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)

8 NOVEMBER 2023, 12.30pm

BOARDROOM, FUSION HOUSE / MS TEAMS

AGENDA

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

OPENING MATTERS				
TB/2023/130 **12.30**	**Chairman's Welcome**	Chairman	v	
TB/2023/131 **12.32**	**Apologies** To note apologies.	Chairman	v	
TB/2023/132 **12.35**	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	d✓	Information/ Approval
TB/2023/133 **12.40**	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 13 September 2023.	Chairman	d✓	Approval
TB/2023/134 **12.45**	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2023/135 **12.50**	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2023/136 **12.55**	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2023/137 **13.00**	**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/2023/138	**Patient Story** To receive and consider the learning from a patient story.	Chief Nurse	p	Information/ Assurance
TB/2023/139	**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✓	Assurance/ Approval
TB/2023/140	**Board Assurance Framework Review** To receive an update on the Board Assurance Framework and approve revisions based on the Executive Risk Assurance Group, Committees' and the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Director of Corporate Governance	d✓	Assurance/ Approval

Agenda

TB/2023/141	**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
STRATEGIC ISSUES				
TB/2023/142	**Maternity and Neonatal Services Update**	Chief Nurse	d✓	Information/ Assurance
TB/2023/143	**New Hospitals Programme Quarter 2 Board Report**	Chief Executive	d✓	Information
ACCOUNTABILITY AND PERFORMANCE				
TB/2023/144	**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
GOVERNANCE				
TB/2023/145	**Annual Report on Medical Appraisal, Revalidation and Governance**	Executive Medical Director	d✓	Ratification
TB/2023/146	**East Lancashire Hospitals NHS Trust Self-Assessment Report 2022-23 for Department of Education, Research and Innovation**	Executive Director of People and Culture	d✓	Ratification
TB/2023/147	**Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Report 2023-24**	Executive Director of Integrated Care, Partnerships and Resilience	d✓	Ratification
TB/2023/148	**Finance and Performance Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information

TB/2023/149	**Quality Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/150	**Audit Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/151	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
TB/2023/152	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2023/153	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2023/154	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2023/155	**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/2023/156	**Date and Time of Next Meeting** Wednesday 10 January 2024, 12.30pm, Boardroom, Fusion House, Innovation Centre / MS Teams	Chairman	v	

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **132**

8 November 2023 **Purpose** Approval
Assurance
Information

Title	Declarations of Interests Report

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

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

Report linkages

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

Name and Title	Interest Declared	Date last updated/ Confirmed
Shazad Sarwar Chairman (from 05.12.2022)	• Committee member of Together Housing Group (from 01.09.2021) • Non-Executive Director member of the Greater Manchester Integrated Care Board (from 01.02.2022). • Managing Director of Msingi Research Ltd. (from 01.07.2015)	12.07.2023
Martin Hodgson Chief Executive (from 01.09.2022) Interim Chief Executive (until 31.08.2022)	• Spouse is the Chief Operating Officer at Liverpool University Hospital NHS Foundation Trust. • Spouse's son worked at University Hospitals of Morecambe Bay NHS Foundation Trust (from November 2019 to October 2021)	12.07.2023
Patricia Anderson Non-Executive Director Interim Chairman (from 01.11.2022 to 04.12.2022)	• Spouse is a retired Consultant Psychiatrist formerly employed at Mersey Care NHS Trust. • Assignment with Knowsley Clinical Commissioning Group, supporting the Accountable Officer for a period of six months (10.05.2019 to 01.10.2019). During this time Mrs Anderson took a leave of absence from the Trust Board at ELHT. • Partnership of East of London Collaborative – Assignment of 1.5 days per month (from 01.12.2020 until 01.02.2021)	12.07.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Kate Atkinson Executive Director of Service Development and Improvement (from 10.02.2023) Interim Executive Director of Service Development and Improvement (to 10.02.2023)	• Brother is the Clinical Director of Radiology at the Trust • Sister-in-law is a Trauma and Orthopaedic Consultant at the Trust • Parent Governor at Blacko Primary School (from 01.04.2022 to 31.03.2026)	12.07.2023
Professor Graham Baldwin Non-Executive Director	• Director of Centralan Holdings Limited • Director of UCLan Overseas Limited • Deputy Chair and Director of UCEA • Chair of Maritime Skills Commission • Member of Universities UK • Treasurer of MillionPlus • Chair of University Vocational Awards Council • Director of Lancashire Enterprise Partnership • Chair of Lancashire Innovation Board	12.07.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Stephen Barnes Non-Executive Director	• Chair of Nelson and Colne College (to 01.05.2023) • Member of the National Board of the Association of Colleges (from to 01.05.2023). • Chair of the National Council of Governors at the Association of Colleges (to 01.05.2023) • Chair of the Nelson Town Regeneration / Deal Board	12.07.2023
Michelle Brown Executive Director of Finance	• Spouse is a paramedic at NWAS • Vice Chair of Governors at St Catherine's RC Primary School, Leyland • Labour Councillor – Clayton West and Cuerden Ward	12.07.2023
Sharon Gilligan Chief Operating Officer Deputy Chief Executive (from 01.01.2023)	• Positive nil declaration	12.07.2023
Jawad Husain Executive Medical Director Deputy Chief Executive (from 10.11.2021)	• Spouse is a GP in Oldham	12.07.2023
Tony McDonald Executive Director of Integrated Care, Partnerships and Resilience	• Spouse is an employee of Oxford Health NHS Foundation Trust • Member of Board of Trustees for Age Concern Central Lancashire Charity (to 27.10.2023)	12.07.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Peter Murphy Chief Nurse	• Spouse works at Liverpool University Foundation Trust.	12.07.2023
Kate Quinn Executive Director of People and Culture (from 01.01.2023)	• Director at Lancashire Institute of Technology • Governor at Goosnargh Oliverson's Church of England Primary School	12.07.2023
Catherine Randall	• Executive Director Derian House Lead for Clinical Services • Independent Chair of the Safeguarding Board • Independent Chair at Blackburn Church of England	13.09.2023
Khalil Rehman Non-Executive Director	• Director at Salix Homes Ltd • Director at Medisina Foundation. • NED at Leeds Community Healthcare Trust (from 01.12.2020)	12.07.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Liz Sedgley Non-Executive Director	• Self Employed Accountant Liz Sedgley FCCA Accountancy and Management Consultancy to SME 25 • Governor at Nelson and Colne Colleges Group • Husband is Financial Controller at Select Medical Ltd	19.09.2023
Richard Smyth Non-Executive Director	• Spouse is a Patient and Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary. • Spouse is a Non-Executive Director at Lancashire Teachings Hospitals Foundation Trust as from 04.02.2019. • Chair of Board of Governors at Bury Grammar School as of 27 March 2023.	12.07.2023

Name and Title	Interest Declared	Date last updated/ Confirmed
Shelley Wright Joint Director of Communications and Engagement for East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BFWH) (from 04.01.2021)	• Post held jointly with Blackpool Teaching Hospitals NHS Foundation Trust	12.07.2023

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
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TRUST BOARD REPORT **Item** **133**

8 November 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 13 September 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:

(133) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 1.00PM, 13 SEPTEMBER 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	
Mr J Husain	Executive Medical Director / Deputy Chief Executive	
Mr P Murphy	Chief Nurse	
Mrs C Randall	Non-Executive Director	
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 M Ireland	Deputy Director of HR & OD
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary	
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs E Cooke	Deputy Director of Communications	
Mr I Devji	Deputy Chief Operating Officer	
Miss K Ingham	Corporate Governance Manager	
Mr M Pugh	Corporate Governance Officer	
Miss T Thompson	Head of Midwifery	Item: TB/2023/117

APOLOGIES

Professor G Baldwin	Non-Executive Director

Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive
Mrs K Quinn	Executive Director of People and Culture
Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council
Mrs L Sedgley	Non-Executive Director
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)

TB/2023/101 CHAIRMAN'S WELCOME

Mr Sarwar welcomed Directors to the meeting. He noted that the current circumstances remained extremely challenging, not only for the Trust but also the wider NHSE, and extended his thanks to all staff members for their ongoing efforts in delivering care to patients. Mr Sarwar added that demand on the Trust's services continued to increase, with over 700 patients a day coming through its Urgent and Emergency (UEC) pathways the previous week and noted that this was likely to continue for the foreseeable future.

Mr Sarwar went on to welcome Mrs Randall to the meeting in her new role as a Non-Executive Director and stated that he looked forward to working with her.

TB/2023/102 APOLOGIES

Apologies were received as recorded above.

TB/2023/103 DECLARATIONS OF INTEREST

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

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

TB/2023/104 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 12 July were approved as a true and accurate record.

TB/2023/0105 MATTERS ARISING

There were no matters arising.

TB/2023/106 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/2023/107 CHAIRMAN'S REPORT

Mr Sarwar provided a summary of his activities to Directors since the previous meeting. He confirmed that he continued to meet with Chairs of both the Integrated Care Board (ICB) and other providers across Lancashire and South Cumbria (LSC) and advised that new governance arrangements, including the implementation of a Transformation and Recovery Board, would allow the ICB and provider organisations to have even closer working arrangements.

Mr Sarwar referred to the NHS 75 celebrations that had taken place throughout July 2023 and commented that it had been good to visit some of the Trust's community hospital sites alongside Mr Murphy and other colleagues. He noted that Clitheroe Community Hospital was a particularly good example of a high-quality service in the local community.

Mr Sarwar informed Directors that an LSC initiative was now in place to develop additional Non-Executive Director (NED) capacity and diversity and advised that he had met a number of candidates in a recent celebration event. He commented that it had been good to meet colleagues who would go on to be potential NEDs in the region and that he looked forward to the programme producing even more high-quality candidates going forward. Mr Sarwar referred to the recent NED recruitment exercise at the Trust and noted that the volume and quality of applicants that had come forward had been very high. He confirmed that a recruitment campaign for additional Associate NEDs would commence later in the month.

RESOLVED: Directors received and noted the update provided.

TB/2023/108 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 advised that both he and Mr Sarwar had attended a national event the previous week in London. He explained that lengthy discussions around the scale of the challenges currently facing the NHS had taken place, particularly in relation to the balance between financial challenges and continuing to deliver quality care, as well as the actions that would need to be taken by all organisations following the conclusion of the trial of Lucy Letby. Mr Hodgson confirmed that a detailed report would be presented later in the meeting to provide assurance around the latter.

He went on to refer to the recent extensive national coverage around Reinforced Autoclaved Aerated Concrete (RAAC) and explained that although the Trust had been affected, it had taken a proactive approach to the issue a number of months ago and had now successfully removed most of the RAAC on its premises. Mr Hodgson extended his thanks to colleagues in the estates and facilities and finance teams for their efforts in managing this.

Mr Hodgson informed Directors that new Fit and Proper Persons Test (FPPT) guidelines had been put forward for consideration by Boards and that it had been indicated that new NHS cancer standards would also be introduced over the coming months. He reported that the Trust had experienced some challenges around its 62-day Referral to Treatment (RTT) performance but confirmed that clinical teams were hard at work to ensure that it would be able to meet its trajectories.

Mr Hodgson informed Directors that several developments had taken place at a Lancashire and South Cumbria (LSC) system level, including a recent briefing hosted by Provider Collaboration Board (PCB) colleagues around the development of Central Services and Clinical Programmes. He referred to the recent announcements made in relation to the New Hospitals Programme (NHP) and commented that it was positive that new builds had been confirmed to replace the currently Royal Preston and Royal Lancaster hospital sites. Directors noted that other work was taking place around the development of the LSC Pathology Collaborative and that a new business case would be produced in the near future to access a new significant amount of capital funding. Mr Hodgson advised that a new Place Integration Deal had also recently been agreed by the ICB, as well as Lancashire County Council and other unitary councils, which set out priorities and the resources required to achieve them. He added that some of this would build on the work during the height of the COVID-19 pandemic to enable the delivery of better health and social care.

Mr Hodgson went on to provide a summary of the developments taking place at Trust level. He referred to the ongoing industrial action being taken by colleagues across the NHS and stressed that while the Trust would always recognise the right of colleagues to take such action, it was undoubtedly impacting the ability to recover activity levels in its services. Mr Hodgson noted that the coordinated action due to be taken by consultant and junior doctor colleagues later in the month would have particularly significant ramifications for planned care programmes. He went on to point out that in addition to the range of national issues facing the Trust, it was also having to contend with a number of issues following the recent implementation of its Cerner Electronic Patient Record (EPR) system. Mr Hodgson emphasised that this process had been a monumental undertaking for the Trust and paid tribute to Executive colleagues and other staff for their work in ensuring a successful 'go live' for the EPR system.

Mr Hodgson went on to provide a summary of other highlights at Trust level, including the recent launch of a new 12-month Clinical Quality Academy programme in conjunction with Blackpool Teaching Hospitals NHS Foundation Trust, the upcoming STAR awards and a number of awards received by services over recent weeks. He referred to the recent passing of one of the Trust's Critical Care nurses and paid tribute to all that they had done for the organisation during their 16 years there.

Mr Hodgson concluded his update by presenting the latest applications for Safe, Personal and Effective Care (SPEC) 'Silver' status from Ribblesdale, ward C10, ward 15, ward C5, Ophthalmology Day Case and Lancashire Women and Newborn Centre Theatres. Directors confirmed that they were content for 'Silver' status to be awarded to these areas.

Mr Barnes commented that it was clear a substantial amount of activity was taking place. He suggested that it would be helpful for the Board to receive an overview of the governance arrangements in place, and other current developments, relating to Place-based partnerships, adding that they were likely to be a key driver for the Trust in its future relationships.

Mr Sarwar agreed that this was a sensible suggestion and noted that the governance in this area was evolving quickly. He proposed that a further update could be provided at a future meeting.

Mr Rehman commented that he felt there was an ongoing lack of clarity around how the ICB's work with the Trust around funding arrangements was benefitting patients on the front line and

stated that it would be helpful for a further demonstration to be provided around this at a later date.

Mr Sarwar pointed out that the ICB was still maturing and explained that the new architectures currently being put in place would help to facilitate more productive discussions around funding arrangements going forward. He noted that it would be vital for the ICB to be able to demonstrate its commitment to value for money as it developed.

Responding to a request for clarification from Mr Barnes around how the funding decisions made by the ICB were debated or challenged, particularly in relation to UEC pressures, Mrs Brown confirmed that discussions were ongoing with ICB colleagues around future tranches of funding and to correct any inaccurate assumptions that may have previously been made around previous funding arrangements. She added that all Trusts in LSC were currently in a deficit position and that this would undoubtedly continue to affect the Trust's own financial position as the year progressed.

In response to a query from Mrs Randall, Mrs Brown explained that to the best of her knowledge, no Quality Impact Assessments had been carried out by the ICB thus far.

Mrs Anderson referred to the information provided earlier in the meeting regarding the substantial numbers of patients coming through the Trust's UEC pathways and expressed concern that there was a seeming lack of recognition of this by the system, particularly with regard to recent funding decisions. She noted that this would only serve to increase the strain being placed onto the Trust's staff.

Mr Hodgson agreed that the lack of additional funding over recent months had put colleagues in a difficult position around maintaining the balance between quality and safety with finances.

Mr Husain agreed that the situation was a worrying one. He pointed out that the Trust's ED had been designed to accommodate around 40 patients and was now having to house an average of 100 or more on a daily basis. He stressed the importance of the Trust securing additional funding as soon as possible, as acute, and non-scheduled patients would continue to be at increased risk in the interim.

Mr Murphy pointed out that the high levels of patient acuity being seen over recent months was another key contributing factor in the pressures being seen. He paid tribute to all colleagues currently working in the ED in very difficult circumstances and highlighted that improvements were recently being seen in a range of areas. Mr Murphy informed Directors

that he would be leading a new group that would be focused on providing additional support to these teams going forward.

Mr Sarwar provided assurances that he and Mr Hodgson would continue to put appropriate levels of challenge back to ICB colleagues around funding decisions and acknowledged that the Board had every right to request more information and clarity around these. He reiterated that transparency around ICB decisions making would become more important going forward to give confidence to stakeholders and to enable LSC to operate properly as a system.

RESOLVED: Directors received the report and noted its contents.

TB/2023/109 PATIENT STORY

Mr Murphy informed Directors that the story being presented had been provided by a patient that had stayed in the ED earlier in the year, shortly after the initial 'go live' of the Trust's EPR system.

Mr Murphy noted that the story was positive overall regarding the conduct of staff and the care provided to the patient, but also reflected how busy the department had been and continued to be. He confirmed that colleagues were now generally much more adept at using the system but advised that there were still issues and challenges that would need to be worked through over the coming months.

Mr Sarwar stated that there also needed to be recognition of the ongoing issues around access to primary care across LSC that were currently beyond anyone's gift to manage. He added that the number of patients coming into the Trust's ED clearly showed the high levels of acuity in local communities.

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

TB/2023/110 CORPORATE RISK REGISTER (CRR) AND RISK PERFORMANCE REPORT

Mr Husain referred Directors to the previously circulated report and provided a summary of key highlights. He reported that there were currently 18 live risks on the CRR and advised that six risks had been deescalated (risk 9296 (unable to provide routine / urgent test for biochemistry requests), risk 9222 (failure to implement NHS Green Plan), risk 8257 (loss of Transfusion Service), risk 8126 (risk of compromising patient care due to lack of an advance

Electronic Patient Record system), risk 9439 (failure to meet internal and external financial targets for the 2022-23 financial year) and risk 8960 (risk of undetected foetal growth restriction, preventable stillbirth and compliance with pulsatility index ultrasound guidance) since the previous meeting. Mr Husain highlighted that there had also been a further reduction of 69% in the number of open risks on the Trust's risk register and a total reduction of 80% in the number of overdue risks over the previous two-year period. He confirmed that all risks continued to be reviewed in detail both by their respective Executive leads and via the regular Risk Assurance Meetings and Executive Risk Assurance Group.

Mr Smyth commented that there had been a clear overall improvement in the management of the Trust's risks over recent months. He noted that there had been an overall increase in the levels of risk on the CRR since the previous meeting, in addition to the Trust's strategic risks on the Board Assurance Framework currently being rated as red, and the potential consequences for patient safety.

Mr Rehman observed that risk 9570 (no capacity for the storage of legacy ECHO images) and risk 9367 (ECHO Images Transfer) both related to fundamental operational issues and enquired if a timeline was available for when these were expected to be resolved.
Mr Husain explained that the potential solution to these issues was complex and would require additional capital from national colleagues. He added that no timeline was available for when the situation was likely to be addressed but stressed that no harm was expected to come to patients in the interim.

RESOLVED: **Directors received the update and assurance about the work being undertaken in relation to the management of risks**

TB/2023/111 BOARD ASSURANCE FRAMEWORK

Mrs Bosnjak-Szekeres confirmed that each individual risk had been revised since the previous meeting and had been reviewed and approved at the most recent meetings of the Quality and Finance and Performance Committees. She explained that many risks remained 'in the red' despite a substantial amount of mitigating activity being in place and that many actions had passed their due dates due to the wider pressures referred to earlier in the meeting. Mrs Bosnjak-Szekeres informed Directors that there would likely be changes to the risk scores assigned in the next round of reporting and confirmed that these would also be presented at their respective sub-committees before being presented to the Board.

Mr Barnes observed that there had been a notable shift in terms of the risks included on the BAF from those that were all fully under the Trust's control to more system-based issues.

Mr Sarwar agreed that there had been a change but stressed that the shift to system working would ultimately be the right answer for patients and staff.

Mr Hodgson pointed out that many risks could only be mitigated effectively by working with system colleagues.

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

TB/2023/112 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 reported that overall levels of incident reporting in the Trust were now back to usual levels, following a dip in June 2023. He highlighted that incidents rated as moderate comprised only 0.5% of this total, compared to the national average of 3%. Mr Husain advised that there had been a rise in severe harms being reported but confirmed that overall levels were still within expected reference ranges.

Mr Husain went on to inform Directors that there were currently 29 open Patient Safety Incident Investigations, four of which had now been open for longer than six months due to multiple factors.

RESOLVED: **Directors noted the report and received assurances about the reporting of incidents via the PSIRF.**

TB/2023/113 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 July 2023. He acknowledged that the report painted a mixed picture overall, with the Trust performing well in a number of areas and less so in others which had been affected by the ongoing industrial action.

b) Safe

Mr Husain referred Directors to the Safe section of the report. He reported that COVID-19 numbers had started to rise over recent weeks, with over ten recent nosocomial outbreaks in

the Trust. Directors noted that there had been no reported cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) since the previous meeting and that the Trust was on trajectory for Clostridium difficile (C. diff) infections.

Mr Murphy advised that a substantial amount of work had taken place to address nursing vacancy levels and confirmed that there had been a significant fall in vacancy numbers. He explained that this would take some time to filter through to the figures provided in the IPR.

Mr Rehman noted that there was a significant amount of discussion taking place nationally around winter pressures and suggested providing more information around what this was expected to look like at one of the Board's sub-committees over the coming months. He also pointed out that Trusts were expected to report back to their Boards on international recruitment, and how the staff recruited in this manner had been treated and requested that an update was also provided on this either at a future Trust Board meeting or via one of the sub-committees.

Mr Sarwar explained that modelling data was being provided through the EPR that would help to provide a clearer picture around what pressures could be expected over the winter period. He added that Trusts were expected to produce winter workforce plans and that this should be considered by relevant sub-committees before coming to a future Board meeting.

RESOLVED: **Directors noted the information and assurance provided within the Safe section of the Integrated Performance Report.**
An update on the Trust's winter workforce plans will be presented at a future meeting of the Board sub-committees.

c) Caring

Mr Murphy referred Directors to the Caring section of the report. He confirmed that a refreshed Patient Experience Strategy was being actively worked on and would be presented at a future meeting.

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 at 1.09 but reported that its Hospital Standardised Mortality

Ratio (HSMR) continued to flag outside of its expected tolerances at 110.5. He reminded Directors that the Trust's HSMR performance had historically been affected by certain coding elements applied by Dr Foster colleagues, particularly in relation to palliative care. Mr Husain confirmed that additional investment had been made into a seven-day palliative care service to address this going forward. He also confirmed that all deaths continued to be reviewed in detail by the Mortality Steering Group.

Referring to the points raised earlier in the meeting regarding the trial of Lucy Letby, Mr Husain provided assurances that all neonatal deaths were scrutinised by the Trust's Medical Examiner service and by joint obstetrics and neonatal reviews, after which they are taken through the Lancashire Maternity Network. He reported that there had been an increase in the number of neonatal deaths in 2022-23 to 23, from 14 in 2021-22, but explained eight of these had been due to congenital abnormalities that were deemed to have been incompatible with life.

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

e) Responsive

Mr Devji reported that the Trust continued to perform well against the 4 Hour A&E standard and for all types of attendances through UEC pathways. He highlighted that the number of the Trust's patients waiting 78 weeks or more for an appointment remained at zero and confirmed that a substantial amount of work was underway to reduce the number of patients waiting 65 weeks or more. Directors noted that the Trust had also maintained a strong position in relation to 28-day diagnostic performance for cancer patients.

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

Mr Ireland reported that there had been a slight increase in sickness and absence levels in July 2023 to just over 6%, adding that the rise in COVID-19 cases raised earlier had contributed to this. Directors noted that appraisal compliance for medical staff was currently at 75%, well under the target of 90%, and that work was ongoing to improve this. Mr Ireland highlighted that work was taking place to develop a new 'cultural dashboard' to bring workforce

metrics, as well as those from the staff survey and other areas, into a single easily accessible location. He confirmed that this would feed directly into the People and Culture Committee once it was in place.

In response to a query from Mr Sarwar, Mr Husain advised that there were no current plans to implement any COVID-19 related restrictions as had been done over previous years. He confirmed that appropriate measures would still be taken for any high-risk patients and that vaccines would be offered to staff over the coming months.

Mrs Brown reported that the Trust was currently £22,000,000 away from its financial plan for the year and referred to the range of key risks, including industrial action and winter pressures, which were likely to continue to affect this over the coming months. She also reported that the Trust had successfully identified £39,000,000 of savings through its Waste Reduction Programme (WRP) but explained that there was a very real possibility that it would not be able to achieve its full savings target of £54,000,000 by year end.

Mr Sarwar stated that the amount of effort that had gone into the Trust's WRP should be recognised by the Board, as well as the ongoing work taking place to increase savings even further.

Mr Hodgson pointed out that £39,000,000 of savings would have been unheard of in previous years and stated that there was significant risk in achieving this. He reiterated that the financial situation across the North West as a whole remained extremely challenging and that additional regulatory measures were likely to be implemented in LSC in the not-too-distant future.

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

TB/2023/114 STAFF SAFETY AND WELFARE UPDATE

Mr Ireland presented a series of slides to Directors summarising the work that had taken place around staff wellbeing and safety over the previous 12-month period. He reported that good progress had been made in promoting the health and wellbeing of Trust staff and highlighted that this had been reflected in the significant improvements in its recent staff survey results. Mr Ireland explained that the Trust's Health and Wellbeing team had focused on seven key themes and actions (Improving personal health and wellbeing, relationships, fulfilment at work, professional wellbeing support, data insights, environment and managers and leaders) and

provided a summary of a range of high impact interventions that had taken place, including the appointment of 270 Wellbeing and Engagement Champions and over 3,000 wellbeing conversations.

Mr McDonald went on to reaffirm the Trust's commitment to its zero-tolerance approach to violence and aggression towards its staff. He pointed out that there were several ways that this could manifest in addition to the more obvious types. Mr McDonald added that there were a number of common risk factors across the NHS as a whole related to mental health wards, medication and drug or alcohol misuse or abuse that also played a role in staff safety. He informed Directors that a future workplan was being developed that included increasing effectiveness of its security services, preparation for the passing of Martyn's Law and improving security management systems and processes in line with local and national initiatives.

Mr Sarwar requested that a full report on Martyn's Law and how the Trust compared with peer organisations around its implementation was provided by the end of March 2024.
Mrs Bosnjak-Szekeres suggested that a 'deep dive' on the Trust's implementation of Martyn's Law could take place at the People and Culture Committee prior to it being discussed at Trust Board.

Responding to a request for further information around the mental health of Trust staff, and how the ongoing pressures were affecting this, Mr Ireland reported that mental health was the number one reason for absences every month. He explained that the Resilience Hub put in place during the COVID-19 pandemic had helped to provide additional support to colleagues but advised that funding had unfortunately been withdrawn from this service earlier in the year. Directors noted that work was taking place to restore this service in the future. Mr Ireland reported that there had been several cases where Trust staff had sadly taken their own lives and confirmed that well developed support mechanisms were in place around deaths in service.
Mrs Atkinson added that an active Mental Health Network was also in place in the Trust and advised that engagement work had taken place with staff during summer around how to further develop the service.

Mr Sarwar stressed the importance of the Trust being able to continue to offer robust health and wellbeing support to colleagues. He added that it was also important for the Board to recognise that this was a complex area that was still evolving and that the Trust's response needed to evolve with it accordingly.

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

TB/2023/115 **RESPONSE TO NHSE LETTER REGARDING INTERNAL REVIEW OF PROCESSES IN RELATION TO LUCY LETBY CASE**

Mr Hodgson referred to the recent conclusion of the trial of Lucy Letby and confirmed that a full public inquiry had been called. He acknowledged that it was not yet clear what would unfold from this inquiry over the coming months and years, but that there was a clear need for assurance to be provided to the Board in the interim around the Trust's existing governance processes to ensure similar events could not occur or would be identified much earlier if they did. Mr Hodgson highlighted that this included the Trust's move to utilising the PSIRF, the presence of a robust and well-developed Freedom to Speak Up (FTSU) service and the recently strengthened FPPT measures referred to earlier in the meeting. He added that the Trust's Professional Standards and Employee Case Review Groups would continue to play a pivotal role in the event that any concerns were raised around clinical or medical staff. Mr Hodgson stressed that the Trust had no intention of resting on its laurels, and clearly recognised that there were lessons to be learned but stated that the suite of safeguarding and governance processes in place demonstrated it would be in a strong position in the interim.

Mr Murphy informed Directors that additional measures were already being worked on, including the planned implementation of a new helpline service to ensure that patients or staff were able to raise concerns safely.

In response to a query from Mrs Randall, Mr Ireland confirmed that the Trust's Whistleblowing and Allegations Against Staff Policies were robust and were reviewed on a regular basis.

Responding to comments from Mr Rehman, Mr Hodgson acknowledged that more consideration was required around the usage of data and promoting the FTSU service going forward.

Mr Sarwar emphasised the need for the Trust to avoid panicking or taking kneejerk responses to the findings from the Letby trial. He agreed that some processes in the Trust may require further strengthening over the coming months and years and that it would be vital to consider how to link this to existing governance structures and processes.

Mr Smyth suggested that the Trust may want to revisit how it triangulated data and to give additional consideration around the use of whistleblowing.

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

An update on the Trust's implementation of Martyn's Law and how this compares with its peer organisations will be provided by the end of March 2024.

A 'deep dive' update on the Trust's implementation of Martyn's Law will be provided at a future meeting of the People and Culture Committee.

TB/2023/116 OVERARCHING STRATEGIC FRAMEWORK AND REFRESH OF TRUST STRATEGIES

Mr Sarwar referred Directors to the previously circulated report. The report provided members of the Trust Board with an update on the Trust's strategic framework including a draft document entitled 'ELHT's Strategic Framework – our overarching business structure', which provided an overarching description of all the Trust strategies, plans and describes how they fit together. Members were asked to review and endorse the document so that it could 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.

The report also provided an update on the Trust's key strategies including a recommendation to extend the existing Digital Strategy and Finance Strategy. As part of this extension, 2023/2024 priorities were provided for both strategies to assure members of progress in this extension period. A draft timetable for presenting new five-year strategies was presented for approval. Members were asked to endorse the extension and key priorities for the Digital Strategy and Finance Strategy and note and approve when new draft strategies will be developed.

Directors confirmed that they were content to approve the recommendations.

RESOLVED: **Directors received the report and approved the recommendations about the overarching strategic framework and refresh of Trust strategies.**

TB/2023/117 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 confirmed that the Trust was compliant with all processes overall, including the requirements related to the Perinatal Mortality Review Tool (PMRT) which it not been able to demonstrate compliance for in the previous year. Miss Thompson referred Directors to the information provided in the report around safety action six and confirmed that a full update on the Saving Babies' Lives Care Bundle Programme would be provided at the November Trust Board meeting. She concluded by providing a summary of the progress made against the other safety actions.

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

TB/2023/118 NEW HOSPITALS PROGRAMME QUARTER 1 BOARD REPORT

The New Hospitals Programme Quarter 1 Board Report and received and noted by Directors.

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

TB/2023/119 NHS IMPROVEMENT ANNUAL BOARD SELF-CERTIFICATION

Mrs Bosnjak-Szekeres referred members to the previously circulated reports and recommended that the Board agree to self-certify as being compliant in all areas.

Directors confirmed that they were content to approve the self-certification and for the Chief Executive and the Chairman to sign them before publication on the Trust Website.

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

Chief Executive and Chairman to sign the self-certification prior to publication on the Trust Website.

TB/2023/120 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL STATEMENT

Mr McDonald requested agreement from Directors for delegated authority to be provided to him and Mr Hodgson to submit the Trust's EPRR Response for the year due to the submission deadline and the Board cycle not being in alignment. He confirmed that the full reports would be presented at the Trust Board meeting in November 2023 for ratification.

Directors confirmed that they were content for delegated authority to be granted.

RESOLVED: Directors agreed to delegate the authority to the Chief Executive and the Executive Director of Integrated Care, Partnerships and Resilience and for the full submission to be presented to the November Trust Board.

TB/2023/121 RATIFICATION OF BOARD SUB-COMMITTEE TERMS OF REFERENCE

The revised terms of reference for the Finance and Performance, Audit and People and Culture Committees were presented to the Board for approval.

Directors confirmed that they were content to approve the revised terms of reference.

RESOLVED: The revised terms of reference for the Finance and Performance, Audit and People and Culture Committees were ratified.

TB/2023/122 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/2023/123 QUALITY COMMITTEE SUMMARY REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2023/124 AUDIT COMMITTEE SUMMARY REPORT

The report was presented to the Board for information.

TB/2023/125 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/2023/126 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2023/127 OPEN FORUM

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

TB/2023/128 BOARD PERFORMANCE AND REFLECTION

Mr Sarwar sought feedback from Directors as to whether they felt the Board had appropriately addressed and fulfilled its objectives in relation to its communities, staff, and stakeholders. He stated that he felt the Board had touched upon communities and its staff in a number of items discussed during the meeting and had recognised that it would need to fully engage with its stakeholders around the challenges expected over the coming months.

Mrs Bosnjak-Szekeres commented that she felt the meeting had maintained a good balance between all areas. She praised the work done by Mrs Atkinson and her team on the Overarching Strategic Framework presented earlier in the meeting and noted that it would serve as the foundation of all the Trust's activities going forward.

Mr Smyth stated that he felt a number of serious and complex issues had been discussed during the meeting and noted that a substantial amount of assurance would be provided to any members of the public or local politicians if they were made aware.

Mr McDonald commented that the patient story had done a good job of showing individual examples of care and compassion set against the real complexities relating to the ongoing delivery of the Trust's services.

RESOLVED: Directors noted the feedback provided.

TB/2023/129 DATE AND TIME OF NEXT MEETING

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

Mr D Byrne, Corporate Governance Officer

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **135**

8 November 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.

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

(135) 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	January/ March 2024	Update: This report will be presented to the People and Culture Committee.
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	March 2024	This item will be presented to the Quality Committee in March 2024.
TB/2023/113: Integrated Performance Report	An update on the Trust's winter workforce plans will be presented at a future meeting of the Board sub-committees.	Executive Director of People and Culture	November 2023	Updates will be presented at the November round of Board sub-committee meetings.

Item Number	Action	Assigned To	Deadline	Status
TB/2023/115: Response to NHSE Letter Regarding Internal Review of Processes in Relation to the Lucy Letby Case	An update on the Trust's implementation of Martyn's Law and how this compares with its peer organisations will be provided by the end of March 2024. A 'deep dive' update on the Trust's implementation of Martyn's Law will be provided at a future meeting of the People and Culture Committee.		March 2024 January 2024	Agenda Item: March 2024 This will be presented to the People and Culture Committee January 2024.
TB/2023/119: NHS Improvement Annual Board Self-Certification	Chief Executive and Chairman to sign the self-certification prior to publication on the Trust Website.	Chairman / Chief Executive	November 2023	Complete
TB/2023/120: Emergency Preparedness, Resilience and Response (EPRR) Annual Statement	Directors agreed to delegate the authority to the Chief Executive and the Executive Director of Integrated Care, Partnerships and Resilience and for the full submission to be presented to the November Trust Board.	Executive Director of integrated Care, Partnerships and Resilience	November 2023	Agenda Item: November 2023

Mr D Byrne, Corporate Governance Officer

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **137**

8 November 2023 **Purpose** Information

Title	Chief Executive's Report
Report Author	Mrs E 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 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

UK Covid-19 Enquiry

This independent public inquiry was set up to examine the UK's response to and impact of the Covid-19 pandemic and learn lessons for the future. The Inquiry is Chaired by Baroness Heather Hallett, a former Court of Appeal judge.

