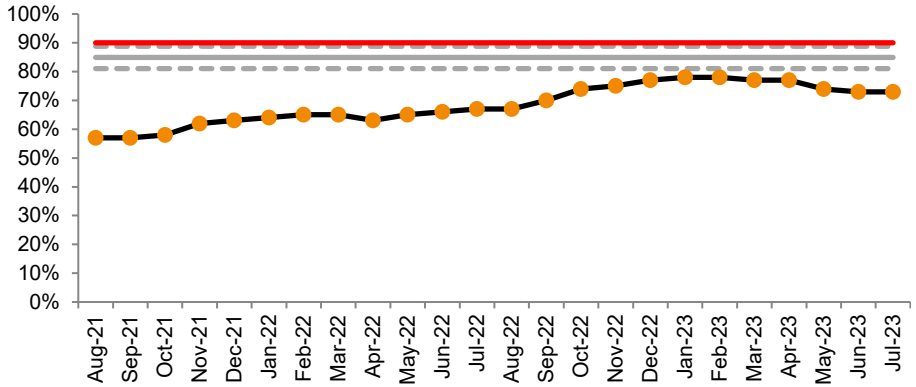
The appraisal rates for consultants and career grade doctors are reported for Apr - July 23 and reflect the number of reviews completed that were due in this period.

They both continue to be above target with 97% completed that were due in the period. 31% 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 July
Basic Life Support	2 years	90%	89
Conflict Resolution Training L1	3 years	90%	97
Equality, Diversity and Human Rights	3 years	90%	97
Fire Safety L1	2 years	95%	95
Health, Safety and Welfare L1	3 years	90%	97
Infection Prevention L1	3 years	90%	97
Infection Prevention L2	1 year	90%	91
Information Governance	1 year	95%	95
Preventing Radicalisation Level 1	3 years	90%	96
Preventing Radicalisation Level 3 †	3 years	90%	80
Safeguarding Adults L1	3 years	90%	95
Safeguarding Adults L2	3 years	90%	94
Safeguarding Adults L3*	3 years	90%	57
Safeguarding Children L1	3 years	90%	96
Safeguarding Children L2	3 years	90%	96
Safeguarding Children L3	3 years	90%	81
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

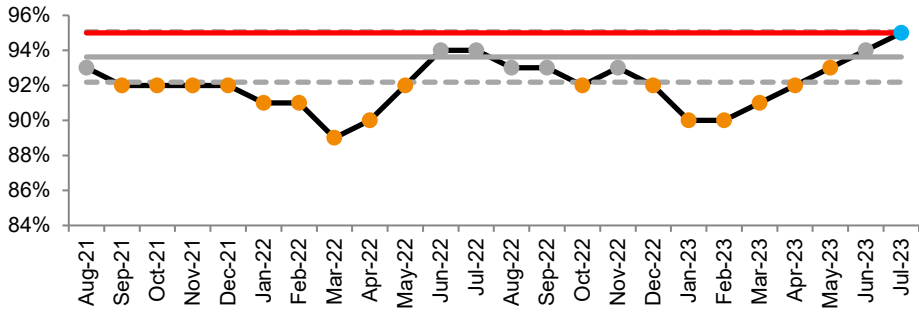
The core skills framework consists of eleven mandatory training subjects, with 19 modules in total. Training is via a suite of e-learning modules and knowledge assessments on the learning hub.

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

4 of the 19 modules are below threshold in July. 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

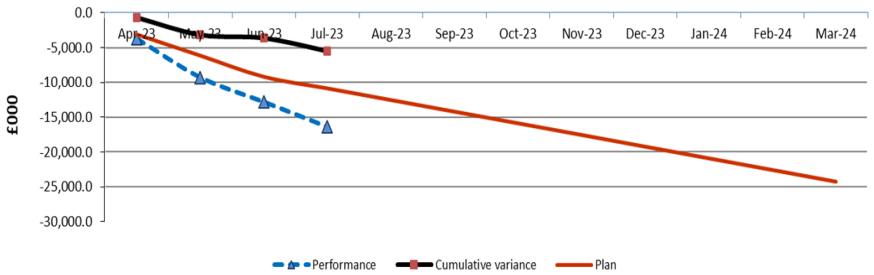


Information governance toolkit compliance is 95% in July which is on the 95% threshold. The trend is now above pre-covid baseline, however remains at risk of not meeting the target.

WELL LED

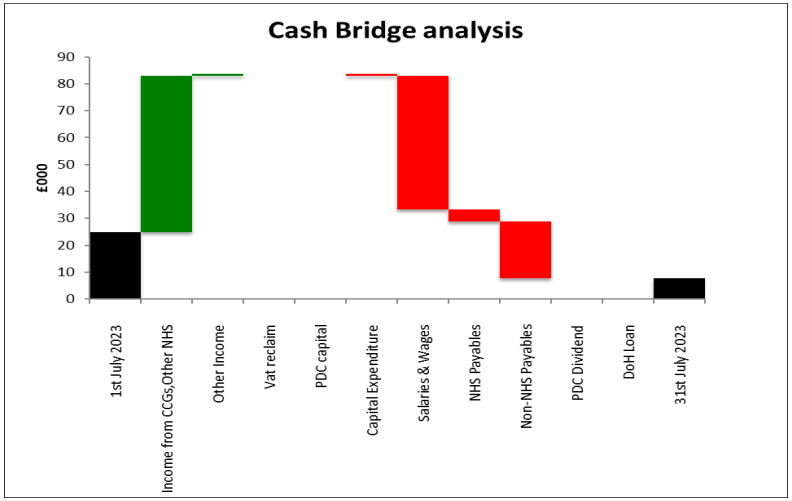
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



The Trust is reporting a breakeven duty deficit of £16.4m for the 2023-24 financial year to date, £5.5m behind plan.

Cash



The Trust's cash balance is £7.7 million as at 31st July 2023.

The Trust is reporting a breakeven duty deficit of £16.4m for the 2023-24 financial year to date, £5.5m behind the £10.8m planned deficit, a movement of £1.9m in the month.

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

The Trust is working to a £30.7m capital programme for 2023-24, a £1.2m reduction from the position reported the previous month, with £6.3m spent against a planned figure of £7.1m for the year to date.

The cash balance on 31st July 2023 was £7.7m, a reduction of £17.2m compared to the previous month, largely due to a £10.5m reduction in payables, a £5.2m increase in receivables and the £3.6m in month deficit. It is now expected that the Trust will need to apply to NHSE for revenue cash support in October to maintain its prescribed minimum cash balance of £2.5m.

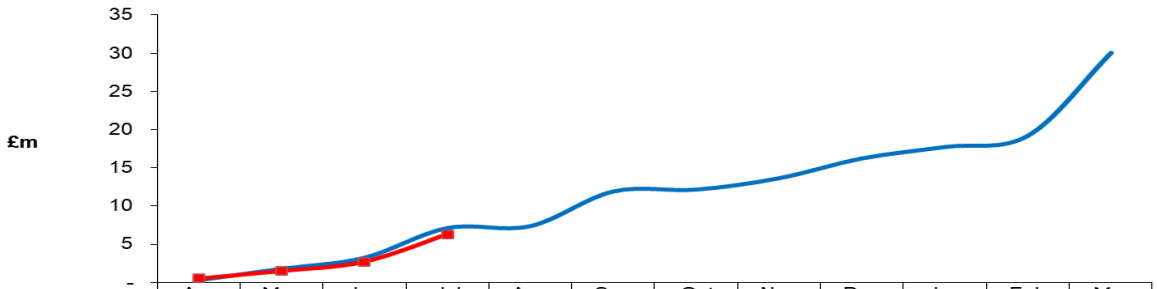
The Trust has met the Better Payment Practice Code (BPPC) target to pay 95% of NHS invoices on time. While Trust performance was slightly below this target for the payment of non-NHS invoices by volume, 98.9% of non-NHS invoices were paid on time by value.

The £12.3 million system gap held by the Trust has been added to the £42.3 million waste Reduction programme that was sitting at 5.4% to increase it to £54.6 million at a 7.4% of the Trusts Total Operating Expenditure. WRP achievement is £10.4m at month 4, £3.7m behind plan. It has been necessary to non-recurrently support this position by £8.0m.

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	7.09	7.34	11.89	12.13	13.63	16.22	17.72	19.22	30.07
Actual	0.54	1.54	2.72	6.31								

The Trust is £0.8m behind its planned capital spend as at 31st July 2023.

Waste reduction programme

WRP schemes analysis

Identified schemes in tracker

Division	Green £000s	Amber £000s	Red £000s	Non Recurrent £000s	Recurrent £000s	Identified Schemes £000s	Annual Target £000s
Trust Wide Schemes	8,000	20	16,064	9,177	14,907	24,084	48,530
Medicine & Emergency Care	204	68	1,854	2	2,124	2,126	1,294
Community & Intermediate Care	2,066	50	0	46	2,070	2,116	410
Surgical & Anaes Services	708	107	0	300	515	815	1,338
Family Care	0	0	0	0	0	0	809
Primary Care	0	0	0	0	0	0	30
Diagnostic & Clinical Support	192	916	285	0	1,392	1,392	1,058
Estates & Facilities	434	662	2,700	882	2,914	3,796	622
Corporate Services	1,229	4	3,358	378	4,214	4,591	387
Education, Research & Innov'N	0	55	29	0	83	83	140
Total	12,834	1,881	24,289	10,785	28,219	39,004	54,618

Schemes to the value of £10.4 million have been transacted in the year to date. Additional identified schemes will be

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **115**

13 September 2023 **Purpose** Assurance

Title	Response to NHSE Letter Regarding Internal Review of Processes in Relation to Lucy Letby Case
Report Authors	Mrs A Brown, Associate Director of Quality and Safety with contributions from: Dr C Gardner, Deputy Medical Director (Quality and Safety) Mrs A Bosnjak-Szekeres, Director of Corporate Governance
Executive sponsors	Mr M Hodgson, Chief Executive/Accountable Officer Mr J Husain, Executive Medical Director/Deputy Chief Executive Mr P Murphy, Chief Nurse Mrs K Quinn, Executive Director of People and Culture

Summary: This paper provides a response to the NHSE letter requesting an internal review of processes in response to the Lucy Letby case. These are processes that have all been previously introduced to the NHS which should be providing the Board with assurance re the safety of patients and the presence of a safety culture that supports staff to raise concerns without obstacles.

Recommendation: Board members are asked to consider the processes, the level of visibility and assurance provided and the recommendation to embed the Freedom to Speak Up training as mandatory for all staff. Board members are asked to consider their own awareness of and visibility within these processes.

Report linkages

Related Trust Goal	Deliver safe, high-quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people
Related to key risks identified on Board Assurance Framework	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. 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.

Related to key risks identified on Corporate Risk Register	Not Applicable
Related to recommendations from audit reports	MIAA Review of Freedom to Speak Up processes Nov 2022
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to here.

Impact

Legal	No	Financial	No
Equality	Yes	Confidentiality	No

Previously considered by: No previous committee

1. Executive Summary - Overview of the Lucy Letby case.

a) On August 18th, 2023, Lucy Letby, a practising neonatal nurse was convicted of murdering seven babies and attempting to murder six others while working at the Countess of Chester Hospital.

b) Manchester Crown Court heard that she targeted 17 babies between June 2015 and June 2016, having originally faced 22 charges - seven of murder and 15 of attempted murder, involving 10 babies. Letby was found to have deliberately injected babies with air, force fed others milk and poisoned two of the infants with insulin.

c) Letby was convicted following a lengthy investigation by Cheshire Police into the alarming and unexplained rise in deaths and near-fatal collapses of premature babies at the hospital. Prior to June 2015, there were fewer than three baby deaths per year on the neonatal unit.

d) Concerns raised by professionals, most notably a consultant who directly approached Board members, were dismissed and not taken through required formal processes for investigation. These Board members have now been suspended and the government is considering the request for both a public enquiry and the introduction of formal regulation of Board members.

2. NHSE Assurance request

a) Following the outcome of the trial, NHS England wrote to all NHS Boards requesting they seek assurance across a number of issues that hindered the early identification and response to Letby's actions, whilst she continued to work within an NHS Trust.

b) NHSE acknowledge that the implementation of Medical Examiners in 2021, and the adoption of the Patient Safety Incident Response Framework (PSIRF) across the NHS should strengthen incident reporting and monitoring, Boards have been required to ensure proper implementation and oversight of these processes.

c) Boards have also been reminded of the recently updated Freedom to Speak Up (FTSU) policy, which must be embedded before Jan 2024 and specifically, requested to urgently ensure:

- All staff have easy access to information on how to speak up.

- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
- Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well.
- Boards are regularly reporting, reviewing, and acting upon available data.

d) Boards are further reminded of their obligations under the recently updated Fit and Proper Person Framework.

3. Medical Examiners

a) The Medical Examiners (ME) service continues to review all deaths at Royal Blackburn Teaching Hospital, Burnley General Teaching Hospital, Pendle and Clitheroe Community Hospitals. So far in the first 28 months of operation the service has scrutinised 5,514 inpatient deaths.

b) The service is made up of a number of medical examiner officers many of whom have prior experience as coroners' officers. The Medical Examiners are all experienced qualified medical professionals. Our medical examiners have diverse backgrounds including Surgeons, Physicians, General practitioners, Obstetricians and Neonatologists. They regularly peer review and seek advice within the ME group, in particular in areas such as obstetric or neonatal deaths.

c) The role of the ME is to scrutinise all non-coronial deaths, and in so doing to support and challenge the attending medical practitioner as to the cause of death. They are also responsible for highlighting deaths where coronial advice or referral is required.

d) In addition, the family are spoken to in all cases and complaints and concerns are logged and escalated.

e) In any case where is thought that a clinical incident may have occurred the ME service raise an incident form which is investigated by the relevant division and results in a patient safety response or IR2. All cases are discussed at the weekly complex cases meeting. If there is a suspicion that a death many have been caused or contributed to by medical error or omission, then a coronial referral is made in addition.

f) Where it is thought there is learning from a death a request for a structured judgement review of the death is required.

g) In the past 12 months 106 incidents have been raised by the ME service. The service has also raised 47 requests for structured judgment reviews and managed 167 complaints in this calendar year.

h) The lead medical examiner and medical examiner officer attend the trust mortality steering group, in order to both report on the service and findings, but also to assist with triangulation of data and other learning from deaths. Whilst the service is independent of the Trust, they share their findings in detail with the group. This includes verbatim responses, good and bad from every relative who is contacted.

i) There have been no cases to date where any concerns relating to the Letby case have been identified.

4. PSIRF assurance

a) The Trust was accepted as an Early Adopter of the PSIRF approach to incidents management and investigation and moved from the Serious Incident Framework model from 01 Dec 2021.

b) All reported incidents (n = 2100 average per month) are reviewed within 24 hours by the incidents team, who escalate any request for further information or identified pattern of concern to the weekly triage meeting with divisional teams.

c) If, following this Divisional triage, any incidents continue to raise questions or concern, they are escalated to the weekly Complex Case meeting. All divisions and representatives from the incidents and investigations team consider each incident and allocate a level of investigation as appropriate. The Medical Examiners, Complaints and Legal team additionally attend to enable triangulation across processes and the identification of themes of concern.

d) National and Local priorities for Patient Safety Incident Investigations (PSII) are used to determine the level of investigation. All deaths within the hospital are

subject to a PSII as a national priority and all external review processes such as Perinatal Mortality Reviews (PMRT) or investigations carried out by the Health Safety Investigation Branch (HSIB) are linked directly into the PSIRF assurance process.

e) All PSII and HSIB reports are presented to the Patient Safety Incident Requiring Investigation group (PSIRI) which is chaired by a non-Executive and signed off jointly with the Executive Medical Director in line with PSIRF requirements for Board accountability.

f) PSIRF assurance reports are provided at every Quality Committee and every Board meeting to ensure visibility and challenge of these processes.

5. Freedom to Speak Up processes.

a) The Trust has 2 Freedom to Speak Up Guardians (1.8WTE) employed and available to support staff through well embedded systems.

b) The Freedom to Speak Up Policy was most recently updated in July 2023 and incorporates the required updates in anticipation of the Jan 2024 deadline.

c) Since 2017 the Trust has averaged approximately 51 contacts with the FTSU service every month. The team widely advertise their support offer at all induction sessions, consultant and band 7 leadership and junior doctor induction.

d) The Trust has posters and online information under the 'See something, say something' branding which contains a QR code providing a direct link to the team.

e) The FTSU team are aware of the national Speaking Up Support Team, which provides support to whistle-blowers after raising concerns, especially where those concerns have resulted in challenge or negative reactions from their employers. Information is available from the team for staff who raise concerns, however it has never been necessary to refer a member of our staff to this service.

f) The FTSU team have worked to address any cultural barriers to accessing their services through establishing champions within each of the staff network groups. If an individual with protected characteristics contacts the team, these champions are asked to provide first contact. It is noted however that access data for the service does not routinely record diversity.

g) The Trust has a highly diverse population and a higher-than-average proportion of staff from Black or Minority Ethnic background. The FTSU team have confirmed

that the proportion of staff accessing their team for support is in line with the wider staff population and no barrier to access for this group is evidenced.

h) The planned focus for October's FTSU month is on addressing barriers to access.

i) Although the FTSU team are employed to work office hours, both members of staff hold a mobile phone and provide a flexible service to enable access to staff who work outside those hours.

j) The FTSU guardians have regular 1:1 meetings with the Chief Executive, Non-Executive lead and Executive Director of People and Culture.

k) Assurance reporting is visible at both the Quality Committee and Board meetings every 6 months. This includes monitoring of actions in response to Internal Audit reports on the FTSU processes and updates of actions resulting from the 5 questions contained within the staff survey.

l) The 5 related questions within the staff survey all currently show a positive local culture in relation to FTSU, however the Trust has responded to wider feedback through the introduction of the Behavioural Framework, which has been directly tied to all staff appraisals, and is currently designing a Cultural Dashboard to enable more visible reporting of these key metrics.

6. Fit and Proper Persons Framework

a) The Fit and Proper Persons Requirements are set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulations). Under the Regulations all individuals in director or equivalent roles must meet the requirements of the Fit and Proper Person Test (FPPT) on appointment and continue to meet them whilst holding office.

b) The Trust has adopted a Fit and Proper Persons Policy, which is accessible to all staff via the Trust's intranet site (policy number HR73: Fit and Proper Persons Policy).

c) The FPPT framework is a key element of patient safety and good leadership in the organisation, and it is recognised by all Board members.

d) Under the policy the Director of Corporate Governance/Chartered Governance Professional is tasked with providing a report to the Trust's Remuneration Committee on an annual basis to confirm that each Board level Director (Executive and Non-Executive) have completed the requirements and have passed all checks/clearances.

e) The Trust's Human Resources department undertake the checks and use a Fit and Proper Person Test checklist which is completed for each Board level Director upon appointment and on an annual basis thereafter.

f) All Board members are also asked to sign an annual declaration that they satisfy the requirements of the Fit and Proper Person Test.

g) The checks for the Directors serving on the Board have been carried out upon appointment and annually thereafter since the requirements came into place in 2014 and are usually completed within the first and second quarters of each financial year.

h) All Directors have passed the Fit and Proper Test and signed their annual declarations for 2023-24.

i) Copies of the test checklists and the signed annual declarations are held on the Directors' personnel files.

j) Following the review of the framework there are new elements relating to the CQC regulation 5 based on the recommendations made by Tom Kark KC. These are as follows:

   i. The NHS Leadership Competency Framework
   ii. FPPT fields in NHS electronic staff record (ESR) to record staff testing
   iii. Board member references
   iv. Extending the scope to include ICBs and ALBs
   v. Clear statement of accountability of Chairs in implementing the framework in their organisations

k) NHS England have committed to a review of the FPPT framework within 18 months.

l) The FPPT framework brings together:

   i. The FPPT assessment at recruitment, annual review and at any time that new information relevant to FPPT becomes available.
   ii. Learning and development offers and the standard set of competencies with minimum levels expected for Board members.
   iii. Appraisal process for Board members (to be available later in 2023-24)
   iv. Specific reference requirements for Board members.

m) All providers are required by 30 September 2023 to:

   i. Use the new Board member reference templates for references for all new Board appointments.

ii. Complete and retain locally the new Board member reference for any Board member that leaves the Board for whatever reason and whether or not a reference has been requested.

iii. Use the Leadership Competency Framework as part of the assessment process when recruiting to all Board roles.

n) By March 2024 all providers are required to fully implement the FPPT framework, incorporating the Leadership Competency Framework, including:

i. First full FPPT annual review of all Board members

ii. Individual self-attestations completed for Board members

iii. Annual submission form completed and submitted to the relevant NHSE Regional Director

iv. ESR database updated.

o) At the end of Quarter 1 of 2024-25 all providers are required to incorporate all the Leadership Competency Framework into the annual appraisals of all Board members for the year 2023-24 using the new appraisal framework. In future years, the appraisal/Leadership Competency Framework and the FPPT assessment cycle should all align.

p) At ELHT we have an embedded annual FPPT testing process and preparations have begun to ensure that the new requirements are implemented by the prescribed timelines. A full report will be presented to the Remuneration Committee and shared with all Board members.

7. Wider Triangulation of concerns

a) The Trust has 2 regular meetings which coordinate wider oversight of staff who are subject either to internal or external review processes. These could be HR processes, police investigations, referrals to either safeguarding or professional bodies.

b) The Professional Standards Group (PSG) coordinates any formal processes ongoing across our medical workforce, including trainees. The Employee Case Review Group coordinates formal processes for all other non-medical staff.

c) Both groups are attended by the Associate Director of Quality and Safety, a chair from the BAME staff network and chaired by the Deputy Medical Director of the Deputy Director of Nursing. This enables senior decision making and coordination

of awareness of risk at a Trust wide rather than divisional level. A Non-Executive Director additionally attends the ECRG.

d) The Trusts additionally works in partnership with the Local Authority and the Police to ensure that the statutory requirements to respond to allegations made against our staff are responded to in line with national guidance and that Trust policy reflects the multiagency agreements developed by the Local Safeguarding Boards. These are known as Local Authority Designated Officer (LADO) and Person in a Position of Trust (PIPOT) processes. Both are led by the Head of Safeguarding who works in partnership with the Deputy Director of HR to ensure decisions are made in line with the legal framework.

8. Conclusion

a) The Board is asked to consider the assurance provided and recommend any improvements to the accessibility or visibility of the assurance processes described.

b) Board members are asked to support the recommendation that the available e-learning module in support of the FTSU process, is made mandatory for all staff.

c) Board members are asked to consider how visible and accessible they are to all staff, and in particular how they enable staff from protected characteristics groups to be heard.

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TRUST BOARD REPORT | **Item** | **116**

13 September 2023 | **Purpose** | Assurance
Approval

Title	Overarching Strategic Framework and Refresh of Trust Strategies
Report Author	Mrs C Vozzolo, Associate Director of Service Development
Executive sponsor	Mrs K Atkinson, Director of Service Development & Improvement

Summary: This report provides members of the Trust Board with an update of our strategic framework including:

1. A draft document entitled 'ELHT's Strategic Framework – our overarching business structure'.
   This document provides an overarching description of all our strategies, plans and describes how they fit together. The document provides staff with a clear summary (in line with our core Trust behaviour of 'keeping it simple') to explain how the Trust aligns strategy, planning and operational delivery.
   Members are asked to review and endorse this document so that it can be communicated and thus used widely in the organisation with the objective of a Board to floor golden thread of understanding and engagement of the Trust's strategic framework.

2. An update on the Trust's key strategies including a recommendation to extend our existing Digital Strategy and Finance Strategy.
   As part of this extension, 2023/2024 priorities are provided for both strategies to assure members of progress in this extension period.
   A draft timetable for presenting new five-year strategies is presented for approval.

Members are asked to endorse the extension and key priorities for the Digital Strategy and Finance Strategy note and approve when new draft strategies will be developed.

Recommendation: The Trust Board is asked to:

1. Endorse the overarching Strategic Framework document.
2. Note and endorse extension to the existing Digital and Finance Strategy
3. Approve the priority summaries for 2023-24 for the Finance Strategy, Digital Strategy and Health Equity Strategy

Approve the timetable for presenting the new five-year strategies as set out in Appendix 2.

Report linkages

Related Trust Goal		Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Drive sustainability
Related to key risks identified on Board Assurance Framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South

		Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
	2	The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities
	3	Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce

Related to key risks identified on Corporate Risk Register	-
Related to recommendations from audit reports	Not Applicable.
Related to Key Delivery Programmes	Urgent & emergency care improvement, elective pathway Improvement, care closer to home/Place based partnerships, tackling health and care inequalities, sustainability.
Related to ICB Strategic Objective	Integrate and strengthen primary and community care. World class care.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

ELHT's Strategic Framework – our overarching business structure

Introduction

1. The Trust has developed 'ELHT's Strategic Framework – our overarching business structure' as a summary and description of our strategic framework, setting out how the Trust completes its business, aligning strategy and planning with operational delivery and accountability. This can be found at Appendix 1.
2. The objective of the document is to provide staff and stakeholders with a clear description of our processes and in line with our core behaviour of 'keeping it simple' reduces all our strategies, plans and delivery programmes into a concise and easy to read/reference guide.
3. The document will be shared widely with senior and departmental leaders who will be encouraged to share this document with their teams and staff. It will also form part of our Trust induction processes as a way of introducing new staff to our strategic framework.
4. Members of the Trust Board are asked to review and endorse this document for use.
5. In support of integrating our strategic framework in all our business, each key Trust strategy now has a summary strategy on a page as a quick reference guide for teams.
6. To monitor progress against our key Trust strategies, each strategy now has a 'strategic dashboard' that incorporates priorities by current year (agreed through our annual planning process) and notes progress against key deliverables so that Executive Directors can be assured of progress. The dashboards form part of the 'Trust Executive Improvement Wall' and are monitored and reviewed by the CEO/Execs on a rolling programme each week at the Weekly Executive Team Meeting. Progress on key strategic plans will also be monitored at the Executive / Divisional Quarterly performance meetings and relevant Trust Sub-Committees.

Trust Key Strategies Update

7. Appendix 2 provides a summary of the Trust's key strategies with a timeline for their formal updates.
8. Two of our Trust Strategies are currently being revised, the Finance Strategy and the Digital Strategy and a new Trust Strategy for Health Equity is being developed. These will be developed and presented back to Trust Board for ratification as per the timeline noted in appendix 2.

9. In the interim, Board members are asked to approve the 'plan on a page' summaries and priorities for 2023-24 for these strategies, found in Appendix 1. These were developed with Board members and through Senior Leadership Group and planning sessions during the 2023/24 Planning round and act as extensions to the existing strategies where appropriate.

Recommendation

10. The Trust Board is asked to:

a) endorse the overarching Strategic Framework document
b) note and endorse extension to the existing Digital and Finance Strategy
c) approve the priority summaries for 2023-24 for the Finance Strategy, Digital Strategy and Health Equity Strategy
d) approve the timetable for presenting the new five-year strategies as set out in Appendix 2.

Appendices

1) ELHT's Strategic Framework – our overarching business structure
2) Trust Strategies and timeline for review

Mrs Catherine Vozzolo, Associate Director of Service Development, 13/09/23

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

ELHT's Strategic Framework

Our overarching business structure

Safe | Personal | Effective

Improving Safe Personal and Effective Care

ELHT Strategic Framework

East Lancashire Hospitals NHS Trust
A University Teaching Trust

East Lancashire Hospitals NHS Trust is one of the largest provider Trusts within Lancashire and South Cumbria providing services to a combined population of approximately 530,000 and employing over 9,600 staff over 5 hospital sites and various community settings.

We are rated by the CQC as good with areas of outstanding practice and have a strong history of delivery against a range of key performance objectives and metrics. This is testimony to our proud and caring staff and is built on our core vision, values and behaviours as an organisation. These run through all that we do; at individual, team, divisional and organisational level.

We are an organisation of constant improvement, development and advancement - our teams never stand still.

Everyone at East Lancashire Hospitals NHS Trust continues to focus a great deal of time and effort on making improvements to services and ensuring that the quality of everything we do makes a tangible, positive difference to the lives of local people.

In such a large, complex, ever improving organisation it is important that we remain focused on our core values and vision and understand how our detailed plans align together to achieve our aims.

Our strategic framework details our overarching approach, summarising our key goals and how these are delivered throughout the organisation. Our framework helps us 'join the dots' of our detailed strategies, plans, delivery programmes and improvement practice, and thus provides a clear organisational framework for delivery.

ELHT Strategic Framework

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Our collective organisational vision is to be widely recognised for **providing safe, personal and effective care.** Our Trust vision is underpinned by our core values. We have committed in all our activities and interactions to put patients first, respect the individual, act with integrity and to serve the community and promote positive change.

Our Strategic Framework (right) summarises how our vision and values are delivered throughout the organisation.

OUR BEHAVIOURS are an important foundation of providing safe, personal and effective care. These are fundamental to ensuring that our values can be achieved.

We have **SIX GOALS**. These are the *golden threads* that weave through all that we do; as individuals, teams and collectively as an organisation.

HOW we deliver our strategies, goals and vision is through our system working, our business structure and key delivery improvement programmes. All our work is underpinned by our improvement practice. We have **11 delivery programmes**, **SPE+ improvement practice** and **business planning** to support delivery.

Our supporting strategies are the cornerstones of our Trust Strategic Framework, providing the plan and the **WHAT** – these strategies provide the details of how we will collectively support delivery of our vision and goals.

Our Behaviour Framework

East Lancashire Hospitals NHS Trust
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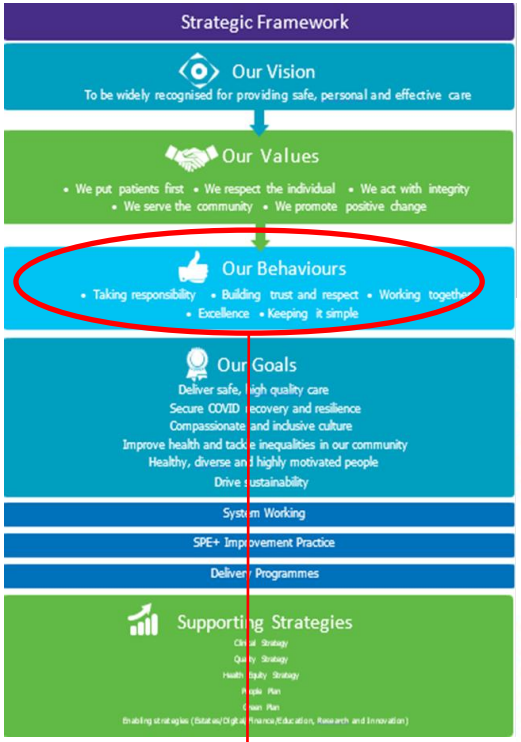
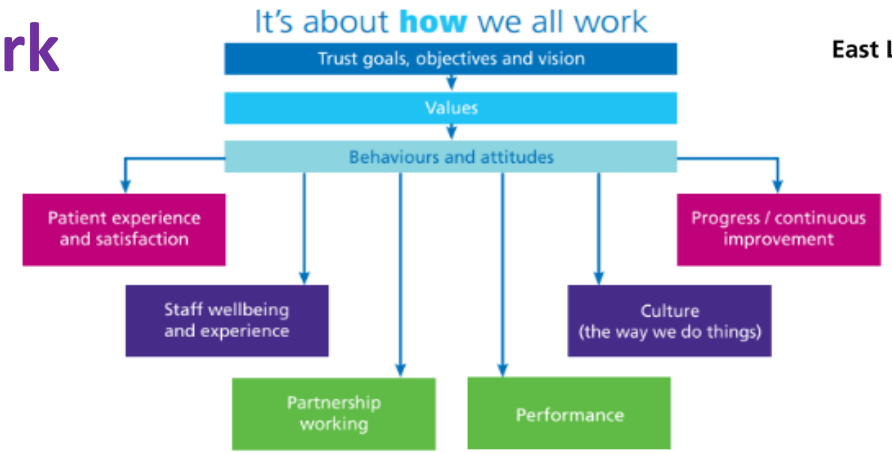


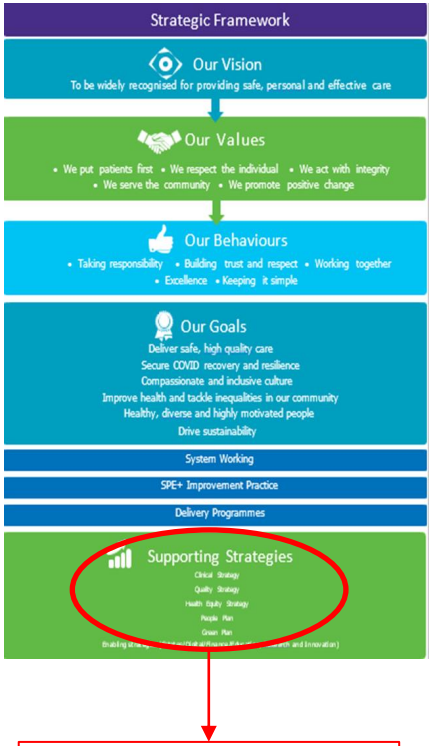
This Framework provides a set of core behaviours and defines how staff can contribute to the success of our organisation. Adopting and embracing these behaviours will help us to achieve our Trust's ambition to deliver Safe, Personal and Effective care.



Improving Safe Personal and Effective Care
SPE+

Supporting Strategies

East Lancashire Hospitals NHS Trust
A University Teaching Trust



There are 4 main Trust Strategies that form the cornerstones of our Trust plans. A 5th strategy for Health Equity is also under development. These are approved, with designated timelines and monitored regularly at Trust Board. The strategies are aligned together so that they fit the pieces of the 'Trust jigsaw' in terms of delivering our plans and ambitions as an organisation.

➢ Clinical Strategy

Our 5-year Clinical Strategy expresses our collective purpose to improve safe, personal and effective care together and our plans to continue to develop the services we provide for our patients.
Our future is defined as a 'hospital without walls', networking as partners in local partnerships and within the bigger integrated system of care across Lancashire and South Cumbria.
We have identified key 5-year improvement priorities across urgent and community care, elective medical and surgical care, diagnostics and population health.

➢ Quality Strategy

Quality commitments are set out in the Strategy to deliver Safe, Personal and Effective Care.
The Strategy incorporates 6 Trust Frameworks : Legal framework, Risk Management Framework, Clinical Effectiveness Framework, Patient Experience Framework, Patient Incident Safety Response Framework and the Health and Safety Framework.
14 Key priorities are identified split under overarching goals of Insight/Safe, Involvement/Personal, Improve/ Effective and Improve+.

➢ People Plan

Our People Plan enables ELHT to recruit the best people, with the right skills and values to an organisation that supports staff to be the best they can be in a culture of community, compassion, inclusion, innovation and improvement to deliver Safe, Personal and Effective Care to the population it serves.
Our key people plan focus :

- Looking after our people
- Belonging in the NHS
- Growing for the Future
- Developing new roles and ways of working

➢ Green Plan

ELHT is committed to achieving the Net Zero goal of 2040 for controllable emissions and 2045 for emissions as well as to supporting its staff, its patients and the wider community in reducing their own emissions, fulfilling its role as an anchor institution. The ELHT Green Plan sets out our road map to Net Zero through a detailed action plan covering nine areas of focus. These include 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.

➢ Health Equity Strategy

Under development – This strategy will be developed in partnership with our key organisations locally and will focus on:

- Addressing inequalities by understanding and working with local communities
- Reducing outcomes by addressing variation and working towards Core20Plus5 domains
- Looking at the wider issues and determinants of inequalities at a system and region level.

Enabling Strategies

East Lancashire Hospitals NHS Trust
A University Teaching Trust

There are 4 enabling strategies within the Trust.

These enable and support all our plans and delivery within the organisation.

These are also approved and monitored through our Trust Board.

➢ **Estate Strategy**

The key principles of the Estates Strategy are

- System First Clinical Strategy (L&SC system)
- Using Infrastructure to create a healthy population
- Delivering a Net Zero National Health Service

Key Estates objectives are outlined by site in the Strategy (RBH/BGH/Other sites) and these are triangulated with other strategies and plans so that estates and facilities support the wider clinical objectives of the Trust.

➢ **Digital Strategy**

The Trust Digital Strategy supports and underpins our service planning and delivery and is a key enabler across all our delivery plans, strategies and improvement practice.

Our strategy is part of the wider ICB Digital Strategy across Lancashire and South Cumbria. We are part of a digital journey to achieve joined up system access and use ensuring that digital solutions are a full part of our future clinical provision.

➢ **Finance Strategy**

The key principles of the Strategy are :

- Ensuring the limited resources are spent on improving the quality of patient care in East Lancashire and the wider Lancashire and South Cumbria footprint
- Meet all statutory financial responsibilities
- Financial Sustainability
- Financial Recovery

These are achieved through sound financial governance arrangements and accurate planning triangulated with activity and workforce plans.

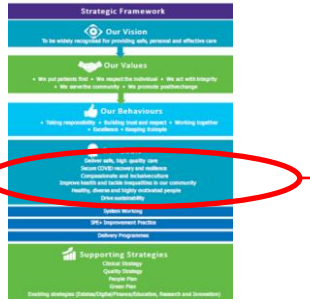
➢ **DERI Strategy**
(DERI- *Education, Research and Innovation*)

The DERI Strategy is split into 3 parts – Education Strategy, Research Strategy and Innovation Strategy.

- There are 7 key priorities of the Education Strategy.
- There are 3 key priorities for Innovation.
- There are 6 key priorities within the Research Strategy.

The priorities are aligned to our wider framework, including our People Plan and are focused on improving and supporting education, research and innovation in the workforce and Trust as key enablers with an underpinning role in providing and improving safe, personal and effective care.