The Inquiry has been established under the Inquiries Act (2005) giving the Chair power to compel the production of documents and call witnesses to give evidence on oath.

To allow a full and focused examination of all the different aspects of the pandemic that are covered in the Terms of Reference, the Inquiry's investigation has been divided into Modules.

The Modules of the Inquiry are announced and then are opened in sequence, after which Core Participant applications are considered. Each module has a corresponding preliminary hearing and full hearing, details of which are published by the Inquiry.

Five Modules have already begun, with one module yet to start:

Active modules

- Resilience and preparedness (Module 1)
  Opened on 21 July 2022, public hearing commenced 13 June - 19 July 2023
- Core UK decision-making and political governance (Module 2)
  Opened on 31 August 2022, public hearing commenced 3 October 2023 and will conclude 14 December 2023
- Impact of the Covid-19 pandemic on healthcare (Module 3)
  Opened on 8 November 2022, preliminary hearings to commence.
- Vaccines and therapeutics (Module 4)
  The Inquiry plans to hear evidence for this investigation in the summer of 2024

- Procurement (Module 5)
  Opened on 24 October 2023, Core Participant application window will be open from 24 October 2023 to 17 November 2023.

Future modules

- Care sector (Module 6)
  The Core Participant application window will be open from 12 December 2023 to 19 January 2024. Public hearings will begin in spring 2025.

Other strands that will be consider are government procurement and PPE, test-and-trace, the government's businesses and financial responses, health inequalities, education, children and young people and other public services.

There is no specific timescale for how long the inquiry will last.

Unprecedented strike action by junior doctors and consultants

The NHS experienced a historic walkout which affected almost all planned care when the first ever joint strike by consultants and junior doctors took place in September.

Consultants took strike action on Tuesday 19 Sept and were joined by junior doctors on Wednesday 20 Sept delivering a Christmas day level of staffing only. Both groups joined in strike action again on 2-4 October, once more only providing Christmas day cover.

Now in the eleventh month of industrial action across the NHS, which has seen more than a million inpatient and outpatient appointments rescheduled, colleagues continue to work hard to provide patients with the best possible care.

The industrial action by consultants in August saw 45,800 appointments disrupted and around 6,000 staff off per day due to industrial action.

Record number of tests and checks in local one-stop shops

The NHS has delivered a record number of potentially lifesaving tests and checks with over 25 million carried out in the last year, new data shows.

Figures released show NHS colleagues delivered more than 25 million checks (25,377,280 August – July) in a year for patients – two million more compared to the same period before the pandemic (23,279,609 to July 2019).

Compared to the same period a decade ago, there has been an almost 50% increase – with 17 million carried out in in the same period in 2013 (17,256,061).

Four new one-stop shops for testing are set to open in England, joining 118 centres already operating in local communities, some in are up and running in shopping centres, making it as convenient as possible for people to get checked. The approval of an additional four community diagnostic centres will add to the 168 one-stop shops already approved.

These centres are playing a key role in carrying out record numbers of tests and checks, with patients able to get tested at convenient locations as close to peoples' homes. Colleagues have now delivered more than five million tests and checks at the local hubs.

More than half a million people have made organ donations via NHS App

People across England are being encouraged to use the NHS App as an easy way to register their organ donation decision – as more than 7,000 patients actively wait for a transplant.

The total number of organ donation decisions registered for the first time through the NHS App has increased by over a fifth over the last year to 546,825 (up 22% from 448,562 last August).

The latest figures, which were highlighted during Organ Donation Week, show that 98,263 new organ donation decisions were registered via the NHS App during the period September 2022 – August 2023.

Overall, organ donation preferences have been managed 4.1million times through the NHS App. Registering a preference on organ donation helps NHS specialist nurses to quickly understand people's wishes, which can ultimately save lives.

Public asked to shape future use of health data

The NHS is inviting the public to influence how their health data is used for better patient care. From the new year until March 2025, a series of events will seek public input on NHS digital and data transformation, including discussions on the Federated Data Platform.

This platform integrates existing NHS data to enhance diagnosis speed, reduce waiting times, and minimise hospital stays. Supported by up to £2 million of funding, these engagement events aim to empower the public to shape policies regarding the use of their health data, building on the success of the 'Powered by Data' campaign initiated by NHS England in June.

This campaign highlighted instances where health data significantly benefited patients and society, such as during the successful COVID-19 vaccination programme.

10,000 virtual ward beds target delivered

New figures show the NHS has delivered on its ambition to roll out 10,000 virtual ward beds by the end of September.

More than 240,000 patients have now been treated on virtual wards thanks to the world-leading initiative, with research showing people who are treated at home recover at the same rate or faster than those treated in hospital.

NHS national medical director, Professor Sir Stephen Powis, has praised the work of local NHS teams in introducing 10,421 virtual ward beds for patients who can get expert treatment for illnesses such as chronic obstructive pulmonary disease (COPD), heart failure or frailty conditions at home. The ambition was delivered despite considerable pressure on urgent and emergency care.

Expanded NHS support available for patients in GP practices

More healthcare professionals have joined local GP practices since 2019, totalling over 31,000. This expansion provides diverse support to patients beyond traditional GP services, including pharmacists, mental health practitioners, paramedics, physios, and social prescribing link workers.

The NHS is actively promoting these resources to address the record numbers of people seeking support from their family doctors. But with one in five GP appointments for non-medical reasons such as loneliness or seeking advice on housing or debts, the NHS wants to make sure that the right help is available.

NHS England responds to CQC State of Care report

Professor Sir Stephen Powis, NHS National Medical Director has responded to the Care Quality Commission (CQC) State of Care report, which can be read here.

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 13 September 2023. A recording of the meeting is available to watch online here: LSC ICB: 13 September 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 – September 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, Chair of University Hospitals of Morecambe Bay NHS Trust. Aaron Cummins, CEO of University Hospitals of Morecambe Bay NHS Trust is lead Chief Executive.

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 September meeting is at the end of this report as Appendix 2.

New Hospitals Programme update
Following the series of roadshow events over summer, Jerry Hawker, Senior Responsible Officer for the Lancashire and South Cumbria New Hospitals Programme, explained the events and the key discussion points in his blog.

There were many thought-provoking questions and observations raised throughout the day, which included:

- The importance of good public transport to new hospital sites
- Conversations across Government departments needed to make new hospital sites more attractive places for NHS staff to live and work
- The need to make sure we build something fit for purpose for local needs, including specialised service provision at Royal Preston Hospital
- The importance of clear, accessible signage
- The need for childcare provision on new hospital sites
- The importance of continued investment in facilities/services at Westmorland General Hospital
- A call for investment in a health hub in Preston.

Each one of these discussion points is important, and Lord Markham CBE and Department of Health and Social Care representatives were able to hear these directly from people in the various sessions.

In October 2023, Kevin Lavery, Chief Executive of NHS Lancashire and South Cumbria Integrated Care Board, explained his vision for the transformational change needed to deliver health and care services in the future. In this blog, Kevin talks about the progress that is needed to support the NHS in Lancashire and South Cumbria's ambitions for the future of healthcare in parallel to the development of two new hospitals on new sites to replace both Royal Preston Hospital and Royal Lancaster Infirmary, with investment in Furness General Hospital.

For the latest news, visit the Lancashire and South Cumbria New Hospitals Programme website.

Ambitious strategy to tackle smoking in Lancashire and South Cumbria announced
The Tobacco Free Lancashire and South Cumbria Strategy 2023-28 is an ambitious five-year plan to address smoking rates and meet the NHS Long Term Plan target of less than five per cent smoking rates across the country by 2030.

The plans were endorsed at a recent ICB board meeting with work beginning on bringing together local authorities, the wider NHS, service providers and communities to help achieve its goals.

The Government recently announced proposed legislation that will make it an offence for anyone born on or after 1 January 2009 to be sold tobacco products – effectively raising the smoking age by one year each year until it applies to the whole population – and while the Tobacco Free Lancashire and South Cumbria Strategy was agreed before those targets were announced, it will complement those proposals.

4. Local and Trust specific updates

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

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

- On 25 October 2023 the seal was applied to a project agreement regarding the conversion of Trust Head Quarters office space to a clinical area between the Trust, and Consort Healthcare. The agreement was signed by Mr Martin Hodgson, Chief Executive and Mrs Michelle Brown, Executive Director of Finance

Site pressures

There continues to be significant pressures across the Trust and colleagues are working incredibly hard to deliver safe, personal and effective care. Due to the unprecedented challenges, an Incident Management Team was set up to support and review our actions and activity focused on easing pressure and optimising patient flow. This included moving the Older People's Rapid Assessment Unit (OPRA) into the Discharge Lounge to create a multi-purpose area and introducing more in-reach activity into the emergency department to support timely acute medical reviews and senior decision making.

In addition, the Improvement Team is working alongside Clinical Flow Discharge Matrons to support ongoing focus on Longer Length of Stay reviews– starting with 21 days and over. The aim is to establish missed opportunities, any learning and recommend clear actions to support a reduction in unnecessary extended length of stay for patients.

Industrial action

As reported as part of the national update section, further periods of industrial action have been organised by a number of unions representing colleagues in a dispute with the Government over pay since the last meeting of the Trust Board. Hospital consultants were on strike from 19-21 September and junior doctors from 20-23 September – which included one joint day of industrial action on 20 September. This was followed on October 2 by 72 hours of industrial action by both junior doctors and hospital consultants who provided Christmas day cover only.

October represented the eleventh month of industrial action and colleagues across the Trust continue to work tirelessly to provide patients with the best possible care in very challenging circumstances. Whilst the Trust respects the right of colleagues to take industrial action, we do recognise the undeniable disruption caused by the absence of clinical colleagues. At the time of writing, there is no further action has been announced.

EPR update

The Trust’s Electronic Patient Record (EPR) system has now been in place for five months and we continue to engage with colleagues across the organisation and patients to understand their lived experience and support them with the transition where possible.

One to one coaching for colleagues began in October and has been rolled out to all clinical teams. The aim of the coaching is to boost knowledge, skills and confidence on the system and to standardise working practices across the organisation. Sessions were fully booked throughout October and received positively. Additional training sessions have been organised as a result of common themes which have emerged from the coaching sessions and other feedback.

The Clinical Informatics team continue to visit all Trust sites capturing and considering feedback openly with colleagues and providing improvement input and support. It is expected this work will be ongoing for some time before the system is operating as expected across the Trust.

The Trust announced Paul Dean, Consultant in Critical Care, as the new Chief Clinical Information Officer (CCIO) following the return of the previous postholder, Jon Ash, to his full-time role in Family Care. Paul brings a wealth of improvement and clinical experience to the role and will be working closely with our clinical teams to take forward the Trust's Data and Digital ambitions.

Subsequently, Miss Clare Cullen, Trauma and Orthopaedic Consultant, has been appointed as Deputy Chief Clinical Information Officer (CCIO). Clare was heavily involved in the implementation of the Electronic Patient Record (EPR) within fracture clinic and the wider outpatient facilities. In her new role, she will be focused on supporting outpatient workflows on the EPR and other digital systems used for outpatient care, as well as supporting outpatient reviews.

Central Services Transformation Update

Earlier this year the Joint Committee of the Lancashire and South Cumbria Provider Collaborative Board (PCB) agreed that corporate services across all five provider Trusts should brought together into one service called 'ONE LSC'.

The services in scope include finance, people and organisational development, communications, governance and legal, digital and information, estates and facilities, along with teams supporting education, training and development.

It was further agreed that ONE LSC would be hosted by one of the provider Trusts in the system and following a robust selection process ELHT was successfully appointed into this role, with the aim of leading the introduction of a new way of working which benefits colleagues and patients, bringing teams closer together and making services more resilient.

The next steps for the Trust are to establish the hosting arrangements, including the establishment of a ONE LSC Leadership team under the structures agreed at PCB Board and focusing on the key programmes for this year.

Colleagues asked for views

The national NHS Staff Survey was launched in September and so far, around 3,000 colleagues have completed it. Feedback will help influence future change and improvements. The Trust has

encouraged teams to respond, as it makes a real difference to how ELHT works and to the working lives of colleagues. A number of actions have been taken as a result of previous feedback.

At week six, over 3,000 colleagues had taken their opportunity to have their say and completed their survey, that is 32.7% of the Trust's workforce which is above the national average but slightly behind our position this time last year. 93 responses, representing 5.6% of bank colleagues have been received. This figure currently falls below the national average of 9.3%.

The survey closes at the end of November with results expected in the New Year. Full details will be provided in due course.

Flu and COVID vaccinations

Colleagues have been offered the opportunity to receive flu and COVID vaccinations. Teams have been out and about across the Trust reminding people about the importance of vaccinations and how they can help reduce the chance of infection.

Colleagues can book appointments for their jab at dedicated hubs or can drop-in, making it as easy as possible to get vaccinated. Last month a vaxathon was organised, with vaccinators visiting community sites with the aim of vaccinating as many colleagues as possible in one week.

To date, over 2,000 colleagues have received the flu vaccination and more than 1,500 have received the covid vaccination.

Winter wellbeing

To support colleagues over the winter months, the Well team launched a special campaign. #WinterWell, encouraging colleagues to look after their health and wellbeing.

Several drop-in sessions were held where colleagues could take a break at the hydration station, get protected with a Flu/Covid jab, engage in wellbeing conversations and take the opportunity to complete the National Staff Survey.

A series of live webinars with HSBC UK were available for colleagues during October and continue during November, on a variety of topics including coping with the cost of living, creating a budget and pensions and retirement plans.

Wellbeing webinars and virtual self-care sessions have also been made available for colleagues to participate in.

Equality, Diversity, and Inclusion

The Trust's fifth Festival of Inclusion took place in October – an annual week-long event dedicated to encouraging a culture of inclusivity and a place where everyone belongs. A series of events were organised, including high profile speakers, workshops, Equali-tea parties, book club, fireside chats and 'belonging breakfasts'.

During the festival, a special event with renowned thought leader, TED speaker, author and producer Nova Reid was held virtually. This provided the perfect place for the Anti-Racism and Allyship Framework to be launched and discussed.

A project team has been established to develop the framework, which encompasses allyship, belonging and compassion, with the Trust's colleague networks and the wider workforce. The aim of the framework is to develop an outstanding culture of belonging and allyship through collective action in becoming an anti-racist organisation.

At the end of October, the Secretary of State for Health, Steve Barclay, wrote to Integrated Care Boards in which he expressed concern that many NHS organisations are "actively recruiting" leaders for diversity, equity and inclusion roles.

The Trust, alongside partner organisations, issued a message to colleagues emphasising that while everyone is responsible for equality, diversity, and inclusion (EDI) through normal management, specialised EDI roles are crucial to address discrimination and ensure safety.

The Trust is dedicated to the Inclusion and Belonging agenda which results in positive impacts on colleagues, patients, and care quality. Our commitment extends to colleague networks, providing opportunities to connect, share experiences, and shape Trust practices. The Positive Difference Strategy outlines our inclusion priorities, with EDI colleagues playing a key role in supporting networks and strategy delivery.

Support for those impacted by Israel and Palestine conflict

Amid the Israel and Palestine conflict, the Trust issued supportive messages and signposted support to colleagues, acknowledging the potential impact on their wellbeing by the unfolding humanitarian crisis.

New Families and Carers Colleague Network

As part of the Trust's ongoing development of colleague networks to bring people together, a new Families and Carers network has been launched. It is for colleagues with caring responsibilities, whether that's for a child, an elderly person or someone else. The network will provide peer support, advice and access to local support services, as well as guest speakers.

New buddy scheme

Work continues to take place to make ELHT a great place to work and to help ensure new starters receive a warm welcome, a buddy scheme has been introduced. It aims to offer new starters the opportunity to link up with a buddy from their team who will provide further advice on general topics such as where to go for lunch or a brew, offer support and answers and make them feel welcome as they acclimatise to the new environment.

Medical students welcomed

The Department of Undergraduate Education welcomed 52 fourth year medical students to ELHT from Lancaster University in September. The students were introduced to the Trust by a range of multi-disciplinary colleagues, for their induction and skills day, ahead of them starting their placements.

ELHT Leadership Forum

An ELHT Leadership Forum was launched in September by Professor Michael West, who has authored, edited and co-edited 20 books and has published more than 200 articles on teamwork, leadership and culture, particularly in healthcare. The forum included a workshop covering compassionate and inclusive leadership.

The upcoming virtual forum on Thursday, November 23, offers colleagues a chance to join an open, inclusive network across ELHT. It's a space for support, experience-sharing, and discussions on leadership development programme content and concepts.

ELHT colleagues attend National Burial Council to help develop bereavement support

Four ELHT colleagues, including Trust Imam Fazal Hassan, attended the eighth annual National Burial Council conference at Euro Garages Head Office Headquarters in Blackburn, along with 260 delegates from England, Scotland, and Wales. The NBC is dedicated to enhancing funeral and bereavement service standards for patients and families within the Islamic faith, and its mission is to collaborate with organisations to improve support and promote good governance.

Key speakers included Chief Coroner Judge Thomas Teague, who discussed leadership in coronial services, and Chief National Medical Examiner Dr Alan Fletcher, who provided insights

into the new medical examiner system across the UK. Dr James Adeley, Lead Coroner for Lancashire, shared information on the close collaboration between local coronial services, hospitals and Muslim funeral directors and out-of-hours provision.

Trust Imam Fazal Hassan expressed the conference's value in networking and learning from senior government advisors and sector professionals to enhance bereavement and end-of-life services.

100th Gynaecology Robot procedure

Obstetrics and Gynaecology Consultant Mr Mark Willett has completed his 100th gynaecology robot procedure with the Burnley General Hospital Robotic Core Team. The first gynaecology robot case was performed by Mr Willett back in November 2020 and the team had to overcome challenges during the COVID pandemic to develop the robotic surgery programme. It has since gone from strength to strength and, collectively as a theatre team, they have now performed over 200 robotic cases of varied speciality.

First for ELHT's Maternity Support Worker

Maternity Support Worker Keelie Barrett has been reappointed to the Royal College of Midwives (RCM) Board for a second term and appointed Vice Chair of the board – both a first for any maternity worker in the UK. Keelie works in family care on the Postnatal ward and has worked for the Trust since 2009. She has worked alongside the RCM on a number of projects including the progression planning and job role specifications for the Maternity Support Workers throughout the UK.

New tobacco inpatient service

A new tobacco inpatient service has been introduced to help provide support and advice to smokers. A team of specialist Tobacco Dependency Advisors will provide professional advice for inpatients, including tips and techniques that offer smokers the best chance of staying smoke free whilst in hospital, in addition to follow-up support upon discharge.

Hospital hosts Olympic-inspired games

Hospital colleagues caring for patients recovering from a stroke devised a creative way of supporting rehabilitation, inspired by the Invictus Games. Marsden Ward at Pendle Community Hospital hosted their own version of the Olympic Games, as a way of reminding patients anything is possible and encouraging exercise to support their recovery. From paper plate discus to help coordination and core stability, through to bowls to support visual scanning and upper limb strengthening, a range of fun activities were put together by the team which had a positive impact on patients' rehabilitation.

Cause of Death – Coronial documentary

In 2020, Channel 5 commissioned Candour, an independent TV production company, to create four 60-minute episodes documenting the work of HM Coroner and involved agencies in the death management process, including Lancashire Teaching Hospitals. The success of the first series led to an expanded second and third series, featuring East Lancashire Hospitals Trust and spanning 16 episodes based at Royal Preston Hospital and Royal Blackburn Teaching Hospital.

The series, with family consent, follows cases from arrival into the mortuary to resolution, including cases going to inquest. This collaboration has provided the Trusts with a unique opportunity for positive national exposure, showcasing lesser-known partnership efforts in Lancashire, with a behind-the-scenes glimpse into critical yet often overlooked aspects of the organisation. The second series is set to air on Wednesday, November 8, at 9 pm on Channel 5.

Emergency Theatres Documentary

Proper Content, an independent TV production company has been commissioned by Channel 4 to produce a new-time documentary series, envisioned as a successor to other familiar brands such as 24 Hours in A&E, Ambulance and One Born Every Minute.

The approach was initiated in 2018 with a pilot, centring on Theatre 6, capturing emergency procedures, evolving priority cases, and showcasing the skills and challenges faced by colleagues.

The aim is an informative and compelling series, spotlighting human stories of patients and the dedication and expertise of the Team. The Trust and production company are in the early stages of engaging with the Theatre Teams, scoping activity and creating production plans. Broadcast is anticipated to be in Summer 2024.

Trust Stakeholder event

The Trust held a virtual event on Monday 6 November for the organisation's core stakeholders including health and social care partners, third sector providers, community organisations, local authorities and education organisations.

The Executive Board provided updates about the services provided by the Trust, the challenges it faces and improvements made. They also answered questions posted by attendees via the chatbox function of the virtual platform. This is one of a regular series of updates provided by the Trust to local colleagues.

Remembrance events

The Armed Forces Veterans Team have organised two special Remembrance services. They are open to all colleagues, patients and families:

- Thursday, 9 November from 10.50am at Lancashire Women and Newborn Centre, Burnley General Teaching Hospital
- Friday, 10 November from 10.50am at the Garden of Memories, Royal Blackburn Teaching Hospital

Memorial Bench for Jasper

ELHT colleagues and visitors gathered for the unveiling of a memorial bench in honour of Jasper, the Trust's therapy dog who passed away earlier this year. Located outside Royal Blackburn Teaching Hospital, the bench was commissioned by GMB Union, M53 East Lancashire Health Branch and crafted by York Disabled Workers Co-Operative.

GMB Branch Secretary Lynette McGaffin shared that as GMB members, they believed honouring Jasper's contributions with a memorial bench would bring happiness to colleagues. The chosen location holds significance as it was Jasper's lunchtime walk spot, where he interacted with colleagues and patients. David Anderson, hospital chaplain and Jasper's owner, expressed gratitude to the Trust for approving the memorial, acknowledging Jasper's impactful presence in many lives.

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:

- Know your numbers week
- Employee of the month
- Organ donation week
- Black history month
- Allied Health Professionals day
- Cyber security

Speak Up Month

To mark this awareness campaign in October, the Freedom to Speak Up team reminded people about the importance of speaking out and encouraging colleagues to become Freedom to Speak Up Ambassadors. They also visited as many areas as possible to speak to colleagues, asking

them to complete a short survey to understand perception and feelings around speaking up to identify any barriers that could be removed. Their aim is to encourage an open, transparent culture where everyone feels hopeful, confident, and safe to speak up.

Wave of Light

A poignant event took place at Lancashire Women and Newborn Centre on Sunday, 15 October, to mark Baby Loss Awareness Week and provide support to families who have experienced the heartache of losing a baby. Families were invited to take part in the ceremony where they could light a candle and remember their baby. There was also an opportunity for parents to have their child's name read out as part of the commemoration.

Celebrating Community Services

The Trust used Community Services Week as an opportunity to recognise our wide range of community and intermediate care services. A week-long campaign focused on the diverse teams available and importance of them in caring for and supporting patients.

Awards and recognition

Star Awards

The Trust's annual colleague recognition event the Star Awards were held via a virtual awards ceremony in October. Over 1,000 viewings of at least 4,000 people tuned in to watch the live event with hundreds of interactions by colleagues on our social media offering messages of support to all the finalists.

The Awards are the highlight of the Trust's recognition calendar and this year there was an overwhelming response – with 600 entries received, our biggest number to date.

The awards were refreshed for this year, including new categories and the introduction of colleague judges, who joined panels to select three finalists, and a winner, in each of the categories, celebrating Trust values, innovation and team members who have gone the extra mile.

The winners this year were:

Jasper's Colleague Kindness Award

Rebecca Brazendale, Deputy Directorate Manager, Surgery

Colleague of the Year

Marion Wilcox, Clinical Nurse Specialist, DERI

Team of the Year (clinical)

AHP Critical Care and Trauma Team

Team of the Year (non-clinical)

ED Supply Chain and Logistics Teams

Volunteer of the Year

Andy and Maxine Whittaker, Pendle

Unsung Hero

Julie Clift, Safeguarding Practitioner

Leader of the Year

Bilal Patel, Science Officer, Haematology

Rising Star

Sophie Butterworth, Project Manager, Family Care

Safe, Personal and Effective Care Champion

Joanne Cranham, CIC

Community, Engagement and Partnerships Award

Joanne Cranham and Cathy Gill, CIC

Wellbeing, Inclusion and Belonging Award

Dilshad Yakub, HCA, CCU

SPE+ Improvement Champion

Gill Phillips and Dhanya Santhosh

People's Health Hero

Head and Neck Team – ENT

Employee of the Year

Dr Deepak Nama, Consultant, Respiratory Medicine

Chairman's Award for Outstanding Lifetime Achievement

Lesley Gaw

The awards were made possible thanks to sponsorship from Equans, Consort and Burnley Hospital – PFI Phase V (Albany and Equans) – which covered the costs of the event and a smaller recognition celebration for the winners in November.

Awards and recognition for oral and maxillo-facial surgical team

Three colleagues from the Oral and Maxillo-Facial Surgical team are celebrating after receiving various awards and recognition for their work. Senior Trainee Mr Danny Adam has been awarded

the gold medal for best performance in the OMFS intercollegiate examination reflecting a culmination of over 15 years of dedication and training. Drs Simon Watkinson and Laura Ewbank have also been awarded Special Service Awards by the British Orthodontic Society for exceptional service to the Society for their hard work in organising several national conferences.

Research shortlisted for multiple awards

Qasim Ahmed won the ‘New to Research Award’ at the Greater Manchester Clinical Research Network awards in October. The Trust was shortlisted for three awards - Bev Hammond was a finalist in the ‘Exceptional Research Delivery Leadership’ category and the Critical Care Research Team for the ‘Transforming Research Delivery’ award. The Trust was also a collaborator for the HARMONIE Respiratory Syncytial Virus study and the Greater Manchester-wide collaboration, which was shortlisted for the Collaborative Working Accomplishment award.

Who Cares Wins

ELHT’s armed forces and veterans team, that has helped more than 1,500 local veterans, was a finalist in the Who Cares Wins Awards that were broadcast on TV in September. Fiona Lamb and Shafiq Sadiq were finalists in the Best Team category. The awards, organised by The Sun in partnership with NHS Charities Together, celebrate the healthcare heroes who go above and beyond to keep us all safe.

ENDS

Emma Cooke
Joint Deputy Director of Communications
30 October 2023

Appendix 2

Provider Collaboration Board – September 2023

- The Provider Collaboration Board (PCB) met on 21 September 2023. As this was a day of Industrial Action by Junior Doctors, following the previous day's joint industrial action with Consultants the meeting was kept brief.
- 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 finance, central services, clinical services and pathology were discussed under Joint Committee working items.

System pressures – acute

- The content of the report was noted.
- Lancashire and South Cumbria performance on cancer, elective and emergency care has generally been positive, with Urgent and Emergency Care (UEC) 4 hour waiting time performance well above the regional and national average. However, ambulance handover pressures are starting to rise, and None Medically Fit to Reside numbers and Lengths of Stay are beginning to grow so the system needs to focus on this and continue to support one another.
- Elective and cancer care are increasingly being impacted by strike action and it was important for the system to be clear on what the financial impact has been. As we go into the winter period there would be a national focus on eliminating 78 and 65 week waiters and reducing the overall size of waiting lists.
- Providers were seeing a dramatic increase in patients attending Emergency Departments (ED), so the work of the Recovery and Transformation Board and Place Based leaders on the out-of-hospital provision was going to be vital. In Blackpool, in particular, the ambulance attendances were exceptionally high and the cancellation of outpatient appointments due to strike action was exacerbating this, as people unable to access these appointments would default to accessing UEC.

- The Integrated Care Board (ICB) suggested that the four Place Based leaders attend one of the regular Trust CEO meetings, and there was a three weekly Local Authority CEO meeting that it would be useful for some PCB colleagues to attend to explore if any further action could be taken in mitigation of the pressures described.
- The PCB expressed their appreciation for ongoing hard work of staff across the system in managing services during the prolonged period of Industrial Action.

System pressures – mental health, autism and learning disabilities

- Lancashire and South Cumbria Foundation Trust (LSCFT) had written to all Place leaders about the high levels of patients (30% of the bed base) who met the criteria for discharge but for whom no out-of-hospital arrangements had been secured. A further meeting about housing had taken place with the Place Based lead for Central Lancashire. There was a reluctance to commission out with current local authority commissioned provision, however there were vacancies within the current provision, the reasons for which needed to be explored. A meeting with all the Place leaders was in the diary and the dialogue would continue.
- The ICB felt that there were some opportunities with large housing associations that needed further exploration and they would be happy to facilitate some meetings.
- A number of Learning Disability placements had failed in the community recently, so these patients had been admitted into the Mental health bed base. This has an adverse impact on the ability to service Mental Health as two beds had been taken down as a result. A number of PICUs had or were about to close, and whilst additional area placements had been sourced in mitigation, these come at a cost and have very conservative admission criteria.
- It had previously been discussed that the autism wait for children was over two-years with around 2,000 children on the list. There had been very positive discussion at ICB, and this was now out to tender for fourth and third sector organisations to come and provide the autism assessment part of the pathway. The intention is to have had all these children assessed by the end of March 2024.

Financial Update

- At month five in-year the system had spent £60m more than projected. Non-delivery of savings was the biggest challenge, and in addition recurrent savings are increasingly slipping and being offset by non-recurrent mitigation. Work was needed across the system to deliver Cost Improvement Plans and stretch targets so we can demonstrate a reduction in run rates and give our regulators confidence that we will deliver the pace of change needed to get things back on track.

- The above would include difficult decisions, so consistent use of data and agreement between all providers on where the gains lie would be key to the success of the programme.

Central Services Transformation Update

- The process for confirming the host Trust had been agreed at PCB Board and had now been concluded. Following the scoring process, East Lancashire Hospital Trust (ELHT) had been successful - the decision was ratified by the PCB Board.
- The bids received had been strong and feedback had been given to Chairs and CEOs. A letter confirming the outcome would be sent to Boards, senior leaders and staff-side representatives across the Integrated Care System (ICS) following the PCB meeting with local communications to follow up by disseminating more widely. The next step would be to establish the hosting arrangement and updates would be brought to Board as things progress.
- The focus would now be on the key programmes for this year including the Bank and Agency Collaborative Project Blue and would then seek to establish the One LSC Leadership team under the structures agreed at PCB Board and would work with ELHT to set up the Executive team and the client facing delivery programmes.
- The key piece of work post December will be the transformation agenda. Within each of the service portfolios, we need to determine how we are going to release Year two and Year three costs and release the efficiencies required.
- There have been number of workshops with each of the professional groups and following feedback there is a view from the central services team that digital and estates and facilities are probably in a position to transition more quickly into the one LSC model. CEOs had asked for some more detail from the Central Services team and the professional groups about what this means in practice, what the risks might be in terms of doing things more quickly and the discussion will be taken into the Central Services Board.
- A bid for funding from the national vanguard programme had been unsuccessful – unfortunately we were viewed as too far ahead to need the support. £30,000 had been received which will help with some project support and Organisational Development and further discussions would take place with the national team about the possibilities of us becoming a really high performing programme with additional resources.
- The programme is on track to achieve £13 million of the £16 million stretch target for Central Services. The majority of this is in procurement and bank and agency.

- The programme is looking to escalate the bank and agency and the medical agency ahead of winter – currently the savings are projected in quarter four moving this forward as it will have an impact in the latter part of the year.
- Some of our teams are involved in national work for functional services which is causing some debate in the workshops and the need for additional discussion and engagement. The challenge is now to agree what good should look like whilst maintaining pace and the agreed timescales.
- The ICB were encouraged by progress but expressed the view there were opportunities to accelerate bank and agency.
- PCB Board recognised the work that had gone on and all the complexities involved and passed on their thanks to all involved.

Clinical Programme Board Update

- The Case for Change had been finalised for the top four priority areas for reconfiguration with input from the regional team and business cases would now be developed.
- Directors of Strategy were pulling together the outcomes on individual Trust positions on fragile services and this would be completed by the end of September. Next steps would be discussed at a time out session in October involving colleagues across the Trusts and the ICB.
- At the first time out session on 4 August there had been agreement on the need to maximise the opportunities provided by the New Hospitals Programme (NHP), particularly those based around the new hospital within Central Lancashire. Work now needed to take place with the NHP team to determine the detail of the business case.
- In the short to medium term, decisions were needed on how to address the structural deficit. An independent, objective and data driven view was going to be important to help develop a clinical reconfiguration plan with clear milestones that all organisations could sign up to in the run up to the NHP coming to fruition. This would be discussed at the next time out in October and at the Recovery and Transformation Board. Lancashire Teaching Hospitals were undertaking a piece of work to establish how Chorley and South Ribble Hospital could continue to be best utilised to free up the Royal Preston site to see what we could get there now as there was the need to maximise the capacity that exists currently.
- There is an issue around the resourcing for the clinical programme as there are a number of people working on project management for whom the funding ceases at the end of October. A collective view is now needed on how to resource this programme to achieve the required outputs.

Transformation and Recovery Board Update

- The first meeting had now taken place and was felt to have been very productive.

Pathology Network Update

- A new LIMS system was being deployed at BTH which was proving challenging in terms of design, training and roll out, so the project was being extended by six months. This has financial implications, so financial assistance was being sought from the NHSE digital team.
- The Digital Pathology Programme had just begun, views of staff were being sought in relation to the workforce strategy, and an exercise had taken place within the network and agreement reached to go out to procurement for all equipment across all four acute provider trusts.
- Significant funding was now back on the table for the development of a model for pathology that included a central facility alongside some locally retained services, and it had been agreed that a business case would be developed. There are challenges as the available funding did not take inflation into account, and an element of the building would need to be developed by 2025.
- The full business case would need to be submitted to the Department of Health and Social Care by the end of the financial year.
- Work was taking place on the terms of reference with appropriate engagement with Trust Boards with a view to allow the decision on the full business case to be made by the Joint Committee of the PCB.
- Directors of Finance had asked for assurance that the process and inputs in relation to the business case be discussed with them in advance and that they remained fully sighted on the development of this before it came back to the Joint Committee. This would be discussed further at the Pathology Board, which would also be seeking assurance that all appropriate stakeholders had been involved in discussions and were fully sighted.
- A Pathology Colleague briefing was taking place on 22 September to ensure that staff had the opportunity hear about the latest developments within the service and have the opportunity to ask questions.

Reflections from and tributes to Kevin McGee

- As this was Kevin McGee's last meeting in his capacity as lead Chief Executive for the Provider Collaborative, he was invited to share his reflections.

- He thanked colleagues for their support and noted how much he had enjoyed his NHS career which for all its challenges had been a great privilege. He felt very optimistic about the future of LSC and was confident that the work taking place on Quality Improvement and Engineering Better Care would make a huge difference to the success of the system. He spoke about the importance of ensuring that LSC competed with other systems to attract good jobs, research and development, education and training, and maintain as many tertiary services as possible, as this would help build social infrastructure and social cohesion and was optimistic that the current LSC leadership would work together to ensure that this happens. He ended by wishing all colleagues the very best for the future.
- All those present reflected on their personal experiences of working with Kevin and wished him well in his new role as Director General of the Gibraltar Health Authority.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **139**

8 November 2023 **Purpose** Approval / Assurance / Information

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.

(139) Corporate Risk Register Report

	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. 1 is a new risk. 16 risks have no movement or change in risk scores. 1 risk is awaiting approval to be removed. 1 risk has been removed.
   b) Numbers of open risks held continue to reduce from 1,709 risks in Q4 2021-22 to 782 at the end of Q2 2023-24, a reduction of 74%.
   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 since the last meeting.

   a) 18 risks are currently held on the CRR. 1 is a new risk. 16 risks have no movement or change in risk scores. 1 risk is awaiting approval to be removed. 1 risk has been removed. A more detailed summary and breakdown is included within the appendices.

   b) The Executive Risk Assurance Group has approved the review and standardisation of risks (approx. 30) arising from the implementation of CERNER and its subsequent inclusion onto the CRR before the next meeting.

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 773 in Q3 2023-24 to date, a decrease of 75%.

   b) Risks identified as being significant or moderate are down from 1,368 risks in Q4 2021-22 to 228 in Q3 2023-24 to date, a decrease of 143%.

   c) Risks remaining open over 3 years old are down from 1,035 risks in Q4 2021-22 to 445 in Q3 2023-24 to date, an 80% decrease.

   d) Overdue risks are down from 230 in Q4 2021-22 to 98 in Q4 2023-24 to date, an 81% decrease.

   e) 2% of tolerated risks have surpassed their review date.

   f) Clinical risks (62%) remain the highest risk type category followed by health and safety risks (18%).

   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 (17%).

   i) Highest numbers of open risks on the risk register are held within Diagnostic and Clinical Services (DCS) (31%).

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 and the impact of industrial action has limited it full implementation. There is a firm expectation of their use within the next reporting period. An example of a completed proforma has been included within the appendices.

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 transfer of risks held 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. New appointments to medical devices and medicines safety officer roles, the risk profiling and mapping of patient safety and clinical management risks and integration of risks held within PWE Healthcare has delayed completion within the target date. There is a firm expectation this will be achieved within the next reporting period.

e) Work to address a steady rise in risks held across divisions scoring 15+ not on the CRR remains 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, process of escalation, improved scrutiny of risk controls and assurances and validity of risk scores against either catastrophic, severe/major and moderate consequence criteria, 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 local 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, process of escalation and risk scoring criteria 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) The review of the effectiveness of Divisional Quality and Safety Board meetings regarding the review and scrutiny of risks.
    h) Supporting services in addressing the 497 foreseeable risks due for review over the next three months.

i) 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.

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

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

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

m) 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.

n) 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

Example of completed proforma

Detailed CRR

Mr J Houlihan, Assistant Director of Health, Safety and Risk, 24 October 2023

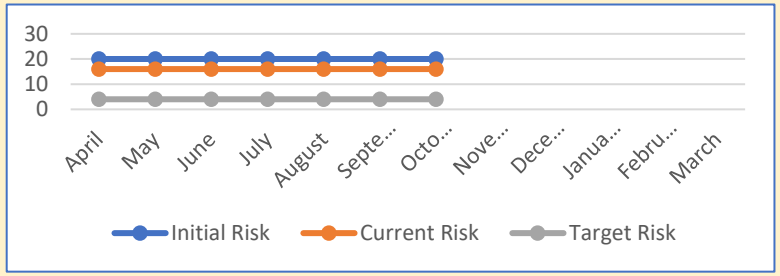
Summary of the CRR

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	9746	Corporate	Inadequate funding model for research, development and innovation	16	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 for Community Intermediate Care Services	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	4932	Trust Wide	Patients who lack capacity to consent to placements in hospital may be being unlawfully detained	15	Limited	⇔
18	8061	Trust Wide	Management of Holding List	12	Limited	⇓

Risks approved for removal 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	5791	Corporate	Failure to recruit and retain to substantive nursing and midwifery posts	12	Adequate	⇓

Example of completed proforma

Strategy: Quality Strategy	**Executive Director Lead:** Executive Director of Integrated Care, Partnerships and Resilience
Risk Title: DATIX ID 7165 - failure to ensure legislative compliance in relation to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013	**Date of last review:** 18 October 2023
Risk Rating (Consequence (C) x Likelihood (L)):  Initial Risk Rating: C4 x L5 = 20 Current Risk Rating: C4 x L4 = 16 Target Risk Rating: C4 x L1 = 04	**Assurance Group:** Quality Committee **Effectiveness of controls and assurances:** Effective X Partially Effective Insufficient **Risk Appetite:** Low / Med / High **Low**

Links to BAF:

BAF ID	Title	Impact	Likelihood	Rating (current)	Effectiveness of Controls
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	5	4	20	Partially Effective

Controls: (What controls, systems and or processes do we already have in place to assist in managing and reducing the likelihood or impact of the risk) 1. Improved data capture and utilisation of incident management module of DATIX. 2. A centralised process is firmly established for the health and safety team to review and submit RIDDOR reportable incidents externally to the HSE. 3. 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.	**Assurances:** (Evidence that the controls/ systems which we are placing reliance on are effective) Service delivery and day to day management of risk and control: 1. Full review of legal requirements and of measuring and reviewing performance completed and remains ongoing. 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.

4. RIDDOR awareness training developed by health and safety team and rolled out to targeted staff groups i.e. members of the health and safety committee, lead specialisms and subject matter experts, occupational health, legal services, divisional quality and safety leads and teams, patient safety investigation leads, with further ad hoc training across divisional groups available, where necessary 5. Increased senior management awareness of RIDDOR to help drive and reinforce the importance of ensuring legislative compliance. 6. New occupational health management system OPAS-G2 now being used to capture and inform of the types of medically diagnosed occupational related disease, infections and ill health identified as being RIDDOR reportable. **Floor to Board Reporting and escalation (Risk and Quality)** All risks relating to health and safety should be visible to the Board / Quality Committee as part of the Assistant Director of Health, Safety and Risk update report**.**	3. Thematic review of RIDDOR performance against legislative requirements included as a standalone agenda item of the health and safety committee, with escalation and or exception reporting to Trust Wide Quality Governance and Quality Committee meetings, where necessary. 4. Continuous reduction in numbers of RIDDOR reportable incidents from 54 in 2020/21, 45 in 2021/22 to 35 in 2022/23. 5. Work to increase compliance with RIDDOR reporting timescales has improved from 15% in 2021/22 to 54% in 2022/23. <u>Specialist support, policy and procedure setting, oversight responsibility:</u> 1. RIDDOR reporting requirements are contained within the scope of incident management policy and procedures. 2. Responsibilities of staff to report any health concerns embedded within scope of organisational health and safety at work policy. 3. Specialist advice, support or guidance readily available from the health and safety team. 4. Collaborative working partnerships established 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. 5. Days lost off work as a result of absence or injury captured as part of HR return to work process. <u>Independent challenge on levels of assurance, risk and control:</u> 1. RIDDOR performance increasingly attracting the interest of the Health and Safety Executive and Care Quality Commission.

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

Mitigating actions: Plans to improve controls/assurance

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

No.	Gap in controls and / or assurance	Action Required	Lead	Due Date	Progress Update/Impact	BRAG
1	No evidence of assurance certain types of medically diagnosed occupational related disease, infections or ill health are being identified or considered by occupational health as being RIDDOR reportable	Revisit and deliver RIDDOR awareness training to occupational health team Ensure occupational diseases are more explicitly included as part of RIDDOR performance reporting	Health, Safety and Risk Manager	Q2 2023	Delivery of training completed. RIDDOR reportable occupational disease now more explicitly included within occupational health performance reports. New Occupational Health Management System OPAS-G2 now introduced and used to capture and inform	G
2	Limited assurance services are benchmarking or using RIDDOR performance as an important driver in reducing the risk	Improve senior management overview, involvement and insight. Include RIDDOR performance as part of Quality and Safety KPI metrics Improve communication and strengthen collaborative working partnerships.	Assistant Director of Health, Safety and Risk	Q2 2023	Increased senior management awareness of RIDDOR to help drive and reinforce the importance of ensuring legislative compliance RIDDOR performance now included as part of Quality and Safety KPI's for 2023/24 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	G

		Better utilisation of Quality and Safety Leads to relay and enact upon important safety critical information across Divisions			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	
3	Limited assurance managers and staff are following policy or procedural controls regarding timely reporting of accidents or incidents, of this being highlighted or captured within management systems or processes or it being performance managed. Delays are being experienced determining RIDDOR reportable injuries, diseases and dangerous occurrences due to the volume and complexity of accidents and incidents requiring review and investigation. Limited assurance lead specialisms or subject matter experts in safety critical roles are benchmarking or using RIDDOR performance as an important driver in reducing mitigating risks or improving safety management systems, processes or behaviours.	Review of incident reporting process to improve quality and quantity of incidents being reported Review of incident investigation process to utilise lead specialisms and or subject matter experts more effectively when reviewing and investigating incidents within their areas of responsibility and control and of determining external reporting requirements of RIDDOR when undertaking investigations Review of triage process to avoid multiple reviews of incidents and duplication Review of health and safety team resources pending outcome of review of process	Assistant Director of Patient Safety and Effectiveness Assistant Director of Health, Safety and Risk	Q3 2023	Feedback regarding review of incident reporting, incident investigation and triage processes has been completed. Awaiting outcome. Total numbers of health and safety incidents requiring review and investigation by the health and safety team to determine RIDDOR status continue to dominate work pressures, accounting for c.25-30% of all incidents reported in DATIX. A breakdown of total numbers are below 2021/22 = 6,539 incidents 2022/23 = 6,705 incidents 2023/24 = 3,168 incidents to date The process of determining RIDDOR reportable incidents and ensuring legislative compliance is extremely time consuming and heavily dependent on the health and safety team which is impacting on effective service delivery.	A
4	Investigations to determine RIDDOR reportable incidents are highlighting gaps in quality management systems or processes and of existing policy, procedure and risk assessment processes not being followed by managers or staff	Gaps in quality management systems are to form part of the workplan of the Health and Safety Committee	Assistant Director of Health, Safety and Risk	Q3 2023	Development and implementation of health and safety strategy will support delivery Completion of regulatory gap analysis will support the action plan of the Health and Safety Committee in seeking assurances of legislative compliance	A
5	The introduction of patient safety learning response timescales identified as part of the new Patient Safety Incident Response Framework (PSIRF) may delay incident investigations and their subsequent impact on external regulatory reporting requirements	Impact assessment being reviewed by PSIRF lead	Assistant Director of Patient Safety and Effectiveness	Q3 2023	In progress	A
6	The replacement of DATIX with the new Total Quality Management System (RADAR) may lead to loss of organisational memory and may delay incident investigations and their subsequent impact on external regulatory reporting requirements	Impact assessment being reviewed by RADAR lead	Health, Safety and Risk Manager / DATIX Manager	Q4 2024	Wider review of ESR and RADAR management systems will help support delivery	A

7	There is no standardised quality management system for capturing total numbers of days lost off work as a result of workplace accident or injury leading to its absence, avoidance and or duplication	Staff days lost off work as a result of injury included as part of human resources sickness management and return to work processes but is not captured as part of DATIX incident management module	Health, Safety and Risk Manager	Q4 2024	Wider review of ESR and RADAR management systems will help support delivery	A
8	Achieve and maintain threshold target of 95% compliance with RIDDOR reporting timescales to reduce risk of legislative backlash	Current trend analysis highlighting a 71% increase in RIDDOR reportable incidents compared to previous year to date figures.	Health, Safety and Risk Manager	Q4 2024	Current compliance levels are at 44% in 2023/24 and remain way below the threshold level of achieving and maintaining 95% compliance.	R

BRAG	Explanation
	Complete / Business as Usual - Completed: Improvement / action delivered with sustainability assured.
	On Track or not yet due - Improvement on trajectory
x	Problematic - Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement
	Delayed - Off track / trajectory – milestone / timescales breached. Recovery plan required.

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 13/10/2023** Risk reviewed. No change in risk score At M5 the Trust is reporting a £23.8m deficit for the 2023-24 financial year to date, £9.6m behind the planned £14.2m deficit at the end of month 6. The reason for the movement from plan is due to a combination of additional costs incurred on the back of industrial action, pay award shortfall in funding and underachievement of the waste reduction programme being the major factor. £10m of the £15m cash required for Q3 has been approved and the Trust must look to apply for emergency public dividend capital. The capital programme is forecast to be overcommitted and mitigations are currently being worked through. **Next Review Date 10/11/2023**	**Date last reviewed**	**13/10/2023**		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					25	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		**LINK TO DATIX ID 9367** **Update 09/10/2023** Risk reviewed. No change in risk score. 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 09/11/2023**	**Date last reviewed**		**09/10/2023**	
			Risk by quarter 2023-24		**Q1**	**Q2**	**Q3**	**Q4**
						20	20	
			8-week score projection		12			
			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.		**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.
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.				
Update since the last report		**Update 26/09/2023** 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 26/10/2023**		**Date last reviewed**		**26/09/2023**
				Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					20	**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.
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.

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.
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.

	12. Continuous review of processes across Acute and Emergency medicine in line with incidents and coronial process.		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 01/10/2023.** Risk reviewed. No change in risk score. Multiple long waits are still being experienced. One severe and one moderate incident has occurred and one incident has been associated with overcrowding. Increased demand still remains, with regular utilisation of the fracture clinic to mitigate overcrowding. Nurse staffing levels maintained to support demand and patient care delivery. Nursing quality markers remain below expectation and are being monitored monthly. A Nursing Assessment and Performance Framework (NAPF) inspection has highlighted ED as remaining red. **Next Review Date 30/10/2023**	**Date last reviewed**	**01/10/2023**
		Risk by quarter 2023-24	**Q1**: **20** / **Q2**: **20** / **Q3**: **20** / **Q4**:
		8 week score projection	**20**
		Current Issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title				
5	9746	**Inadequate funding model for research, development and innovation**				
Lead		Risk Lead: Julia Owen Exec Lead: Katie Quinn	**Current score**	**16**	**Score Movement**	⇧
Description		The Research, Development and Innovation Service within DERI is not centrally funded by the Trust. It is financed through complex funding streams such as the National Institute for Health Research (NIHR), Clinical Research Network (CRN) Greater Manchester and from income generated from commercial and non-commercial research activity. This model of funding is no longer sustainable	**Gaps and potential actions to further mitigate risk**			**Gaps / weaknesses in controls** 1. Commercial and non-commercial study income subject to change without warning leading to fluctuations in income or performance expected for funding provided and is non recurrent making forecasting extremely challenging. 2. Failure to look at funding model of Research, Development and Innovation could result in significant and rapid loss of highly skilled workforce and infrastructure severely damaging the Trust's ability to deliver vital ground breaking research for patients. These staff groups are specialised and once lost will take a considerable amount of time to re-establish. 3. Income generated from research and innovation rarely provides a within financial year return on investment in staffing resource and can take a few years for a new post to develop the surrounding portfolio within the service and is subject to exterior pressures within clinical and support services. 4. Research support function and SMT does not directly generate income, but is vital to support the research activity, be that developed research or hosted. The skilled expertise and advice given to prospective researchers helps increase potential for successful funding applications. Average success rate for grant applications is 17%, with unsuccessful grant applications still requiring support. 5. Not replacing staff has increased risk of not being able to deliver certain functions of the service, as well as increased pressure and stress on staff remaining, with current pressures unsustainable. **Gaps / weaknesses in assurances** 1. Rebalancing research portfolio to include more income generation from commercial research is happening but takes time to grow and establish. 2. Generated income limited without a dedicated research facility as clinical priority will take precedence for capacity (including support services). 3. Current recruitment freeze to non-clinical roles having an impact on staffing capacity to deliver current and expand research portfolio in line with DERI strategy and Research Plan. 4. Additional resource supporting invoicing and chasing aged debt only a temporary measure. 5. Future benefits of investment realised over a longer trajectory such as research capability funding and income generation.
Controls and Assurances in place		Controls 1. Finance within DERI moved from substantive education posts into research. 2. Investment in additional resources (B6 0.4 WTE and B4 0.2 WTE) for a six month period has allowed for better scrutiny and control of contractual and financial assessment of projects, timely raising of invoices and chasing aged debt. 3. Agreed proposals within business plan will see consistency in approach and alignment with other NHS organisations. 4. Procurement of Edge Research Management System allows for improved efficiency at capturing and costing for research activity and better financial oversight that was previously held. Assurances 1. Annual negotiations held with NIHR and CRN to proportionately increase investment to reflect balance and expansion of research portfolio across services allowing for movement of some posts to the CRN funding stream. 2. Fortnightly finance meetings between R&I Accountant, Deputy Divisional Manager for DERI and Head of R&I Department to review income and budgets. 3. Additional funding routes and benchmarking of financial models across other NHS organisations being explored. 4. Engagement with senior finance personnel and good lines of communication with executives to form a collaborative approach to the business plan.				
Update since the last report		**Update 24/10/2023** Risk reviewed. No change in risk score. Paper presented to Board in Aug-23 accepted in principal and requires all funding options to be fully explored. KPI's to increase amount of commercial research included as part of DERI research plan. There is currently no capacity for additional trials needing pharmacy technical services i.e. IV reconstruction. New ways of querying contractual and financial assessment of projects, timely raising of invoices and chasing aged debt is being explored.	**Date last reviewed**	**24/10/2023**		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					16	**16**	
			8-week score projection	**16**			

		Next Review Date 13/11/2023		**Current issues**	System wide external influences
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.
Controls and Assurances in place		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		**Update 18/10/2023** Risk reviewed. No change in risk score. Agency / locum consultants are currently being used to backfill gaps in on call HPB rota and sickness. HPB team continue to remain off the general surgery on call rota to ensure gaps in HPB rota are mitigated. **Next Review Date 19/11/2023**		**Date last reviewed**	**18/10/2023**
				Risk by quarter 2023-24	Q1: ; Q2: 16; Q3: 16; 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		**LINK TO DATIX ID 9570** **Update 10/10/2023** Risk reviewed. No change in risk score. 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 10/11/2023**	**Date last reviewed**	**10/10/2023**		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					16	**16**	
			8-week score projection	**12**			
			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 28/09/2023** Risk reviewed. No change in risk score. Potential for review of risk score to reflect additional recruitment and additional controls. **Next Review Date 28/10/2023**	**Date last reviewed**	**28/09/2023**		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
				16	**16**	**16**	
			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 23/10/2023** 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 30/11/2023**	**Date last reviewed**	**23/10/2023**			
		Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
			16	**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. Delays are being experienced determining RIDDOR reportable injuries, disease and dangerous occurrences due to the increasing volume and complexity of accidents and incidents requiring review and investigation. 2. There is limited assurance managers and staff are following policy or procedural controls regarding the timely reporting of accidents or incidents, of this being highlighted or captured within management systems or processes or it being performance managed. 3. There is no standardised investigation process or quality management system used to capture total numbers of days lost off work as a result of workplace accident or injury leading to its absence, avoidance or duplication. 4. The introduction of patient safety learning response timescales identified as part of the new Patient Safety Incident Response Framework (PSIRF) may delay incident investigations and their subsequent impact on external regulatory reporting requirements. 5. 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. 6. Lead specialisms and or subject matter experts are not being utilised effectively with regards the review and investigation of incidents within their own areas of responsibility and control and of determining external reporting requirements of RIDDOR when undertaking investigations. 7. Investigations to determine RIDDOR reportable incidents highlighting gaps in quality safety management systems or processes and of policy/procedural controls and risk assessment processes not being followed by manager and staff. 8. 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. RIDDOR performance increasingly attracting the interest of the HSE and CQC. 2. No evidence of assurance lead specialisms or subject matter experts in safety critical roles are benchmarking or using RIDDOR performance as an important driver in reducing mitigating risks or improving safety management systems, processes or behaviours. 3. Numbers of accidents and incidents being reviewed or investigated by the health, safety and risk team to determine RIDDOR status account for 25-30% of all accidents and incidents reported in DATIX. This is not sustainable and continues to significantly impact on the work and resources of the team e.g. 6,539 were reviewed or investigated in 2021/22, 6,705 in 2022/23 and 2,966 in 2023/24 to date.
Controls and Assurances in place	<u>Controls</u> 1. RIDDOR reporting requirements contained within the scope of the incident management policy and procedure. 2. Responsibilities of staff to report any health concerns embedded within organisational health and safety at work policy. 3. Improved data capture and utilisation of incident management module of DATIX. 4. A centralised process is firmly established for the health and safety team to review and submit RIDDOR reportable incidents externally to the HSE. 5. Days lost off work as a result of a workplace accident or injury captured as part of the human resources sickness management and return to work processes. 6. 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. 7. 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 or subject matter experts, occupational health services, divisional quality and safety leads and teams and patient safety investigation leads. Further ad hoc training across divisional groups available, where necessary. 8. Increased senior management awareness of RIDDOR to help drive and reinforce the importance of ensuring legislative compliance. 9. New Occupational Health Management System OPAS-G2 now being used to capture and inform of the types of medically diagnosed occupational related disease, infections and ill health identified as being RIDDOR reportable. <u>Assurances</u> 1. Full review of legislative requirements completed and reviewed. 2. Specialist advice, support and guidance on RIDDOR reporting requirements readily available from the health, safety and risk team. 3. Continuous monitoring and review of all accidents and incidents to staff, patients, contractors and members of public reported in DATIX undertaken by the health, safety and risk team. 4. Thematic review of RIDDOR performance against legislative requirements included as an agenda item of the Health and Safety Committee, with escalation and or exception reporting to the Quality Committee, where necessary. 5. RIDDOR reportable occupational disease more explicitly included within occupational health performance reporting. 6. 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. 7. RIDDOR performance included as part of Quality and Safety KPI performance metrics for senior management oversight and review. 8. Evidence of continuous reduction in numbers of RIDDOR reportable incidents being externally reported to the HSE i.e. from 54 in 2020/21 to 45 in 2021/22 to 38 in 2022-23.		

			4. Current trend analysis highlighting a 71% increase in RIDDOR reportable incidents compared to previous financial year to date Q1/Q2 2022/23 = 11 and Q1/Q2 2023/24 = 23 5. Although work to increase compliance with reporting timescales has significantly improved, from 12% in 2021/22 to 53% in 2022/23, current compliance levels are at 44% in 2023/24 and remain way below the threshold level of achieving and maintaining 95% compliance.
Update since the last report	**Update 18/10/2023** Risk reviewed. No change in risk scoring. The risk rating remains the same to reflect gaps and or weaknesses in existing controls and of limited assurances of ensuring legislative compliance, as well as demonstrable evidence of increasing awareness and activity from external regulatory bodies i.e. CQC etc. It is anticipated this risk will reduce when performance data presented at the Health and Safety Committee has highlighted the target threshold of 95% has been achieved and is being suitably maintained. **Next Review Date 17/11/2023**	**Date last reviewed**	**18/10/2023**
		Risk by quarter 2023-24	**Q1** 16 / **Q2** 16 / **Q3** 16 / **Q4**
		8 week score projection	**16**
		Current issues	Systems, 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 19/10/2023** 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 remains a concern with numbers of patients awaiting review of appointments unable to be accommodated. **Next Review Date 17/11/2023**	**Date last reviewed**	**19/10/2023**

Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	16	16	16	
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 24/10/2023** Risk reviewed. No change in risk scoring. Active RTT pathways = 37,799 >18 weeks = 17,632 of which 1,745 are >52 weeks, 341 are >65 weeks, 8 are >78 weeks and 4,130 at risk of breaching 65 weeks by end of Mar-24 Micromanagement of all 65 and 78 week breach risks continue to monitored at weekly PTL meetings. Patients continue to be seen in order of clinical priority and a revised clinical harm process has been implemented to ensure patient safety, Recovery trajectories and plans are currently being developed. **Next Review Date 24/11/2023**	**Date last reviewed**	**24/10/2023**
		Risk by quarter 2023-24	Q1: 15 | Q2: 15 | Q3: 15 | Q4:
		8 week score projection	**12**
		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.

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.

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.

Update since the last report

Update 24/10/2023
Paper presented to senior leadership team outlining current issues and proposed resolution. No major incidents have been reported to date.

Next Review Date 30/11/2023

Date last reviewed	24/10/2023			
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				
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.				
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.	**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.	
Update since the last report		**Update 18/10/2023** Risk reviewed. No change to risk scoring. LFRS have issued enforcement action. Improvement works being monitored and reviewed by the Fire Safety Committee. **Next Review Date 17/11/2023**	**Date last reviewed**	**18/10/2023**		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
				15	**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**	**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.
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.		
Update since the last report	**Update 18/10/2023** Risk reviewed. No change to risk scoring. LFRS have issued enforcement action. Improvement works being monitored and reviewed by the Fire Safety Committee. **Next Review Date 17/11/2023**	**Date last reviewed**	**18/10/2023**

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

No	ID	Title				
16	7008	Failure to comply with the 62 day cancer waiting time targets				
Lead		Risk Lead: Matthew Wainman Exec Lead: Sharon Gilligan	**Current score**	**15**	**Score Movement**	⟺
Description		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 29/09/2023** 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 some impact due to CERNER implementation. Risk score to be reviewed following data analysis. **Next review date 27/10/2023**		**Date last reviewed**	**29/09/2023**	
				Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**15**	
				8 week score projection	**12**			
				Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
17	4932	**Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained (Tolerated Risk)**

Lead	Risk Lead: Lyndsay Parsons Exec Lead: Peter Murphy	**Current score**	**15**	**Score Movement**	⟺

Description	Patients referred to Lancashire County Council and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DoLS) authorisation are not being assessed by these agencies within the statutory timescales, or at all, which means the DoLS is in effect unauthorised.	**Gaps and Potential actions to further mitigate risk**	**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 17/10/2023** 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 17/11/2023**	**Date last reviewed**	**17/10/2023**		
		Risk by quarter 2023/24	**Q1**	**Q2**	**Q3**	**Q4**
			15	**15**	**15**	
		8-week score projection	**15**			
		Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

No	ID	Title
18	8061	Management of Holding List

Lead	Risk Lead: Leah Pickering Exec Lead: Sharon Gilligan	Current score	12	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 24/10/2023** Risk reviewed. Risk score reduced to 12. Awaiting approval for removal from the CRR. Whilst there are high volumes of patients there are few reported incidents of patients sustaining severe or major harm as a result of any delays incurred. **Next Review Date 22/12/2024**	**Date last reviewed**	**24/10/2023**

Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	20	20	12	

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

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **140**

8 November 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 October 2023. In addition, the Finance and Performance Committee, Quality Committee and have reviewed and discussed the revised document at its most recent meetings and agreed to recommend the revisions to the Board for ratification. The People and Culture Committee will receive the BAF at its meeting on 6 November 2024 and verbal recommendations will be made to the Board.

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 and changes are highlighted in green on the individual BAF risk sheets.

There is one proposed revision to the scoring of risk 3 from 16 (C4 x L4) to 20 (C4 x L5).

The Executive are monitoring the tolerated risk scores and target risk scores at the Executive Risk Assurance Group (ERAG) in light of the current challenges.

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, October 2023

Executive Risk Assurance Group, 26 October 2023

Finance and Performance Committee, 30 October 2023

Quality Committee, 1 November 2023

To be considered by the People and Culture Committee, 6 November 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 September 2023, including any updates to the actions, assurances and controls.
3. The full BAF is presented to the Finance and Performance Committee, Quality Committee and People and Culture Committee. 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. 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 4	BAF 3
	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. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
2. There have been minor updates to the controls section of the risk. These are detailed in the BAF risk sheet.
3. With regard to the actions section of this risk, there have been a number of updates, including changes to the due dates for 4 of the actions (2, 3, 4 and 8), the details of which are also included in the detailed BAF sheet.

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.

4. The section detailing the links to the Corporate Risk Register (CRR) has been updated to reflect the revised CRR risks. For clarity, there has been one new addition to the CRR which relate to this risk (ID 8725).
5. There have been 2 new additions to the controls section of the risk, which are which are detailed in the BAF sheet.
6. With regard to the actions section of the risk, there have been additional updates added to the progress section for actions 1, 3, 5 and 6. These additions, which are in the detailed BAF sheet.

Risk 3: (Risk Score 20 (C4 x L5) 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.

7. The risk score has been increased to reflect the current pressures being experienced throughout the Trust's emergency and urgent care pathways. The previous risk rating was **16 (C4 x L4)**, the new risk score is proposed to be **20 (C4 x L5)**.
8. The Executive Directors have undertaken a line-by-line review of the risk to streamline its content and have proposed that a number of controls and sources of assurance be

removed from the BAF as they are classed as 'business as usual', are ongoing and form part of the everyday operational management of the risk.

9. 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.

10. There have also been a number of revisions to the actions, including to the due dates (for actions 8 and 9). The rationale for the revised dates is included within each update. There has also been one additional gap in control identified, with actions being included. This gap relates to the temporary lack of data, including theatre utilisation data as a result of the implementation of Cerner Electronic Patient Record (EPR) system.

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.

11. The section detailing the links to the CRR has been updated to reflect the revised CRR risks. For clarity, there has been one new addition to the CRR which relates to this risk (ID 9746) and there has been one risk removed (ID 5791).

12. The Executive Director responsible for the risk has undertaken a line-by-line review of the risk to streamline its content and it is proposed that a number of controls and sources of assurance be removed from the BAF as they are classed as 'business as usual', are ongoing and form part of the everyday operational management of the risk.

13. In addition, there have been three new sources of assurance included the details of which are set out in the detailed BAF sheet.

14. There have been updates to all but one of the actions and there have been extensions to the due dates on 4 actions (1, 4, 5 and 6), the reasons why are also detailed in the BAF sheet.

15. Furthermore action 2 has been marked as complete, although it is worth noting that continual monitoring of capacity will be undertaken, as will the exploration of all future funding opportunities.

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.

16. There have been a small number of updates to the controls and assurances section of the BAF risk, all of which are shown in the detailed BAF sheet.

17. 4 actions have been updated with 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. The action relating to ICS system financial governance has now been completed.

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

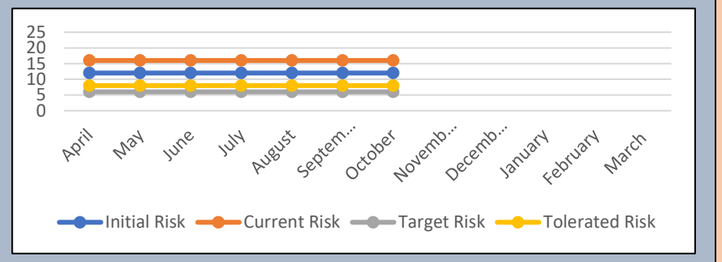
Date of last review: Executive Director: October 2023
ERAG: October 2023

Lead Committee: Finance and Performance Committee

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

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

Current Risk Rating: **C4 x L4 = 16**
Initial Risk Rating: C4 x L3 = 12
Tolerated Risk C4 x L2 = 8
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. System-wide programmes in process of being finalised. PMO review/methodology development complete but resourcing of PMO to be finalised and still outstanding which is why a revised date has been previously noted. It Is unlikely that PMO will be funded but a methodology is being applied across the system.	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	End March/April 2024	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. Last update on progress to the Committees and Board was in September 2023. An update will be provided at the end of quarter 4/beginning of quarter 1.	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	December 2023	Initial stakeholder workshops held to identify opportunities for improvement/collaboration and further workshops planned 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 –last update September 2023. Due to the timings of the PCB meetings, this has now moved to October/November 2023 PLACE priorities have been identified and these have been aligned with ELHT priorities and goals at a workshop in October with both BwD and Lancs PLACE leads.	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 has been completed as planned by the end of September and will be presented to a future Board meeting for information (January to March 2024).	A
6.	Community service alignment 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	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. Updates are provided to F&P on a monthly basis and a detailed due diligence timeline is currently in progress.	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	~~October 2023~~ December 2023	System Programme Management Office and programme methodology in development. System resource scoping underway to align to Programmes for 2023-24. Ongoing review of ELHT capacity requirements.	R

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 Sept 23 – ELHT plans in place and 24/25 planning starts Autumn 2023. PMO delayed due to funding which is still being explored. Update to be provided October 2023 – due date extended. Date extended again until December 2023 as funding remains an issue.	
9.	Full implementation of ELHT Accountability Framework	Full implementation of Trust Accountability Framework	Director of Finance/Director of Service Development and Improvement	October 2023	Final review of framework completed, sharing with Trust Board and Senior Leadership Group planned during Autumn 2023 (due date extended) Quarterly review meetings commenced in July for Q1.	A

BAF Risk 2 – Quality and Safety

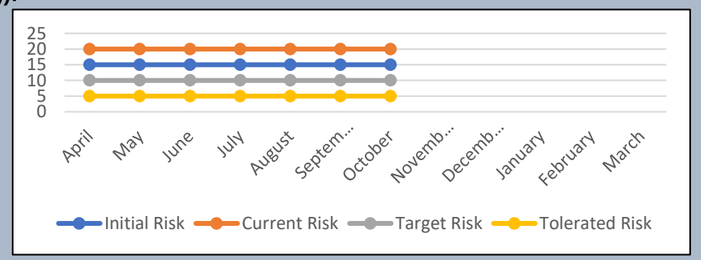
Risk Description: The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.		**Executive Director Lead:** Executive Medical Director and Executive Director of Nursing	
Strategy: Quality Strategy	**Links to Key Delivery Programmes:** Quality and Safety Improvement Priorities	**Date of last review:** Executive Director: October 2023 ERAG: October 2023	**Lead Committee:** Quality Committee

Links to Corporate Risk Register:

Risk ID	Risk Descriptor	Risk Rating
9557	Patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provision.	**20**
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**20**
9570	No capacity for the storage of legacy ECHO images	**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**
7165	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	**16**
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**
8725	Lack of senior clinical decision making and inconsistent medical cover for Community Intermediate Care Services	**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. these are being presented to the Trusts Quality Committee on 1st November for Trust approval and then to ICB Quality Committee at the end of November for sign off. .

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 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 Group, Patient Experience Group, Clinical Effectiveness Committee, Infection

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 Walkrounds including Executive and Non-Executives
- 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.
- Acute medical physician in reach into A&E from 8.30am to 8.30pm
- 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

Prevention and Control Steering Group, Safeguarding Board, Medicines Management Committee, Blood Transfusion Committee, Organ Donation Committee, Health and Safety Committee, 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 Plan, 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.
- 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.
- Due to sustained and increased unscheduled attendance and admission, twice a day IMT meetings have been stood up along with daily meeting with Place based partners and stakeholders. These meetings will be managed according to the OPEL level declared by the organisation
- 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 have now been identified and included in the update Patient Safety Incident Response Plan due to be approved at Quality Committee on 1st November.