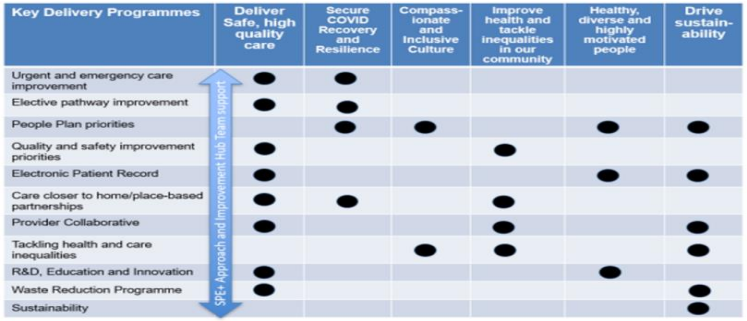
System Working: Key Delivery and Improvement Programmes



There are **11 Trust-wide Delivery and Improvement Programmes** that form part of our system working.

Each programme has an executive Senior Responsible Officer (SRO) and a detailed plan or strategy to ensure delivery.

The programmes form our core business in the Trust and are monitored and delivered through key Trust wide Board meetings that cascade through corporate/divisional teams.



Key Delivery and Improvement Programmes (mapped to the Trust's Goals)

Key Delivery and Improvement Programme	SRO	Related Plan or Strategy	Monitoring & Delivery Through BAF plus :
Urgent & Emergency Care Improvement	Executive Director of Integrated Care, Partnerships and Resilience	UEC Improvement Plan	• Emergency Care Improvement Steering Group (ECIP) • Finance & Performance Committee
Elective Pathway Improvement	Chief Operating Officer	Elective Care Improvement Plan	• Elective Care Board (on hold) • Finance & Performance Committee
People Plan Priorities	Executive Director of People and Culture	People Plan & Strategy	• People and Culture Committee
Quality & Safety Improvement Priorities	Executive Medical Director Chief Nurse	Quality Strategy	• Quality Committee
eLancs Programme	Executive Director of Finance	EPR Cerner Programme	• Senior Leadership Group • Finance & Performance Committee
Care Closer to Home / place-based partnerships	Executive Director of Integrated Care, Partnerships and Resilience	Community Transformation Plan	• ELHT Community Transformation Board
Provider Collaborative	Executive Director of Service Development and Improvement	PCB Clinical Strategy and Business Plan	• Provider Collaborative Board • Provider Collaborative Delivery Group
Tackling Health & Care Inequalities	Executive Director of Integrated Care, Partnerships and Resilience	Health Equity Plan	• Pennine Lancs Health Equity Alliance
R&D, Education & Innovation	Executive Director of People and Culture / Executive Medical Director / Executive Director of Service Development and Improvement	DERI Strategies	• DERI Strategic Board • People and Culture Committee • Quality Committee
Waste Reduction Programme	Executive Director of Finance	Waste Reduction Plan Financial Strategy	• Financial Assurance Board • Finance & Performance Committee
Sustainability	Executive Director of Finance	Financial Strategy	• Financial Assurance Board • Finance & Performance Committee

System Working:
Trust Business Planning Cycle

East Lancashire Hospitals NHS Trust
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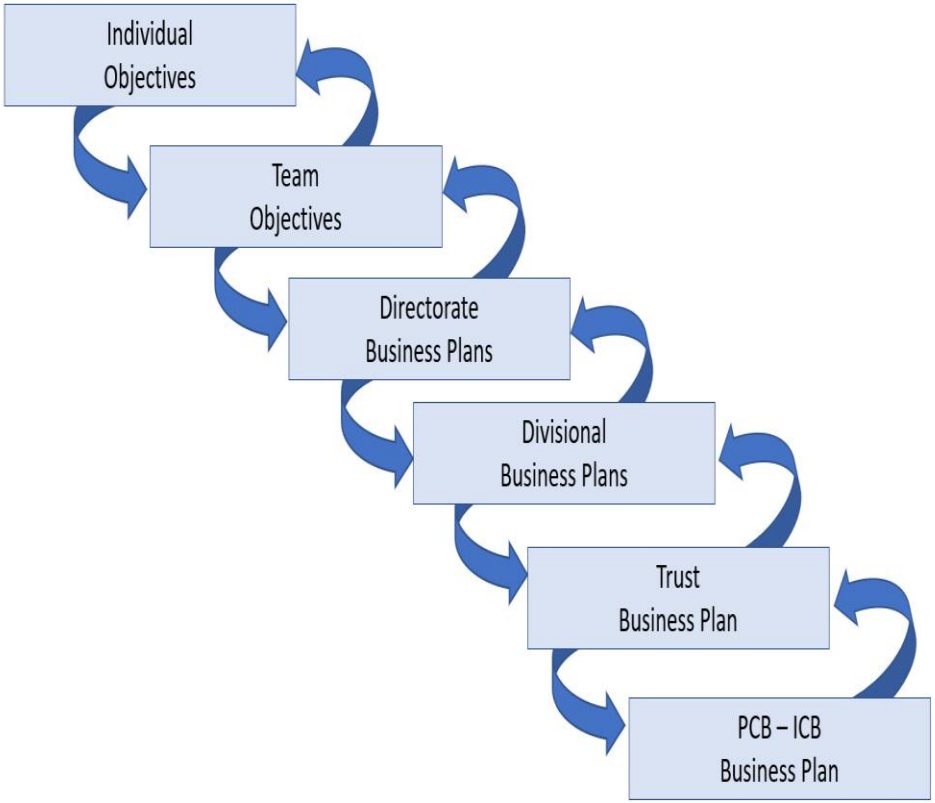
The Business Planning cycle links Directorate, Divisional and Corporate function plans to Trust wide strategies, programmes and plans, and also ICB wide plans and strategies. The Business Plans pull everything together in one place for a clinical team.

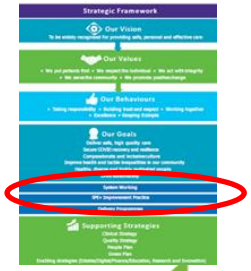
The Directorate/local plans feed into Divisional plans, which feed into Trust plans, which feed into ICB plans. Annual priorities are set each year through our planning cycle, which drive the practical actions that deliver our strategic objectives and priorities. This is coupled with the delivery of the Trust strategies and plans, which form our Strategic Framework.

Business Plans include workforce, finance, activity, performance, quality and safety. They incorporate any objectives for that Division/Directorate that is part of Trust strategies such as the Clinical or Quality Strategy, as well as key aspects of our 11 delivery programmes.

The Business Plan is therefore the central 'go to' document for a departmental team and pulls their key parts of the relevant Trust strategies, programmes and plans into one place.
This ensures that departmental plans are aligned fully to Trust strategies and our overarching vision, values and goals. This process, through appraisals, also aligns team and individual objectives to the Trust vision, values and goals.

Our Trust Annual Report captures all the Trust's activities.





ELHT Improvement Practice

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Improving Safe Personal and Effective Care

SPE+

Improvement Continuum

Clinical Effectiveness and Audit
Measures existing practice against evidence-based clinical standards

Improvement
Use of SPE+ improvement method to achieve 'small steps' (continuous improvement) and 'big leaps' (radical transformational redesign)

Research and Development
Generates new knowledge where no or limited research evidence available

Innovation
New ways of working (policies, systems, products, technologies, services and delivery methods)

Underpinned by Information/Knowledge Management, Skills/Education, Organisational Development

Corporate functions working together

Quality Governance ⟷ Performance + Informatics ⟷ HR&OD ⟷ Improvement Hub ⟷ DERI Directorate of Education, Research and Innovation

Supporting Clinical and Operational Teams delivering Safe Personal Effective Care

Improving Safe, Personal and Effective Care underpins all we do and developing a culture of learning and improvement is at the core of how we will ensure we can deliver the best outcomes for our patients.

Our Improvement Continuum describes our overall approach, ensuring we have the right combination of methods and approaches, supported by skills and organisational development to continuously improve and innovate.

Our Quality Strategy, SPE+ Improvement Practice Development Plan and Education, Research and Innovation Strategy and Plans will support delivery of our ambitions.

Alignment - Joining the Dots….

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Vision	Trust Goals	Trust Strategies	Enabling Strategies	Delivery & Improvement Programmes
Safe	Deliver safe, high quality care	Clinical Strategy		Quality & Safety Improvement Priorities
				Urgent & Emergency Care Improvement
	Secure Covid recovery & resilience	Quality Strategy		Elective Pathway Improvement
Personal	Improve health and tackle inequalities in our community	Health Equity Strategy		Care closer to home/Place-based partnerships
				Tackling health & care inequalities
				Provider Collaborative
	Compassionate & inclusive culture	People Plan	DERI Strategies	People Plan Priorities
	Healthy, diverse and highly motivated people			R&D, Education & Innovation
Effective	Drive Sustainability	Green Plan	Digital Strategy	Electronic Patient Record
			Finance Strategy	Waste Reduction Programme
			Estate Strategy	Sustainability

SPE+ Improvement Practice / Business Plans

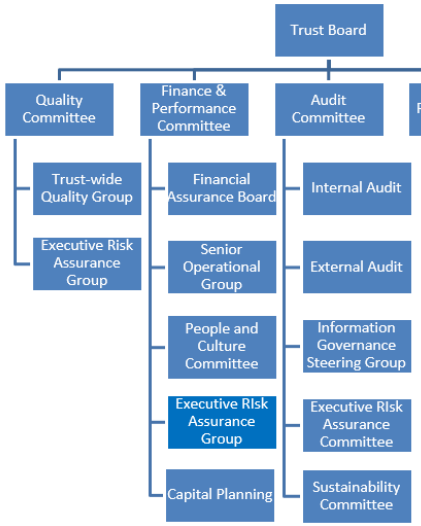
Delivery & Monitoring:
Performance & Accountability Framework

East Lancashire Hospitals NHS Trust
A University Teaching Trust

The Performance & Accountability framework fosters a culture of responsibility, accountability, empowerment, and continuous improvement whilst setting out clear protocols for when corrective action is needed. The framework outlines key roles, reporting lines and accountability and ensures that the Trust has a consistent approach to performance management whilst also encouraging empowerment of staff, collaboration, communication and co-operation between teams.

The aim of this framework is to empower our staff to play a prominent role in continuously improving our services, and subsequent to that:

i. Ensure that all objectives are aligned to deliver our strategic priorities
ii. Set clear priorities at each level of the organisation
iii. Recognise the importance of all individuals in achieving our strategic aims
iv. Establish appropriate key performance indicators
v. Set out the review process for each year.



The Trust Board gains its assurance through a number of sub-Board committees, chaired by Non-Executive Directors, which report to the Trust Board, chaired by the Chairman.

Weekly Executive Leadership Wall

Executive Team Meeting and Senior Leadership Group

Divisional/Corporate/Directorate Meeting Structure inc Divisonal Performance Meetings

The role of individuals

- Understand the objectives of their department through their departmental business plans and PDR process. We want to empower staff the play a prominent role in taking ownership of success.
- Everyone is encouraged to raise any issues of concern through their departmental hierarchy remembering that 'the standard you walk past is the standard you accept.' It is of upmost importance that our staff continue to identify areas of improvement and are able to raise concerns freely.
- Individuals must ensure they are up to date with all mandatory and role specific training and adhere to all policies relating to their role and department.

The role of local leaders

- Local and place-based leaders (Directorates, individual teams, ward-based team etc) are fully accountable for their areas of responsibility.
- Key to fostering positive working environments allowing staff to flourish, being open to improvement ideas, promoting new learning and a culture that empowers staff to improve their working environment.
- Responsible for identifying proactively issues of underperformance and acting upon them promptly and avoiding necessity for escalation.
- Identify and mitigate issues out with their control that impact on performance by working with colleagues and escalating where needed.

The role of Divisional Triumvirate/Corporate management

- The Divisional triumvirate and Corporate management teams are pivotal in creating an environment that allows the staff in those areas to flourish.
- The Divisional Triumvirate is accountable for the delivery of their division's objectives and is made up of a Divisional Medical Director, a Divisional Director of Nursing, and a Divisional Director of Operations. For corporate teams, this accountability will be through the management structures of the individual corporate departments and is likely to be a single manager.
- Directly accountable for achievement of their area's objectives and responsible for the effective management of all their teams and services which they deliver. Will actively encourage and demonstrate the use of SPEC+ improvement.

The role of the Executive team

- Leadership style that gives our staff a voice and empowers all staff.
- Actively encourage improvement through the SPEC+ framework.
- Use of visual management, kata coaching and the Gemba (go and see) to gain assurance.
- Collectively accountable to the Trust Board for running the Trust's business, for proposing and developing the Trust's strategy and overall objectives for consideration and approval by the Trust Board.
- Jointly responsible for implementing the decisions of the Board of Directors and its Committees and providing information, support, and assurance to the Board of Directors.
- Oversee the operational business of the Trust and will ensure delivery of objectives, plans and strategies.

Delivery & Monitoring: The Board Assurance Framework

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Board Assurance Framework (BAF)

The BAF is a framework that ensues our core business is managed appropriately, integrating the Trust's strategic framework combining strategies, planning and delivery programmes to manage organisation business and associated risks

Consistent approach to performance management and also encourages collaboration, communication and co-operation between teams to ensure any early warning concerns or failings trigger the appropriate action and response.

Seeks to align information which balances quality, operational delivery, impact on staff and patients with the finances

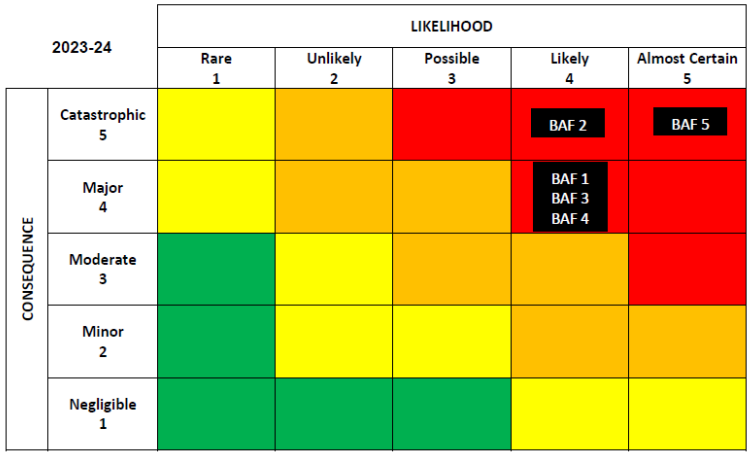
The framework outlines key roles, reporting lines and accountability.

The BAF and associated BAF risks are monitored through the Trust Board

BAF risks are displayed through organisational heat maps

BAF risks are linked to all the Trust's Delivery Programmes

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

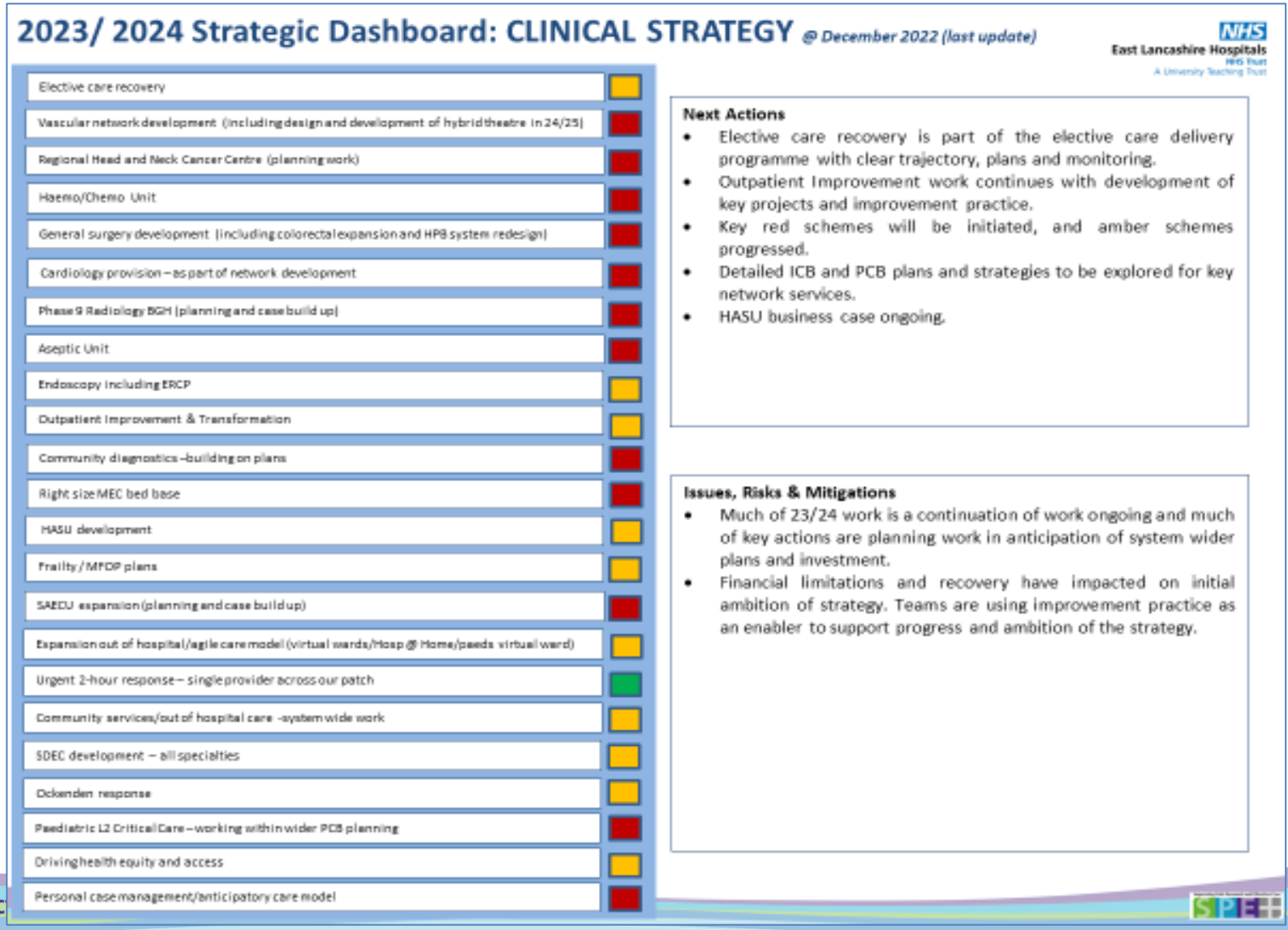


East Lancashire Hospitals NHS Trust
A University Teaching Trust

Delivery and Monitoring: Strategic Dashboards

Our Strategic Dashboard monitors all our key Strategies and Enabling Strategies within the Trust and is updated annually. The Strategic Dashboard compliments our performance dashboards and ensures delivery of our key strategic aims. Our dashboard is monitored through our Senior Leadership Group and Trust Board and is an annual list of priorities for each Strategy. The RAG status indicates progress. It is regularly reviewed at our Executive Wall.

Example Dashboard

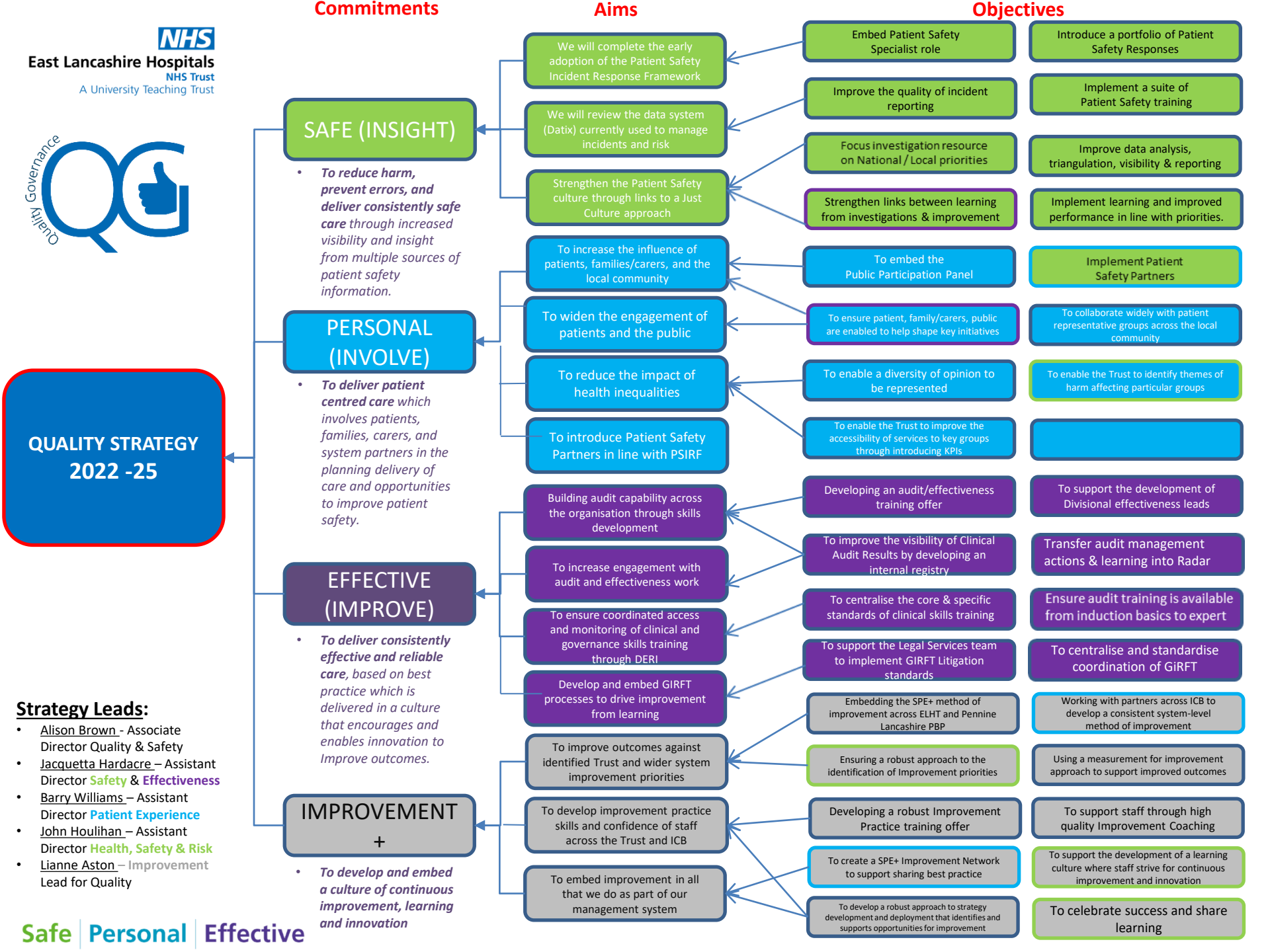


Online Links to Full Strategy Documents:

Full Strategy Documents, as well as associated ‘summary plan on a page’ and relevant podcasts and ‘all things strategy’ can be found at :

Oli Homepage / Corporate tab / Corporate Documents and Trust Board / Corporate folders / Strategy & Plans

Appendices :
Trust Strategies – Quick Reference Summaries

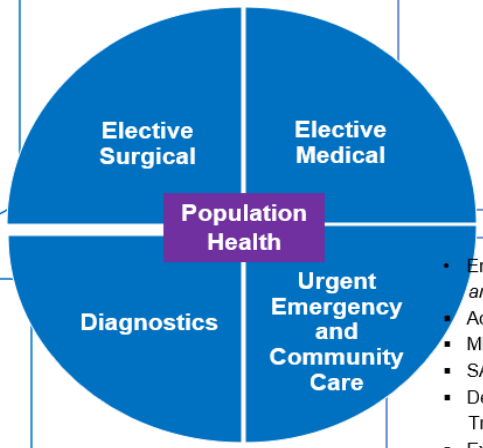

Commitments
Aims
Objectives
East Lancashire Hospitals NHS Trust
A University Teaching Trust
Quality Governance
QUALITY STRATEGY 2022 -25
SAFE (INSIGHT)
To reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.
PERSONAL (INVOLVE)
To deliver patient centred care which involves patients, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety.
EFFECTIVE (IMPROVE)
To deliver consistently effective and reliable care, based on best practice which is delivered in a culture that encourages and enables innovation to Improve outcomes.
IMPROVEMENT +
To develop and embed a culture of continuous improvement, learning and innovation
We will complete the early adoption of the Patient Safety Incident Response Framework
We will review the data system (Datix) currently used to manage incidents and risk
Strengthen the Patient Safety culture through links to a Just Culture approach
To increase the influence of patients, families/carers, and the local community
To widen the engagement of patients and the public
To reduce the impact of health inequalities
To introduce Patient Safety Partners in line with PSIRF
Building audit capability across the organisation through skills development
To increase engagement with audit and effectiveness work
To ensure coordinated access and monitoring of clinical and governance skills training through DERI
Develop and embed GIRFT processes to drive improvement from learning
To improve outcomes against identified Trust and wider system improvement priorities
To develop improvement practice skills and confidence of staff across the Trust and ICB
To embed improvement in all that we do as part of our management system
Embed Patient Safety Specialist role
Improve the quality of incident reporting
Focus investigation resource on National / Local priorities
Strengthen links between learning from investigations & improvement
To embed the Public Participation Panel
To ensure patient, family/carers, public are enabled to help shape key initiatives
To enable a diversity of opinion to be represented
To enable the Trust to improve the accessibility of services to key groups through introducing KPIs
Developing an audit/effectiveness training offer
To improve the visibility of Clinical Audit Results by developing an internal registry
To centralise the core & specific standards of clinical skills training
To support the Legal Services team to implement GIRFT Litigation standards
Embedding the SPE+ method of improvement across ELHT and Pennine Lancashire PBP
Ensuring a robust approach to the identification of Improvement priorities
Developing a robust Improvement Practice training offer
To create a SPE+ Improvement Network to support sharing best practice
To develop a robust approach to strategy development and deployment that identifies and supports opportunities for improvement
Introduce a portfolio of Patient Safety Responses
Implement a suite of Patient Safety training
Improve data analysis, triangulation, visibility & reporting
Implement learning and improved performance in line with priorities.
Implement Patient Safety Partners
To collaborate widely with patient representative groups across the local community
To enable the Trust to identify themes of harm affecting particular groups
To support the development of Divisional effectiveness leads
Transfer audit management actions & learning into Radar
Ensure audit training is available from induction basics to expert
To centralise and standardise coordination of GiRFT
Working with partners across ICB to develop a consistent system-level method of improvement
Using a measurement for improvement approach to support improved outcomes
To support staff through high quality Improvement Coaching
To support the development of a learning culture where staff strive for continuous improvement and innovation
To celebrate success and share learning
Strategy Leads:
Alison Brown - Associate Director Quality & Safety
Jacquetta Hardacre – Assistant Director Safety & Effectiveness
Barry Williams – Assistant Director Patient Experience
John Houlihan – Assistant Director Health, Safety & Risk
Lianne Aston – Improvement Lead for Quality
Safe | Personal | Effective

Clinical Strategy 2022-2027: Summary

East Lancashire Hospitals NHS Trust
A University Teaching Trust

5-Year Improvement Priorities

- Elective care recovery post pandemic and BGH elective site development
- Centre of excellence for robotic surgery
- Vascular arterial surgery/hybrid theatre – partner in Vascular Network
- Regional Head and Neck Cancer Centre
- Paediatric Surgery Centre
- HPB/general surgery expansion



- Heart care centre/expansion of cardiology provision
- Gastroenterology hepatology service
- Explore opportunities for regional TB/neurology
- Cross-Division Therapy Team and ACP expansion – 7-day services/levelling up across Pennine Lancashire
- Mental health in schools
- Development of SEND
- Enhanced POSCU (paediatric oncology)
- Outpatient maternity ante-natal consultations
- Haematology/Chemotherapy Unit

- Phase 9 BGH radiology
- Aseptic Unit
- ERCP/specialist endoscopy
- Diagnostic hub for both endoscopy and cardio-respiratory
- Outpatient transformation

- Ensuring 1st class emergency services *(front door development /111/bed base and workforce review/Pathways focus)*
- Acute Stroke Centre and stroke recovery (HASU)
- MFOP strategy, frailty pathway
- SAECU expansion
- Develop and improve ELHT's trauma services, working within the LSC Major Trauma network
- Expansion of out of hospital/agile care model (virtual wards/Hosp@Home)
- Urgent 2-hour response – single provider across our patch
- Ageing Well programme
- 24/7 collaborative care navigation hub
- Level 2 paediatric critical care / Level 3 NICU Improvement
- SDEC development – all specialties
- Maternity transformation programme
- Ockenden response actions
- Paediatric emergency flow development
- Emergency gynaecology and EPAU service development
- Maximising advantages of ACP/PA/ANP roles in PWE practices

Population Health
- Integrated pathways with GPs, community and social care services and a key role in prevention
- Driving health equity and access
- Personal case management/anticipatory care model

Vision: *"Our strategy expresses our collective purpose to provide safe, personal and effective care. Our future is defined as a 'hospital without walls', networking as partners in local partnerships and within the bigger integrated system of care across Lancashire & S Cumbria"*

Aims & Focus

- Ensure a 1st class emergency service
- Within elective care we will 'build back better' after covid through clear improvement plans.
- To recognise and build on our clinical strengths and thus our 'offer' to the system.
- To play a part in addressing the health and wellbeing of our population and to reduce health inequalities.
- Be 'digital by default' to help clinicians provide safer, more effective care for patients.
- Have a strong underpinning clinical workforce to support our plans
- Productivity, efficiency and reduction in waste and variation are key threads
- Improvement, Education, Research and Innovation underpin and support us to be the best that we can be.
- To ensure that equality and diversity is a key thread throughout our strategy.

Expected Outcomes / Impact

- Improved Population Health through seamless pathways with a focus on prevention of ill health and injury
- Health equity and access for our local population
- Whole system integrated pathways for patients, with no boundaries or duplication
- Care focused on personal case management, anticipatory care and holistic care centred around patients and their families
- Elective care that is timely, clinically effective, efficient and which delivers consistently high patient experience and outcomes
- Emergency care-patients consistently receive high quality care when they are at their most vulnerable.

ELHT People Plan 2019-2024: Summary

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Our overall ambition is to *enable ELHT to recruit the best people, with the right skills and values to an organisation that supports staff to be the best they can be in a culture of community, compassion, inclusion, innovation and improvement to deliver Safe, Personal and Effective Care to the population it serves.*

Workforce if a key enabler for all our strategies and plans. East Lancashire Hospitals NHS Trust (ELHT) the Trust spends approximately 70% of its budget on its workforce, and like all NHS Trusts, is critically reliant on its workforce. To ensure the ongoing delivery of safe, personal and effective care we must both look after and manage our workforce as an employer of choice, as well as planning a sustainable workforce for the future that is representative of our community.

Key Focus of the Plan :

- Recruitment and Retention
- Engagement and Communication
- Leadership, organisational development and talent management
- Workforce Transformation (WFT)
- Equality and Inclusion People
- Health and Wellbeing
- Education and Training

People Plan Priority	How
Looking after our People	Enhanced Health & Wellbeing Programme
	Ongoing delivery of Lead Employer for Covid vaccination
	Flexible and Agile Working
	Health & Wellbeing conversations
	Violence reduction exemplar

People Plan Priority	How
Belonging in the NHS	Formalising talent management approaches to secure more diversity at all levels in the organisation
	Increase recruitment from local community
	EDI Recruitment & retention project
	Veteran Aware Project

People Plan Priority	How
Growing for the Future	Further International Nurse Recruitment
	Developing a "head hunting" approach to recruitment
	Undertake Lead Employer role for Reservist model
	Digital Staff Passport
	Development of Retention strategy
	Increase recruitment from local community

People Plan Priority	How
Developing new roles and ways of working	LSC Diagnostic Network Hosting arrangement
	Pathology Collaborative
	Delivery of PCB workforce plan
	Volunteers - Lead Employer model for Reservists
	Flexible and agile working
	Workforce transformation

ELHT GREEN PLAN 2022-2025: summary

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Our Green Plan Vision

Net Zero: resource consumption and Greenhouse Gas (GHG) emission reductions that align with NHS net zero targets

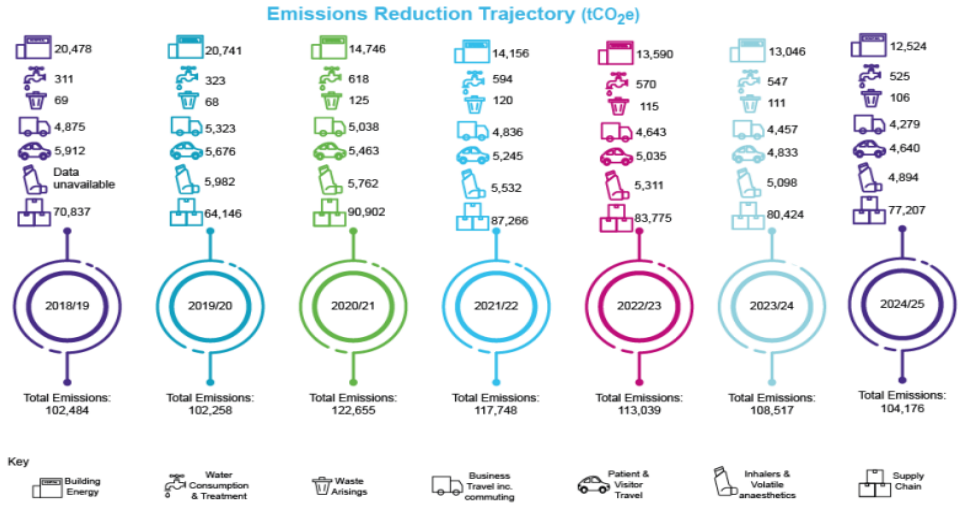
Climate Resilience: reducing the environmental impact of our activities and provide a basis for us to become a climate change-resilient organisation

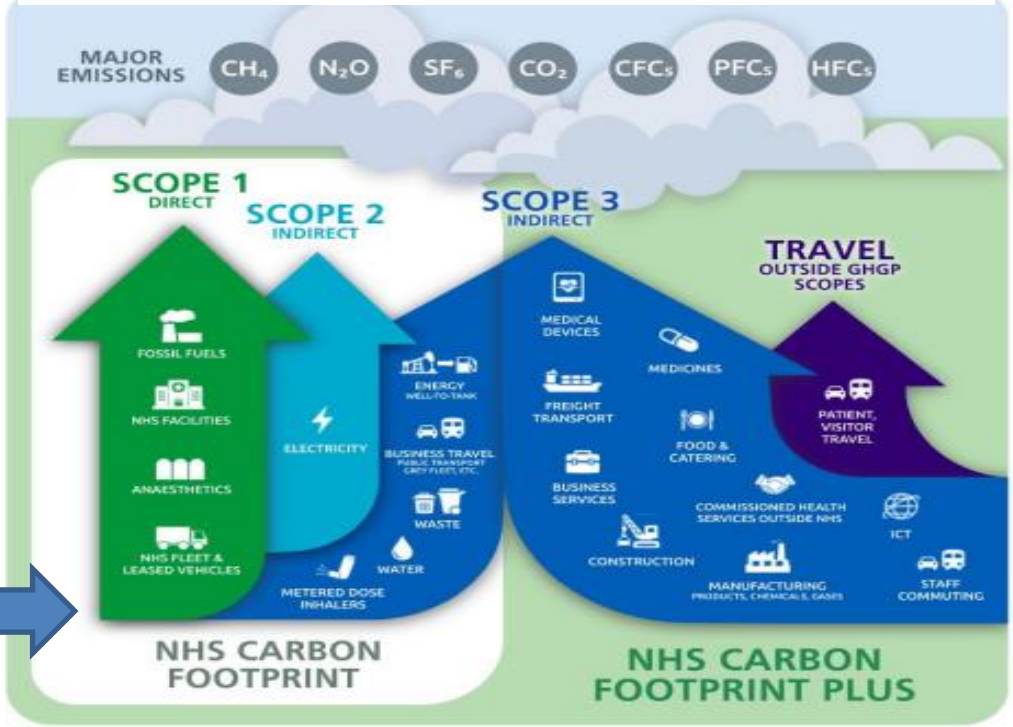
Social Value: actions that leverage our role as a place-based anchor institution to accomplish social value

3-Year Improvement Priorities

Our Green Plan has nine Areas of Focus that appraise our status and set actions to be achieved within the next three years:

1. Workforce and Systems Leadership
2. Sustainable Models of Care
3. Digital Transformation
4. Travel and Transport
5. Estates and Facilities
6. Medicines
7. Supply Chain and Procurement
8. Food and Nutrition
9. Adaptation





Scope 1 and 2 emissions are those that we can control and directly influence. Some scope 3 emissions such as waste and business travel can also be directly influenced

DERI Strategy 2022-2027 Summary

(Directorate of Education, Research & Innovation)

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Our Mission is to work in partnership to improve people's health and wellbeing through innovative healthcare that is supported by excellence in education and research

Our vision is to be nationally recognised as an outstanding provider of innovative high-quality education and research in support of safe, personal and effective care for all

- In education we want to be renowned for providing excellent education, training and learning opportunities to support the current and future workforce in delivering the best care for our patients
- In research we want to work with system partners to integrate research activity into all areas of ELHT for the benefit of our patients and colleagues
- In Innovation we want to become recognised across the region as an exemplar site for the development and adoption of innovative practice within healthcare through greater collaboration with local and regional partners

Education Plan Priorities

- Develop a competent, capable and sustainable workforce with equal opportunity for all
- Provide excellent education and training opportunities for the future workforce
- Support and empower educators, trainers, mentors and supervisors
- Provide high quality learning environments with a culture for lifelong learning
- Develop excellence in patient safety training through simulation
- Ensure effective governance for all education and maximise the use of resources and funding to support delivery of the Education Plan
- Work in partnership to lead the education agenda forwards utilising a system wide approach

Research Plan Priorities

- Increase patient, carer and wider stakeholder involvement in our research activity, to identify needed interventions and support effective implementation
- Support the development of our workforce to actively seek out the best evidence to help improve outcomes and experiences for people, including patients and carers
- Raise research awareness and further a culture of enquiry and critical thinking to engage colleagues in the Trust's research agenda
- Enable effective leadership and create a supportive infrastructure with good collaboration which will provide access to resources, training and research opportunities for all
- Strengthen our existing and develop new partnerships to further enhance and develop our areas of clinical research for patient benefit
- Develop our organisational systems