Specialist support, policy and procedure setting, oversight responsibility:

- Integrated Care Board (ICB) have confirmed their contract requirements in relation to Quality reporting. Internal systems have been updated to ensure timely data and exception submission. First submission completed at the end of Q2.
- ICB has split the assurance and safety functions with new leadership and focus.
- Monthly Quality Review Meetings with ICB Quality Team have recommenced
- Maternity and Newborn Safety Investigations (MNSI) (formerly Health Safety Incident Board) 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.
- Regular meeting with Specialist Commissioner for tertiary services (Vascular, HPB, Neonates)

Independent challenge on levels of assurance, risk and control:

- Annual organisational appraisal report.
- CQC inspections and preparation/evidence gathering ongoing.
- The Internal Audit Plan for 2023-24 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 provided to the Quality Committee.
- 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	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. Patient safety specialists are working with Deputy Director of HR to integrate staff safety metrics alongside patient safety.	A

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					PSS Summit held in June 2023 following a number of Never Events and focused on receiving staff feedback on ELHT safety culture and 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. Domestic Abuse and Sexual Violence workshop attended by Deputy Chief Nurse and Executive Director of People and Culture in October 2023, with a Trust meeting now in the calendar to commence the resultant work.	
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 2023~~ ~~IT have suggested a date of the end of October 23 for implementation of Radar as a result of the new EPR rollout.~~ Further delay in implementation due to lack of resource	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. The Trust continues to pay for both the Datix and Radar licences which is a continued cost pressure for the Trust. IG issues continue to require clarification from the Chief Information Officer 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 and needs to be extended to March 2024 to support implementation of Radar. The new RADAR system is now due to be launched 1st April 2024.	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. Increased requirement to manage patients who require detention under section 5.2 of the MHA, or who display challenging behaviour	Continued working with Integrated Care System (ICS) partners to commission mental health provision (refer to BAF 4) 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/ 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. October 2023	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 took place in October 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. 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. Next update to the Board in January 2024	A
5	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~~ January 2024 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. 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 – preparations at Trust level are ongoing.	G
		b) Introduction of Liberty Protection Safeguards. (LPS)	Executive Director of Nursing/ Executive Medical Director	This date has been removed and there is no further date for implementation confirmed.	Awareness raising ongoing. Potential significant workload associated to cover approx. 260 annual applications. The impact of LPS remains unknown. 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. An announcement was made on 05.04.2023 that the implementation of LPS would be delayed 'beyond the life of this Parliament'. As a result, all internal and external local and national working groups have been stood down for the immediate future.	G

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
6	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.	Project Lead and the Trust's Communications Team have created a draft website in respect of communication package to support the implementation of PSPs. 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. Patient Experience summit content yet to be agreed, summit date may need to be pushed back to late November or February 2024. Funding for the PSPs needs (including how many we can employ) to be agreed with Finance department.	G
7	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
8	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. Impact on the Trust's financial trajectory, patient and staff wellbeing, cancer waiting times, 65 week waits training of junior doctors.	A

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

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

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

Strategy: Clinical Strategy & Operational Strategy

Links to Key Delivery Programmes: Elective and Emergency Pathway Improvement

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

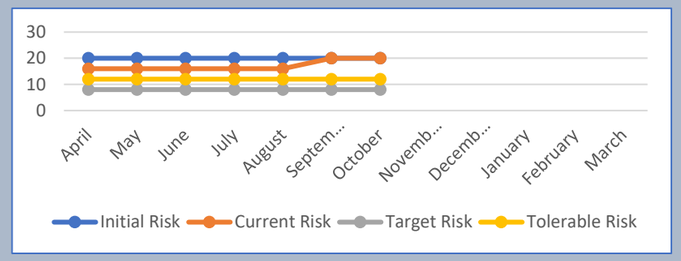
Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register

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

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

Current Risk Rating: **C4 x L5 = 20**
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).

Overall planning and delivery processes:

- Robust annual planning processes and review processes in place to continually assess clinical and operational demand and capacity across all specialities, modalities and points of delivery.
- 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.
- 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 Urgent and Emergency Care Delivery Board (UECDB)) for urgent and emergency care (UEC) in place. Further work around primary care access needs to be confirmed from place leads/ICB, work is being carried out around priority wards and integrated neighbourhood care.
- 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.

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

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

- The Trust met its trajectory to achieve the target in relation to 78-week waiters by 31 March 2023. There is further focus on preventing build up and reduction of >65 weeks in 2023/24 towards eliminating over 65 week waits by March 2024.
- Clear trajectories for other key targets for Referral to treatment times, 4-hour UEC target, Cancer, Diagnostics and activity levels in place and monitored via reporting to weekly operational team meeting, executive team meeting, senior leadership group.
- Site meetings 7 days a week ensuring timely escalation of delays (potential and actual) with corrective actions.
- Mobilisation of 24/7 IHSS service complementing the 24/7 ICAT service and Monday to Friday between 8am – 4pm for the ED front door team.

Specialist support, policy and procedure setting, oversight responsibility:

- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital.
- Cancer Alliance support on focussed areas requiring improvement.
- Integrated Performance Report and remedial and improvement plans reviewed at Senior Leadership Group, Quality Committee, Finance and Performance Committee and Trust Board.
- Lancashire and South Cumbria oversight and co-ordination via Elective Activity Co-ordination Team, Elective Care Recovery Group, Lancashire and South Cumbria Chief Operating Officers meetings.
- In relation to the requirement for 6-week diagnostic performance to be at 95% by March 2025, trajectories in place 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 UECDB 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.

Independent challenge on levels of assurance, risk and control:

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

Operational Management processes: • Active implementation and monitoring of elective improvement plans for 2023/24, diagnostic clearance plans and OP booking to ensure effective support for delivering the overall plan. We are refreshing the recovery plans to take into account the impact of industrial action, Cerner implementation and essential theatre lifecycle work • Successful implementation of waiting list validation (including chatbot) in place with value for money alternatives being explored. Validation status being monitored on the national metrics ensuring 12-week cycle. • 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. • Fortnightly Emergency Care Improvement Programme (ECIP) being refocused to support UEC improvements. • 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. • 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. • Winter arrangements will consider a further escalation bed once the fire prevention works is completed and the Heart Centre is in place. Oversight arrangements: • Refreshed Outpatient improvement boards chaired by Executive Director of Service Development and Improvement • Weekly operational meetings to monitor progress against KPIs, chaired by COO /Deputy COO. • Monthly outpatient steering group chaired by the Executive Director of Service Development and Improvement overseeing outpatient improvement plan with Patient and Public Panel representatives. • 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.	• Delivery of trajectories are monitored at ICB level through the meetings • 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.

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 107% of 2019/20 activity.	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), EPR roll-out, and essential theatre lifecycle work.	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
					All controls are being applied, but a lack of workforce due to industrial action and clinical teams familiarising themselves with the new EPR is impacting the performance. Executive Director of Service Development and Improvement leading work to optimise the application of Cerner in outpatients.	
2	Diagnostic clearance to 95% of patients receiving a diagnostic test within 6 weeks of referral 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 has been impacted by the implementation of Cerner, with booking being particularly affected. There is an Executive Director led weekly meetings in place to address this and an improvement has been held during October 2023. 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 November 2023 meeting as there was a focus on non-elective recovery at the October meeting).	A
3	Increased >62-day backlog	Joint work with the Cancer Alliance on improvement Continued Tumour site level detail to prevent backlog Continued transparency of backlog delays at tumour site level for targeted preventative interventions Refresh of the cancer action plan to focus on delivery of faster diagnostic standard, 31 and 62-day standards.	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 tele-dermatology service and embedding FIT for colorectal referrals. Achieving trajectory for faster diagnosis standard, developing a trajectory for 31-day standard and working to get back on trajectory for 62-day standard and exploring external support.	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	December 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.	A
5	Maintain capped theatre utilisation at a minimum of 85%	Performance oversight and support Sustain improvements in achieving specialties and intensive support for other specialties	Chief Operating Officer	December 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. Due to cerner implementation we have not got theatre utilisation data; however we continue to work with colleagues at GIRFT to correct this and ensure that the improvements previously put in place are embedded.	**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
6	Continued risk of >78 week RTT breaches and risk of not delivering < 65 week maximum wait by March 2024.	Demand and capacity at specialty review completed with improvement actions Consultant and 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	March 2024	Nil >78-week breaches between March and July 2023. There have been 2 patients who have waited over 78 weeks for treatment in August 2023 and there have been no 78 week breaches since. 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 and essential theatre lifecycle works. 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. Refreshed trajectories have been developed.	R
7	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	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. Timeline moved to December as a result of LSCFT winter planning review for capacity. No further update is available at this time	A
8	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 March 2024 ~~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. Not achieved as a result of exceptional demand on ED and UC services during the months of September and October 2023. Actions in place also include extending acute physician in-reach to the ED to support post take management plans for clinical decision making and treatment. Relocation of OPRA and ED streaming to release cubicle capacity within the ED to support timely first assessments and the use of fracture clinic to support ED overflow.	A
9	Strengthen ward discharge bundle and clinical ownership for timely discharges	Embed the discharge bundle across all wards with clinical champions to promote best practice.	Executive Medical Director/ Executive Chief Nurse/Executive Director	End of March 2024 ~~September 2023~~	The discharge bundle has been introduced across all wards. Initial internal audit (draft) suggests low compliance. Plans in place to re-establish the discharge	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
		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.	of Integrated Care Partnerships and Resilience	New deadline set due to the ongoing implementation and learning from Cerner and refocusing on Everyday Matters to support safe and timely patient flow/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 now commenced in post and is supporting community bed management.	
10	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. Further plans in place for winter bed capacity within MEC. Winter plan confirms the mobilisation of a winter escalation ward (B6) at the RBTH site from December 2023. In addition, subject to Board approval a further 15 community beds will be mobilised with the transfer of the Albion Mill site from LSCFT to ELHT.	**A**
11	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 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 has met 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. No update available for the November meeting, however this will be provided at the Committee meetings at the end of November 2023.	A
12	Temporary lack of data, including theatre utilisation data as a result of the implementation of Cerner (this was an expected outcome of the implementation of the system).	As a first step there is a need to rebuild all operational reports to the previous standard, with the second stage of the work to improve upon the quality of reports.	Chief Operating Officer	End December 2023	The Trust is working with Cerner and the national teams to ensure that this is progressing at pace, weekly updates are provided by the Trust's informatics Team.	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: October 2023
ERAG: October 2023

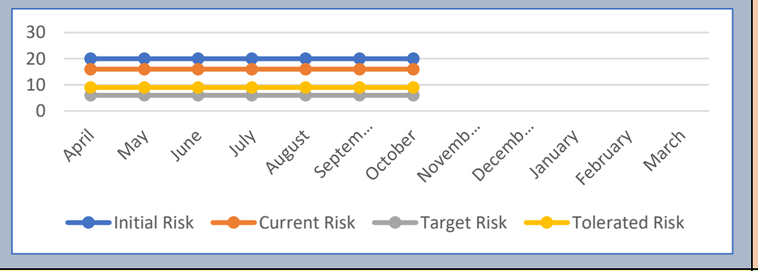
Lead Committee: People and Culture Committee

Links to Corporate Risk Register:

Risk Number	Risk Descriptor	Risk Rating
9746	Inadequate funding model for research, development and innovation	16

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)

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

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

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

- The Trust's Staff Safety Group oversees the day-to-day operational risks and interventions to ensure staff safety matters are addressed.
- Eight 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
  - Veterans
- Agreement that the Chief Executive will act as the Executive Sponsor for the BAME Network.
- Launch of Anti-Racist Framework and allyship framework during the 2023 Festival of Inclusion.
- 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.
- Included FTSU within the Trust's mandatory training programme.
- 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.
- Flexible working manifesto in place to assist staff and managers in exploring opportunities to work flexibly.
- The Trust's Leadership Forum is embedded 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 Core Management Pathway and additional leadership modules will be launched in October 2023 September.
- Reviewing Divisional workforce metrics and support through reinstated Divisional Performance Meetings.
- 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.

BAF Risk 4 – Culture Workforce Planning & Redesign

- 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. Further work will be undertaken to increase the number of agreed job plans as part of the Waste Reduction Programme.
- Medical Recruitment and Retention Steering Group
- Workforce, Resilience and Sustainability Programme established across the PCB.
- Industrial action cell established within the Trust to plan for and mitigate against the impact of proposed industrial action.
- Programme of Winter Wellbeing in place to support staff
- Culture dashboard being developed for inclusion in divisional performance review meetings and for presentation at P&C Committee.

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

- Executive 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
- ICS OD Collaborative being 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 is participating in developing the ICS Belonging Strategy.
- Recruitment, retention and staff in post data is monitored through IPR and Quarterly Workforce Report to People and Culture Committee.
- Human Resources (HR) Directors Group across the ICS inform and monitor delivery of the system level workforce agenda but also direct Trust activity where collaboration has been agreed or where opportunities have been identified.

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

- WRES and Workforce Disability Equality Standard (WDES) standards are monitored nationally and reported to the Trust Board on an annual basis.
- National Staff Survey reports and benchmarks the Trust's performance against other organisations at a national and regional level.
- Required to work within the national FTSU framework and are accountable to the National Guardian for delivery.
- Requirement to report regularly to the ICB People Board to provide assurance and address areas of challenge.
- Workforce Plan submission – there is an annual workforce plan submission to the national regulator which is triangulated internally with finance and activity data and aligned to our clinical strategy. This is monitored through the Integrated Care Board (ICB).
- Workforce Race Equality Standard (WRES) and Workforce Diversity Equality Standard (WDES) action plans with timelines in place. Regular reporting to the Board on progress. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust staff networks.
- Monitored by NHS England and the ICB on our bank and agency spend – have been identified as good practice – drives recruitment strategies for the Trust.
- Workforce Audit Plan – translates to Annual Internal Audit Plan – escalated to Sub-Committees.
- There is a Bank and Agency Oversight Group in place across the PCB to ensure delivery against the Value Stream Analysis (VSA) outputs.

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

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

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

BAF Risk 4 – Culture Workforce Planning & Redesign

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~~ January 2024	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. This item was presented to the People and Culture Committee in September 2023. The work to roll out and embed the behaviour framework is ongoing and will be continually monitored through the Trust's Culture Dashboard which will be presented to the People and Culture Committee in January 2024	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	Complete	A paper was presented to Executive Team to provide a rationale for supporting the networks with protected time and a small budget. 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. 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. The task relating to exploring protected time for the Networks has been completed but there remain outstanding actions with regard to exploring funding. At this time there is no additional funding to support this. Whilst this action is complete, there is a need to continually monitor capacity and explore all future funding opportunities.	B
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. The Trust remains on track for achievement of zero nurse vacancies by the end of July 2024 and will provide an update to the People and Culture Committee in January 2024.	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~~ March 2024	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 People and Culture Committee. The wider retention strategy requires further development and will be taken through the	G

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Executive Team and then be presented to 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. Whilst the above actions have been completed, this work is ongoing, particularly around the exploration of further flexible working opportunities and the Trust wishes to build on the learning from the National People Promise exemplars, of which LSCFT is one and this is the reason for the revised deadline.	
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 March 2024 ~~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. 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. International nurse recruitment is on target, as set out in action 3 (above) and work continues with partners in relation to other roles. It is likely, given the current levels of industrial action and future winter pressures that the timeframe for this work will move to March 2024.	A
6	Risk of staff leaving the NHS due to burnout.	Delivery of the Enhanced Health & Wellbeing offer to the ICS. Next steps are to revise the model and proposition.	Executive Director of People and Culture	End of March 2024 ~~September 2023~~	Following the exploration phase proposals to spend the £1.5m awarded to the ICS are being developed and will co-incide with the model. 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.	~~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 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. Following a review of in and out of scope services to move to One LSC. OH and wellbeing may now be part of the later phase (D3). Work continues to develop a future model. OH and wellbeing team have robust plans to support staff wellbeing through its Winter Well campaign, flu and COVID vaccination campaign. This will continue through until March 2024. Regarding the future model, the timescale is now likely to be March 2024	
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 November 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. No further update is available at this time.	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: October 2023
ERAG: October 2023

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR):

Risk ID	Risk Descriptor	Risk Score
9771	Failure to meet internal and external financial targets for the 2023-24 financial year	25

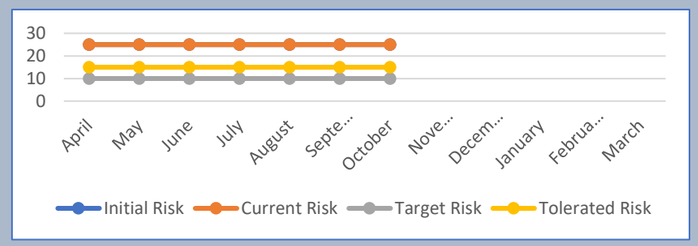
Risk Rating (Consequence (C) x Likelihood (L)):

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 in place including additional Trust level controls
- Medium term financial strategy to Finance and Performance Committee October 2023
- Financial plans for 2023-24 developed via annual planning process, signed off at the Trust Board in July 2023.
- Divisional financial recovery plans in place and overseen by the Executive Director of Finance as well as lead Directors, reviewed at Financial Assurance Board.
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations. The last review was completed in April 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.
- Trust breakeven duty not breached
- Financial plan and delivery of ongoing performance scrutinised via Finance and Performance Committee with key risks identified
- Corporate Risk Register updated for latest financial risks facing the organisation with action plans in place to mitigate risks which are regularly reviewed and updated
- Divisional, Trust wide and system Waste reduction programmes continuing to be developed, savings not fully identified.
- Additional financial controls are in place to reduce spend.
- *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. Counter fraud workplan for 2023-24 agreed.
- Mersey Internal Audit Agency (MIAA) audit of Care Quality Commission (CQC) Well-led evidence completed
- 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.

BAF Risk 5 – Financial Sustainability

	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 September 2023~~ Financial plan will not be formally agreed. Contract – end December 2023	System plan agreed internally but with significant financial risk. Plans received but not accepted/approved.. 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 ~~September 2023~~ March 2024	£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. Revised timeline due to the challenging financial situation.	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	Complete	Complete – governance through System Finance Group 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	~~BA~~
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~~ Q3 2023-24	Remains outstanding – Block contract review underway; part of financial strategy and recovery 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 September2023~~ TBC	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 An update will be provided to the Finance and Performance Committee in November/December and to the Board in January 2024	R

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **141**

8 November 2023 **Purpose** Approval / Assurance / Information

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 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	-	

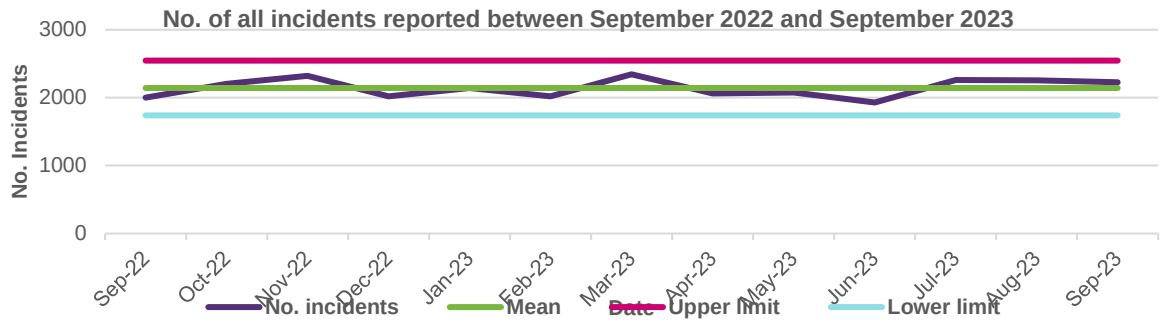
Impact

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

Previously considered by:

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 recovered in July 2023 and has stayed level. This reduction was mainly due to the impact of Cerner being launched.

1.3 There is a consistent increase in the number of incidents where a patient safety incident may have contributed to the death of a patient (see appendix A) since May 2023. This equates to a total of 14 reported incidents, of these 12 are subject to either a Trust Patient Safety Investigation or Maternity and Newborn Safety Investigation (MNIB) previously HSIB. Two incidents have since been reviewed by the complex case panel and no lapses in care or treatment have been identified.

Table 1: Breakdown of categories and location/speciality of incidents reported as Death since May 2023.

	AMU	Colorectal / return to theare	Ward D3	ED	Endocrinology	Ward B18	Neonatal ICU	Urgent Care Centre	Vascular Surgery / ICU	Total
Communication problems	0	0	0	1	0	0	0	0	0	1
Discharge or transfer problem	0	0	0	1	0	0	0	0	0	1
Escalation Area and Use	0	0	0	1	0	0	0	0	0	1
Ill health	0	0	0	0	0	0	0	1	0	1
Medication	0	0	0	0	0	0	0	0	1	1
Neonatal / NICU	0	0	0	0	0	0	2	0	0	2
Return to theatre	0	1	0	0	0	0	0	0	0	1
Slips, trips and falls	1	0	1	0	0	0	0	0	0	2
Treatment problem/issue	0	0	0	1	1	2	0	0	0	4
Total	1	1	1	4	1	2	2	1	1	14

2. Duty of Candour

2.1 There have been 34 reported incidents of moderate and above harm in August and September 2023, of which Duty of Candour applies, as set out in CQC Regulation 20. The Trust has continued to demonstrate 100% with no breaches reported.

Duty of Candour	KPI	Apr	May	Jun	Jul	Aug	Sep
No. of breaches	0	0	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 and there has been a reduction in overall management in August 2023. The KPI dashboard has been shared with Divisions who are all currently monitoring and putting actions in place to reduce the number outstanding, most Divisions are reporting that the reduction has been due to high levels of annual leave in month and therefore capacity to complete IR2s has been reduced.

3.3 The Patient Safety KPI dashboard is shared at a monthly Divisional Directors of Nursing meeting to raise awareness and escalation of areas of improvement required.

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 Patient Safety KPI target.

4.2 Three of the Division (DCS, Family Care and MEC) have stated due to system pressures and annual leave over the summer months there has been a backlog awaiting review and approval. Divisions have been asked to ensure timely reviews are completed and PSRs are 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 development as safety improvement actions. Each division provides a bi-monthly report to the Lessons Learnt Group which highlights trends/themes from PSRs, safety improvements being implemented to support the improvement in patient/staff safety.

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

5.1 In August and September 2023, the Complex Case meeting reviewed 43 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 PSII 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 September, the Trust had 32 open PSII incidents of which 5 are being investigated by MNSI formally HSIB.

5.3 There are currently 8 internal PSIIs which have been open longer than 6 months and 2 MNSI reports.

5.3.1 The Trust has no control on timescales for 2 MNSI reports.

5.3.2 The are several factors for the 8 PSII currently overdue including issues with divisional family liaison officers contacting families in a timely minor to discuss TOR, availability of staff to interview and delays in the development of safety improvement plans by Divisions.

5.3.3 7 of the PSIIs have been completed and are currently being reviewed by either Divisional Patient Safety Incident Response Groups (DPSIRG) or awaiting approval at PSIRI.

5.3.4 1 PSII relates to a complex complaint not a reported incident, the lead investigator is currently completing the draft report.

5.4 In August and September 3 PSII reports have been approved by PSIRI for closer and a further 3 reviewed but require amendments before PSIRI panel approve.

6. Never Events PSIIs

6.1 The Trust has reported no new Never Events 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) – Investigation and report completed and approved by PSIRI, division currently working on implementation of Safety Improvement Plan.*

- *Transfusion of ABO incompatible blood component – Investigation and report completed and approved by PSIRI, division currently working on implementation of Safety Improvement Plan. ELHT Patient safety alert underdevelopment regarding learning and actions.*
- *Wrong site surgery (injection) – Investigation completed; draft report been presented at PSIRI 1st November for Trust approval.*
- *Wrong Implant – Investigation completed report currently being drafted. Expected to be at PSIRI end of November for final approval.*
- *Misplaced NG Tube – Investigation completed report currently being drafted. Expected to be at PSIRI end of November for final approval.*

7. PSIRI Panel Approval and Learning from Reports

7.1 During August and September 2023, 3 new PSII reports were presented at the Trusts PSIRI panel. Of these all required minor amendments of either the report or the safety improvement plans.

7.1.1 Incident resulting in death (eIR1234203) - The report highlighted opportunities to:

- improve safety netting process for patients where cancer is not considered likely with speciality level oversight.
- Improve the surgical booking systems to ensure patients cannot be booked onto the incorrect pathways.
- Improve the pre-operative appointment process checks and pre-operative patient review process by anaesthetic staff.
- Improve escalation processes when the service experiences delay in cancer pathways.
- Review and implement cancer performance monitoring and escalation policies and processes, in line with all current relevant national cancer targets.

7.1.2 Internal transfer of patient from ED to other areas of the Trust (eIR1240804) – The areas highlighted for improvement were:

- Review process in the Emergency Department for identification and preparation of patients for transfer, whilst recognising the balance

required with other pressures in the service, maintaining patient safety and providing support to staff to follow the guidance.

- Review of existing action to ensure it is achievable, relevant and provides assurance the guidance on transfers is being followed.
- Emergency Department to implement a process for monitoring the accurate calculation of National Early Warning Scores to drive improvement.
- Acute Medical Unit to review process for communication with the medical team when patients have ben escalated to the Acute Care Team.

7.1.3 Incident resulting in death (eIR1246664) –The areas highlighted for improvement in the report were:

- Emergency Department to review processes for the handover of patient information during Board Rounds, balancing the pressures on the service whilst maintaining patient safety, and ensuring that clinical factors, risk assessments and triage categories are considered, to ensure that patients are escalated and prioritised.
- Ensure that all Emergency Department colleagues are aware of triage categories and timescales, and when breached it is appropriately escalated.
- Ensure all Emergency Department equipment checks are undertaken.
- Ensure that patients and families are communicated with when investigations are ordered and why they are being undertaken.
- Emergency Department clinical and practice education continues to develop systems and processes already in place and make improvement to support timely recognition and escalation of deteriorating patients.
- Surgery and Anaesthetic Division to re-visit improvement work for the review of complex and urgent patients in the Emergency Department. The Division to ensure that colleagues are aware to raise concerns to the Consultant on call. Surgical Team to use the findings of the investigation during teaching sessions with all medical grades.
- The Emergency Department and Surgery and Anaesthetic Division to use the findings of the investigation to highlight the importance of open communication with other specialties, to ensure a wholistic and joined up approach to care and treatment takes place.

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 from across the Trust.

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 now taken place with key leads and three new local priorities have been presented at the quality community and approved:

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

8.4 On approval of the new local priorities by Quality Committee the updated PSIRP will be presented at the ICB Quality committee for their 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 see table 3:

Table 3: Patient Safety Syllabus Training (as of 19th October 2023)

Patient Safety Training Modules	Target	% of staff completed training
Patient Safety Level 1a – all staff	**Q1 = 50%**	85.5%
Patient Safety Level 1b – Boards and senior leadership	**Q2 = 70%**	65.7%
Patient Safety Level 2 – Essential to role	**Q3 = 85%**	77.6%
	Q4 = 95%	

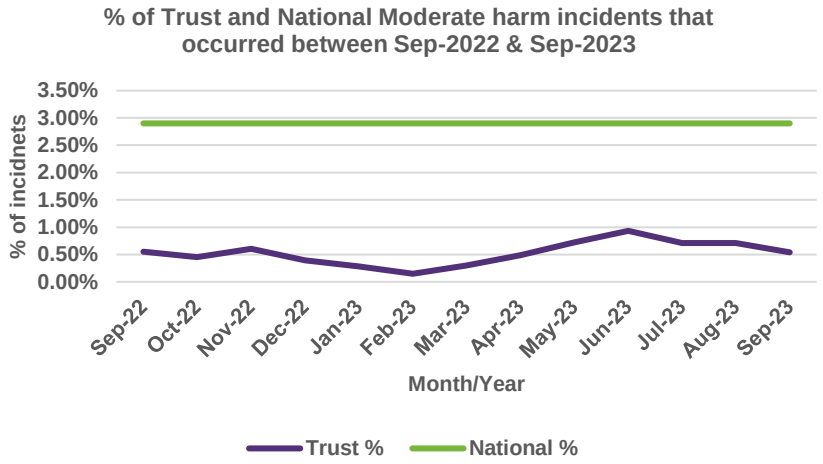
Patient Safety Level 1b training for Trust Boards and Senior Leaders (band 8a and above) has not achieved the quarter 2 target of 70%. Remember to all staff to complete patient safety training has been sent out in the Trust weekly bulletin.

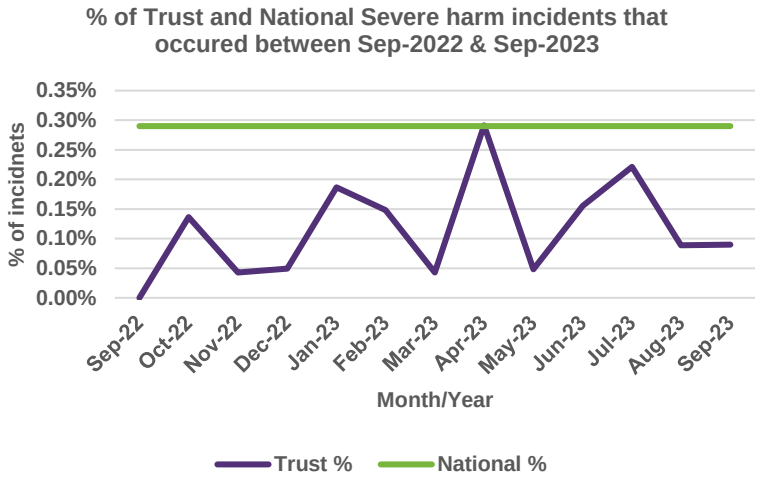
10. Maternity specific serious incident reporting in line with Ockenden recommendations

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 55 maternity related incidents have been reported on StEIS of which:

- 30 have been approved and closed.
- 15 have been agreed for de-escalation from StEIS
- 5 are currently being investigated by MNSI (previously HSIB)
- 4 are currently under investigation by the Trust.
- 1 is awaiting feedback from the Division.

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	July	Aug	Trend	Total Number IR2s open over 30 days
CIC	No. open by month	303	328	336	368	391	↑	44 (an increase of 12)
	(total no. investigated) % completed within 30 days	(245) 80.86%	(267) 81.40%	(284) 84.52%	(303) 82.34%	(348) 89.00%		
DCS	No. open by month	153	143	122	141	128	↓	123 (a decrease of 16)
	(total no. investigated) % completed within 30 days	(91) 59.48%	(81) 56.64%	(77) 63.11%	(91) 64.54%	(76) 59.38%		
FC	No. open by month	185	199	238	330	253	↑	130 (a decrease of 18)
	(total no. investigated) % completed within 30 days	(119) 64.32%	(131) 65.83%	(154) 64.71%	(225) 68.18%	(201) 79.45%		
MEC	No. open by month	998	959	796	883	885	↓	316 (a decrease of 60)
	(total no. investigated) % completed within 30 days	(751) 75.25%	(642) 66.94%	(578) 72.61%	(629) 71.23%	(624) 70.51%		
SAS	No. open by month	367	374	386	457	385	↓	329 (a decrease of 60)
	(total no. investigated) % completed within 30 days	(207) 56.40%	(213) 56.95%	(252) 65.28%	(332) 72.65%	(248) 64.42%		
Corp	No .Open by month	48	68	40	70	53	↓	116(an increase of 23)
	(total no. investigated) % completed within 30 days	(13) 27.08%	(28) 41.18%	(16) 40.00%	(34) 48.57%	(20) 37.74%		

** The best preforming division is CIC and most improved is Family Care. Corporate Services is the lowest preforming division with most incidents within Estate and Faciliates*

Appendix B: KPI Dashboards for PSRs

Division	Number of PSRs open	Jun	Jul	Aug	Sept	Trend >90
CIC	No. open	41	41	43	26	↓
	No. open more than 90 calendar days	15	5	7	6	
DCS	No. open	6	8	11	11	↑
	No. open more than 90 calendar days	1	1	4	6	
FC	No. open	28	35	33	27	↑
	No. open more than 90 calendar days	13*	13*	14*	15*	
MEC	No. open	83	118	135	157	↑
	No. open more than 90 calendar days	25	25	36	39	
SAS	No. open	44	49	41	49	↓
	No. open more than 90 calendar days	1	9	12	11	

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

Appendix C: 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	21	22				138
No. incidents agreed as PSII including (HSIB/PMRT)	5 (1)	4 (0)	5 (2)	2 (0)	1(0)	5(0)				22 (3)
No. over 6 mths	N/A	N/A	3	6 (2)	10(2)	10(2)				
Total No. of PSIIs Open	N/A	N/A	30 (6)	29 (5)	29(5)	32(5)				
No. approved/closed by PSIRI	0	4 (1)	3 (1)	3 (1)	1(0)	2(0)				13 (3)

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **142**

8 November 2023 **Purpose** Approval / Assurance / Information

Title	Maternity and Neonatal Services Update
Report Author	Tracy Thompson, Divisional Director of Midwifery and Nursing (Maternity Safety Champion)
Executive sponsor	Peter 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 (NHSE) – 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.
- Note the report and any barriers that may impact on the implementation and longer-term sustainability plans for delivery aligned with the maternity and neonatology safety ambition.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and 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:

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.

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	Progress update to present & Comments
1. Perinatal Mortality Review Tool (PMRT)		Compliant – Q2 Report submitted, as below.
2. Maternity Services Data Det (MSDS)		Compliant and Complete. July data submitted and as per publication of the scorecard in October – all areas passed.
3. Transitional Care (TC)		Compliant – Q2 TC audit progress and ATAIN report submitted, as below
4. Clinical Workforce		Compliant – Neonatal Nursing, Medical and Anaesthetic workforce reviews to be submitted to January Trust Board
5. Midwifery Workforce		Compliant – Midwifery staffing review Jan-Jun 2023 submitted to September Trust Board. Jul-Dec review to be submitted to January Trust Board.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		Compliant –Implementation is progressing well and on track for compliance required by February 2024.
7. MNVP User Feedback		Compliant – East Lancashire MNVP meeting took place in October 2023 and minutes/ outcomes will be shared once received from HealthWatch.
8. Training		Core competency framework version 2 local training plan is underway, to be submitted to January Trust Board.

		Anaesthetic compliant with PROMPT training currently at 69% - this needs 80% compliance for CNST
9. Board Assurance		Compliant – PQSM Minimum Data Set is submitted within the update to inform Trust Board discussion.
10. HSIB / NHS Resolution		Compliant – Tracker of cases to be reported held with Governance team.

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 [as of 24.10.2023]

* 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 month has been reached.

**Please note the 'reports not due' section beneath each compliance figure to ascertain if the compliance % is yet to increase due to further cases in that month yet to reach deadline.

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	Thresh	Jun-	Jul-	Aug-	Sep-	Monthly Trend
SAFETY ACTION 1	PMRT01a	Total Number of Stillbirths (= 24 weeks)		3	2	1	1	
	PMRT01b	Number of Neonatal Deaths		2	2	2	0	
	PMRT01c	Number of late fetal loss between 22+0 and 23+6 weeks		0	0	0	1	
		Total Eligible Cases		5	4	3	2	
	PMRT02a	a) i Number of cases reported to MBRRACE within 7 days		5	4	3	2	
			100%	100.0%	100.0%	100.0%	100.0%	
	PMRT03a	a) ii Number of cases with surveillance data to MBRRACE		5	4	3	2	
			100%	100.0%	100.0%	100.0%	100.0%	
	PMRT06a	c) i Number PMRT tool started 2 months		5	4	3	1	
			95%	100.0%	100.0%	100.0%	*	
	PMRT06b	Number PMRT draft reports not due		0	0	0	1	
	PMRT04a	c) ii Number PMRT draft reports by 4 months		3	2	0	0	
			60%	60.0%	50.0%	*	*	
	PMRT04c	Number PMRT draft reports not due		0	2	3	2	
	PMRT05a	c) ii Number PMRT published reports by 6 months		2	2	0	0	
			60%	40.0%	50.0%	*	*	
	PMRT05c	Number PMRT published reports not due		3	2	3	2	

For deaths of babies in June 2023, the draft report is due for completion in October 2023 (within 4 months.) As above, 2/5 cases have not been drafted in this time frame, however this will not affect the CNST compliance as these cases have been passed to HSIB for investigation or require input from another Trust. In these circumstances, CNST advises that these cases will be 'excluded from the standard validation of the requirement.'
Therefore, the compliance for eligible reports to be drafted within 4 months of death has been met for deaths of babies June 2023 at 100% according to CNST requirements.

For deaths of babies in June and July 2023, the dashboard reflects that some of the 4 month and 6 month deadlines for review draft and publication are not yet due, hense the compliance figures currently reflecting 50%, 40%, 40%. Of those which have been due, all have been met.

Further detail is 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 compliance has been met.
An action plan is in place following the reviews using the PMRT tool and can be viewed within the report.

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

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

'2) July 2023 data contained valid ethnic category (mother) for at least 90% of women booked in the month.'

'3) i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.'

'3) ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.' Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable – this is the case for ELHT Maternity Services and is reflected in the scorecard below as a rate of 0.0 and 'passed.'

The 'Clinical Negligence Scheme for Trusts: Scorecard' in the Maternity Services Monthly Statistics Publication Series published compliance with all elements of Safety Action 2 in October 2023, as below, ELHT maternity services are compliant with 11/11 Clinical Quality Improvement Metrics (CQIMs) and are compliant with the further asks of 2) and 3)i above.

Organisation Name: EAST LANCASHIRE HOSPITALS NHS TRUST
Reporting Period: July 2023
NHS England

Note: The most recent available reporting period is based on provisional data. All Provisional figures are subject to change and will be reassessed after the final submission window has closed.

1. CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	430			Passed
CQIMDQ14	480	500	96.0		Passed
CQIMDQ15	470	470	100.0		Passed
CQIMDQ16	435	470	92.6		Passed
CQIMDQ24	430	435	98.9		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	285	405	70.4	Passed
CQIMDQ08	405	490	82.7	Passed
CQIMDQ09	480	500	96.0	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	480	500	96.0		Passed
CQIMDQ11	210	480	43.8		Passed
CQIMDQ12	15	480	3.1		Passed
CQIMPPH	15	480		27	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	480	500	96.0		Passed
CQIMDQ22	470	470	100.0		Passed
CQIMDQ23	435	470	92.6		Passed
CQIMPreterm	30	470		68	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	480	500	96.0		Passed
CQIMDQ15	470	470	100.0		Passed
CQIMDQ16	435	470	92.6		Passed
CQIMDQ18	280	470	59.6		Passed
CQIMDQ20	15	265	5.7		Passed
CQIMTears	15	265		49	Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	480	500	96.0	Passed
CQIMDQ15	470	470	100.0	Passed
CQIMDQ16	435	470	92.6	Passed
CQIMDQ18	280	470	59.6	Passed
CQIMDQ26	470	470	100.0	Passed
CQIMDQ27	515	515	100.0	Passed
CQIMDQ28	180	515	35.0	Passed
CQIMVBAC	10	50	20.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	480	500	96.0	Passed
CQIMDQ31	490	490	100.0	Passed
CQIMDQ32	440	490	89.8	Passed
CQIMDQ33	490	490	100.0	Passed
CQIMDQ34	280	490	57.1	Passed
CQIMDQ36	480	480	100.0	Passed
CQIMDQ37	200	480	41.7	Passed
CQIMDQ38	490	490	100.0	Passed
CQIMDQ39	470	480	97.9	Passed
CQIMRobson01	5	60	8.3	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	55	100	55.0	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	65	80	81.2	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	515	500	103.0	Passed
CQIMDQ04	515	515	100.0	Passed
CQIMDQ05	60	515	11.7	Passed
CQIMSmokingBooking	60	515	11.7	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	475	480	99.0	Passed
CQIMSmokingDelivery	50	475	10.5	Passed

2. EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	480	515	93.2	Passed

3. MCoC i

Indicator	Numerator	Denominator	Rate	Result
COC_DQ04	510	515	99.0	Passed

MCoC ii

Indicator	Numerator	Denominator	Rate	Result
COC_DQ05	0	0	0.0	Passed

4. Provisonal Window Submission

Indicator	Result
Provisonal Submission	Passed

5. Submission Portal Registration

Indicator	Result
Registered Submitters	Passed

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 (July, August, September 2023 reviews – **Appendix 3),** and the findings inform the ATAIN action plan **(Appendix 3)** to be reviewed and signed off by the Trust Board.

'Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.'

An audit of Q1 (Apr-June) against the transitional care guidance was complete, presented to the joint audit meeting within division and actions identified. Q2 (Jul-Sep) data is under review

and will be presented to the division for consideration and identified actions on the 17th November 2023.

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

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.'

The options appraisal and action plan, as submitted to Trust Board in September 2023 has been discussed amongst the consultant body at the speciality board on the 6th October 2023. An action was taken to hold a further consultant meeting specific to discussions on this topic. Progress will be reported to Trust Board as available. **(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. Audit of September, October, and November, up to 7th December 2023 as per CNST requirements will be reported to January Trust Board.

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 100% compliance with both requirements as reflected in reports for May – September 2023.

Birthrate+ Staffing Establishment

'Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. Where deficits in staffing levels have been identified must be shared with the local commissioners'

Birthrate+ business case has been completed, submitted, and presented on behalf of the clinical triumvirate to the direct of finance and team. Review and challenge processes taken place with an ask to stratify the risks associated and timings of funding to be aligned with the ask of CNST. ELHT have a bespoke action plan to supports these findings.

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. 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.'

On the 27th September 2023, LMNS lead midwife for the implementation of Saving Babies Lives v3 conducted a quality assurance visit to establish ELHT progress. 48 of the 70 interventions across the care bundle are currently implemented, and ELHT maternity and neonatal services are at 68% implementation.

An overview of the progress with the 6 elements of SBL following the LMNS QA visits at the end of September are as follows:

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	4/10 interventions implemented and evidenced **(40%)**
Element 2 - Fetal Growth Restriction	12/20 interventions implemented and evidenced **(60%)**
Element 3 - Reduced Fetal Movement	1/2 interventions implemented and evidenced **(50%)** [1 intervention contains 4 asks)
Element 4 - Effective fetal monitoring during labour	3/5 interventions implemented and evidenced **(60%)**
Element 5 - Reducing preterm births and optimising perinatal care	24/27 interventions implemented and evidenced **(89%)**
Element 6 - Management of Diabetes in Pregnancy	4/6 interventions implemented and evidenced **(67%)**

Key points to raise within the SBLv3 interventions:

Element 1 – Reducing Smoking in Pregnancy – *'Instigate an opt-out referral for all women who have an elevated CO level (4ppm or above), who identify themselves as smokers or have quit in the last 2 weeks for treatment by a trained tobacco dependence treatment adviser (TDA) within an in-house tobacco dependence treatment service.'*

Currently at ELHT pregnant smokers are triaged and referred to Blackburn with Darwen pharmacies or if a resident out of BwD they are contacted to self-refer to Change Grow Live which is a new company that has taken over the contract formerly held with Quit Squad.

However, plan to implement an in-house tobacco dependence treatment service are underway as led by the Prevention Lead Midwife. The service will 'soft launch' in December 2023 starting with visibility in Antenatal Clinic and the family hubs in East Lancashire and Blackburn, with a plan for the full team to be live in January 2024. Interviews for the three funded band 4 maternity tobacco dependency advisors are took place on the 26th October 2023 with a plan for the full team to be in post by the end of November. The Smoking in Pregnancy guideline has been amended to reflect this change in service and is being reviewed via the guidelines group on the 3rd November 2023 to further be approved at Quality and Safety Board and circulated prior to the full launch of this service to support staff.

Element 2 – Fetal Growth Restriction (FGR) – *'As part of the risk assessment for FGR, blood pressure should be recorded using a digital monitor that has been validated for use in*

pregnancy.' The implementation tools states a requirement for 'Evidence of a plan to roll out use of digital monitors'. ELHT are in the process of formulating this action plan to demonstrate roll out.

Element 3 – Reduced Fetal Movement (RFM) – *'Information from practitioners, accompanied by an advice leaflet (for example, RCOG or Tommy's leaflet available in multiple languages) on RFM, based on current evidence, best practice and clinical guidelines, to be available to all pregnant women by 28+0 weeks of pregnancy and FM discussed at every subsequent contact.'* The Tommy's 'feeling your baby move' leaflet is within the recommended reading of every woman's Badgernotes app to access, this is available in English as well as various key languages.

Element 4 – Effective fetal monitoring during labour – *'At the onset of every labour, there is a structured risk assessment undertaken which informs the clinicians recommendation of the most appropriate fetal monitoring method at the start of labour. This risk assessment should be revisited throughout labour as part of a holistic review.'* Intrapartum risk assessment and Fetal Monitoring Review Tool both in place and audited by the Fetal Monitoring Lead Midwife.

Element 5 – Reducing Pre-term Birth and optimising perinatal care – for women identified to be potentially at increased risk of imminent preterm birth, the number of recognised optimisation interventions available and achieved are measured monthly and published to the Trust via the North West Neonatal Operational Delivery Network (NW ODN) Optimisation Report. To further support achievement of the interventions and increase compliance the Perinatal Working Group have implemented the PeriPrem Passport **(Appendix 5)** which is a 'package of care to give premature babies the best chance at birth and protect their brains'.
This is a nationally accepted tool and has been ratified for use locally via Women's Health Quality & Safety Board (WH QSB). The pilot of this tool has started at ELHT as of October 2023. Parents and families receive one version of the passport, which helps them to understand and track the care their baby is receiving. Clinicians receive another version of the passport to prompt and monitor the interventions they are giving and improve data recording and quality.

Element 6 – Management of Diabetes in Pregnancy -*'Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing*

diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements.' ELHT maternity services currently offer a one stop clinic and the minimum required roles to ensure a multi-disciplinary team are in place. The multi-disciplinary team are collaborating to review current clinic models and develop plans to see lower risk patients in separate clinics from those with complexities.

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

There are three key asks of this safety action within CNST Year 5. This relates to:

i) Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the delivery plan and MNVP guidance.

A full update of progress with liaison with MNVP to hear service user voices and to co-produce improvements has been submitted to the Quality Committee 1st November 2023 **(Appendix 6)**

ii) Ensuring an action plan is co-produced with the MNVP following annual CQC maternity survey data publication.

A key theme from the CQC survey and MNVP feedback has demonstrated delays in the postnatal discharge pathway which has been discussed for feedback and co-production of further improvements at the October MNVP meeting. Minutes of this meeting will be submitted to Trust Board once received from HealthWatch.

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

Updates and assurance of this aspect are reported to the Patient Experience Group **(Appendix 7).** Points i) and ii) will be reported through ELHT Patient Experience Group moving forward.

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

The 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, this forms the basis for the development of ELHT Maternity services local training plan, which will be presented to Trust Board in January. Attendance to required training sessions continued from Version 1 of the framework continue to be monitored against the 80% attendance compliance requirement. Escalation has been made with regards to Anaesthetic training compliance for the PROMPT training sessions, this is currently at 69%.

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?

'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:

Perinatal Quality Surveillance Dataset

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

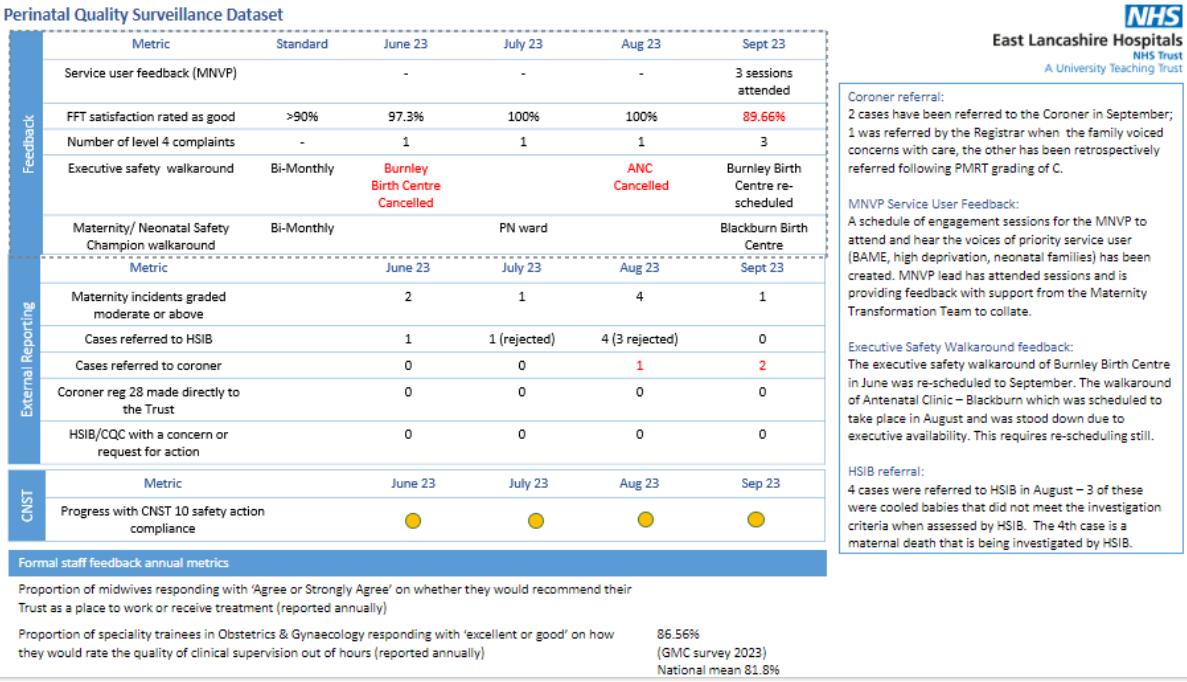
CQC Metric Ratings	Overall	Safe	Effective	Caring	Well led	Responsive
	Good	Good	Good	Good	Good	Good
On the maternity improvement programme?		No				

	Metric	Standard	June 23	July 23	Aug 23	Sept 23
Perinatal Data	1:1 care in labour	100%	100%	100%	100%	100%
	Stillbirth rate	<4.4/1000	6.28	4	4	2.1
	Term admissions to NICU	<7%	7.29	5.07%	6%	5.78%
	Obstetric haemorrhage >1.5 litre	<5%	3.37%	3.07%	3.00%	3.12%
	3rd/4th degree perineal tear	<5%	2.51%	3.8%	2.8%	2.7%

	Metric	Standard	June 23	July 23	Aug 23	Sept 23
Staffing/Training	Maternity NICE red flags		1	0	0	0
	Dedicated obstetric consultant presence on labour ward	90hrs/week	90	90	90	90
	Midwife to birth ratio (establishment)	<1.28	1.27	1.27	1.26	1.26
	Midwife to birth ratio (in post)	<1.28	1.27	1.27	1.26	1.26
	Training compliance for all staff groups (CNST)	>90%	92%	94%	>90%	>90%

Stillbirth rate:
There was an unexpected spike in stillbirth numbers in June 2023 increasing our overall rate. This has stabilised in July. For assurance, once the stillbirth number is corrected (TOPFA removed) the rate is within the expected threshold. Themes and trends continue to be monitored through the PMRT process. Initial reviews of the June cases have not highlighted any immediate safety concerns.

Term admission to NICU:
The Division are aware of an increasing trend in term admissions to NICU. ATAIN reviews highlight CTG classification and documentation/communication issues as the main themes. A joint maternity/neonatology group will be looking at quality improvement projects to improve this rate. This will link in with other workstreams, including the caesarean section and induction of labour working groups.
The rate of unexpected admissions to NICU has been raised at a regional level with the neonatal ODN and will be continued to be closely monitored in the Maternity/Neonatology Governance Board.



Perinatal Quality Surveillance Dataset

	Metric	Standard	June 23	July 23	Aug 23	Sept 23
Feedback	Service user feedback (MNVP)		-	-	-	3 sessions attended
	FFT satisfaction rated as good	>90%	97.3%	100%	100%	89.66%
	Number of level 4 complaints	-	1	1	1	3
	Executive safety walkaround	Bi-Monthly	Burnley Birth Centre Cancelled		ANC Cancelled	Burnley Birth Centre re-scheduled
	Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly		PN ward		Blackburn Birth Centre

	Metric	June 23	July 23	Aug 23	Sept 23
External Reporting	Maternity incidents graded moderate or above	2	1	4	1
	Cases referred to HSIB	1	1 (rejected)	4 (3 rejected)	0
	Cases referred to coroner	0	0	1	2
	Coroner reg 28 made directly to the Trust	0	0	0	0
	HSIB/CQC with a concern or request for action	0	0	0	0

	Metric	June 23	July 23	Aug 23	Sep 23
CNST	Progress with CNST 10 safety action compliance	●	●	●	●

Formal staff feedback annual metrics	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	86.56% (GMC survey 2023) National mean 81.8%

'Evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff' Staff feedback is heard via the Executive Safety Walkarounds which take place bi-monthly and over each year cover all Maternity and Neonatal areas. Feedback is collated via the Patient Experience Team and use of Civica and themes are discussed with the Safety Champions and alongside other routes of staff feedback, such as the SCORE survey and Maternity and Neonatal Safety Champion walkarounds, inform improvements which are communicated to teams via the Maternity and Neonatal Transformation Newsletter **(Appendix 8).** Please note a number of the executive walkarounds have been cancelled with a priority of re-scheduling.

'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?

The Perinatal Quality Surveillance Model – Minimum Data Set as above contains monthly data of the number of HSIB/ MNSI cases reported and accepted or rejected. Rationale and further detail are also included within the data set for assurance and/ or discussion where needed.

Quality and Safety leads met with NHS Resolution in conjunction with the legal team on the 28th September 2023 and confirmed that to date all early notification cases have been reported through the reporting wizard as required.

3. Conclusion

On behalf of ELHT maternity and neonatology services this bi-monthly assurance report to ELHT Trust Board provides 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
October 2023

Appendix 1 – CNST-MIS Y5 Guidance

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

Appendix 2 – PMRT Q2 Report with Action Plan

PMRT Quarterly report July-Sept 23 (1

Appendix 3 – ATAIN Q2 Report & Improvement Plan

ATAIN Q2 report July-September 23 (1)

Appendix 4 – Compensatory Rest Action Plan

Public Trust Board
Report consultant rest

Appendix 5 – PeriPrem Passport

03028-PERIPrem-Ba
by-Passport-No-crops

Appendix 6 – Quality Committee Floor to Board Report (October)

Floor to Board
Quality Committee Oc

Appendix 7 – Patient Experience Group Report (August)

Family Care Peg
August 2023 3.8.23 (1

Appendix 8 – Maternity and Neonatal Transformation Newsletter

Mat Neo newsletter -
Version 3.pdf

Appendix 9 - Floor to Board Minutes

[5] 03.08.2023 -
Floor to Board.docx

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **143**

8 November 2023 | **Purpose** | Approval / Assurance / Information

Title	New Hospitals Programme Quarter 2 Board Report
Report Author	Mrs R Malin, New Hospitals Programme, Director
Executive sponsor	Mr M Hodgson, Chief Executive / Accountable Officer

Summary: The purpose of this report is to provide an update on the Lancashire and South Cumbria New Hospitals Programme for the Quarter 2 period: July to September 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 2.
- Note the activities planned for the next period.

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:

NEW HOSPITALS PROGRAMME Q2 BOARD REPORT

1. Introduction

1.1 This report is the 2023/24 Quarter 2 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. 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.

3 National New Hospital Programme

3.1 **Enabling works business case** – the Trusts were delighted to have been successful in obtaining funding to commence due diligence on the potential new sites e.g. technical ground surveys and supporting professional expertise. These works will continue for some time and will bring a greater level of certainty as to the deliverability of these sites ahead of public consultations.

3.2 **National guidance** – as part of cohort 4 of the national New Hospital Programme, L&SC NHP will be a full adopter of national guidance e.g. 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.

3.3 During Quarter 2, the L&SC NHP team have supported the national New Hospital Programme team with several data exercises including Hospital 2.0 assessment, costing approach and model and articulating benefits. These have been undertaken to support the national programme team in understanding the L&SC schemes in a greater level of detail and also to ensure a consistent approach across all new hospital schemes.. The L&SC NHP team have welcomed their continued involvement in a number of workshops focused on the development of national ambitions around Hospital 2.0.

4 Progress against plan (for the period July to September 2023)

4.1 **Potential new sites** –the L&SC NHP team has commenced significant preparatory work to appoint advisors to determine the viability of potential new sites for the new hospital builds for each of Royal Lancaster Infirmary and Royal Preston Hospital. In parallel, the Programme team will also continue to consider and assess any further sites put forward against the existing criteria.

4.2 **Public consultation planning** – L&SC NHP is working with NHS England and the national New Hospital Programme team regarding the approach to future public consultations 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. The Strategic Oversight Group (SOG) has reviewed the milestones and dependencies to deliver the public consultations and the Decision-Making Business Cases (DMBC).

4.3 **Governance** – the enabling works (due diligence on the potential new sites) have shifted the programme into a delivery mode and the governance is now evolving to deliver these outcomes. It is anticipated new arrangements will be implemented during Q3 following presentation and discussion of the proposed terms of reference with the

Trust's Board of Directors. The SOG has also reviewed and approved a revised risk management strategy and register focusing on the delivery of the programme objectives.

5 Public, patient and workforce communications and engagement

5.1 A summer series of national New Hospital Programme roadshow events visited Preston on 16 August 2023, as Government representatives arrived to discuss the next steps for building two new hospitals in the region. The roadshow event held at Royal Preston Hospital was an opportunity for Health Minister Lord Markham CBE to hear first-hand from staff and patients of University Hospitals of Morecambe Bay NHS Foundation Trust and Lancashire Teaching Hospitals 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 Lancaster Infirmary and Royal Preston Hospital 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, as well as the benefits of investing in improvements to Furness General Hospital. 94 people attended across the various sessions during the day.

5.2 Interaction with L&SC NHP digital communication channels continues to grow, with focus on driving traffic to the New Hospitals Programme website and providing information via Facebook and Twitter, with a new LinkedIn channel launched in August 2023. Social media toolkits continue to be shared with Lancashire and South Cumbria NHS Communications teams on a regular basis, with ongoing sharing of NHP content through partner channels.

5.3 The following new website content was published in Quarter 2:

- Where to build two new hospitals? (6 July 2023)
- Lancashire and South Cumbria NHS welcomes national New Hospital Programme roadshow (16 August 2023)
- Join the National New Hospital Programme patient involvement event (13 September 2023)
- The New Hospital Programme roadshow – what happened? (14 September 2023)
- Kevin McGee on the New Hospitals Programme (28 September 2023)

5.4 **Stakeholder management** – All Lancashire and South Cumbria and neighbouring MPs, Council Leaders and Chief Executives, and Health Overview and Scrutiny Committee Chairs and Members were invited to attend a roundtable discussion led by Lord Markham CBE as part of the national NHP roadshow on 16.08.23. The MP for South Ribble attended, along with Council representatives from across Lancashire and South Cumbria (with Leaders and CEOs or their deputies from Blackburn with Darwen Council, Chorley Council and South Ribble Council, Lancashire County Council, Preston City Council and Westmorland and Furness Council and Health Overview and Scrutiny Committee Members from Burnley, Chorley, Lancaster, Lancashire South East, Lancashire, Preston, South Ribble, Ribble Valley and Westmorland and Furness Council.

5.5 Members of the Programme team updated the Lancashire Health and Adult Services Scrutiny Committee on 12 July 23 and an update on the L&SC NHP was provided to Westmorland and Furness Health and Adults Scrutiny Committee on 15 September 2023 by the UHMBT Executive Lead.

6 Next period – Q3 2023/24

6.1 **Enabling works business case** - the Programme will focus on the delivering the technical assessments required for the due diligence on potential new sites. In parallel, the NHP team will progress a detailed business case regarding the potential new sites.

6.2 **Governance model** - the team will commence the implementation of the new model, delegated authorities and embed a revised decision-making matrix.

6.3 **Consultation approach** – the team will scope the tasks and resource required for future public consultations and pre-consultation engagement. This includes the overarching approach to consultation, a communications and engagement strategy and consultation and pre-consultation engagement plans. The timeline for such consultations will ultimately be determined by the critical dependencies.

7 Conclusion

7.1 This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 2 of 2023/24.

8 Recommendations

8.1 The Board is requested to:

- Note the progress undertaken in Quarter 2.
- Note the activities planned for the next period.

Rebecca Malin
Programme Director
October 2023

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **144**

8 November 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 September 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 August at 78.1%.
- Average fill rates for registered nurses/midwives and care staff remain above threshold.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) was above the 72% improvement trajectory in September and the 76% threshold at 76.1%.
- Friends & family scores remain above threshold for inpatients, outpatients, community, and maternity.
- 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 continues to show a significant reduction on pre-covid levels at 6.3%
- There were 59 Delayed discharges at the end of September, below trajectory (79).
- There were 59 operations cancelled on the day (non-clinical). This reduced on pre-covid levels.

Areas of Challenge

- There were 6 Steis reportable incidents in September. 0 of these were never events
- There were 11 healthcare associated clostridium difficile infections, 14 post 2 day E.coli bacteraemia and 8 Klebsiellas detected in month.
- There was 1 P.aeruginosa bacteraemia identified in September, bringing the year to date total to 8 vs the annual trajectory of 7.
- The Hospital Standardised Mortality Ratio (HSMR) remains 'above expected levels'.
- There was 1 maternal death in August (not previously reported).
- There were 1116 breaches of the 12 hour trolley wait standard (50 mental health and 1066 physical health).
- There were 619 ambulance handovers > 30 minutes and 89 > 60 minutes. Following validation, 42 were due to ED delays and 47 were due to non-compliance with the handover screen.
- Friends & family scores in A&E are below threshold, although low number of responses must be noted.
- Performance against the cancer 62 day standard remains below threshold in August at 76.5%.

- There were 20.5 breaches of the 104 day cancer wait standard.
- The 6wk diagnostic target was not met at 13.6% in September.
- In September, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 69,596, which is above the trajectory.
- The number of RTT pathways over 65 weeks has increased to 863, which is above the trajectory.
- In September, there were 3715 breaches of the RTT >52 weeks standard.
- In September, there were 7 breaches of the 28 day standard for operations cancelled on the day.
- Sickness rates are above threshold at 6.6%
- The Trust vacancy rate is above threshold at 5.8%
- Compliance against the Appraisal (AFC staff) remains below threshold.
- Compliance against the Information Governance Toolkit is below the 95% threshold at 94%.
- Temporary costs as % of total pay bill remains above threshold at 13%.
- The Trust is reporting a breakeven duty deficit of £23.8m for the 2023-24 financial year to date, £9.6m behind the £14.2m planned deficit, a movement of £0.3m in the month.

No Change

- The Summary Hospital-level Mortality Indicator (SHMI) has remained as expected at 1.10.
- The complaints rate remains below threshold and is showing no significant variation.
- 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	9		
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	2		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	53	34		
M124	E-Coli (HOHA)	n/a	11		
M124.ii	E-Coli (COHA)	n/a	3		
M124.iv	E-Coli cumulative from April (HOHA & COHA)	129	75		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	0		
M155.ii	P. aeruginosa bacteraemia (COHA)	n/a	1		
M155.3	P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)	7	8		
M157	Klebsiella species bacteraemia (HOHA)	n/a	5		
M157.ii	Klebsiella species bacteraemia (COHA)	n/a	3		
M157.3	Klebsiella species bacteraemia cumulative from April (HOHA& COHA)	41	25		
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	30.1		
M69	Serious Incidents (Steis)	No Threshold Set	6		
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%	97%		
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	23%		
C40	Maternity Friends and Family - % who would recommend	90%	92%		
C42	A&E Friends and Family - % who would recommend	90%	80%		
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%	96%		
C15	Complaints – rate per 1000 contacts	0.40	0.20		
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.10		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at May-23)	Above Expected Levels	109.7		
M74	Hospital Standardised Mortality Ratio - Weekday (as at May-23)	Above Expected Levels	110.4		
M75	Hospital Standardised Mortality Ratio - Weekend (as at May-23)	Within Expected Levels	107.7		
M159	Stillbirths	<5	1		
M160	Stillbirths - Improvements in care that impacted on the outcome	No Threshold Set	n/a		
M89	CQUIN schemes at risk	CQUIN schemes have been reintroduced for 2022/23			

Responsive

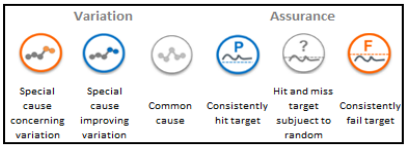
	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	76.0%	74.9%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	76.0%	76.1%		
M62	12 hour trolley waits in A&E	0	1115		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	619		
M84	Handovers > 60 mins (Arrival to handover)	0	89		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	59.5%		
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set	66.8%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	59,892	69,596		
C37.4	Referral to Treatment (RTT) 65 Weeks (Ongoing)	152	863		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	1630	3715		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	5.0%	13.6%		
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	76.5%		
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	70.3%		
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	89.1%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	100.0%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	80.8%		
C36	Cancer 62 Day Consultant Upgrade	85.0%	67.3%		
C25.1	Cancer - Patients treated > day 104	0	20.5		
C47	Cancer - % Waiting over 62 day (Urgent GP Referral)	N/A	15.30%		
C46	Cancer - 28 Day faster diagnosis standard	75.0%	78.1%		
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	7		
M138	No.Cancelled operations on day	No Threshold Set	59		
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%	6.3%		
M78	Trust level total sickness rate	4.5%	6.6%		
M79	Total Trust vacancy rate	5.0%	5.8%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	72.0%		
M80.35	Appraisal (Consultant)	90.0%	99.0%		
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%	94.0%		
F8	Temporary costs as % of total paybill	4%	13.0%		
F9	Overtime as % of total paybill	0%	0%		
F1	Cumulative variance to planned financial performance (deficit) (£m)	£0.0	-£9.6		
F2	WRP achieved YTD - variance to plan (£m)	£0.0	(£10.7)		
F3	Liquidity days	-25.8	-32.0		
F4	Capital spend v plan	85.0%	144%		
F18a	Capital service capacity	0.6	-0.1		
F19a	Income & Expenditure margin	-3.5%	-6.8%		
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%	92.9%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	96.8%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	95.4%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	96.9%		

NB: Finance Metrics are reported year to date.

KEY

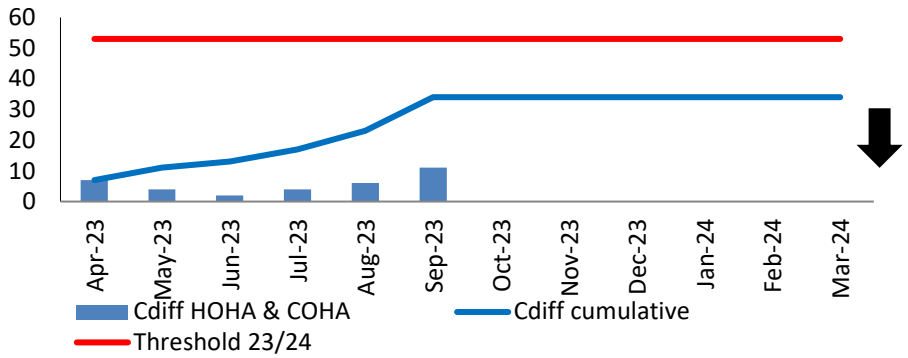


SPC Control Limits

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

SAFE

C Difficile (HOHA &



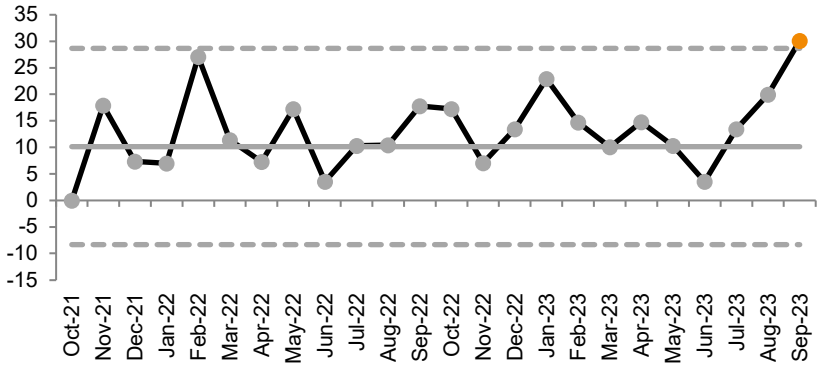
There were 0 post 2 day MRSA infection reported in September. So far this year there have been 3 cases attributed to the Trust.

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 11 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in September; 9 cases were HOHA and 2 were COHA.

The year to date cumulative figure is 34 (HOHA & COHA). The detailed infection control report will be reviewed through the Quality Committee.

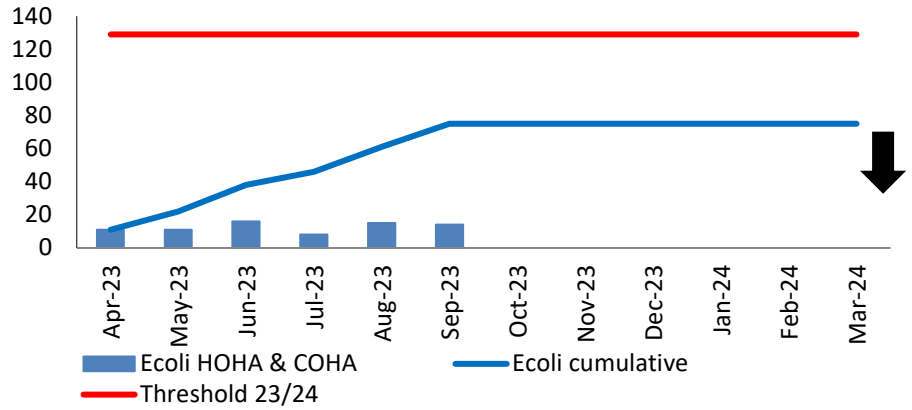
C Diff per 100,000 Occupied Bed Days (HOHA)



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

SAFE

E. Coli (HOHA & COHA)

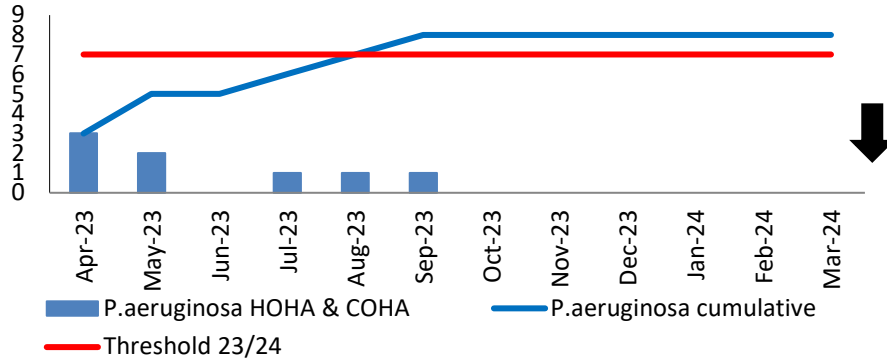


The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

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

There were 14 reportable cases of E.coli bacteraemia identified in September; 11 HOHA and 3 COHA. The year to date total is 75.