Innovation Plan Priorities

- Investment in colleagues, patients and carers to develop and foster an innovation culture
- Investment in infrastructure to support innovative practices
- Greater collaboration with innovation agencies and organisations and as a result increased work with local and regional business partners

ELHT Digital Strategy: Key priorities 2023-24

- **Implement and embed use of Cerner Millennium EPR and begin optimisation**
- **Implement Miyaflow solution**
- **Migrate to new integration centre**
- **Commence legacy systems decommission/ housekeeping protocol**
- **Develop strategies for increased ICB corporate collaboration**
- **Further develop the Bedrock data warehouse to support service development**
- **Develop community systems in line with primary and community clinical strategies**
- **Set out Data & Digital strategy and governance approach**

Developments/Improvements

- **Acute ePR System – June 2023**
  Single digital care record/PAS/ePR
- **Record Sharing**
  Digital Record Sharing – c1,000 daily
  Direct access to LPRES
- **Digital Inclusion**
  Planned roll out of #LCSOptimise tool to support patients through digital means while waiting for their procedure.
  Enables risk stratification of patients pre-op including deprivation scores/ health equity
- **Keeping in touch with patients**
  Cerner theatre system allowing relatives to check on patient flow in theatre suite
- **Patient Portal – ICB**
  Roll out of ICB Patient Portal to allow patients to interact with ELHT on appointments.
- **Equipment/Technology**
  Significant volume of equipment (Desktops/WoWs) rollout to hospital sites

Skills/Innovations

- **Simulation Suite**
  Development of digital simulation suite
- **NW ISDN**
  Re-engagement with NW Skills Development Network
  Role & Career Profiling in line with skills matrix/PDR
- **Data & Digital Leadership**
  Development of Data & Digital leadership approach
- **Education/Partnership**
  Enhancement of links with local education providers
- **Innovation**
  Roll out of ICB Patient Portal to allow patients to interact with ELHT on appointments.
- **Equipment/Technology**
  Programme Plan to facilitate resource planning
  Evaluation of Innovation Opportunities
  ICB Opportunities

Accessibility

- **Integrated Care Records**
  Share Card Record/LPRES for record sharing across ICB.
  PRISM for record sharing in NW
- **Image Sharing**
  Re-Single PACs/VNA gateways
  Cardiology Single Storage
- **Access to Patient Records**
  Cerner Millennium ePR
  Linking ELHT ePR solutions
  Access to LPRES through Cerner
- **Single Sign-on** – Enhancing single sign-on approach
- **Cloud First/Resilience** – 24/7 always-on strategy
- **Virtual Consultations** – 120+ stations already enabled for VC; expansion of capability
- **Remote Monitoring/Telemetry** –
- Close work with EBME to expand capability in partnership with ICB
- **Infrastructure Upgrades**
  Core Network upgrades and optimisation
  Replacement of legacy technologies
  Equipment upgrades and standardisation

ELHT Estate Strategy 2019-2024: Summary

System First Clinical Strategy

Royal Blackburn Hospital

- Aseptic Suite combined with Haematology and chemotherapy unit – 3rd floor Phase 6
- Hyper Acute Stroke Unit
- Hybrid Theatre
- Innovation and Education Centre (Medipark)
- RAAC removal
- Key Worker Accommodation
- Specialist Centres e.g. Vascular, head and neck
- Pharmacy Robot
- Outpatients Review
- Multistorey Car Park including EV charging
- Expansion of Endoscopy Facilities
- Fire Stopping and Life Cycle Programme(modular ward as an enabler)
- Wind Turbine
- EPR – Estate Opportunities
- Improved ventilation, increased single rooms
- Phase 1 – 4 Environmental improvements
- Digitisation of Medical Records
- Improving staff facilities
- Paediatric Outpatient Service

Links and Considerations:
Health Infrastructure is an enabling ecosystem for a sustainable health system and Healthier population

Using Infrastructure to create a healthy population

Burnley General Hospital

- Community Rapid Diagnostic Centre
- Theatre and Elective Centre
- Phase 2 of land development (Calico Programme –Education, Key worker Accommodation)
- Multistorey Car Park including EV charging
- Demolition of block 1 (7m backlog maintenance)
- Site Electrical Infrastructure
- Expansion of Endoscopy Facilities
- Fire Stopping and Life Cycle Programme(modular ward as an enabler)
- Decentralisation of steam generation
- Wind Turbine
- Electronic patient records- estate opportunities
- Digitisation of Medical Records
- Improving staff facilities

Links and Considerations:

- ICB Clinical Estates Health Infrastructure Strategy
- NHS Long Term Plan
- Greener NHS
- New Hospital Programme
- Backlog maintenance reduction
- Flexible use of healthcare estate usership not ownership

Delivering a Net Zero National Health Service

Community Hospitals and Healthcare Facilities

- Repurposing of Accrington Victoria site
- Repurposing of Pendle Community Hospital Site
- Rossendale Endoscopy expansion of service
- Fire Stopping and Life Cycle Programme
- Integrated Care Team Facilities

Links and considerations:

- Staying Well
- Preventative Services
- Integrated Care
- Environmental Sustainability

ELHT Financial Strategy: Summary Priorities 2023-24

The Trusts Financial Strategy is twofold, one as an enabler to the Trusts Strategic Framework and secondly in working collaboratively across Lancashire and South Cumbria in shaping the financial framework as a system.

Key Principles

- Ensure the Trust carries out its business of providing healthcare within sound Financial Governance arrangements that are controlled and monitored through robust audit and accounting mechanisms that are open to public scrutiny on an annual basis
- Meet all statutory financial responsibilities
- Deliver an accurate financial plan triangulated with activity and workforce plans forming the Trusts Business plan, incorporating any objectives that are part of the Trusts strategies
- Support the delivery of the Trusts Waste Reduction Programme
- Financial sustainability, working to improve the Trusts underlying financial position
- As we mature as a Lancashire and South Cumbria system, continue to support a system-based approach to planning and delivery; working collaboratively with system partners to standardise practice and maximise opportunities
- Work to shape the financial framework for Lancashire and South Cumbria ICS and achieve system financial recovery and balance
- Enable delivery of the NHS planning priorities for 2023-24+
- Engage all finance staff in improving NHS finance, to support the delivery of quality services for patients, supported by the vision of One NHS Finance
- Maintain One NHS Finance's Towards Excellence Finance Accreditation Level 3, recognising organisational excellence.

Key Objectives

Ensuring the limited resources are spent on improving the quality of patient care in East Lancashire and the wider Lancashire and South Cumbria footprint

Meet all statutory financial responsibilities

Financial Sustainability

Financial Recovery

Key Developments & Improvements

Additional Controls as an enabler to Financial recovery

Continuous Improvement

Standardisation and Collaboration

Use of digital solutions to both produce and interpret data

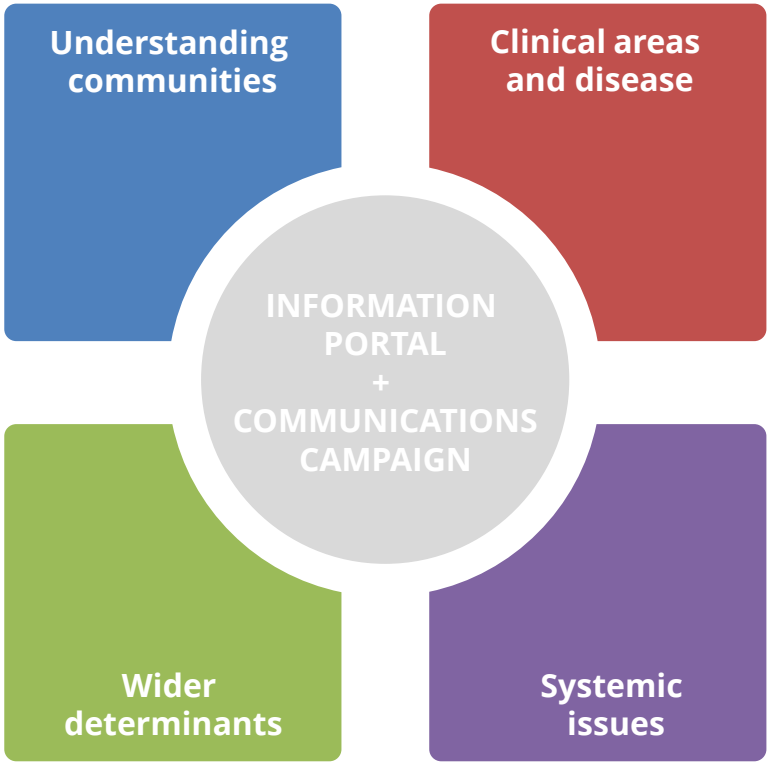
Roll out of the PLICS improvement plan

Health Equity Strategy: Priorities and themes 2023-24

Initial areas of focus, as identified through the Pennine-Lancs, Health Equity Alliance

Addressing inequalities

- Priority Wards
- RTT/non-RTT screening
- Early cancer diagnosis
- Enhanced health checks
- Patient/public engagement programme



Core20Plus5 domains

- Mental health in ED
- Gestational diabetes
- Workplace respiratory illnesses
- Reduce variation in stroke care

Region-specific issues

- Adverse childhood events
- Ageing well initiatives
- Improving housing partnerships
- Cost of living crisis
- Smoking cessation

Encompassing themes

- Anti racism campaign
- Marmot review
- Joint health and wellbeing strategies
- Local workforce development

Appendix 2 – Timeline for Trust strategy reviews and updates

Trust Strategy	Dates of Current Strategy	Development of New Strategy	Committee to Review Strategy and Date	Proposed date for ratification by Board
Clinical Strategy	2022-2027	During 2026	Quality Committee April 2027	May 2027
Quality Strategy	2022-2025	During 2024	Quality Committee April 2025	May 2025
People Plan	2019-2024	Reviewed every two years	People and Culture Committee April 2024	May 2024
Green Plan	2022-2025	During 2024	Finance and Performance Committee April 2025	May 2025
Health Equity Strategy	Plan on a page for 2023-24 New Strategy – being developed	During 23/24	Quality Committee April 2024	May 2024
Estates Strategy	2019-2024	During 2023	Finance and Performance Committee February 2024	March 2024
Digital Strategy	Plan on a page for 2023-24	During 2023	Finance and Performance Committee February 2024	March 2024
Finance Strategy	Plan on a page for 2023-24	Full strategy review in draft format	Finance and Performance Committee October 2023	November 2023
DERI Strategy	2022-2027	During 2026	People and Culture Committee April 2027	May 2027

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

PUBLIC TRUST BOARD REPORT **Item** **117**

13 September 2023 **Purpose** Assurance Information

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

Summary: The purpose of this report is to provide:
1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Maternity Safety Ambition, specifically relating to the ten CNST 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 Drive sustainability
Related to key risks identified on Board Assurance Framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
	2	The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
	3	A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.

	4	The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Related to key risks identified on Corporate Risk Register	-
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	Clinical Negligence Scheme for Trust – Maternity Incentive Scheme (CNST-MIS) Maternity & Neonatal 3-year delivery plan
Related to ICB Strategic Objective	-

Impact

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

Previously considered by:

1. INTRODUCTION

The purpose of this report is to provide:

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

2. A monthly progress summary with any exceptions will be evidenced at ELHT trust boards with clear plans specifically relating to the ten CNST maternity safety actions included in year 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 Progress overview

Safety Action	Progress/ Status	Compliance and Evidence
1. Perinatal Mortality Review Tool (PMRT)		Compliant – Q1 (May June July) report and updated action plan included below. **(Appendix 2)**
2. Maternity Services Data Det (MSDS)		Compliant – July 2023 MSDS submission completed. Results to be published October 2023.
3. Transitional Care (TC)		Compliant - Q1 (Apr May June) TC audit completed and being reported to directorate audit meeting 15th September 2023. ATAIN Q1 report and action plan submitted to Trust Board **(Appendix 3)**
4. Clinical Workforce		Requested support in July 2023 and awaiting HR/ Medical staffing response required regarding short-term and long-term locum use and processes – support meeting put in place on behalf of Family Care to complete the ask. This will be reported at November Trust Board following completion. Compensatory Rest options appraisal and action plan submitted to Trust Board **(Appendix 4)**

5. Midwifery Workforce		Compliant – Bi-annual staffing paper completed January-July 2023 reported to September Trust Board **(Appendix 5)**
6. Saving Babies Lives v3 Care Bundle (SBLv3)		Implementation tool released on the 6th of July, meetings underway in division, triangulating assurance mechanisms with LMNS colleagues to confirm evidential requirements and trajectories to meet the recommendations. Element 1 – Reducing Smoking – Tobacco Dependency Advisor (TDA) roles require progress through cluster review process to enable implementation of in-house service as per requirement. Escalation to HR management – delay with JD/ PS cluster review process.
7. MNVP User Feedback		Meeting arranged to meet with MNVP chair in September. 'Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation' Planning as a service a schedule of engagement meetings with service users aligned for the above evidence which requires MNVP direct involvement and engagement.
8. Training		Compliant – gap analysis to review changes from Core Competency Framework Version 1 to Version 2 is underway
9. Board Assurance		Cancellation of executive walkrounds (19th June and 7th August), have been re-arranged in September 2023 by the Patient Experience Team. Maternity & Neonatal Safety Champion walkrounds have continued. The maternity minimum data set is submitted to Trust Board for discussion **(Appendix 6),** minutes to evidence review of the claims scorecard against incidents and complaints are submitted to Trust Board **(Appendix 7),** minutes to evidence Board Level Safety Champion discussion with Quad leadership team via Floor to Board meetings are submitted to Trust Board **(Appendix 8)**
10. NHS Resolution		Compliant with the process but evidence required for Q1.

2.2 Key updates and exceptions per Safety Action

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

Table 1 Perinatal Mortality Review Tool – Dashboard of Cases within Y5 reporting period

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

CNST - PMRT

(All measures reported against month of death)

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

		Reporting Measure	Threshold	May-23	Jun-23	Jul-23	Aug-23	Monthly Trend
SAFETY ACTION 1	PMRT01a	Total Number of Stillbirths (= 24 weeks)		2	3	2	1	
	PMRT01b	Number of Neonatal Deaths		0	2	2	0	
	PMRT01c	Number of late fetal loss between 22+0 and 23+6 weeks		1	0	0	0	
		Total Eligible Cases		3	5	4	1	
	PMRT02a	Number of cases reported to MBRRACE within 7 days		3	5	4	1	
			100.00%	100.0%	100.0%	100.0%	100.0%	
	PMRT03a	Number of cases with surveillance data to MBRRACE within 28 days		No Date Recorded	5	4	1	
			100.00%	n/a	100.0%	100.0%	100.0%	
	PMRT04a	Number PMRT draft reports by 4 months		*	*	*	*	
			60.00%	*	*	*	*	
	PMRT05a	Number PMRT published reports by 6 months		*	*	*	*	
			60.00%	*	*	*	*	

Further detail in included within the quarterly report submitted to the Trust Board **(Appendix 2)** inclusive of the details of the deaths reviewed, with evidence that the PMRT has been used to review eligible perinatal deaths and the required standards have been met.
An action plan is in place following the reviews using the PMRT tool and can be viewed within the report above.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
'Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.'

An MSDS submission of the July 2023 data has been completed prior to the end of August as per the requirement for compliance. The 'Clinical Negligence Scheme for Trusts: Scorecard' in the Maternity Services Monthly Statistics Publication Series which is to be used as the

evidence for this requirement will reflect July 2023 data in October 2023, and will therefore be included in Trust Board reporting in November 2023.

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

'A structured process is in place which demonstrates a joint Multidisciplinary maternity and neonatal approach to Review all admissions to the NNU (Neonatal Unit) of infants equal to or greater than 37 weeks.'

A quarterly report has been completed (April, May, June 2023 reviews – **Appendix 3),** and the findings inform the ATAIN action plan **(Appendix 3)** to be reviewed and signed off by the Trust Board.

The Maternity scorecard data shows an increase in the Term Admission to NICU (Neonatal Intensive Care Unit) rates from February 2023:

Division of Family Care - Section 3 - Maternity Scorecard

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

Reporting Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Monthly Trend
Percentage of Neonatal Admissions - Term Babies	G <=5% A 6-7% R >7%	5.03	5.35	4.94	5.07	5.73	6.70	5.23	5.67	6.31	7.69	7.47	9.26	7.29	

This has been recognised and reviewed by the Clinical Director for Neonatology, the perinatal quadrumvirate and the wider team (Jan-Jun 2023 data and cases), and the main indication for Term Admissions to NICU is respiratory disease (data shows 60%, 118/195), therefore the action plan reflects the improvement work underway with regards to respiratory disease it is recognised that the 7 avoidable admissions to NICU within the last quarter may not require an action plan as the findings do not amount to a theme. These reviews are monitored through the weekly ATAIN meetings and individual actions aligned with standard governance processes in division.

Of the 118 babies admitted due to respiratory disease 65% were born by C-Section which is higher than the 41% average of births by C-Section for the Trust indicating that the mode of delivery has an impact on respiratory disease and admission to NICU. These findings are reflected in the action plan including review of the C-Section pathway, assisted births and improvement work for uninterrupted skin to skin contact for infants born in theatre.

The maternity scorecard also shows a rise in the C-Section rate for the Trust:

Division of Family Care - Section 3 - Maternity Scorecard														* = Data not relevant for month n/a = Data not available at time of report
Reporting Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Monthly Trend
Percentage of Babies Born by Caesarean Section	G <30% A 30-35% R >35%	34.67	35.78	40.04	38.98	35.56	44.21	38.41	44.21	38.46	40.85	39.21	42.39	41.63	
Percentage of Babies Born by Emergency Caesarean Section	G <=17% A 18-22% R >=23%	17.76	22.79	23.12	20.87	21.77	28.76	22.76	22.53	21.72	21.97	23.20	25.72	26.57	
Percentage of Babies Born by Elective (Cat 4) Caesarean Section	G <=13% A 14-18% R >=19%	16.91	12.99	16.92	18.11	13.79	15.45	15.65	21.67	16.74	18.88	16.01	16.67	15.06	

The likelihood of emergency C-Section increases where labour is induced, and the induction of labour rate has also increased:

Division of Family Care - Section 3 - Maternity Scorecard														* = Data not relevant for month n/a = Data not available at time of report
Reporting Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Monthly Trend
Total Number of Women Induced		210	232	252	221	195	217	243	209	215	240	203	233	224	
Percentage of Women Induced	G <30% A 30-40% R >40%	44.97	44.27	48.18	44.38	42.30	47.17	49.90	45.73	49.20	46.78	47.88	48.85	47.16	

National directives and NICE guidance have contributed to the offer of induction of labour which translates into an increase in induction rate. A working group has been initiated to review the local induction rate, with analysis of the data to review indications and appropriateness for inductions of labour identifying any themes for improvement.

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

Obstetric Short Term and Long Term Locum

‘1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota

or

b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)

or

c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.'

As exception reported within the table on page 3.

Obstetric medical workforce - Compensatory Rest

'Provide evidence of standard operating procedures and their implementation by October 2023 to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board.'

(Options Appraisal and Action plan – Appendix 4)

Obstetric medical workforce – Consultant Attendance

'Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG (Royal College of Obstetricians and Gynaecologists) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service.' Audit of consultant attendance against RCOG guidance for June, July, August 2023 has been completed and finds 100% compliance.