P.aeruginosa



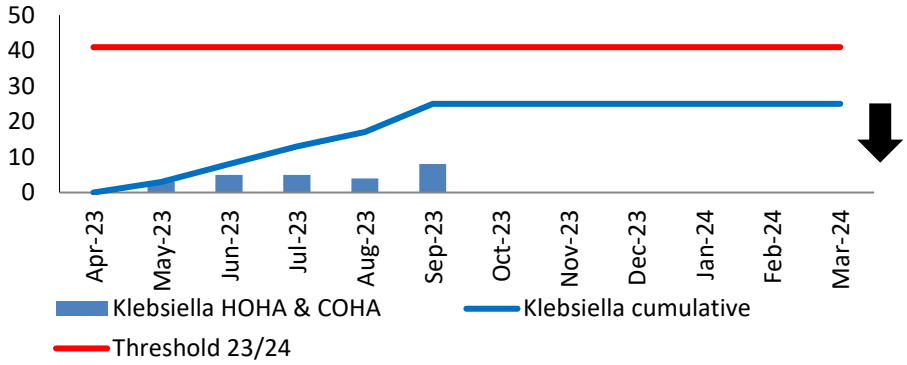
From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England.

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 September (COHA), which brings the year total to 8 vs the annual trajectory of 7.

There were 8 reportable cases of Klebsiella identified in September; 5 HOHA and 3 COHA.

Klebsiella



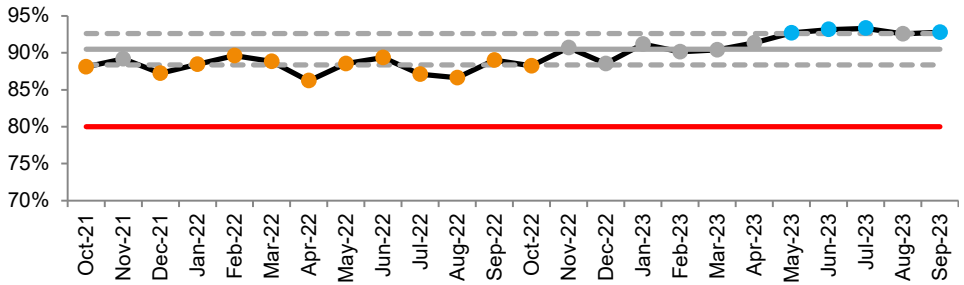
Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

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

SAFE

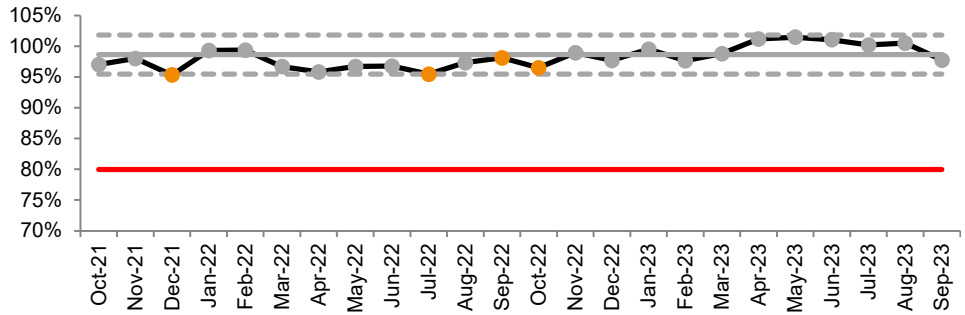
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



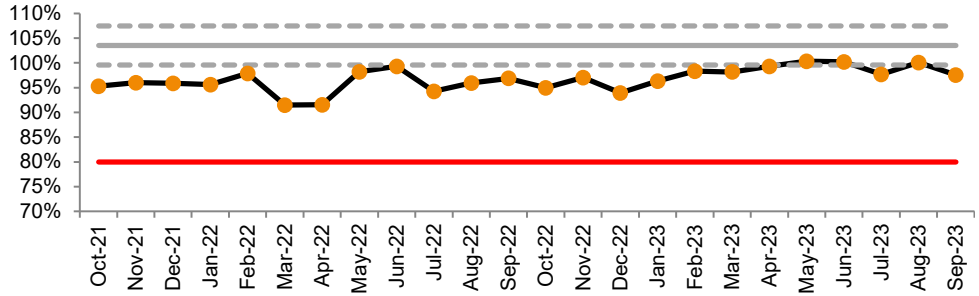
The average fill rate for registered nurses/ midwives during the day is showing improving variation when compared to the pre covid levels. Based on current variation will consistently be above threshold.

Registered Nurses/ Midwives - Night



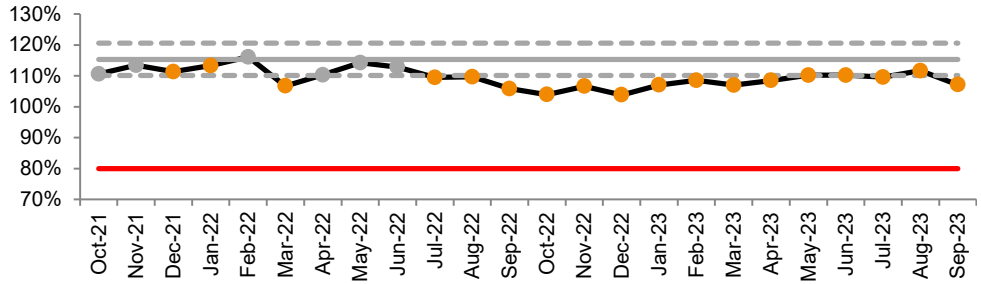
The average fill rate for registered nurses/ midwives at night is similar to pre-covid levels and based on current variation will consistently be above threshold.

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.

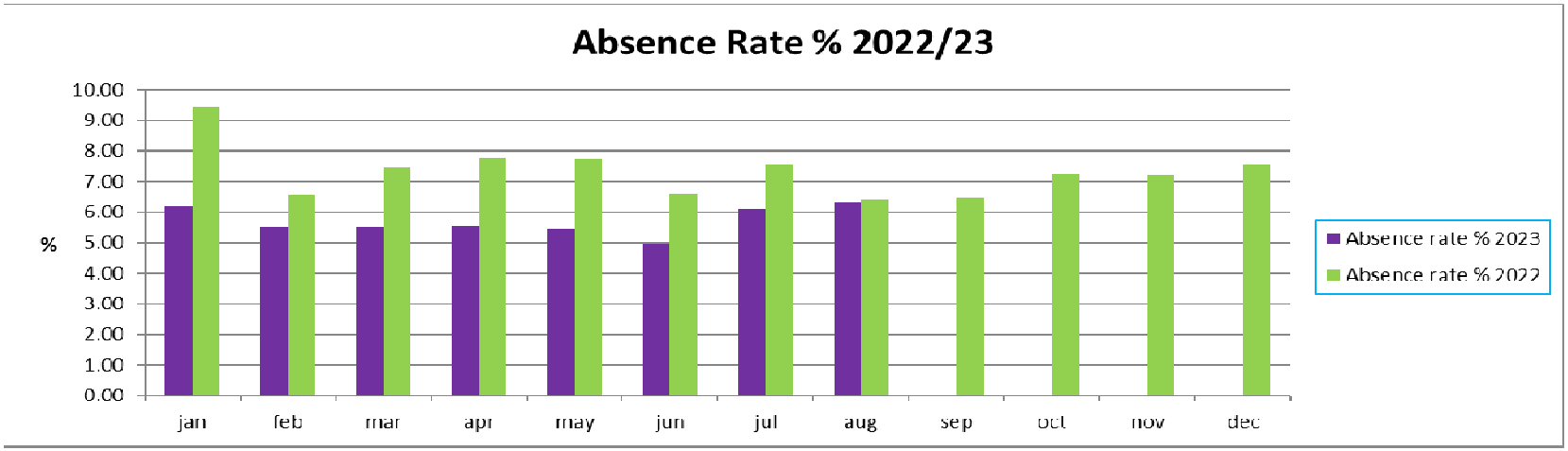
Care Staff - Night



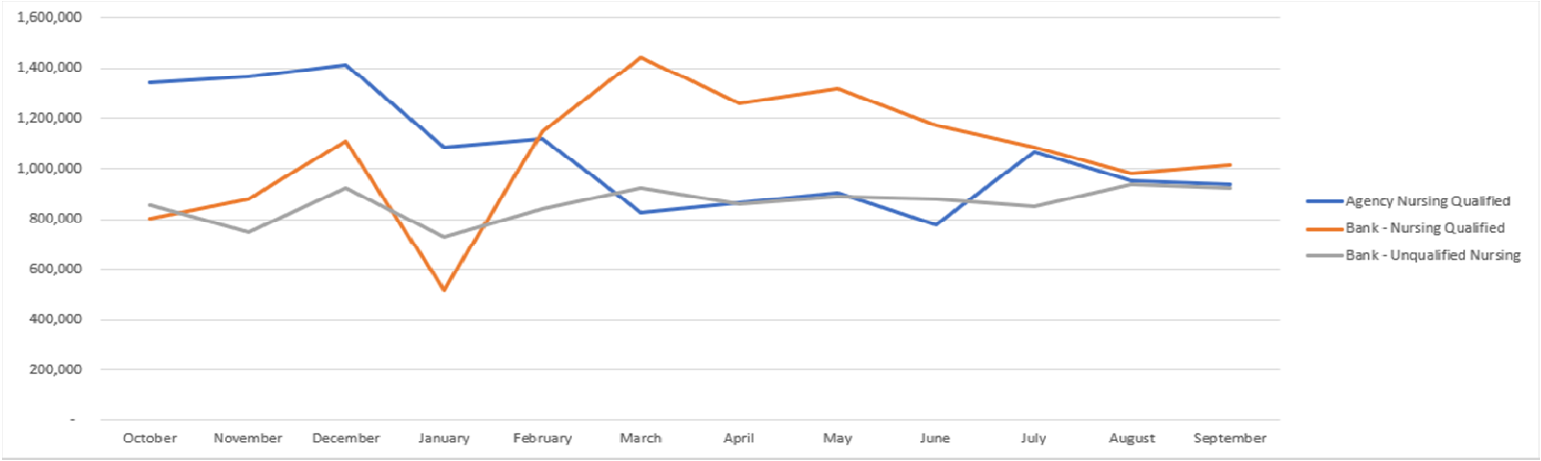
The average fill rate for care staff at night remains above threshold, however is showing a reduction on pre covid levels. Based on current variation will consistently be above threshold.

SAFE

Staffing in September 2023 remains challenging. Overall Nursing and Midwifery absence rates for September were unavailable at the time of the report. The data below shows the trends for 2023 taken from Power Bi.



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 September 2023, no area 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.

Latest Month - Average Fill Rate

SAFE

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Sep-23	92.8%	97.6%	97.8%	107.2%	29,886	8.26	0	2	2	1

Monthly Trend

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)
Nov-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
Aug-23	92.6%	100.1%	100.5%	111.7%	30,062	8.54	1	2	0	0
Sep-23	92.8%	97.6%	97.8%	107.2%	29,886	8.26	0	2	2	1

National Nursing Red Flags

SAFE

On reviewing September 2023 data there were 0 Nursing Red Flags reported

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)

8am exec call to support team working in the emergency pathway – look at activity and staffing

HCA recruitment days planned.

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 in August
20 in September

ELHT has agreed to recruit 8 international midwives. 6 have passed their OSCEs and working as qualified midwives. 2 more will arrive before December 2023

Nurse recruitment data task and finish group commenced, to agree data set and source to enable oversight of all nursing pipelines, vacancies and allocations.

Recruitment of legacy Nurse to help retain staff completed. Recruitment under way to recruit more pastoral Nurses to support our new registered

Family Care Staffing Summary – September 2023

SAFE

Maternity (Midwife to Birth Ratio)

Month	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Staffed to full Establishment	01:28	01:27	01:27	01:27	01:27	01:27	01:26	01:27	01:27	01:26	01:26
Excluding mat leave	01:27	01:27	01:27	01:27	01:28	01:27	01:26	01:27	01:27	01:26	01:26
Maternity leave	-	-	-	5.16	4.52	3.40	3.40	3.40	3.40	3.04	3.04
With gaps filled through ELHT Midwife staff bank	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage
Per week	21.74	17.99	25.73	21.54	25.71	18.25	16.77	21.58	17.50	20.74	19.14
Midwifery vacancies (Maternity VRS) -11wte	-	-	-	25 wte (11)	26 wte (11)	26 wte (11)	26 wte (11)	26 wte (11)	26 wte (11)	25 wte (11)	24 wte (11)

On reviewing Datix for September 2023 there were 21 incidents reported under the Midwifery Red Flags category and 11 under the Maternity staffing issues category. There were 0 Paediatric Nursing staffing incidents and 0 Gynaecology Nursing staffing incidents.
Midwifery red flag events (applies to Midwifery only)
A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

· Delayed or cancelled time critical activity
· Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
· Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)
· Delay of more than 30 minutes in providing pain relief
· Delay of 30 minutes or more between presentation and triage
· Full clinical examination not carried out when presenting in labour
· Delay of 2 hours or more between admission for induction and beginning of process
· Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
· Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour (National Institute for Clinical Excellence 2021

No NICE midwifery Red flags following review of the 21 incidents.
Midwifery local red flags reported as follows

Midwifery local red flags reported as follows:
Missed or delayed Care (13)
8 reported No Harm impact prevented.
5 reported No Harm impact not prevented.
These incidents reported were for wait times in antenatal clinic, missed postnatal visits, delays in receiving appointments due to Cerner IT issues and a missed blood sample.
Inability to attend rostered training (2)
2 were reported under this category both results No Harm impact Prevented.
Delayed or cancelled time critical activity (2)
1 reported for a delay in an elective caesarean section due to activity. No Harm impact prevented.
1 reported for a delay in an antenatal lady having a Bartholin's cyst excised. No harm impact not prevented.
Induction of labour outside of 4 hours (4)- induction process had commenced.
4 reports of women waiting more than 4 hours for transfer to Birth Suite for an ARM. All No Harm Impact Prevented
There was a further 12 incidents reported under Staffing issues for Maternity.
5 for staff shortages on a shift
1 staff indicated concerns due to the activity on triage and antenatal ward.
4 staff moved to other areas of work.ie closure of Birth Centres.
1 medical staff shortage in antenatal clinic impacted on midwives leaving work late.
1 missed break.
All reported as No Harm Impact prevented.

Maternity
Midwifery Staffing reviews with the appropriate risk assessments/mitigation for shortfalls remain in place x 4 daily at each safety huddle. (Additional staffing/ leadership huddles will take place in periods of extreme staffing pressures to plan accordingly within maternity services; midwives are redeployed to other areas within the services to ensure acuity and activity meets safe staffing requirements. Bank filled duties remain static as reflected and monitored in monthly figures. Local midwifery red flags noted at each handover and report reviewed weekly with governance and maternity teams. 20 midwives commencing in post 9th October will confirm WTE in October staffing report. All reflected as above in detail.

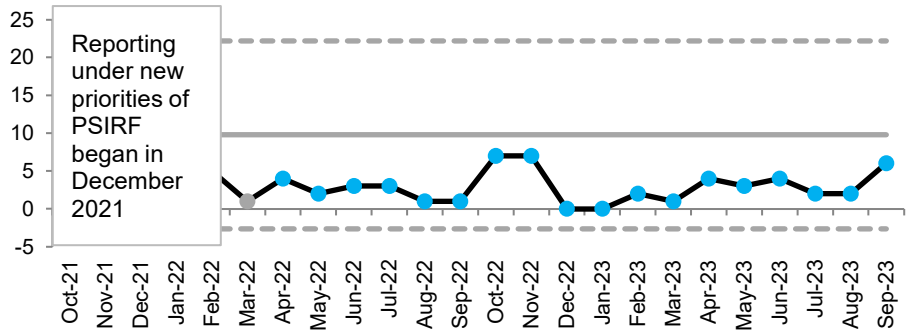
Neonatology
Acuity has peaked at several periods in September. Daily maternity/ Neonatology safety huddles inclusive of safe staffing tool completed four hourly to support QIS cover as acuity has been high for intensive and special care infants. Risk assessments prior to agency nurse cover requests to Director and Deputy director of nursing if shortfalls in QIS or nurse cover ratios are not met with bank cover.

Paediatrics – No staffing exceptions. Shortfalls reflect acuity and dependency as reflected in planned and actual

Gynaecology – No staffing exceptions/ Interim move to ward 16 at BGH due to trust fire regulation work remains in place. The work has not commenced yet, due to other issues identified within the trust. A Risk assessment has been completed cross divisionally, in draft at present. No nursing red flags reported for theatre transfers control in place.

SAFE

Serious Incidents



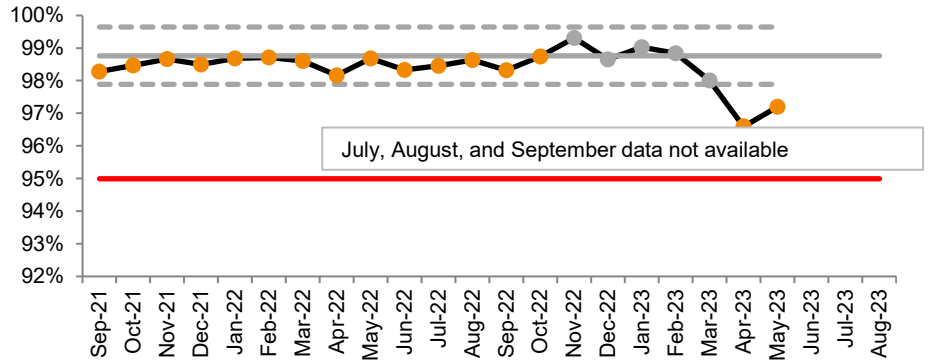
PSIRF Category	No. Incidents
National priority - Incident resulting in death	5
National priority - Maternal death	1

There were no never events reported in September.

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

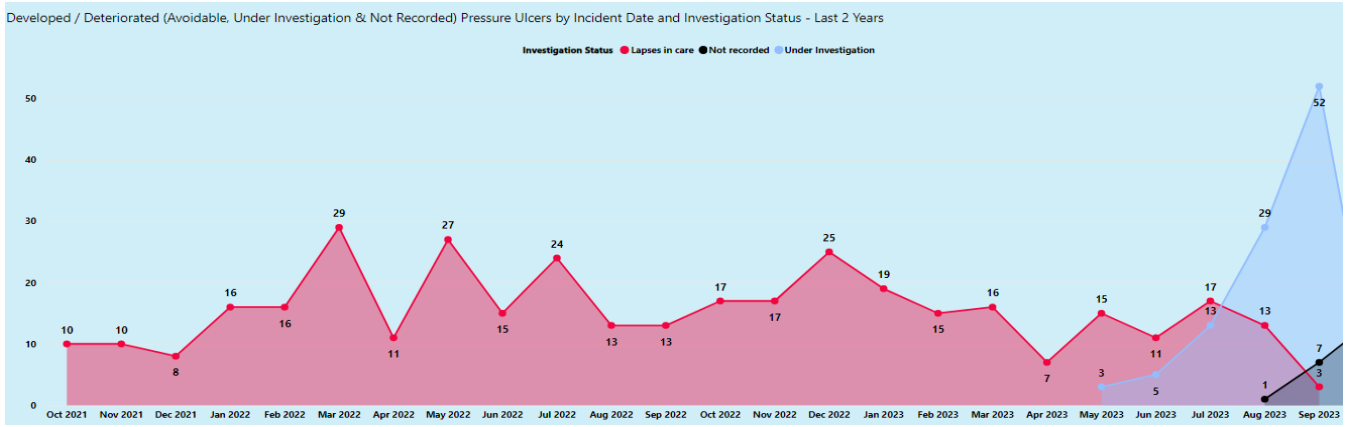


Venous Thromboembolism (VTE) assessment trend - data not available for July, August, and September.

SAFE

Pressure Ulcers

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



There have been 65 lapses in care confirmed from the 1 April 2023 however all listed patient safety reviews have not yet been heard at Pressure Ulcer Review and Learning Panels within Divisions.

There continues to be a strong focus on the prevention of skin damage across the Trust as pressure ulcer prevention needs to be everyone's responsibility. DERI are progressing with informing relevant staff of the requirement to undertake both e-learning modules following the Trust agreement to make pressure ulcer and moisture associated damage training both essential and annual which should equip staff with the right knowledge and skills.

The National Wound Care Strategy Programme has consulted and completed a pressure ulcer clinical recommendations and clinical pathway. This will now be piloted within 2 Trusts in Autumn to identify and plan what level and type of implementation support will be required to implement and embed across NHS England.

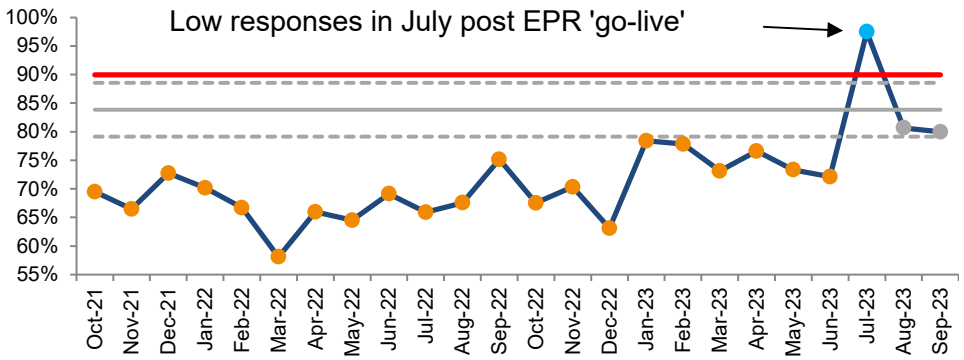
Category of Pressure Ulcer	Total Number of Lapses in Care		
	2021-2022	2022-2023	1.4.2023 – 30.9.2023
2	44	73	22
3	14	6	3
4	3	9	5
Unstageable	25	33	5
DTI	53	92	30
TOTAL	139	213	65

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.

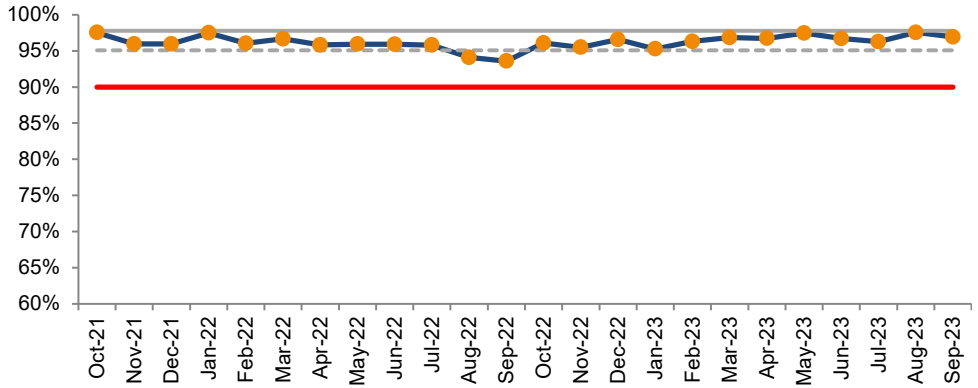
Baseline period for SPC comparison is Apr 18 - Mar 20

Friends & Family A&E



A&E scores are below threshold in September. The trend is showing normal variation when compared to the baseline (Apr 18 - Mar 20), 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.

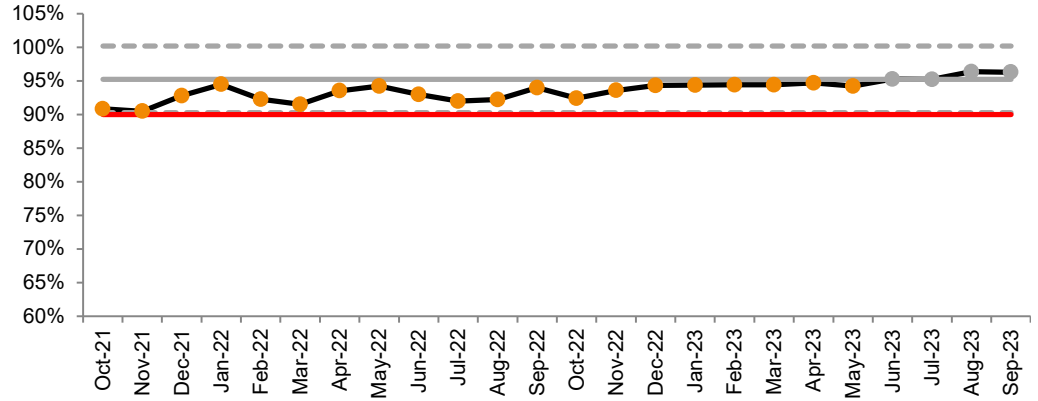
Friends & Family Inpatient



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

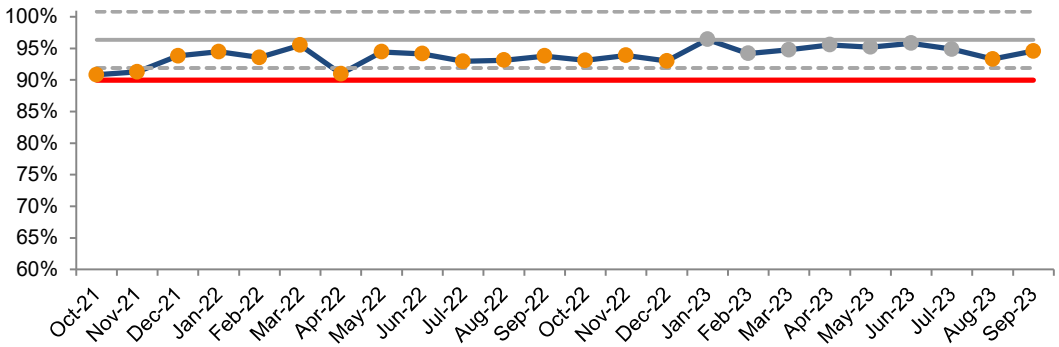
Friends & Family Outpatients



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.

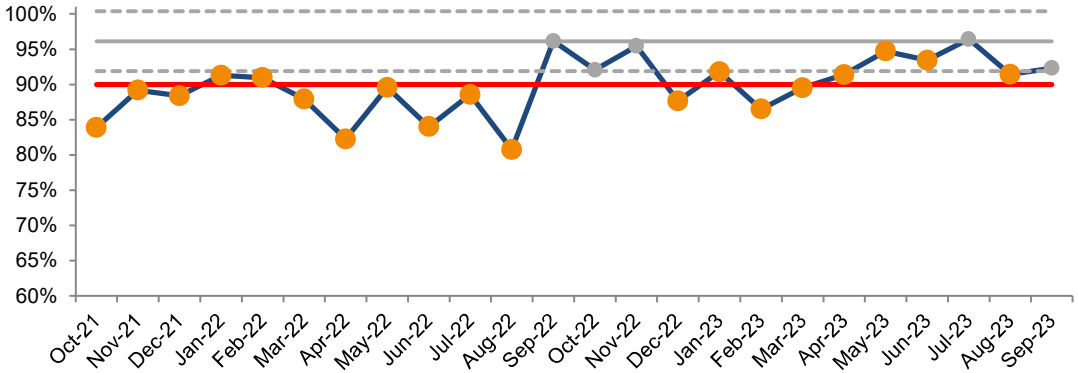
Friends & Family Community



Community scores are above target but showing deterioration when compared with pre-covid levels.

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

Friends & Family Maternity

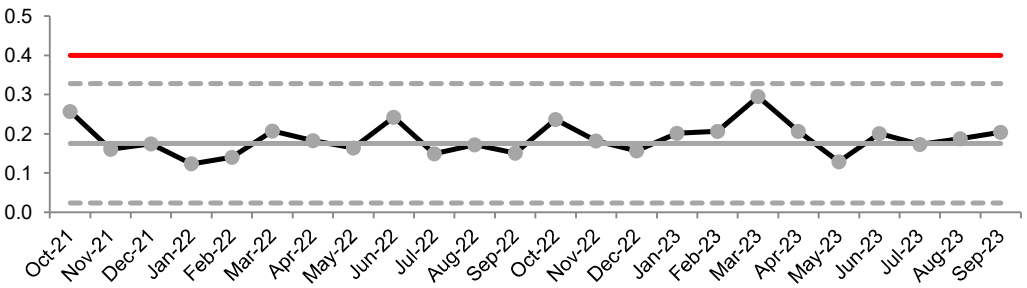


Maternity scores are above target this month and are within the normal range when compared to the pre-covid levels.

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

CARING

Complaints per 1000 contacts



The Trust opened 24 new formal complaints in September.

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

For September the number of complaints received was 0.20 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	97.13	95.15	94.84	98.24	96.04
Community	Diagnostic and Clinical Support	100	99.16	96.81	100	98.91
Community	Family Care	91.67	-	-	90.91	91.07
Community	Surgery	100	92.94	-	-	94.96
Delivery	Family Care	100	66.67	100	100	95.83
Inpatients	Community and Intermediate Care Services	90.82	84.83	89.8	90.1	88.89
Inpatients	Diagnostic and Clinical Support	98.81	86.51	84.43	93.97	90.18
Inpatients	Family Care	97.02	94.08	95.09	95.95	95.52
Inpatients	Medicine and Emergency Care	93.14	80.38	80.05	86.57	83.65
Inpatients	Surgery	93.94	89.43	90.98	92.86	91.65
OPD	Diagnostic and Clinical Support	98.1	96.49	97.12	88.97	96.22
OPD	Family Care	98.53	95	98.96	98.04	98.04
OPD	Medicine and Emergency Care	99.39	93.73	96.77	96.67	96.21
OPD	Surgery	100	91.89	100	-	95.38
Other	Surgery	85	79.17	91.67	58.33	79.41
SDCU	Family Care	97.5	96.43	97.5	96.25	97.03
	Total	**96.1**	**91.6**	**92.79**	**94.53**	**93.54**

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

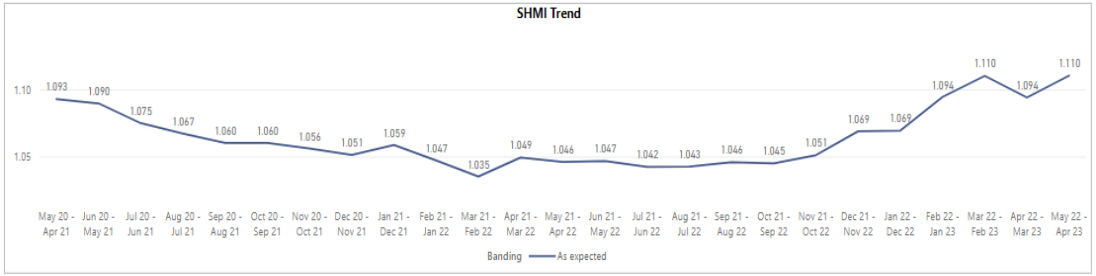
The threshold is a positive score of 90% or above for each of the 4 competencies.

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

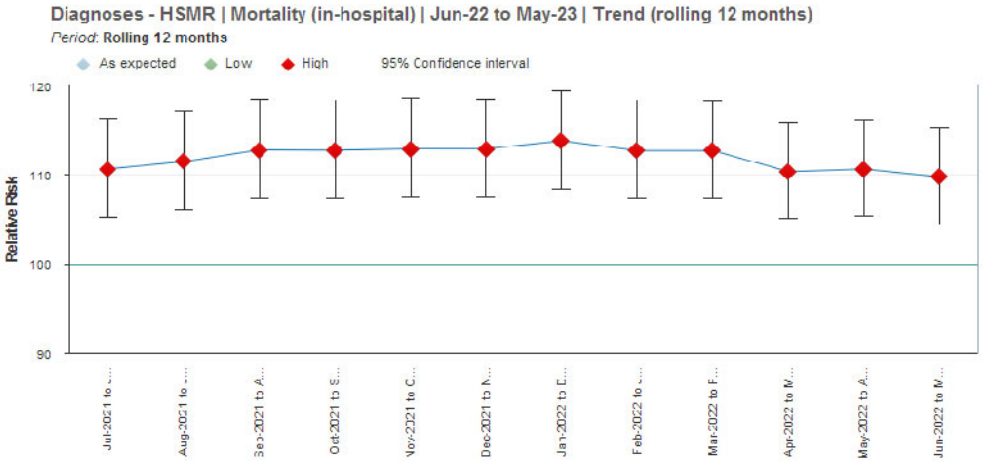
SHMI Published Trend



Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month Jun 22 – May 23
	ALL
TOTAL	109.7
Weekday	110.4
Weekend	107.7

Dr. Foster HSMR monthly trend



The latest Trust Summary Hospital-level Mortality Indicator (SHMI) value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period May 22 to Apr 23 has increased from last month, however remains within expected levels at 1.10, as published in Sept 23.

The latest indicative 12 month rolling Hospital Standardised Mortality Ratio (HSMR), (Jun 22 – May 23) has decreased from last month and remains 'above expected levels' at 109.7 against the monthly rebased risk model.

The benchmark model has been adjusted this month to account for data up to Mar 23, 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, Secondary malignancies, Urinary tract infections, Repiratory failure, Congestive heart failure nonhypertensive, Acute cerebrovascular disease and Aspiration pneumonitis.

Pneumonia, Secondary Malignancies and Cancer of bronchus, lung 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	24	12	9	8	17	13							83
Allocated for review	46	212	250	262	214	163	230	24	7	5	4	1	5							46
SJR Complete	46	212	250	262	214	162	224	15	1	3	2	0	1							22
1 - Very Poor Care	1	1	0	0	1	1	1	1	0	0	0	0	0							1
2 - Poor Care	8	19	22	34	35	22	39	4	0	1	0	0	1							6
3 - Adequate Care	14	68	70	70	65	49	73	3	1	0	2	0	0							6
4 - Good Care	20	106	133	129	103	78	105	7	0	2	0	0	0							9
5 - Excellent Care	3	18	25	29	10	12	6	0	0	0	0	0	0							0
Stage 2																				
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	40	5	0	1	0	0	1							7
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	2	0	0	0	0	0	0							0
Allocated for review	6	18	21	30	35	22	38	5	0	1	0	0	1							7
SJR-2 Complete	6	18	21	30	35	22	36	1	0	1	0	0	0							2
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0	0	0	0							0
2 - Poor Care	3	6	7	13	13	10	19	1	0	0	0	0	0							1
3 - Adequate Care	2	10	13	13	21	10	13	0	0	1	0	0	0							1
4 - Good Care	0	1	0	2	1	1	3	0	0	0	0	0	0							0
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0	0	0	0							0

	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar 20	Apr 20 - Mar 21	Apr 21 - Mar 22	Apr 22 - 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	5	4	4	16	8	0	0	0	0	0	0	37
stage 1 requiring completion	0	0	0	0	0	1	6	9	6	2	2	1	4	0	0	0	0	0	0	24
Stage 1 Backlog	0	0	0	0	0	1	6	9	11	6	6	17	12	0	0	0	0	0	0	61
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	0	0	0	0	1	0	0	0	0	0	0	5
Stage 2 Backlog	0	0	0	0	0	0	10	4	0	0	0	0	1	0	0	0	0	0	0	5

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.

There are currently 15 outstanding reviews; 8 SJR for completion, 3 SJR 2 for completion, 4 LD reviews for completion.

Deaths recorded; July -1, August - 1, September - 1.

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 2 submission is 27th November and 27th October for the PSS schemes.

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	57					
*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	86					

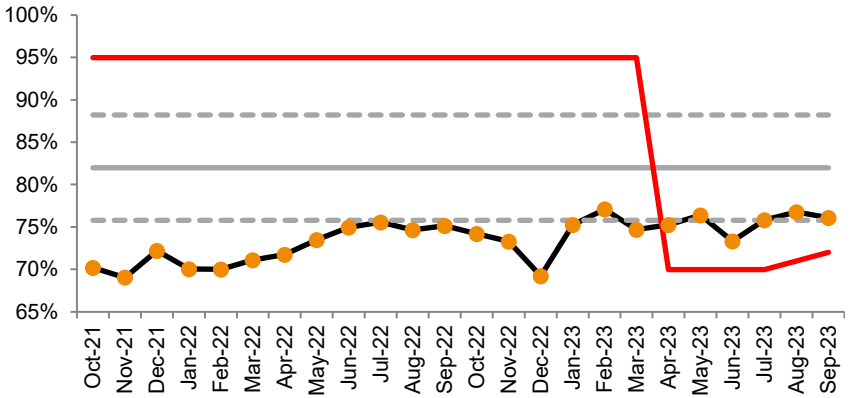
EFFECTIVE

**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	97					
**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	82.5					
**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	68					
*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

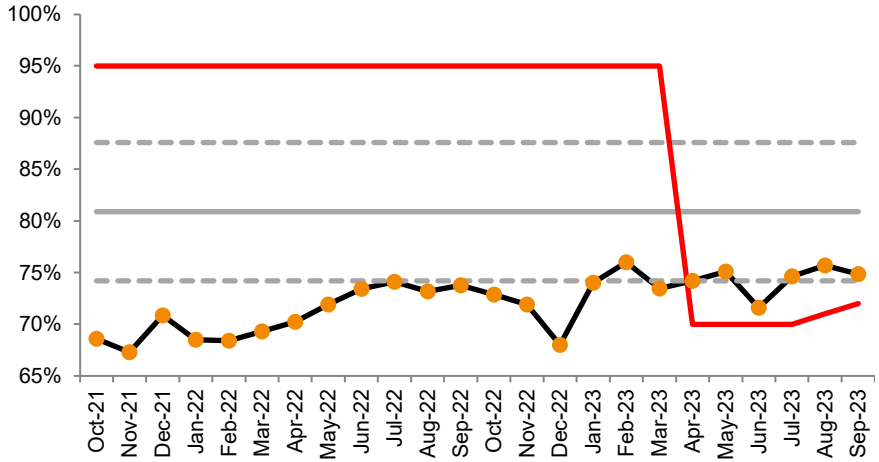
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 76.09% in September, which is above the 76% threshold and above the improvement trajectory (72%).

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

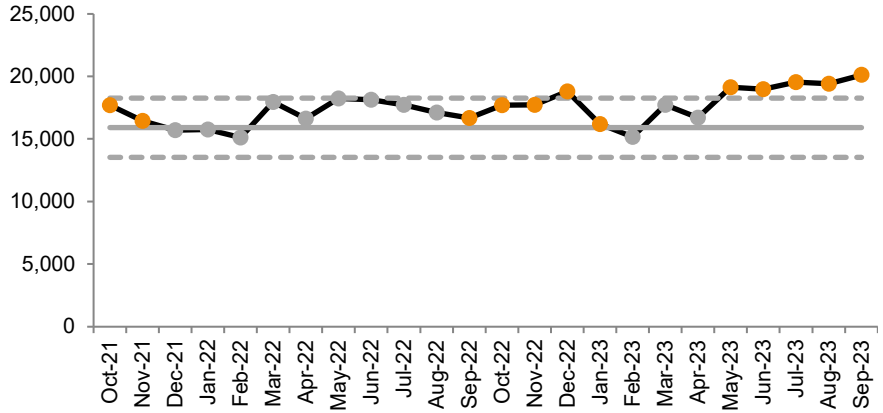
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 74.85% in September.

The national performance was 71.6% in September (All types).

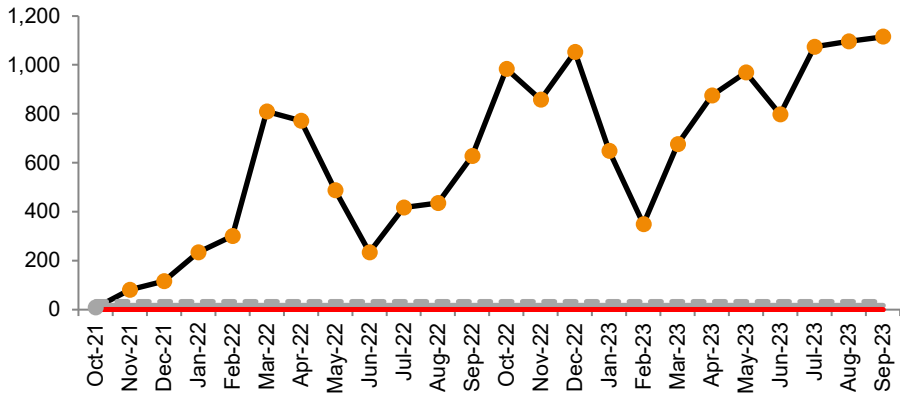
A&E Attendances - Trust



The number of attendances during September was 20,119, which is above the nornal range when compared to the pre-covid baseline.

RESPONSIVE

12 Hr Trolley Waits

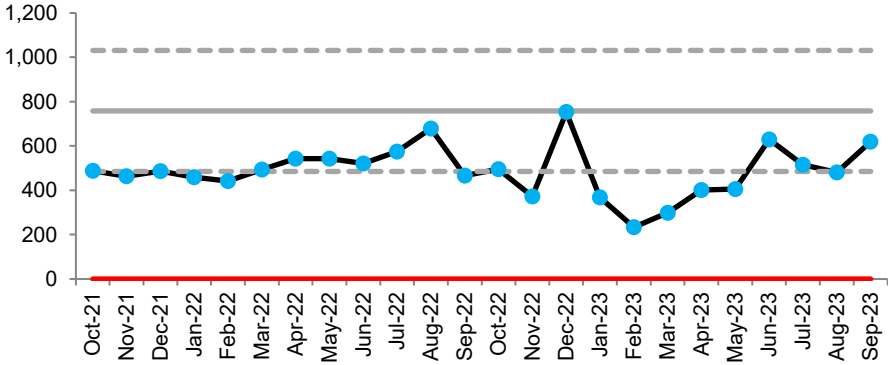


There were 1115 reported breaches of the 12 hour trolley wait standard from decision to admit during September, which is higher than the normal range. 50 were mental health breaches and 1066 were physical health.

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

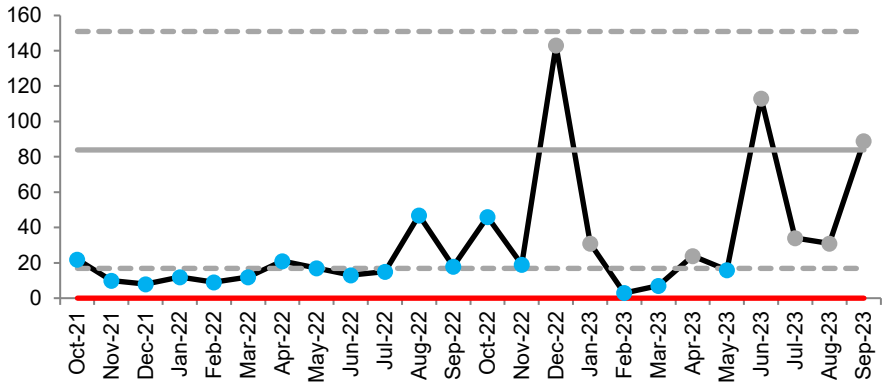
	Mental Health	Physical Health
No. 12 Hr Trolley Waits	50	1066
Average Wait from Decision to Admit	47hr 02 min	23hr 05 min
Longest Wait from Decision to Admit	143hr 54 min	51hr 55 min

Ambulance Handovers - >30Minutes



There were 619 ambulance handovers > 30 minutes in September. 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 89 ambulance handovers > 60 minutes in September.

Following validation, 42 were due to delays in ED and 47 were due to non-compliance with the handover screen.

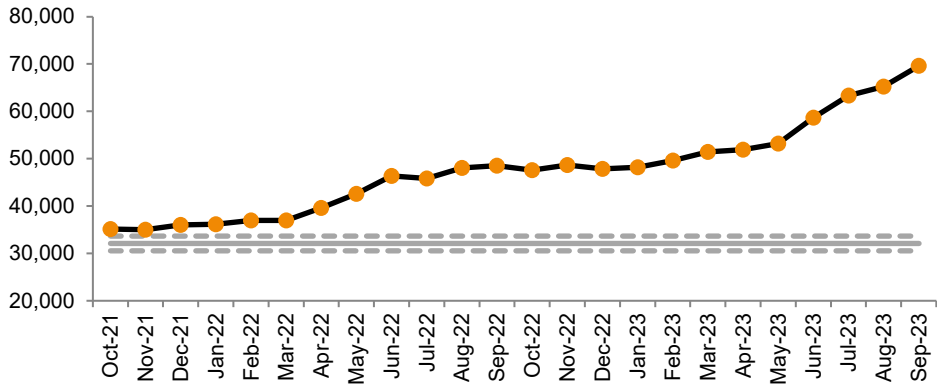
The average handover time was 27 minutes in September and the longest handover has been reported by NWAS as 6hr 50 and was an NWAS delay.

RESPONSIVE

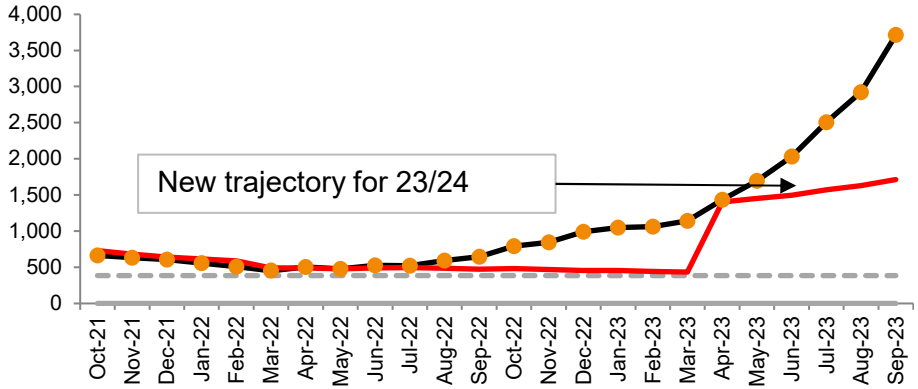
At the end of September, there were 69,596 ongoing pathways, which has increased on last month and is above pre-COVID levels.

There were 3715 patients waiting over 52 weeks at the end of September which has increased on last month and is above trajectory.
There were 863 patients waiting over 65 weeks at the end of September which has increased on last month and is above trajectory.
We are aware of a number of data quality issues impacting on performance post EPR go live, which the Trust is working on to resolve.
There were 0 patients waiting over 78 weeks

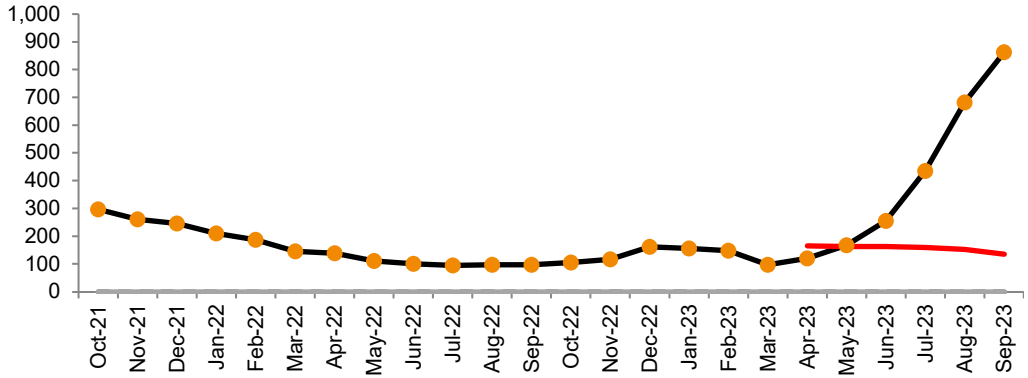
Referral to Treatment (RTT) Total Ongoing



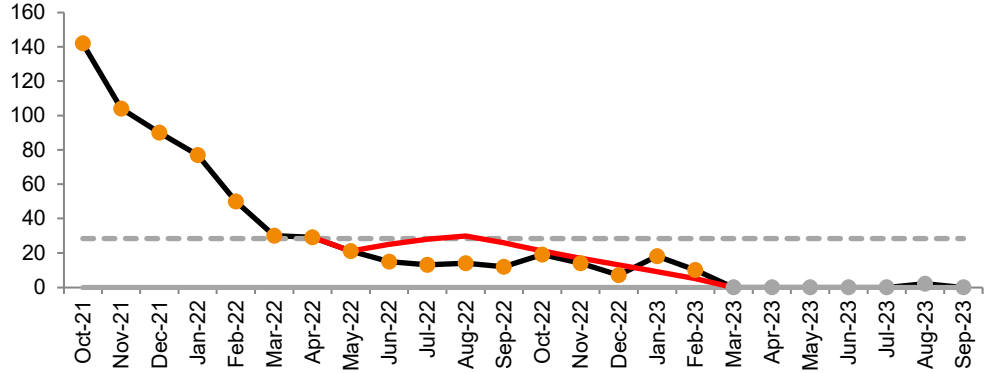
RTT Total Over 52 wks



RTT Total Over 65 wks



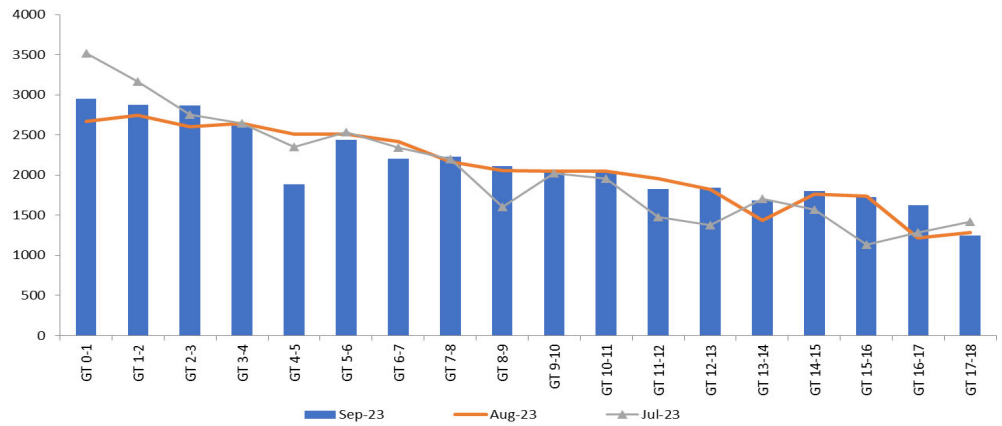
RTT Total Over 78 wks



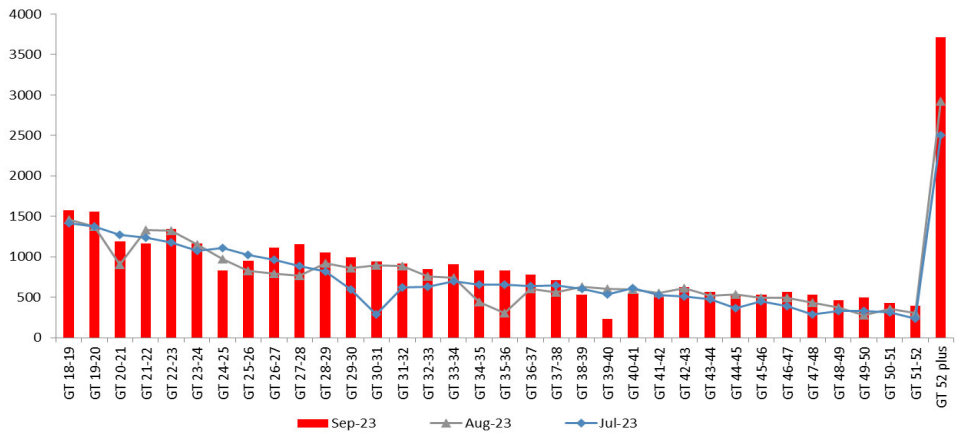
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

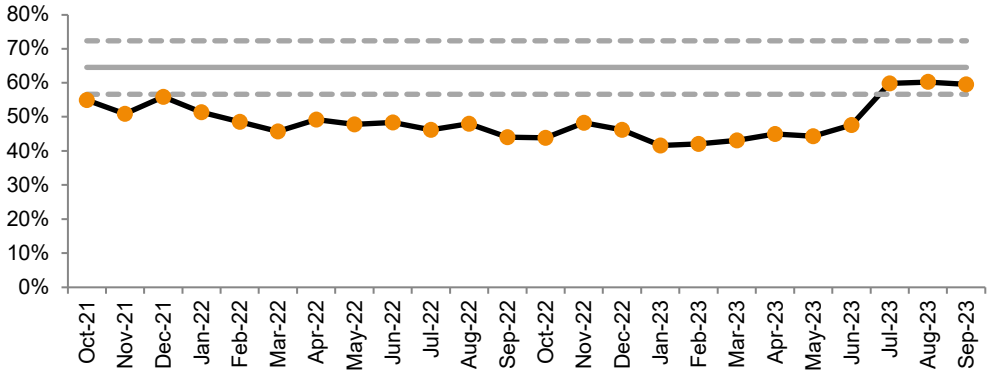


RTT Over 18 weeks

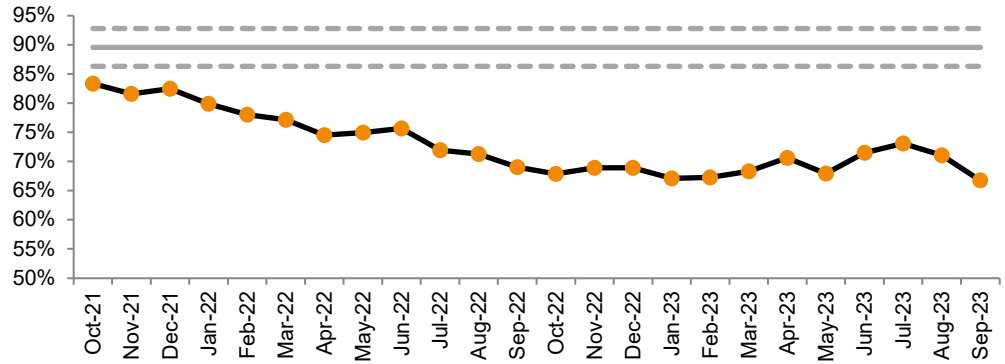


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted

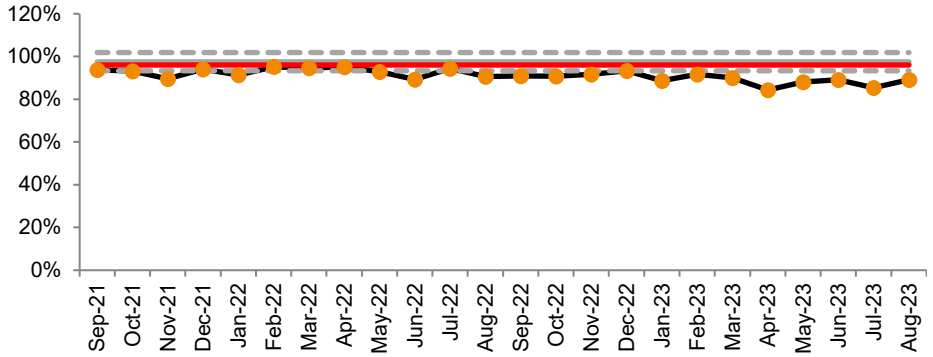


RTT Non-Admitted



RESPONSIVE

Cancer 31 day

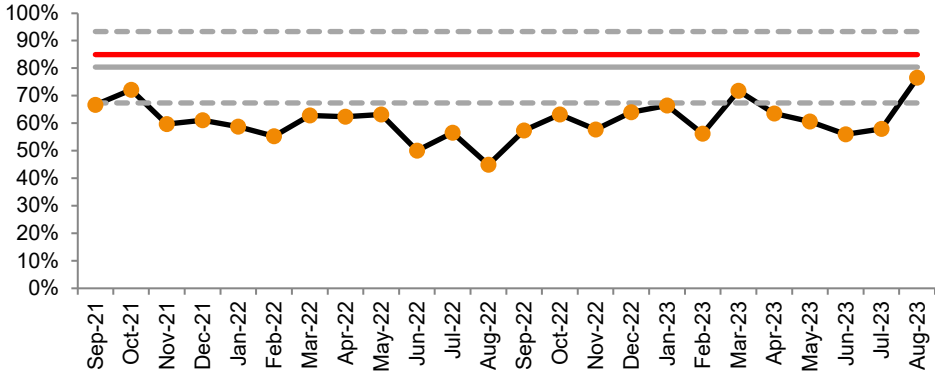


The 31 day standard was not achieved in August at 89.1%, below the 96% threshold.
National performance August - 91.0%

Q1 was not achieved at 87.2%
National performance 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

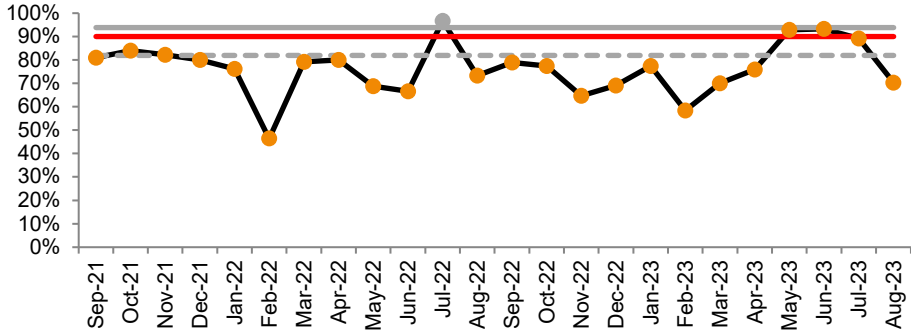


The 62 day cancer standard was not achieved in August at 76.5% below the 85% threshold.
National performance August - 62.8%

Q1 was not achieved at 62.4%
National performance 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



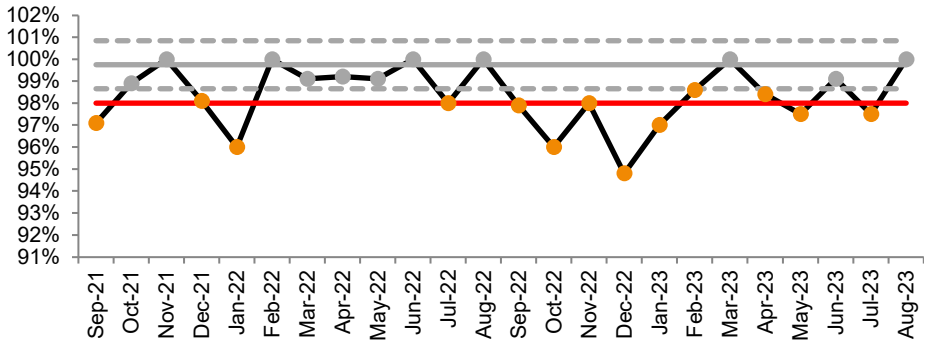
The 62 day screening standard was not achieved in August at 70.3%, below the 90% threshold.
National performance August - 65.1%

Q1 was achieved at 90.6%
National performance 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)

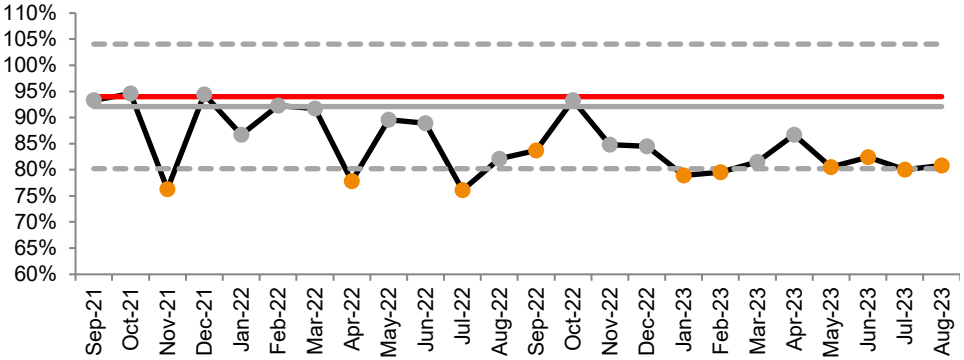


The subsequent treatment - drug standard was above target in August at 100%
National performance August - 97.7%

Q1 was achieved at 98.4%
National performance Q1 - 97.6%

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

Cancer - Subsequent treatment within 31 days (Surgery)

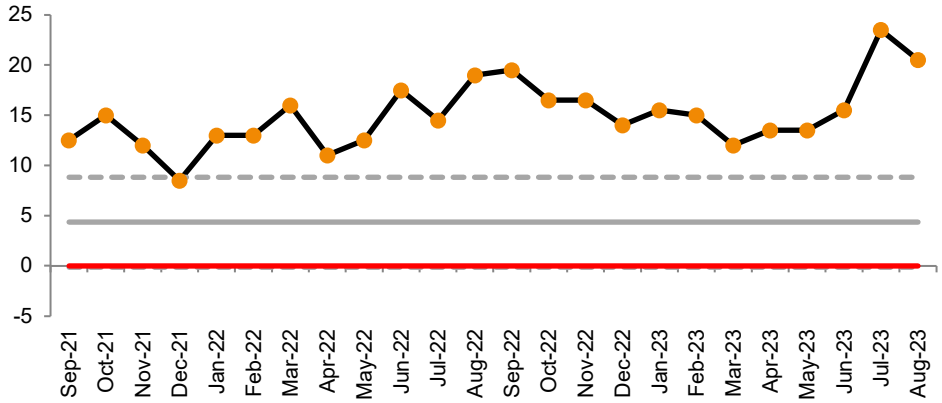


The subsequent treatment - surgery standard was not met in August at 80.8%, below the 94% standard.
National performance August - 77.8%

Q1 was not achieved at 82.9%
National performance 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

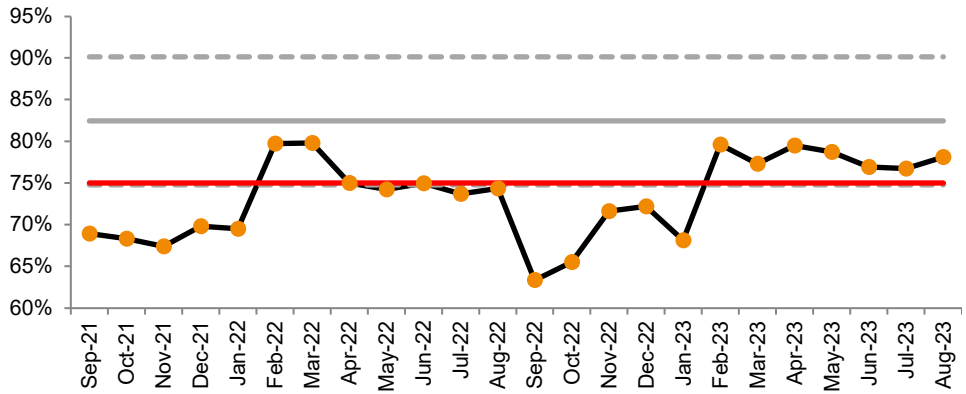


There were 20.5 breaches allocated to the Trust, treated after day 104 in August and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the consultants involved in the pathway as required.

The trend is showing a significant increase on the baseline.

RESPONSIVE

Cancer 28 Day faster diagnosis

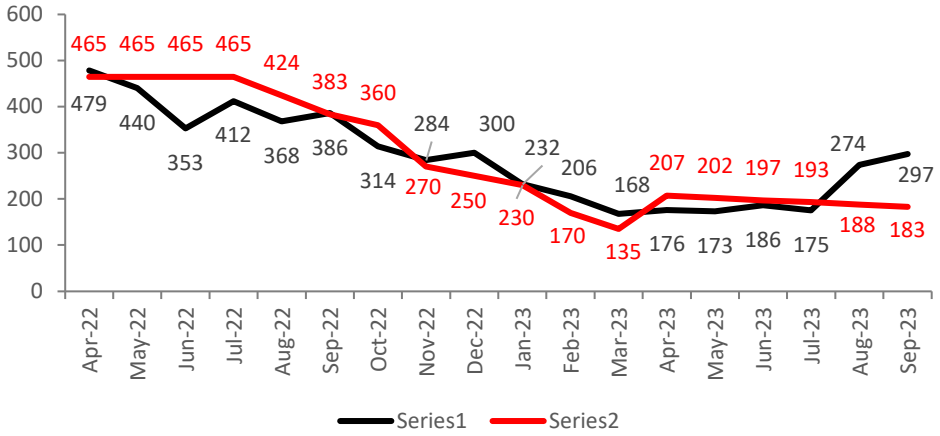


The 28 day faster diagnosis standard achieved the target in August at 78.1%.
National performance August - 71.6%

Q1 was achieved at 79.5%
National performance Q1 - 72.0%

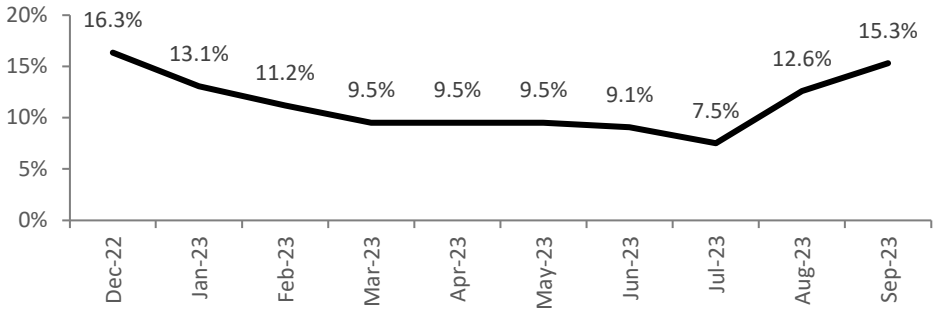
The trend is showing significant deterioration when compared to the pre-covid baseline.

Cancer >62 day vs trajectory



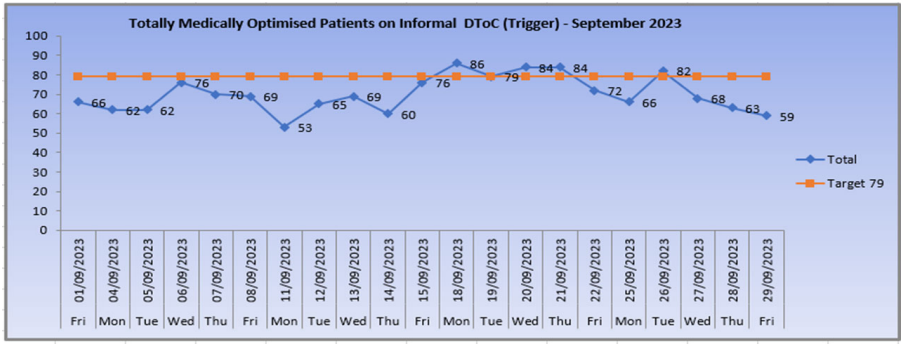
At the end of Sept the number of patients >62 days was 297 vs 183 trajectory. This was 15.3% of the total wait list.

Cancer % Waiting >62days (Urgent GP Referral)



RESPONSIVE

Delayed Discharges

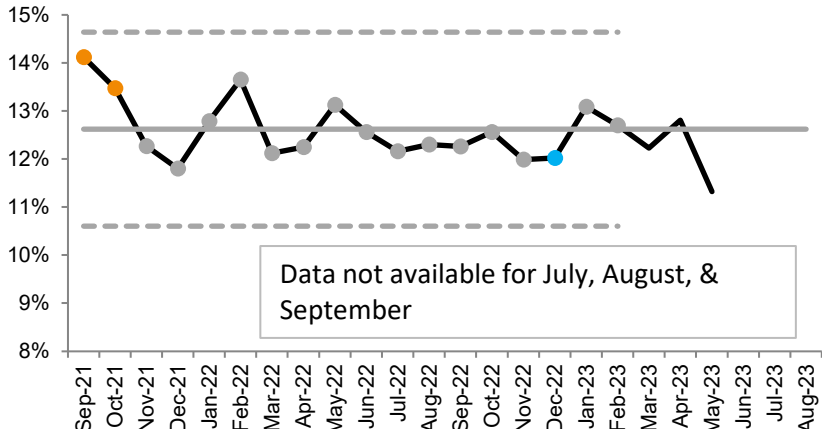


We continue to discharge patients using the rapid discharge principles set out in the Hospital discharge and community support: policy and operating model government guidance, utilising pathways 0-3. Pathways are being used to ensure patients have a discharge plan identified from admission, with pathway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

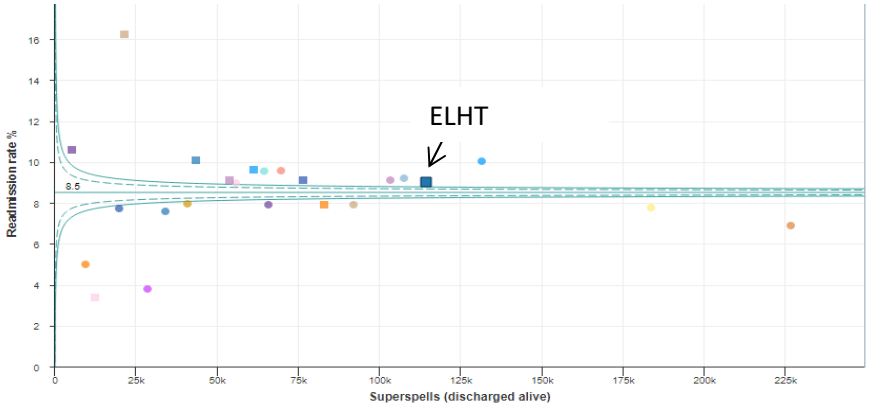
Data not available for emergency readmission.