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

Supernumerary Co-ordinator and 1:1 Care

'The midwifery coordinator in charge of labour ward must have supernumerary status' and 'All women in active labour receive one-to-one midwifery care'. Evidence from the BirthRate+ Acuity App continues to confirm compliance with both requirements as reflected in reports for May, June, and July 2023.

Midwifery Staffing Oversight Report (Appendix 6)

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

'The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. Providers should use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. These percentages will be calculated within the national implementation tool.'

SBLv3 lead clinician is in the process of reviewing a gap analysis of the requirement changes from version 2 to version 3 of the care bundle. Element 1 Reducing smoking in pregnancy has been reviewed and a working group has commenced to collate the evidence required which will be input into the implementation tool.

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

'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.'

A working group within Maternity and Neonatal services took place on the 31st August with specific focus on the requirements to 'evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation.'

A full update regarding improvements ongoing within Maternity and Neonatal services results from user feedback and progress against the Maternity CQC survey themes and actions was reflected within the Floor to Board report submitted to Quality Committee on the 30th August 2023. **(Appendix 10)**

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

New training needs analysis (TNA) tool has been received alongside the publication of Version 2 of the Core Competency Framework within the CNST Year 5 guidance. NHS England have provided a 'how to' guide for use of the tool which is currently being reviewed alongside a gap analysis of the changes from Version 1 of the framework. Attendance to required training sessions continued from Version 1 of the framework continue to be monitored against the 90% attendance compliance requirement.

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?
'The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions.' Cancellation of executive walkrounds (19th June and 7th August), have been re-arranged in September 2023 by the Patient Experience Team. Walkrounds performed by the Maternity and Neonatal Safety Champions continued on the 22nd March and 26th July, with focus on the Postnatal Ward and Transitional Care.

'Evidence that a review of maternity and neonatal quality is undertaken at every Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs).'
Perinatal Quality Surveillance Model (PQSM) Minimum Data Set **(Appendix 7)**

'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 complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan.'
This Quorate meeting including board level safety champions took place on the 13th of July 2023, this was in the recommended time frame in version one of the MIS schemes as captured and evidenced in the meeting minutes **(Appendix 8).** A further discussion is due to take place November 2023.

'Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting

period) and that any support required of the Board has been identified and is being implemented.'

Quality, Safety, and performance are closely monitored within Maternity services here at ELHT, any immediate actions to maintain a high standard of quality and safety for mothers and families in collaboration with the maternity and neonatal safety champions is demonstrated with evidence to support any actions through bi – monthly floor to board meetings. A copy of the most recent floor to board minutes are reflected in **(Appendix 9)**

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Processes are in place, evidence for Q1 awaiting submission to Maternity Transformation Team. A full update will be brought to November Trust Board.

3. 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.

Perinatal Quadrumvirate:

Tracy Thompson, Divisional Director of Midwifery and Nursing
Martin Maher, Clinical Director of Obstetrics
Savi Sivashankar, Clinical Director of Neonatology
Charlotte Aspden, Directorate Manager of Maternity and Neonatology
September 2023

Appendix 1 – CNST-MIS Y5 Guidance

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

Appendix 2 – PMRT Q1 Report

Quarterly PMRT Report Q1 (1).doc

Appendix 3 – ATAIN Q1 Report & Action Plan

Atain report Q1 2023 Apr-Jun (1).docx

ATAIN Action Tracker - Aug 2023.pdf

Appendix 4 – Compensatory Rest Action Plan

Public Trust Board Report consultant rest

Appendix 5 – Midwifery Staffing Oversight Paper

Maternity Bi annual staffing paper - CNST

Appendix 6 – Maternity Minimum Data Set

PSQM dataset Sept 2023 (1).pptx

Appendix 7 – Triangulation: Review of Claims Scorecard, Incidents, Complaints

CNST 9 Minutes 13 07 23.docx

Appendix 8 – Floor to Board Minutes

[5] 03.08.2023 - Floor to Board.docx

Appendix 9 – August 2023 Quality Committee Report: Floor to Board

Floor to Board Quality Committee Au

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **118**

13 September 2023 | **Purpose** | Approval / Assurance / Information

Title	New Hospitals Programme Quarter 1 Board Report
Report Author	Mr J Hawker, New Hospitals Programme, SRO Mrs R Malin, New Hospitals Programme, Director
Executive sponsor	Mrs K Atkinson, Executive Director of Service Development and Improvement

Summary: The purpose of this report is to provide an update on the Lancashire and South Cumbria New Hospitals Programme for the Quarter 1 period: April to June 2023.

This quarterly report is presented to the following Boards:

- University Hospitals of Morecambe Bay NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Provider Collaborative

Recommendation: It is recommended the Board:

- Note the progress undertaken in Quarter 1.
- Note the activities planned for the next period.

Report linkages

Related Trust Goal	Deliver safe, high quality care Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability	
Related to key risks identified on Board Assurance Framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
Related to key risks identified on Corporate Risk Register	-	
Related to recommendations from audit reports	-	
Related to Key Delivery Programmes	Care closer to home/placed-based partnerships, Provider Collaborative.	

Related to ICB Strategic Objective	1. Improve quality, safety, clinical outcomes and patient experience. 2. To equalise opportunities and clinical outcomes across the area. 3. Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees. 4. Meet financial targets and deliver improved productivity. 5. Meet national and locally determined performance standards and targets. 6. To develop and implement ambitious, deliverable strategies.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

NEW HOSPITALS PROGRAMME Q1 BOARD REPORT

1. Introduction

1.1 This report is the 2023/24 Quarter 1 update from the Lancashire and South Cumbria New Hospitals Programme (L&SC NHP).

2 Background

2.1 University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) and Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) are working with local NHS partners to progress the case for investment in new hospital facilities.

2.2 The L&SC NHP is part of cohort 4 of the Government's national New Hospital Programme (NHP).

2.3 The L&SC NHP offers a once-in-a-generation opportunity to develop cutting-edge facilities, offering the absolute best in modern healthcare and addressing significant problems with the current ageing hospital buildings. This will provide patients with high-quality, next generation hospital facilities and technologies. Hospital buildings will be designed in a way to meet demand, while remaining flexible and sustainable for future generations. The aim is to support local communities, bringing jobs, skills and contracts to Lancashire and South Cumbria businesses and residents.

2.4 On 25 May 2023 the Government announced a record investment of more than £20 billion, ring-fenced for the next phase of the national New Hospital Programme, which brings proposals for new cutting-edge hospital facilities for Lancashire and South Cumbria a step closer.

2.5 Following the May 2023 statement to the House of Commons from the Secretary of State for Health and Social Care, the local NHS was delighted to welcome the announcement of two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital 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.

2.6 Being able to build new hospitals on new sites will be truly transformational, giving us the freedom to design our services and facilities around the needs of our patients, future-proofing services for the next generation. This once-in-a-generation opportunity will be a huge contribution to our recovery as a health and care system after Covid-19,

bringing new facilities and much needed investment into our area for the benefit of patients and colleagues. The L&SC NHP gives us a real opportunity to achieve our ambitions for being an exemplar health and care system by transforming the way we work across our hospitals in Lancashire and South Cumbria, enabling us to improve quality, safety and patient experience for our whole population and have a positive impact for our NHS colleagues, who undertake incredible work to support our communities every day.

2.7 The existing Royal Lancaster Infirmary and Royal Preston Hospital sites will remain in place and deliver services to our population until new hospital facilities are opened. What this means for future hospital services needs to be worked through. The local NHS will continue to keep communities involved and provide further updates as more information becomes available.

3 National New Hospital Programme

3.1 **Programme business case** – following review of the national programme business case by the Major Projects Review Group in Q3 and Q4, the local NHS welcomes the subsequent government announcement on 25 May 2023, confirming national funding for the next phase of the national New Hospital Programme, which paves the way for new hospital facilities in Lancashire and South Cumbria.

3.2 This means that L&SC NHP can progress with the business cases for two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital as part of a rolling programme of national investment in capital infrastructure beyond 2030. The L&SC NHP will continue to work with partners across Lancashire and South Cumbria along with NHS England to determine the requirement and focus of any future public consultation.

3.3 **Enabling works –** Whilst a construction start date for two new hospitals is now delayed until 2030, the national NHP is committed and keen to support the L&SC NHP to progress, ensuring readiness for 2030 (or earlier should there be any change). In line with this, the L&SC NHP welcomed the opportunity to bid for enabling / early works funding. This will be focused on work that enables two new hospitals, including further work on potential new sites.

3.4 **National guidance** – as part of cohort 4 of the national NHP, L&SC NHP will be a full adopter of national NHP guidance on Hospital 2.0, an integrated systems approach built on best practice standards and delivery solutions, enabling best-value

procurement and Modern Methods of Construction (MMC). The aim of this is to drive an accelerated programme, creating transformative environments that will benefit patients and the public as a whole. A critical part of this system will be the ability to create prototypes to enable quick learning, collaboration and validation of hospital design including new greener and safer ways of building.

3.5 During Quarter 1, the L&SC NHP team have attended a number of workshops focused on the development of national ambitions around Hospital 2.0. Sessions to date have covered topics such as the approach to building design considering the needs of patients and staff; cost and benefits; delivery plans and phasing; commercial strategy; roles and responsibilities; out of hospital / community care considerations; clinical services; and addressing environmental targets. This forms part of six months of engagement sessions to maximise the opportunity for collaboration and co-creation of Hospital 2.0 between local schemes and the national NHP.

4 Progress against plan (for the period April to June 2023)

4.1 **Potential new sites** – work is underway to assess the viability of potential locations for new hospital builds for each of Royal Lancaster Infirmary and Royal Preston Hospital. Following an initial land search, the NHS in Lancashire and South Cumbria has been working in partnership with town, city and county councils to assess the deliverability of a number of potential sites, including environmental, planning and highways considerations, capacity for utilities and high-level design. Travel and transport analysis will also form a key element of consideration of viable sites. The programme team will continue to consider and assess any sites put forward against the existing criteria. There is still a lot of work to be completed in this area and further information will be shared in due course. New builds on new sites would be within around a 10-mile radius of the current Royal Lancaster Infirmary and Royal Preston Hospital sites respectively.

4.2 A Strategic Infrastructure Group has been established with representatives from Lancaster City Council, Preston City Council, Chorley Council, South Ribble Borough Council, Lancashire County Council, L&SC NHP and the ICB to focus on a strategic approach to potential new sites and the existing hospital sites.

4.3 **Public consultation planning** – L&SC NHP is working with NHS England and the national NHP team regarding the approach to future public consultation and will continue to work with local Health Overview and Scrutiny Committees, who are instrumental in determining the requirement to consult and the approach to be taken.

5 Public, patient and workforce communications and engagement

5.1 **Funding announcement** – Following the Government announcement of national funding on 25 May 2023, communications have been shared with key internal and external stakeholders, colleagues, partner organisations, local and national media, and local people. This included issuing updates to Boards, Governors and Foundation Trust Members, with internal communications shared with colleagues across Lancashire and South Cumbria Trusts and NHS Lancashire and South Cumbria Integrated Care Board (ICB). A media release on the funding announcement was issued, with a number of interviews held, resulting in widespread coverage across local media. Social media news alerts and email updates have been shared through L&SC NHP channels and shared by partners. The frequently asked questions continue to be updated on the L&SC NHP website on a regular basis, with ongoing enquiry handling.

5.2 The Health Minister Lord Markham and the national New Hospital Programme is embarking on a series of roadshow events throughout the summer including Lancashire and South Cumbria. This event is an opportunity to learn more about the national New Hospital Programme and discuss proposals for the Lancashire and South Cumbria schemes with Health Minister and members of the national New Hospital Programme team. The L&SC NHP is very much looking forward to hosting this event and taking this opportunity to further involve and engage a range of local stakeholders and colleagues.

5.3 **Stakeholder management** – Updates regarding the funding announcement have been issued to MPs; Local Authority leaders, Chief Executive Officers, Health Overview and Scrutiny Committees, and Health and Wellbeing Boards; and wider partners, with the repeat of an offer to meet with the L&SC NHP team to discuss programme progress further.

5.4 In response, meetings have been held to discuss the next phase of the L&SC NHP and the announcement of two new hospitals on new sites to replace Royal Lancaster Infirmary and Royal Preston Hospital, with investment in Furness General Hospital, with Simon Fell MP (Barrow and Furness), Mark Menzies MP (Fylde) and David Morris MP (Morecambe and Lunesdale) during June 2023.

5.5 Members of the Programme team updated the Lancashire Health and Adult Services Scrutiny Committee on 12 July 23 and attendance at Westmorland and Furness Health

and Adults Scrutiny Committee and Cumberland Health Overview and Scrutiny Committee is in the process of being arranged.

5.6 **Your Hospitals, Your Say** – the report which brings together all the valuable input from the engagement work undertaken to date was published in September 2022. A British Sign Language (BSL) version of the Your Hospitals, Your Say report has been produced, with support from Lancashire Teaching Hospitals NHS Foundation Trust's Blended Learning team. The BSL video is now available on the Your Hospitals, Your Say section of the NHP website, along with an Easy Read version and accessible website content.

6 Next period – Q2 2023/24

6.1 The Programme will continue to work on assessing the viability of potential locations for new hospital builds for each of Royal Lancaster Infirmary and Royal Preston Hospital and preparations for future public consultation. The Programme team will commence discussions with the national NHP regarding the timing of business case products and work with ICB colleagues to develop an agile governance model.

7 Conclusion

7.1 This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 1 of 2023/24.

8 Recommendations

8.1 The Board is requested to:

- Note the progress undertaken in Quarter 1.
- Note the activities planned for the next period.

Rebecca Malin
Programme Director
July 2023

Jerry Hawker
Programme Senior Responsible Officer

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **119**

13 September 2023 **Purpose** Approval / Information

Title	NHS England Annual Board Self-Certification
Director sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance

Summary: NHS providers need to self-certify after the end of the financial year as to whether they have:

1. Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have a regard to the NHS Constitution (condition G6)
2. Complied with governance arrangements (condition FT4) and
3. (for Foundation Trusts only) The required resources available if providing Commissioner requested services (CRS) (condition CoS7).

The attached documents provide the draft self-certification by ELHT for the financial year 2022-23 against the conditions G6 and FT4.

It is recommended that the Trust self-certifies as confirming compliance with both conditions. The narrative setting out the factors for confirming compliance is provided in the attached templates issued by the regulator.

The Board is asked to review the draft self-certification and agree for it to be signed by the Chairman and the Chief Executive before its publication on the Trust website.

Recommendation: The Board is asked to agree the annual self-certification for signing by the Chairman and the Chief Executive before its publication on the Trust website.

Report linkages

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

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2022-23

Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

ELHT is not a Foundation Trust, so we have not responded to question 3a, 3b and 3c as they are not applicable.

The Trust reported a £4.172 million adjusted financial performance deficit for the 2022-23 financial year. The Trust was on trajectory to achieve a breakeven position, however given the uncertainty at year end of pay awards, following rejection of the pay offer, posted a deficit to allow for an additional pay award accrual.

The Trust continues to work with partners within Lancashire and South Cumbria ICB and has agreed an individual planned deficit of £24.3 million within a system planned deficit of £80 million for 2023-24.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Mr Shazad Sarwar	**Name**	Mr Martin Hodgson
Capacity	Chairman	**Capacity**	Chief Executive/Accountable Officer
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2022-23** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Embedded Board and Committee structures have been revised to include the formation of a new People and Culture Committee to ensure that workforce matters and staff wellbeing at the heart of the Trust's activities in delivering safe, personal and effective care. Board development programme delivered by an external supplier is under review due to a change in the chairmanship of the Board. However, Board Development and Strategy sessions continue to take place on a bi-monthly basis, providing the Board with an opportunity to have focused conversations on matters of strategic importance at Trust, system and national level. The Trust was awarded 'good' rating by CQC overall and in the well-led domain in its last formal inspection in September 2018 with some service areas rated 'outstanding'. In addition, the Trust has had several recent CQC inspections, including for maternity services and received positive feedback and retained its 'good' rating with areas of 'outstanding'.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	As above; in addition, the annual review of the Board Assurance Framework and risk appetite was carried out by the Board; annual review of risks as part of the Annual Governance Statement; regular review of the BAF and Corporate Risk Register by the Audit Committee, Finance and Performance Committee and Quality Committee and the Board. The newly formed People and Culture Committee will also receive reports on risks under its remit. The Annual Head of Internal Audit Opinion for 2022-23 was Significant Assurance.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Same as the response under statement 1 and effective operational structures; Divisional accountability framework has been completed. Senior Leadership Group acts as a senior operational decision body with delegated authority, annual self-assessment of the effectiveness of the Committees reinstated following COVID-19 and escalation of matters to the Trust Board as appropriate continues.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Oversight of each of the matters under this statement is overseen by the Trust Board and where appropriate delegated to the relevant risk and assurance Committee. In instances where matters require escalation then the Board has the final oversight and decision making authority on further mitigation and residual risks.	#REF!

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Board composition reviewed as part of the Board development plan and concentrates on good governance and risk management. All Executive (voting Director) positions are held by full time employees of ELHT. The Chief Executive / Accountable Officer was substantively recruited in August 2022, afollowed by the recruitment for the substantive Executive Director of Service Development and Improvement, Execuitve Director of People and Culture and Executive Chief Nurse. The Trust has got an established succession planning and leadership development process in place, ensuring that recruitment for Executive posts results in high-quality appointments. The vacancies for NED positions are filled in a timely manner working with NHSE and two new Non-Executive Directors, one with a clinical and one with finance background, have commenced in post on the 1 September 2023. The Trust also has a succession planning programme for Non-Executive Director vacancies by appointing Associate Non-Executive Directors who then have the opportunity to apply for substantive posts. The Quality Committee which is a sub-committee of the Board meets monthly and receives reports from various risk committees in relation to patient care and quality of services and sends summary reports and escalates matters to the Board as appropriate. The Trust was awarded 'good' rating by CQC overall and in the well-led domain in its last formal inspection in September 2018 with some service areas rated 'outstanding'. In addition, the Trust has had several recent CQC inspections, including for maternity services and received positive feedback and retained its 'good' rating with areas of 'outstanding'.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	See response for statement 5 in relation to the Board composition; the Board members undertake an annual Fit and Proper Persons Test (FPPT) check and the Director of Corporate Governance/Chartered Governance Professional reports to the Remuneration Committee on the outcome of the same. All Board Executive and Non-Executive Director positions are filled on a permanent basis. Recruitment is currently underway for a number of Associate Non-Executive Directors to work with the Board. The HR department is supporting talent management and succession planning at all levels of the organisation.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____

Name Mr Shazad Sarwar

Signature _____

Name Mr Martin Hodgson

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A The Trust continues to monitor its risks and review the action plans where performance of the national standards requires improvement.

OK

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **120**

13 September 2023 **Purpose** Information Assurance

Title	Emergency Preparedness, Resilience and Response (EPRR) Annual Statement
Report Author	Mrs H Taylor, Head of EPRR
Executive sponsor	Mr T McDonald, Executive Director of Integrated Care, Partnerships and Resilience

Summary: This paper describes the Trusts current position with regards to emergency preparedness, resilience and response (EPRR) pending the submission of a formal Statement of Assurance by 30 September 2023.

Recommendation:

a) To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it fulfils its statutory and non-statutory duties and obligations.

b) To give delegated authority to the Chief Executive and the Executive Director of Integrated Care and Partnerships to submit the EPRR Assurance Statement on behalf of the Trust. The final Assurance Statement will be presented to the Trust Board at its next meeting.

Report linkages

Related Trust Goal	Deliver safe, high quality care Secure COVID recovery and resilience
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Related to key risks identified on Corporate Risk Register	N/A
Related to recommendations from audit reports	N/A
Related to Key Delivery Programmes	N/A
Related to ICB Strategic Objective	State which ICB Strategic Objective the paper relates to here.

Impact

Legal	Yes	Financial	No
Compliance with Health & Social Care Act 2022			
Compliance with Civil Contingencies Act 2004 and subsequent amendments			
Equality	No	Confidentiality	No

Previously considered by:

Executive Summary

1. This paper summarises the current position of the Trust in relation to the NHS Core Standards Assurance for emergency preparedness, resilience and response (EPRR) and provides the Trust Board with assurance that ELHT meets its statutory duties under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012 and its other non-statutory obligations.

2023/24 EPRR Assurance Process

2. The EPRR Core Standards Assurance Process commenced in June this year. This process requires the Trust to complete a comprehensive self-assessment in relation to compliance against a set of national core standards. For the first time this year, NHS England are also asking for trusts to provide evidence on how we meet each of the individual core standards.

3. The process for 2023 will require a statement of assurance in relation to 10 specific areas:

- **a.** Domain 1 - Governance
- **b.** Domain 2 - Duty to risk assess
- **c.** Domain 3 - Duty to maintain plans
- **d.** Domain 4 - Command and Control
- **e.** Domain 5 - Training and Exercising
- **f.** Domain 6 - Response
- **g.** Domain 7 - Warning and Informing
- **h.** Domain 8 - Cooperation
- **i.** Domain 9 - Business Continuity
- **j.** Domain10 - CBRN

4. Following key themes and common health risks raised as part of last year's annual assurance process the 2023/24 EPRR annual deep dive will focus on EPRR responder training. Training is a fundamental element of embedding resilience within organisations as part of the cycle of emergency planning.

5. For the period 2023/24, the Trust will be reported as **Substantial compliance with a percentage compliance of 90%.** 56 standards are assessed as green, and 6 standards

assessed as amber. The Trust will now progress towards fully achieving these core standards with a robust action plan.

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	1	1	0
Training and exercising	4	3	1	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business continuity	10	9	1	0
Hazmat/CBRN	12	10	2	0

6. The Trusts EPRR Assurance Statement will be submitted to the ICB by 30th September 2023. As these nationally prescribed timescales and do not align to the existing Trust Board schedule, the Trust Board are requested to give delegated authority to the Chief Executive and the Executive Director of Integrated Care, Partnerships and Resilience to issue the assurance statement on behalf of the Trust. The final Assurance Statement will be presented to the Trust Board at its next meeting.

Recommendations

7. The Trust Board is asked to:

- **a.** To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it fulfils its statutory and non-statutory duties and obligations.
- **b.** To give delegated authority to the Chief Executive and the Director of Integrated Care and Partnerships to submit the EPRR Assurance Statement on behalf of the Trust. The final Assurance Statement will be presented to the Trust Board at its next meeting.

Heather Taylor, Head of EPRR, 6th September 2023.

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **121**

13 September 2023 **Purpose** Approval

Title	Ratification of Board Sub-Committee Terms of Reference a) Finance & Performance Committee b) Audit Committee c) People and Culture Committee
Executive sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance

Summary: The terms of reference for the Finance & Performance Committee, Audit Committee and People and Culture Committee have been reviewed in line with their current work plans and best practice. They have been reviewed by their respective Committees during the months of July and September 2023 and are presented to the Board for ratification.

Recommendation: The Board is asked to consider and ratify the revised terms of reference for the Finance & Performance Committee, Audit Committee and People and Culture Committee.

Report linkages

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

	5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to here.
Related to ICB Strategic Objective	State which ICB Strategic Objective the paper relates to here.

Impact

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

Previously considered by:

TERMS OF REFERENCE: FINANCE AND PERFORMANCE COMMITTEE

Constitution

The Board has established the Finance and Performance Committee to provide assurance about the delivery of the financial and operational plans approved by the Board for the current year and for the longer-term future, develop forward plans for subsequent financial years for consideration by the Board and examine in detail risks to the achievement of national and local performance and activity standards.

Purpose

To support the Trust Board in the analysis and review of Trust financial and performance plans, providing advice and assurance to the Board on financial and performance issues.

It will:

- Review the annual business plans prior to Board approval and submission to the Integrated Care System (ICS)/Regulator and review plans for the longer term.
- Review financial performance against income, expenditure and capital budgets and consider the appropriateness of any proposed corrective action.
- Review progress against waste reduction and improvement programmes, (including the procurement programme, estates and facilities programmes, ELFs Performance, PFI programme and business plans supporting new investment) and consider the appropriateness of any proposed corrective action.
- Consider the financial performance in the current year and look ahead to expected performance for the subsequent 2-5 years and review all significant financial risks.
- Regularly review cash flow forecasts, the adequacy of funding sources and receive assurance on the robustness of the Trust's key income sources.
- Provide the Board with a forum for detailed discussions and assurance of progress against the annual business plan including the delivery of the Waste Reduction Plan and Improvement Plan
- Assess the performance of the organisation against all national and system/local performance and workforce standards and consider plans for the longer term.
- Provide the Board with a forum for detailed discussions around the financial and performance elements of the Board Assurance Framework and the Corporate Risk Register.

- Review progress made against key delivery and improvement programmed and assess whether they are aligned to existing work programmes.

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)
Chief Executive
Executive Director of Finance
Chief Operating Officer
Executive Director of Service Development and Improvement
Executive Director of People and Culture

The Chief Nurse and the Executive Medical Director will attend the Committee meeting by invitation for items within their remit.

In attendance

Director of Corporate Governance/Company Secretary
Associate Director of Quality and Safety
Associate Director of Service Development and Improvement

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 a minimum of 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 the Standing Financial Instructions.

Quorum

Two Non-Executive Directors/Associate Non-Executive Directors and two Executive Directors. 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

Integrated Performance Report

Finance Report

Improvement Report

Restoration Update

Feedback from Finance Assurance Board

Alternate Meeting Items

Private Finance Initiative (PFI) Update

Board Assurance Framework

Corporate Risk Register

Quarterly Items

Workforce Report (Agency Spend Element)

Model Hospital Update

Procurement Report

Tender Reporting (when required)

Annual/Alternate Years Items

National Planning Guidance/Financial Planning

Outsourced services report (Hosted Services)

Consultancy Services spend report (Trust and system level)

Integrated Care Board Finance Report

Population Health Reports

Digital/IMT Report

Community Care Performance (yearly report)

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 financial and performance 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, or as required as part of the Trust Board governance 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.

The Terms of Reference will be reviewed on an annual basis or on a more frequent basis should its be required.

Committee Services

Lead Director: Executive Director of Finance

Secretarial support: Corporate Governance Team

Committees reporting

Finance Assurance Board

TERMS OF REFERENCE: AUDIT COMMITTEE

Constitution

The Board has resolved to establish a Committee of the Board to be known as the Audit Committee. The Committee is an independent Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. The Audit Committee is the high-level risk committee operating on behalf of the Board and concerns itself with the function and effectiveness of all committees. It is the Committee that brings all aspects of governance and risk management together.

Purpose

The Audit Committee is charged with ensuring that the Board and Accounting Officer of the organisation gain the assurance they need on governance, risk management, the control environment and on the integrity of the financial statements, as well as other elements of the Annual Report and Accounts.

The role of the Audit Committee is a challenging one and it needs strong, independent members with an appropriate range of skills and experience. The Committee acts as the "conscience" of the organisation and demonstrates strong constructive challenge where required. For example, risks arising from increasing fiscal and resource constraints, new service delivery models, information flows on risk and control and the agility of the organisation to respond to emerging risks. In addition, it has a role in assuring the effectiveness of other Board sub-committees, but this should not interfere with the requirement for the Audit Committee to maintain independence.

The Audit Committee fulfils a major role in providing independent and objective assurance through the work of internal and external auditors and counter fraud, reviewing reports and intelligence from external bodies including regulators and seeking assurance from internal teams and the sub-committees of the Board, such as the Finance and Performance Committee and Quality Committee.

It is essential that the Audit Committee understands how the governance arrangements support the achievement of the Trust's strategies and objectives, especially:

- The Trust's vision and purpose.
- The mechanisms in place to ensure effective organisational accountability, performance and risk management.

- The roles and responsibilities of individuals and committees and other groups to support the effective discharge of the Trust's responsibilities, decision making and reporting.

The Committee must also understand the organisation's business strategy, operating environment and the associated risks. It must take into account the role and activities of the Board and other Committees in relation to managing risk and should ensure that the Board discusses its policies, attitude to and appetite for risk to ensure these are appropriately defined and communicated so management operates within these parameters.

Duties and Responsibilities

The duties of the Committee are categorised as follows:

Governance, Risk Management and Internal Control

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular the Committee will review the adequacy and effectiveness of:
  - All risk and control related disclosure statements, in particular the Annual Governance Statement together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to their endorsement by the Board.
  - The underlying assurance processes that indicate the degree of achievement of the corporate objectives, the effectiveness of the management of the principal risks and the appropriateness of the above disclosure statements.
  - The policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
  - The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.
- In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors, managers and sub-committees of the Board as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with

indicators of the effectiveness.

- This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

- The role of the Audit Committee in relation to internal audit should include advising the Accounting Officer and the Board on the:
  - Internal Audit Charter and periodic internal audit plans, forming a view on how well they reflect the organisation's risk exposure and support the Head of Internal Audit's responsibility to provide an annual opinion.
  - adequacy of the resources available for internal audit.
  - terms of reference for internal audit.
  - results of internal audit work, including reports on the effectiveness of systems for governance, risk management and control, and management responses to issues raised.
  - annual internal audit opinion and annual report.
- The Committee shall ensure that there is an effective internal audit function that meets mandatory *NHS Internal Audit Standards* and provides appropriate independent assurance to the Audit Committee, the Chief Executive and the Board. This will be achieved by:
  - consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
  - review and approval of the Internal Audit Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
  - considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.
  - ensuring that the internal audit function is adequately resources and has appropriate standing within the organisation.
  - the annual review of the effectiveness of internal audit.

External Audit

- The Committee shall review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:
  - consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
  - discussion and agreement with the external auditors, before the audit commences, of the scope and nature of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
  - discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
  - review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- The Committee shall review and monitor the external auditor's independence and objectivity.
- The Committee will also review the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements.

Other Assurance Functions

- The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications for the governance of the organisation.
- These will include, but will not be limited to, any reviews by Department of Health and Social Care arms- length bodies or regulators/ inspectors and professional bodies with responsibility for the performance of staff or functions.
- In order to preserve the independence of the Committee Chair and members, the Committee will receive matters of escalation from the Board Sub-Committees, particularly the Finance and Performance Committee, Quality Committee and People and Culture Committee.
- To ensure that the Committee maintains a strategic focus the Committee will continue to strengthen its links with the Board Assurance Framework (BAF) and will focus its agendas, where appropriate, on matters contained within the BAF, including the

annual review of the BAF.

- To seek assurance on the implementation of guidance and recommendations from external inspection and accreditation visits from the Quality Committee.
- In addition, the Committee will review the work of all other committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the work and functionality of the Quality Committee, Finance and Performance Committee and People and Culture Committee, which report to the Board on all aspects of clinical and financial governance, people and risk management.
- The Audit Committee will approve the Quality Account prior to publication on behalf of the Board.

Counter Fraud

- The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Financial Reporting

- The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance and review significant financial reporting judgements contained within them. The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
- The Committee will receive the quarterly report on waivers.
- The Audit Committee will review the annual report and financial statements before submission to the Board, focussing particularly on:
  - The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
  - Changes in and compliance with accounting policies, practices and estimation techniques
  - Unadjusted mis-statements in the financial statements
  - Significant judgements in preparation of the financial statements
  - Significant adjustments resulting from the audit
  - Letter of Representation

- Qualitative aspects of financial reporting,
- whether the annual report and accounts, taken as a whole, are fair, balanced and understandable, and provide the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy.

- In reaching a view on the accounts, the Committee will consider:
  - key accounting policies and disclosures;
  - assurances about the financial systems which provide the figures for the accounts;
  - the quality of the control arrangements over the preparation of the accounts;
  - key judgements made in preparing the accounts;
  - any disputes arising between those preparing the accounts and the auditors; and
  - reports, advice and findings from external audit (especially the Audit Completion Report – ISA 260 Report)

Whistleblowing

- The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

Management

- The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.
- The Committee shall receive the annual report on the declarations of interest and the Trust's registers of gifts and hospitality will be presented twice per year in accordance with best practice.

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.

Membership

The Committee members are appointed by the Board from amongst the independent and objective Non–Executive Directors and the Associate Non-Executive Directors of the Trust and consist of not less than three members.

One of the members of the Committee will have the required qualifications to be an Audit Committee Chair and will be appointed Chairman of the Audit Committee by the Board.

The Audit Committee should corporately possess knowledge/ skills/ experience/ understanding of:

- accounting;
- risk management;
- internal / external audit; and
- technical or specialist issues pertinent to the organisation's business.
- experience of managing similar sized organisations;
- the wider relevant environments in which the organisation operates
- the accountability structures

The Chairman of the Trust shall not be a member of the Committee.

In Attendance

The Executive Director of Finance, Executive Medical Director, Chief Nurse, Director of Corporate Governance/Company Secretary and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee members will meet privately with the external and internal auditors.

The Chief Executive or their deputy will be requested to attend the meeting where the Trust's Annual Governance Statement and Annual Accounts/Report are presented/ approved. They will also be invited to attend when the Committee considers the draft internal audit plan. All

other Executive Directors will be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

Frequency

A minimum of four meetings per annum will be held in accordance with the timetable agreed by the Trust Board and an additional meeting to approve the annual accounts and report. Members or their nominated representative are expected to attend at each meeting.

The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

It is good practice for the Chair of the Audit Committee to meet with the Accounting Officer, the Executive Director of Finance, the Head of Internal Audit and the external auditor's senior representative outside of the formal Committee structure.

Quorum

Two members of the Committee must be present to ensure quoracy.

Members are expected to attend at least 75% of the meetings but in the unusual event that a member of the Committee cannot attend the following are the delegated deputies.

- Chair of the Committee – A member of the Committee
- Member of the Committee – A Non-Executive Director or Associate Non-Executive Director
- Executive Directors, who would normally be in attendance or in attendance because of the nature of the agenda items, may be deputised to a senior manager within their corporate structure.

Acting as the Auditor Panel

- Under Section 9 of the Local Audit and Accountability Act 2014, the Trust is required to appoint an Auditor Panel.
- The role of the Auditor Panel is to advise on the selection, appointment and removal of the external auditors as well as on the maintenance of an independent relationship with that auditor, including dealing with possible conflicts of interest.
- The Trust has agreed that the Auditor Panel will be made up of the Non-Executive Directors serving on the Audit Committee and the Executive Director of Finance.
- The Auditor Panel will have a role in establishing and monitoring the Trust's policy on the awarding of non-audit services.

- The Trust must consult and take account of the Auditor Panel's advice on the selection and appointment of the external auditor. The advice given by the Panel must be published and should the Trust not follow that advice, the reasons for not doing so must also be published.
- The Auditor Panel must have at least three members, including a Chair who is an independent Non-Executive member of the Trust Board, in this case the Panel Chair will be the Chair of the Audit Committee. The majority of the Panel's members must also be independent and Non-Executive Directors/Associate Non-Executive Directors of the Trust Board.
- In order to take a decision, the Auditor Panel must be quorate, which means that the independent members (NEDs and Associate NEDs) must be in the majority and there must be at least 2 independent members present or 50% of the Auditor Panel's total membership, whichever is the highest.
- Proceedings are valid only if the majority of the members of the Panel present at the meeting are independent members.
- The Auditor Panel is an advisory body only. Responsibility to the actual procurement and appointment of the auditors remains with the Trust Board. The Chair of the Auditor Panel will be required to provide a report to the Board about the activities and decisions of the Panel.

Other Matters

- The minutes of the Audit Committee meetings shall be formally recorded by the Corporate Governance Team and a summary report submitted into the Board. From each meeting the Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.
- For monitoring compliance purposes, the Committee will report to the Board after each meeting. At least once each calendar year it will, as part of its regular reporting to the Board, the Committee will report specifically cover the statement about the fitness for purpose of the Board Assurance Framework (following the annual review by the Committee), and assurance that the risk management system is complete and embedded in the organisation and the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the Quality Accounts.

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or agent and all employees are directed to co-operate with any request made by the Committee.

As well as having the permanent members of the Committee, the Committee is empowered to co-opt Non-Executive members for a period of time (not exceeding a year, and with the approval of the Board) to provide specialist skills, knowledge and experience which the Committee needs at a particular time and procure specialist advice at the expense of the organisation on an ad-hoc basis to support them in relation to particular pieces of committee business.

Reporting

The Committee will report to the Trust 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, within the Lancashire and South Cumbria (LSC) Integrated Care System (ICS) have agreed to delegate the following functions to the PCB Joint Committee, where such matters affect the Trusts and can benefit the population of 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 will ensure that it is fully involved in the decision making and engagement process in relation to the strategic collaborative items and this will be enacted through an Executive function with representation from the Non-Executive

contingent of directors.

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.

Committee Services

Lead Director: Executive Director of Finance

Secretarial Support: Corporate Governance Team

TERMS OF REFERENCE: PEOPLE AND CULTURE COMMITTEE

Constitution

The Trust Board has established a Committee with delegated authority to act on its behalf in matters relating to workforce, organisational culture, staff safety and governance to be known as the People and Culture 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 on all aspects of the delivery of the Trust's People Strategy, and that workforce related risks are being appropriately managed and that the evidence to support that assurance is scrutinised in detail, on behalf of the Board.

Duties and Responsibilities

The Committee will:

- Oversee the development and delivery of the People Strategy and relevant national or local policy drivers and ensure that it supports the Trust's strategic vision and values and consider any proposed significant initiatives relating to its delivery.
- To monitor and review workforce risks contained within the Board Assurance Framework and the Corporate Risk Register. Test the robustness of the systems and processes in place to appropriately control and mitigate associated risks.
- 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.
- Receive regular assurance reports on all aspects of workforce from the Executive Director of People and Culture. Commission any evidence-based assurance required, on behalf of the Board in order to satisfy itself, and the Board, in relation to achievement of workforce and Organisational Development (OD) objectives and priorities.

- Receive regular assurance reports on the work being carried out by each of the Trust's Staff Inclusion Networks and to provide support to the networks on behalf of the Board, where required.
- Receive regular reports on the work being undertaken across the Trust in relation to staff health and wellbeing, as well as assurance reports relating to the implementation of learning from the annual NHS Staff Survey.
- Scrutinise the effective and efficient use of resources in relation to the workforce and OD, through evidence-based 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 workforce situation that may threaten the quality of patient care or staff safety and oversee the process within the Trust to ensure that appropriate action is taken to ensure that staff can freely speak up, if concerned.
- Receive assurance about staffing safeguards such as the Guardian of Safe Working and the Freedom to Speak Up Guardian.
- Receive professional staffing reviews relating to both nursing and midwifery services.
- To receive assurance reports about the work being undertaken to recruit and retain staff.
- 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 reports and assurance on the high impact actions regarding Equality, Diversity and Inclusion, as set out in the NHS Equality, Diversity, and Inclusion Improvement Plan including about the:
    - Embedding fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
    - Developing and implementing an improvement plan to eliminate pay gaps
    - Developing and implementing an improvement plan to address health inequalities within the workforce.
    - Implementing a comprehensive induction, onboarding and development programme for internationally recruited staff.

- Creating an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

- Receive assurance reports from the Department of Education, Research and Innovation on the work being undertaken to continue to develop the workforce, improve the awareness of the Trust's research agenda and uptake of projects/increase income from research and strengthen existing and develop new research partnerships.
- Consider matters referred to it by other Committees and groups across the Trust provided they are within the Committee's remit.
- The cycle of business sets out how the Committee will discharge this responsibility in more detail.

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 Director of People and Culture
- Chief Nurse and Executive Medical Director (who will attend on a rotational basis, unless both are required)
- Executive Director of Finance
- Executive Director of Service Development and Improvement

Should any item on the Committee agenda require individual votes to be cast, only voting Executive Board members can vote.

Attendance

The following will be regular attendees of the People and Culture Committee, although other officers of the Trust may be invited to attend the Committee to report on items within their remit.

- Director of Corporate Governance
- Deputy Director of People and Culture
- Deputy Director Of Education, Research & Innovation
- Associate Director of Organisational Development

- Associate Director of Staff Wellbeing and Engagement
- Partnership Officer

Other Executive Directors and senior staff will be invited to attend the meetings as required.

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 5 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. 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

Each Meeting

Board Assurance Framework

Corporate Risk Register

Workforce Performance Report

Alternate Meetings

Workforce Strategy Update

Doctors and Dentists in Training Safe Working Hours

DERI Strategy Update

People Strategy Update

Wellbeing Strategy Update

Staff Survey Action Plan Update
Guardian of Safe Working (Doctors and Dentists in Training)

Twice per year
Freedom to Speak Up/Guardian of Safe Woking

Annually
People Strategy
Wellbeing Strategy
DERI Strategy
National Staff Survey
Annual Workforce Race and Disability Equality Standards (WRES and WDES) Reports
Trust Education Board
Revalidation and Appraisal Report

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 reporting on matters of people and culture.

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 Director of People and Culture

Secretarial Support: Corporate Governance Team

Committees reporting

The Committee will receive minutes from each of its reporting committees:

- People and Culture Delivery and Governance Group
- Staff Safety Committee
- Employee Sponsor Group
- BAME Oversight Group
- Staff Inclusion Networks
- Inclusion Group

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **122**

13 September 2023 **Purpose** Information

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

Related to key risks identified on Corporate Risk Register	9771 - Failure to meet internal and external financial targets for the 2023-24 financial year
Related to recommendations from audit reports	Assurance Framework Key Financial Controls Risk Management Core Controls
Related to Key Delivery Programmes	Finance Strategy and Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Meeting: **Finance and Performance Committee**
Date of Meeting: **12 June 2023**
Committee Chair: **Stephen Barnes, Non-Executive Director**

ITEMS APPROVED

- The minutes of the previous meeting held on 24 April 2023 were approved as a true record of the meeting.

ASSURANCE RECEIVED

1. Action Matrix

Members received a brief update on the Better Care Fund (BCF), with members being advised that the Integrated Care Board (ICB) had agreed to full transparency on decisions.

2. Finance Reporting

Members were updated on progress made in month 1 and 2 of the financial year. Members were informed that the Trust continued to forecast a breakeven position for the end of the financial year and was currently £3.1 million off plan against the planned deficit of £6 million. Members were informed that high bank staff usage in May was due to the three Bank Holidays. Members were informed that the Trust had a cash balance of £26 million, noting that this was the lowest it had been for some time. It was explained that this was not unexpected and that there had been several capital creditors at the end of the financial year that were paid over April and May.

Members were advised that the NHS pay award was due to be paid for agenda for change staff at the end of June, however the Trust would not receive the income for this until July. Furthermore, it was currently unknown how much income the Trust was to receive for the pay award.

Members were informed that the Trust had always undertaken a straight split across the year for savings programme, enabling the pressure to be seen from the start of the year and helping to focus minds to achieving the goal.

The Committee was informed that capital spend was on plan and that the auditors were currently reviewing the plan and the use of vesting certificates. It was explained that vesting certificates were not allowed to be used by some Trusts, however they provided the flexibility for capital money to be used efficiently. Members noted that nothing of concern had been raised by the auditors as part of the review, and were advised that the main schemes for 2023/24 remained the Electronic Patient Record (EPR) system, emergency flow and the replacement of the roof at the Blackburn site.

Members were updated on the Better Payment Practice Code (BPPC), being advised that the previous issue with processing agency invoices was now better. An update was provided on the Waste Reduction Programme (WRP), commenting that a new governance process had been established. Members were informed that Mr Hodgson was now the Chair of the Finance Assurance Board (FAB), and the Divisions were working through the targets.

The Committee were informed that further opportunities were being identified, including the cost of wholesale gas prices reducing. Furthermore. £35 million of efficiencies had been identified but not yet delivered. In addition, agreed rates for agency staff where now in place across the system and the Trust had not used off framework pricing for 6 weeks. Members were informed that reviews into car parking charges and the shuttle bus would also be undertaken.

The Committee were informed that financial recovery meetings had been established with the Divisions, and the Workforce Control Group had been re-established which would look at re-banding appeals and nonrecurrent posts.

An update was provided on the National Cost Index, advising that this had previously been reported at 100.1. Members were advised that every Trust had been informed that there had been a national issue and the index had changed accordingly with the Trust now having an index of 104. It was remarked that the positive aspect from this showed that there were some opportunities to investigate to meet the financial gap including oncology, midwifery, and pathology direct service.

3. Integrated Performance Report (IPR)

Members were provided with an update on the Trust's current performance, being informed that the Trust was on trajectory for the 4-hour target at 76.45% and that work continued to improve this area. Members were informed that there had been a number of 12-hour breaches, with Mental Health being particularly challenged. Furthermore, the month had seen the highest daily attendance at 650 and that there had been 968 patients over the month that had waited longer than 12 hours.

Members were informed that the Referral to Treatment (RTT) figures remained good, however this would be monitored following the go-live for the Cerner EPR. In addition, there were currently 0 patients that had waited 78 weeks or longer for treatment. An update on the Trust's Cancer position was provided, advising that it had now been deescalated from Tier 2. Members were informed that the Trust was rated 66 out of 80, with 80 being the best performing, and that the Trust was currently 6.5% above trajectory.

4. Fire Safety 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 informed that at both sites, a ward had been closed to enable the fire improvement programme of work to proceed.

5. Review of Terms of Reference

Members were presented with a draft version of the Finance and Performance Committee Terms of Reference for comment prior to presentation at the next meeting and ratification by the Trust Board.

ITEMS TO ESCALATE TO THE AUDIT COMMITTEE AND TO THE TRUST BOARD

No items were escalated to either the Audit Committee or Trust Board but the Committee continued to remain concerned for the financial challenges for the current financial year which are discussed at Committee and Trust Board level.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **123**

13 September 2023 **Purpose** Information

Title	Quality Committee Summary Report
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mrs T Anderson, Interim 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 28 June 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 Board Assurance Framework	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.
Related to key risks identified on Corporate Risk Register	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. 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. ID 6190: Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales. ID 8839: Failure to achieve performance targets. ID 8257: Loss of transfusion service. ID 7008: Failure to comply with 62-day cancer waiting time target.
Related to recommendations from audit reports	Assurance Framework Risk Management Core Controls
Related to Key Delivery Programmes	Clinical Strategy, Quality Strategy, People Strategy, Corporate Governance Model and Trust Wide Quality Improvement Programmes.
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Meeting: **Quality Committee**
Date of Meeting: **28 June 2023**
Committee Chair: **Naseem Malik, Non-Executive Director**

ITEMS APPROVED

The minutes of the previous meeting held on 24 May 2023 were approved as a true record of the meeting.

ASSURANCE RECEIVED

1. Patient / Staff Safety

Members received an overview of the Trust's Electronic Patient Record 'go live' process and a summary of the progress made with its implementation since. It was noted that after a series of initial successes, the Trust had started to experience network stability issues which, in turn, led to a significant deterioration in the responsiveness of the EPR system. The Committee was advised that this had resulted in temporarily moving the Trust into downtime business continuity arrangements, which had enabled further testing of the EPR and colleagues to catch up on transferring patient data. It was confirmed that the issues being seen were similar to those seen during 'go lives' at other organisations and that robust, Executive-led plans were in place to address them.

The Committee:

Agreed for a further update on the Trust's implementation of its EPR system to be provided at the meeting taking place in September 2023.

Agreed for an update on the outcomes from the Trust's patient safety congress event to be provided at a future meeting.

2. Safeguarding Annual Report

The latest iteration of the Safeguarding Annual Report was presented to the Committee. It was noted that the Trust's safeguarding reporting and governance structure had been revised over recent months, including the Safeguarding Committee moving to taking place on a monthly basis, the development of a new cycle of business and the implementation of quarterly 'deep dives' across portfolio areas and in each of the Trust's clinical divisions. Members noted that there were some ongoing concerns regarding the use of restraint in the Trust and the low

training levels associated with this but were assured that steps were being taken to mitigate these issues.

The Committee:

Agreed for minutes from the Trust's Safeguarding Committee to be provided at future meetings for noting and information.

3. Health & Safety Committee Annual Report

Members received the annual report from the Trust's Health and Safety Committee. It was noted that there had been a strong focus on managing and monitoring any areas requiring improvement following regulatory activity and that significant improvements had been made in pathology laboratory areas. The Committee was also informed that the substantial amount of fire improvement works taking place across the Trust were being actively coordinated by Executive colleagues and that another substantial piece of work around injury claims would be taking place at a later date.

4. Nursing Assessment and Performance Framework Update

The Committee received an update on the Nursing Assessment and Performance Framework (NAPF) performance. It was highlighted that the number of areas receiving red ratings had decreased since the previous update provided to members and that the number of areas rated as green had continued to remain steady.

5. Patient Safety Incident Response Framework Report

Members received a summary of the latest figures from the Patient Safety Incident Response Framework. It was noted that there had been a surge in severe harms reported in April 2023 but that these had all been related to a number of falls by the same patient. Members were also advised that the five Never Events reported since January 2023 remained under investigation and that one was likely to be deescalated in the near future following confirmation that all appropriate processes had been followed.

The Committee:

Agreed for a further update on the findings and lessons learned from recent Never Events to be provided at a future meeting.

6. Infection Prevention and Control Report

The Committee was informed that there had been a surge in the number of cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) but that no lapses of care had been identified in any subsequent investigations. It was highlighted that blood culture contamination rates had continued to fall and that there were currently no COVID-19 patients or outbreaks in the Trust.

7. Corporate Risk Register Report

Members were informed that there were currently 18 live risks on the CRR and that two risks had been removed since the previous meeting. The Committee was also informed that several risks were expected to be de-escalated from the Corporate Risk Register following the next meeting of the Executive Risk Assurance Group.

8. Board Assurance Framework

The latest iteration of the Board Assurance Framework (BAF) following its annual review process was presented to the Committee. Members noted that the number of risks had been reduced from 12 to 5 following revisions by the Executive team and that the Trust's risk appetite statement had been revised to be more expansive than it had been in previous years.

The Committee:

Confirmed that they were content to recommend the revised BAF and risk appetite statement to the Board for ratification.

9. CQC Update

Members were informed that the Trust continued to liaise with colleagues from the CQC on a regular basis and that regular preparatory meetings had been put in place for a potential Well-led inspection. It was confirmed that an unannounced inspection of the Trust was highly likely to take place later in the year as several trigger events had taken place over recent months.

ITEMS TO ESCALATE TO THE AUDIT COMMITTEE AND TO THE TRUST BOARD

None.

ITEMS RECEIVED FOR INFORMATION

None.

TRUST BOARD REPORT **Item** **124**

13 September 2023 **Purpose** Information

Title	Audit Committee Summary Report
Report Author	Mr M Pugh, Corporate Governance Officer
Executive sponsor	Mr R Smyth, 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 22 June 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 Board Assurance Framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
	2	The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
	3	A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
	4	The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Related to key risks identified on Corporate Risk Register	9557 Patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provision. 9336 Lack of capacity can lead to extreme pressure resulting in a delayed care delivery. 8033 Complexity of patients impacting on ability to meet nutritional and hydration needs. 7165 Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). 8808 Burnley General Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke. 7764 Royal Blackburn Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke. 4932 Patients who lack capacity to consent to placements in hospital may be unlawfully detained 8061 Management of Holding Lists 9336 Lack of capacity can lead to extreme pressure resulting in a delayed care delivery. 8941 Potential delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology. 6190 Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales. 8839 Failure to achieve performance targets. 7008 Failure to comply with 62-day cancer waiting time target. 5791 Failure to recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance. 9771 - Failure to meet internal and external financial targets for the 2023-24 financial year
Related to recommendations from audit reports	All recommendations
Related to Key Delivery Programmes	Care Closer to Home/Place-based Partnerships, Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement People Plan Priorities Finance Strategy and Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money.

Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Meeting: **Audit Committee**
Date of Meeting: **22 June 2023**
Committee Chair: **Richard Smyth, Non-Executive Director**

ITEMS APPROVED

- Members approved the audited annual accounts and financial statements for 2022/23, subject to the final numbers and form being provided.
- Members approved the Annual Report and Annual Governance Statement subject to any amendments.
- Members approved the Modern Slavery Statement.
- Members approved the Quality Account Report 2022/23 subject to the update of selected wording.

ASSURANCE RECEIVED

1. Review and Approval of the Head of Internal Audit Opinion

Members were informed that the overall Head of Internal Audit Opinion for 2022-23 was one of "Substantial Assurance" with attention being directed to the wording in section one of the report that verdict had been applied based on a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently. Furthermore, context for the overall opinion was provided, noting that this had been made based on the level of risk awareness of the Trust, and the target and effective use of Internal Audit as part of the system of internal control. Members were informed that the Trust had directed the auditors to known risk areas which had the potential to affect the outcome of the report. It was explained that this was a positive action to have taken, with the Internal Auditors explaining that rather than the Trust directing the auditors to areas that would definitely result in substantial assurance, they had instead been directed to areas where a positive impact could be made.

2. Audit Completion Report from Mazars, External Auditors and Letters of Representation

Members were informed that all work was nearly completed and anything still outstanding was due to be finished imminently. Members were informed that it was anticipated that an unqualified audit opinion would be provided.

Members were informed that with regards to value for money, a significant weakness relating to financial sustainability had been reported, with the Trust's Finance team being praised for their openness when discussing any issues and working to the agreed position.

Members were informed that the Trust was working to a materiality of £12 million, which equated to approximately 1.75% of expenditure, and that Mazars were required to report anything classed as non-trivial. Members were advised that a number of significant issues below this limit had been reported due to the identified risk, and that the report set out the work planned to address the risks.

Members were informed that all work had been completed on how revenue income was recognised with no issues being found. In addition, property plant equipment had been reviewed due to a number of instances where vesting certificates had been provided but the goods had not yet been received. Mazars confirmed that this had not been undertaken to a significant or excess amount.

Members were informed that a new risk for 2022/23 was the application of IFRA16 and how leases were recorded, noting that this was a complex requirement, however the team had worked hard to identify leases and apply the standards.

Members were informed that one new internal audit recommendation had been suggested, relating to inventory control issues in theatres. It was explained that during the course of the audit, there had been a number of conversations about the potential to refer the Trust to the Secretary of State under Section 30 about the Trust's financial position and potential to not achieve the breakeven position. Members were advised that under the current guidance this did not need to take place, however the guidance was in the process of being refreshed and could change in the future.

Members commented how evident the good relationship between the Trust and external auditors was from the report and underpins the principles of openness and transparency the Trust prides itself on.

3. Review and Approval of the Audited Annual Accounts and Financial Statements 2022/23

The Committee approved the audited annual accounts and financial statements for 2022-23,

subject to the final numbers and form being provided. The Committee Chair commented that they understood that these were now in the process of being finalised.

4. Review and Approval of the Annual Report and Annual Governance Statement 2022/23

Members were asked to approve the reports as currently drafted, subject to any amendments and were advised that once any amendments had been added, the final version would be distributed for final sign off. Members approved the Annual Report and Annual Governance Statement.

Members provided approval for the Annual Report and Annual Governance Statement subject to any amendments.

5. Modern Slavery Statement

Members were informed that the Modern Slavery Statement had been included within the annual report and had been reviewed in co-operation with Procurement and Safeguarding colleagues to ensure it was up to date. Members were advised that following approval, this would be published on the Trust website. Members approved the Modern Slavery Statement.

6. Quality Account Report 2022/23 Sign-Off

Members were informed that the Quality Account Report for 2022-23 was being presented to the Committee for approval prior to the 30 June submission date. It was explained that the paper had been shared with the Trust Board and external stakeholders for comment, and that it told the quality journey of the organisation. Members noted that the report had been seen by the Quality Committee and would be shared by the Trust Board once approved.

Members approved the Quality Account Report 2022-23.

ITEMS TO ESCALATE TO THE AUDIT COMMITTEE AND TO THE TRUST BOARD

No items were raised for escalation the Trust Board but the Committee remained concerned for the challenges faced in the current financial year which continue to be discussed at Committee and Trust Board level.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **125**

13 September 2023 **Purpose** Information

Title	Trust Board (Closed Session) Summary Report
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mr S Sarwar, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 12 July 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 Board Assurance Framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
	2	The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
	3	A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
	4	The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.

	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	-	
Related to recommendations from audit reports	-	
Related to Key Delivery Programmes	-	
Related to ICB Strategic Objective	-	

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	Yes

Previously considered by:

Meeting: **Trust Board (Closed Session)**

Date of Meeting: **12 July 2023**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 28 April and 10 May 2023 were approved as a true record of the meeting.

ITEMS DISCUSSED

At the meeting of the Trust Board on 12 July 2023, the following matters were discussed in private:

a) Summary from June Board Strategy Session.

b) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.

c) Lancashire and South Cumbria Integrated Care System Joint Forward Plan 2023 onwards.

d) Approval of Draft Financial Plan including Savings Target 2023-24.

e) Never Events Update

f) Fire Remediation Programme Update: Burnley General Teaching Hospital and Royal Blackburn Teaching Hospital.

g) Electronic Patient Record Progress Overview.

h) Nosocomial Infections Update.

i) Industrial Action Update.

ITEMS RECEIVED FOR INFORMATION

None.