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

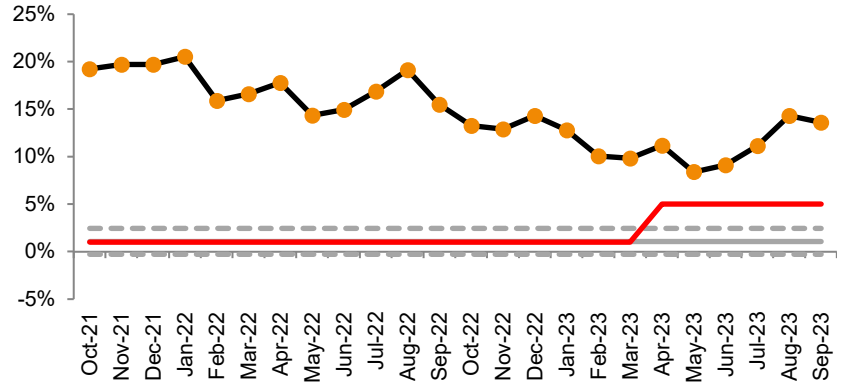
Emergency Readmissions



Readmissions within 30 days vs North West - Dr Foster
June 2022 - May 2023



Diagnostic Waits



In September, 13.6% 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, however there are issues with data quality post EPR implementation, impacting on performance.

Nationally, the performance is failing the 5% target at 27.5% in August.

RESPONSIVE

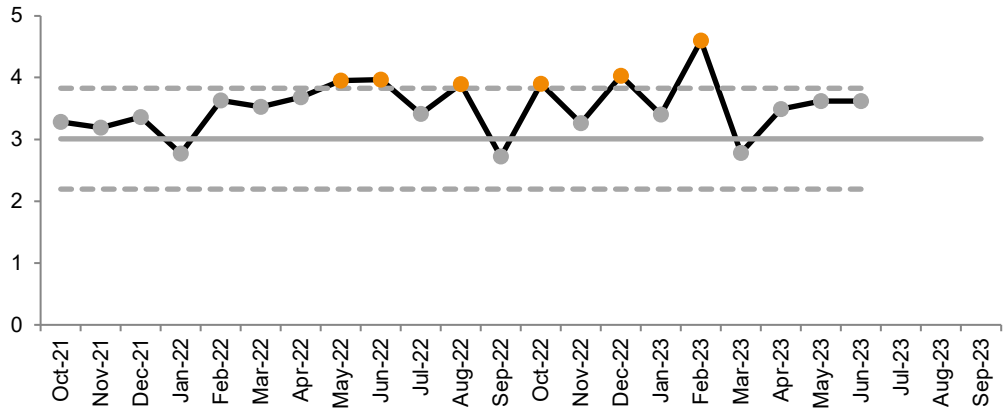
Average length of stay benchmarking

Dr Foster Benchmarking June 22 - May 23

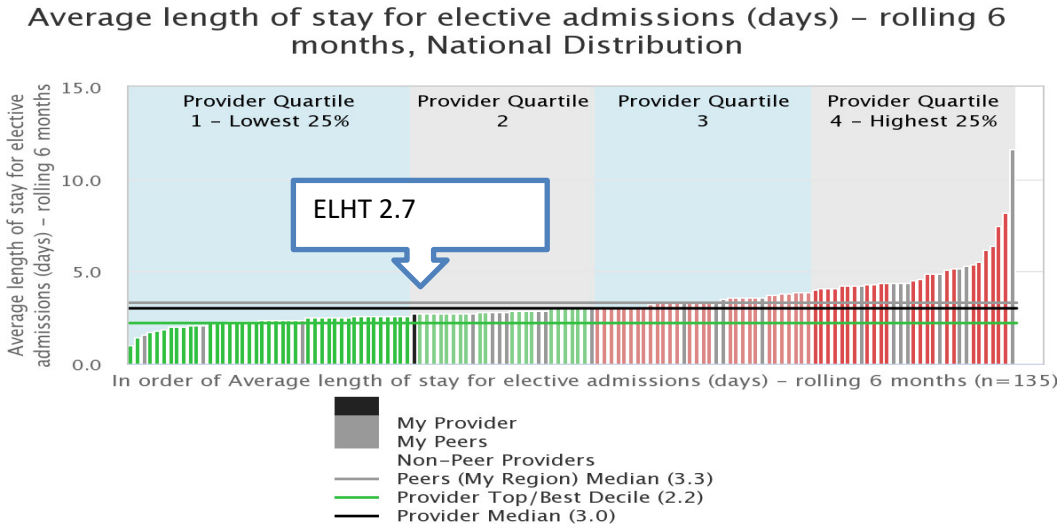
	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	62,609	10,441	52,168	3.2	2.7	-0.5
Emergency	61,622	61,622	0	4.1	4.6	0.5
Maternity/ Birth	12,500	12,500	0	2.4	2.3	-0.1
Transfer	226	226	0	7.9	24.0	16.1

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

Average length of stay - elective



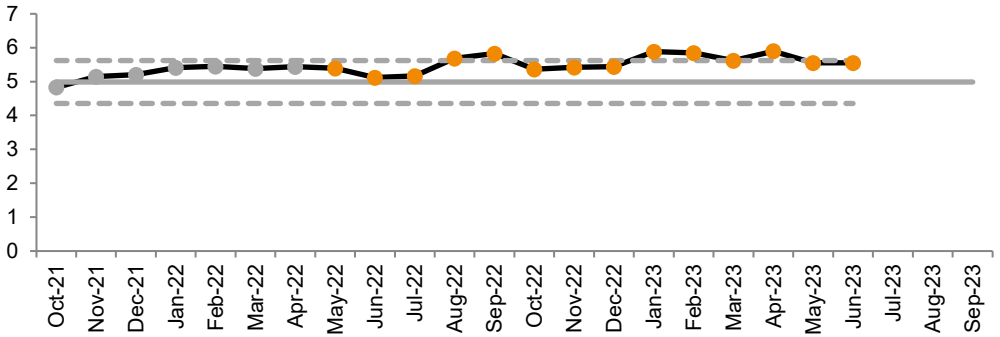
The Trust elective average length of stay is not available for July, August & September.



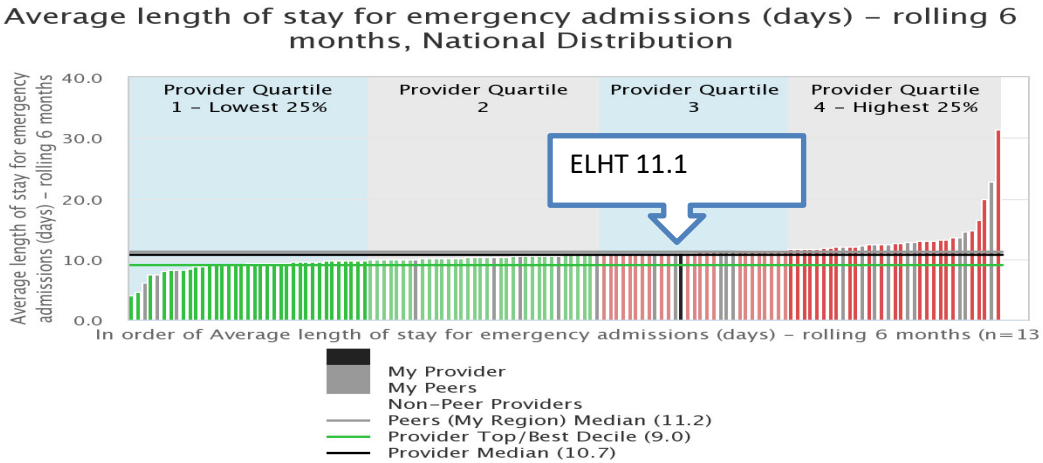
Data up to June 23 from the model health system shows ELHT in the second quartile for elective length of stay. Excludes day case.

RESPONSIVE

Average length of stay - non elective

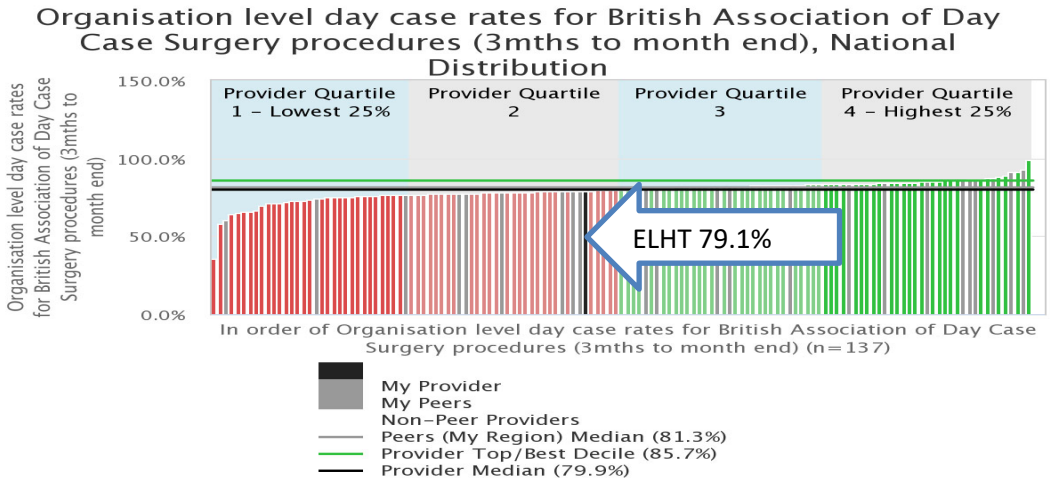


The Trust non-elective average length of stay is not available for July, August, and September.



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

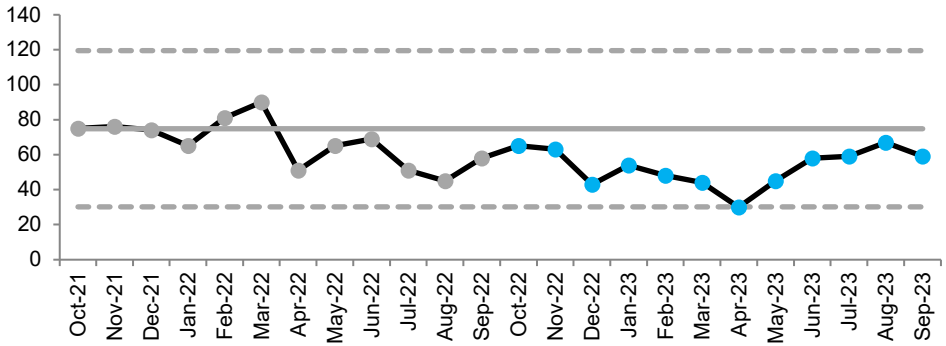
Daycase Rate



Model health system data based on latest 3 months up to June 23, shows ELHT in the second quartile for daycase rates at 79.1%. Data is for adults only

RESPONSIVE

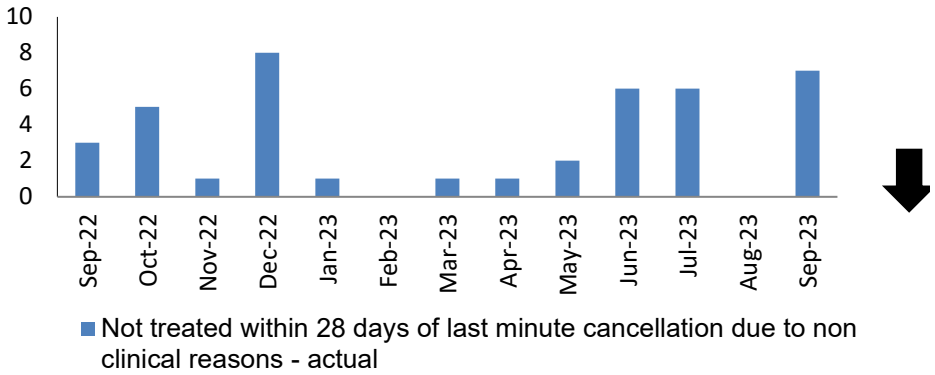
Operations cancelled on day



There were 59 operations cancelled on the day of operation - non clinical reasons, in September.

The trend has improved compared to pre-covid levels.

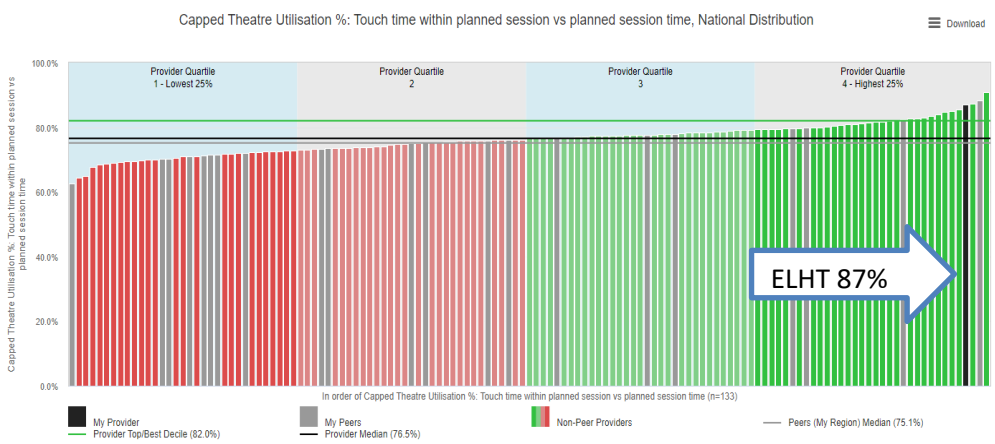
Operations cancelled on day - breaches of 28 day



There were 7 ‘on the day’ cancelled operations not rebooked within 28 days in September.

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

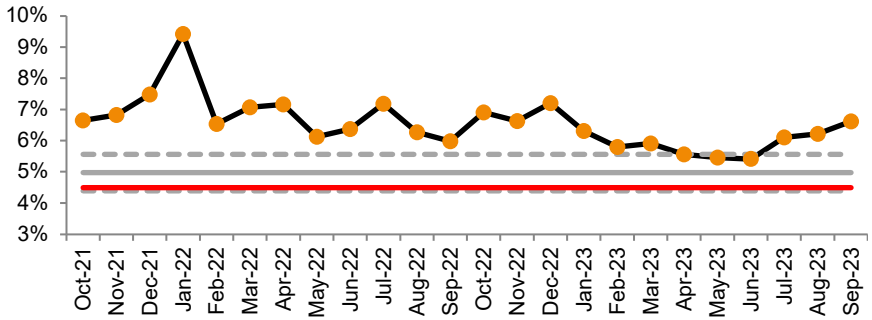


Data taken from 'The model hospital' shows capped theatre utilisation at 87% for the latest period to 18th June 23. This is in the fourth quartile nationally, with 4 being the highest and 1 the lowest.

Data quality issues post EPR implementation have impacted on reporting of theatre utilisation rates. the Trust is working to resolve these and provide an updated position.

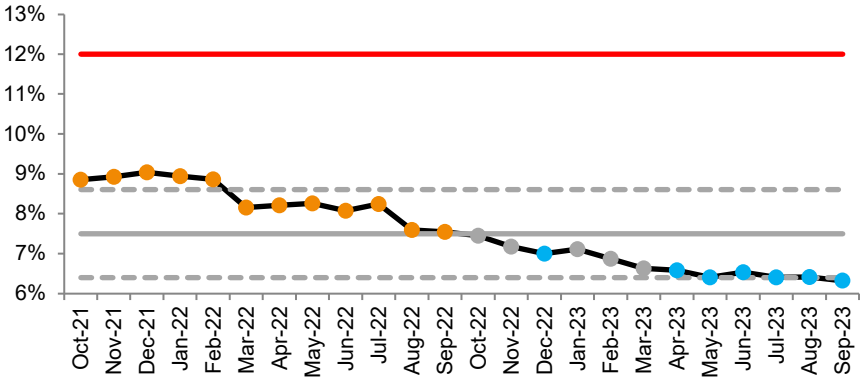
WELL LED

Sickness



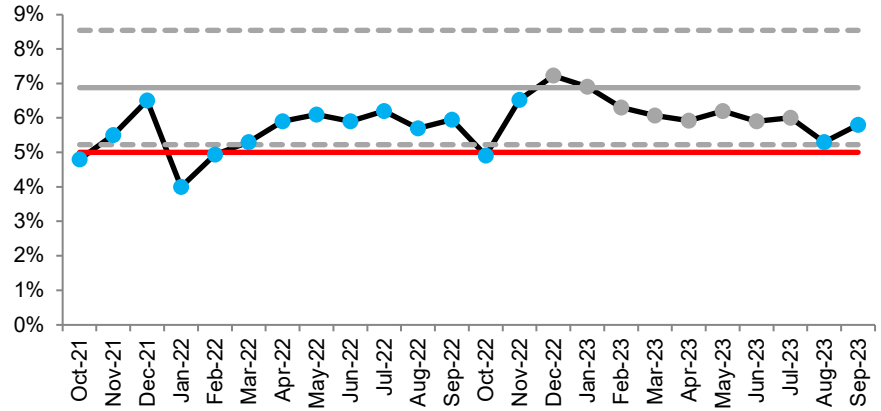
The sickness absence rate was 6.6% for September which is above the threshold of 4.5%. The trend is significantly higher than the pre covid baseline and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 6.3% in September 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



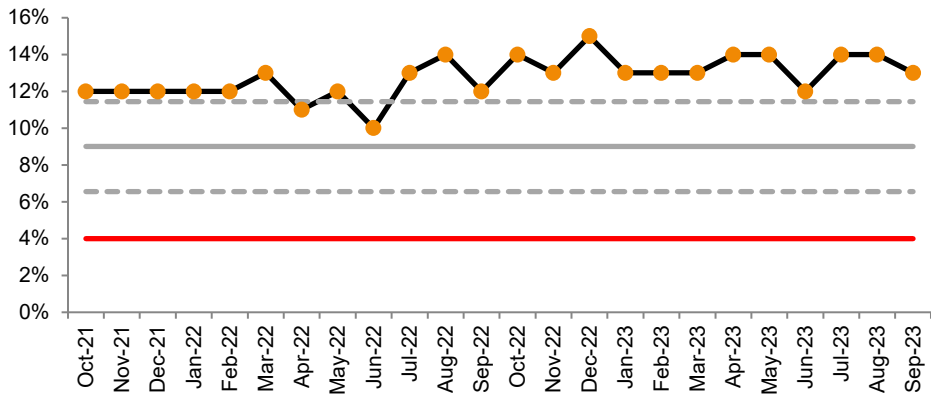
The vacancy rate is 5.8% for September which is above the 5% threshold.

The trend is showing improvement 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 %



In September 2023, £5.5million was spent on temporary staff, consisting of £1.5 million on agency staff and £4.0 million on bank staff.

WTE staff worked (9,912 WTE) was 90 WTE less than is funded substantively (10,002 WTE).

Pay costs are 427K more than budgeted establishment in September.

At the end of September 23 there were 559 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	4	0
In discussion with 1st stage manager	125	31
Mediation	0	0
Appeal	0	0
1st stage sign off by consultant	51	13
1st stage sign off by manager	55	4
2nd stage sign off	40	10
3rd stage sign off	76	22
Signed off	16	6
Locked Down	0	0

As at September 2023, there were 367 Consultants and 86 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.

Appraisals

The appraisal rates for consultants and career

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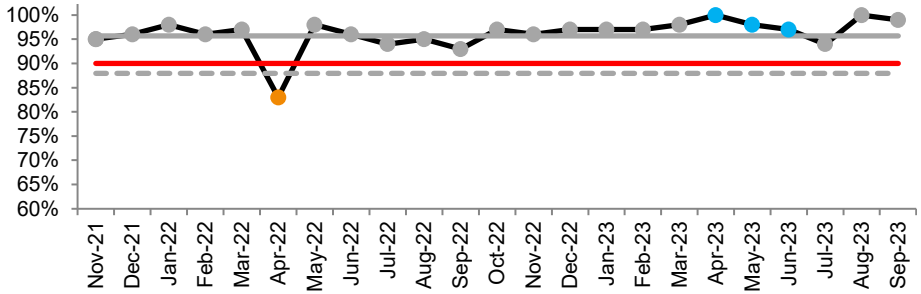
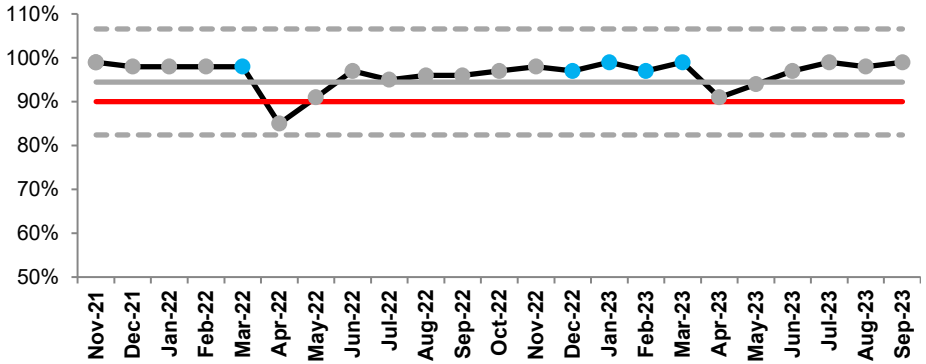
Appraisals, Consultant



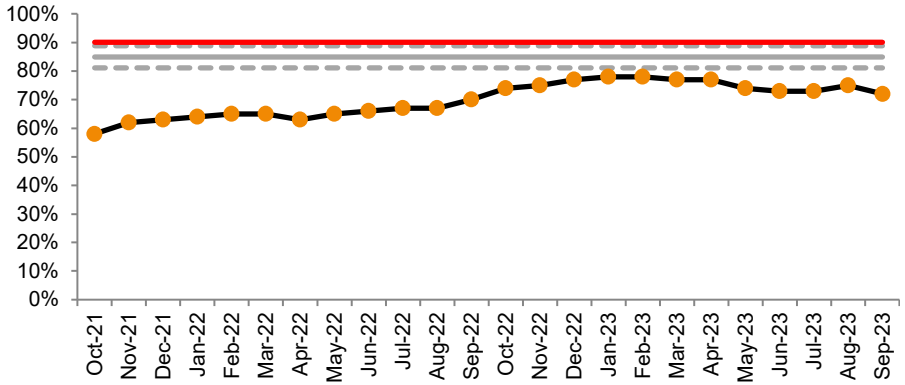
grade doctors are reported for Apr - September 23 and reflect the number of reviews completed that were due in this period.

They both continue to be above target with 99% completed that were due in the period. 48% 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 September
Basic Life Support	2 years	90%	88
Conflict Resolution Training L1	3 years	90%	97
Equality, Diversity and Human Rights	3 years	90%	96
Fire Safety L1	2 years	95%	94
Health, Safety and Welfare L1	3 years	90%	96
Infection Prevention L1	3 years	90%	97
Infection Prevention L2	1 year	90%	92
Information Governance	1 year	95%	94
Preventing Radicalisation Level 1	3 years	90%	96
Preventing Radicalisation Level 3 †	3 years	90%	85
Safeguarding Adults L1	3 years	90%	95
Safeguarding Adults L2	3 years	90%	94
Safeguarding Adults L3*	3 years	90%	66
Safeguarding Children L1	3 years	90%	96
Safeguarding Children L2	3 years	90%	96
Safeguarding Children L3	3 years	90%	83
Safeguarding Children L4	3 years	90%	100
Safer Handling Level 1	3 years	95%	95
Safer Handling Level 2 (Patient Handling)	3 years	95%	90

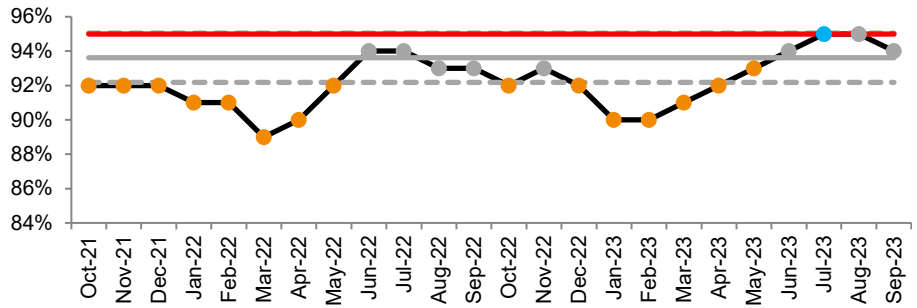
The core skills framework consists of eleven mandatory training subjects, with 19 modules in total. Training is via a suite of e-learning modules and knowledge assessments on the learning hub.

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

7 of the 19 modules are below threshold in September. 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.

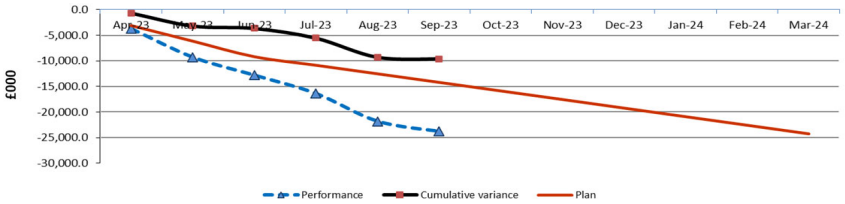
Information Governance Toolkit Compliance



Information governance toolkit compliance is 94% in September which is below the 95% threshold. The trend is now above pre-covid baseline, however remains at risk of not meeting the target.

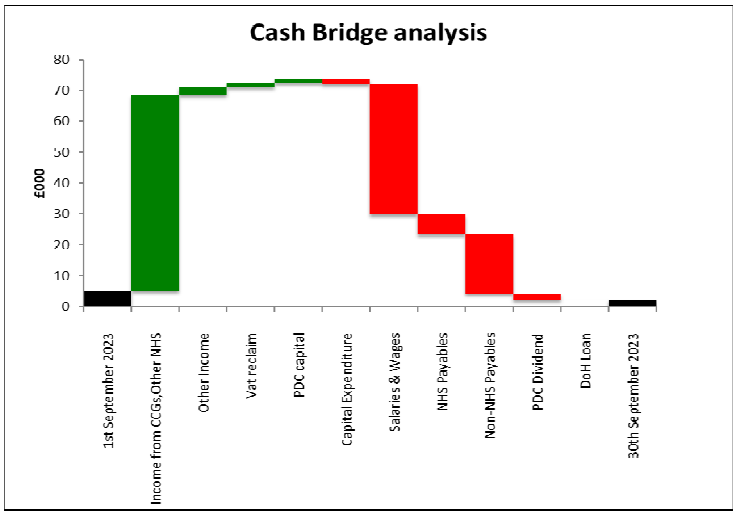
WELL LED

Adjusted financial perfomance



The Trust is reporting a breakeven duty deficit of £23.8m for the 2023-24 financial year to date, £9.6m behind plan.

Cash



The Trust's cash balance is £2.1 million as at 30th September 2023.

The Trust is reporting a breakeven duty deficit of £23.8m for the 2023-24 financial year to date, £9.6m behind the £14.2m planned deficit, a movement of £0.3m 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 now working to a £28.2m capital programme for 2023-24, although the forecast outturn position is a £2.5m overspend, largely as a result of increased costs on two high value capital schemes. The outturn position also reflects a £7.1m adjustment to transfer PFI lifecycle costs previously charged to revenue to capital.

The cash balance on 30th September 2023 was £2.1m, a reduction of £3.1m compared to the previous month. The application submitted to NHS England (NHSE) last month for £15m Public Dividend Capital (PDC) revenue support in quarter three, including £10m for October, has now been approved.

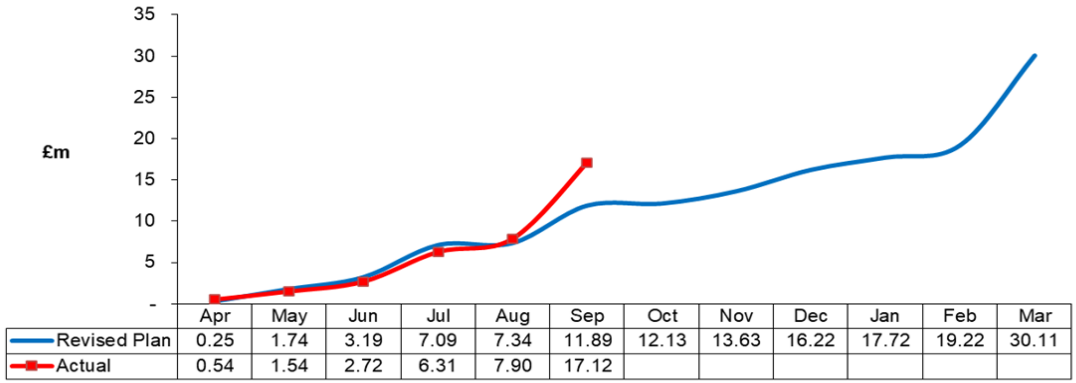
The Trust has met the Better Payment Practice Code (BPPC) target to pay 95% of invoices on time by value for the financial year to date. However, the impact of the Trust's financial performance in 2023-24 on its cash position has had an impact on BPPC performance which remains below target for non-NHS invoices by volume.

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 £14.6m at month 6, £10.7m behind plan. It has been necessary to non-recurrently support this position by £8.8m.

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	30.11
Actual	0.54	1.54	2.72	6.31	7.90	17.12						

The Trust is £5.2m ahead of planned capital spend as at 30th September 2023, largely due to an adjustment to transfer £7.1m of PFI lifecycle costs from revenue to capital.

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	15,963	0	8,808	16,321	8,451	24,771	48,530
Medicine & Emergency Care	975	1,151	0	1,206	920	2,126	1,294
Community & Intermediate Care	2,082	42	0	109	2,015	2,124	410
Surgical & Anaes Services	834	107	0	300	641	941	1,338
Family Care	180	20	0	0	200	200	809
Primary Care	10	10	0	0	20	20	30
Diagnostic & Clinical Support	277	831	288	0	1,395	1,395	1,058
Estates & Facilities	1,286	1,564	1,150	882	3,118	4,000	622
Corporate Services	1,809	104	1,358	647	2,624	3,271	387
Education, Research & Innov'N	150	15	10	0	174	174	140
Total	23,566	3,843	11,614	19,464	19,558	39,022	54,618

Schemes to the value of £14.6 million have been transacted in the year to date. Additional identified schemes will be

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TRUST BOARD REPORT **Item** **145**

8 November 2023 **Purpose** Ratification

Title	Annual Report on Medical Appraisal, Revalidation and Governance
Report Author	Uma Krishnamoorthy, Associate Medical Director (Appraisal and Revalidation)
Executive sponsor	Mr J Husain, Responsible Officer, Executive Medical Director

Summary: This report provides evidence of compliance against GMC and NHS England standards for Medical Appraisal and Revalidation. The report has been presented to the People and Culture Committee and verbal recommendation for the ratification of the submission will be provided by the Committee Chair to the Board.

Recommendation: The Board is asked to approve the report and sign the included Statement of Compliance for submission to NHS England.

Report linkages

Related Trust Goal	Deliver safe, high-quality care
	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.
Related to key risks identified on Corporate Risk Register	Please refer to the Corporate Risk Register for the associated risks.
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	People Plan Priorities
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/No

Equality	No	Confidentiality	Yes/No

To be considered by: People and Culture Committee, 6 November 2023

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TRUST BOARD REPORT

8 November 2023

Item **146**

Purpose Ratification

Title	East Lancashire Hospitals NHS Trust Self-Assessment Report 2022-23 for Department of Education, Research and Innovation
Report Author	Mrs J Owen, Deputy Director of Education, Research & Innovation
Executive sponsor	Mrs K Quinn, Executive Director of People & Culture

Summary: Heath Education England (HEE) now merged within NHSE and requires all placement providers to submit an annual Self-Assessment Report (SAR). The SAR relates to the standards within the Quality Framework that organisations are expected to have in place to provide a quality learning environment for the learners they have responsibility for. The reporting period for this SAR is April 2022-March 2023.

Recommendation: The Board is asked to ratify the submission following the Chair's Action and email exchange with Board members which included the full submission document.

Report linkages

Related Trust Goal *(Delete as appropriate)*	Deliver safe, high quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework *(Delete as appropriate)*	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: 9777 Loss of Education, Research and Innovation accommodation and Facilities
Related to recommendations from audit reports	
Related to Key Delivery Programmes	DERI Strategy and Education Plan.
Related to ICB Strategic Objective	People & Culture/Workforce

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	Yes/No

Previously considered by:

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TRUST BOARD REPORT

9 November 2022

Item **147**

Purpose Ratification

Title	Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Report for 2023-24
Executive sponsor	Mr T McDonald, Executive Director of Integrated Care, Partnerships and Resilience

Summary: This paper describes 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.

Recommendation: The Board is asked to note the report and ratify the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement which was submitted under the delegated authority granted at the September 2023 Board meeting.

Report linkages

Related Trust Goal		Deliver safe, high-quality care.
Related to key risks identified on assurance framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
	2	The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
	4	The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Impact

Legal	Yes	Financial	No
Compliance with Health & Social Care Act 2022			
Compliance with Civil Contingencies Act 2004 and subsequent amendments			
Equality	Yes	Confidentiality	Yes

Previously considered by:

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Report for 2023/24

Executive Summary

1. This report provides an overview of the Trusts emergency preparedness, resilience and response during the past 12 months and provides assurance that East Lancashire Hospitals Trust meets its statutory duties under the Civil Contingencies Act 2004, NHS Act 2006 and the Health and Social Care Act 2012 and its other non-statutory obligations.

2. This report also summarises the current position of the Trust in relation to emergency preparedness and business continuity arrangements based on the completion of the annual EPRR Core Standards Framework and Statement of Assurance submission.

2023/24 EPRR Assurance Process

3. The comprehensive EPRR core standards assurance process has been undertaken and ELHT has submitted an initial level of Substantial Compliance, which this Trust Board is asked to ratify (Appendix A). The completed self-assessment and action plan can be found in Appendix B and C respectively.

4. The initial declaration and submission including supporting evidence for the EPRR core standards assurance process that all Trusts and Integrated Care Boards submit is subject to a further scrutiny through a 'check and challenge' review process with NHS England's Regional EPRR Team. Where necessary, as part of NHS England's review, further supplementary evidence may be requested to support the submission and this will inform a final review, declaration and submission.

5. The areas where we scored partially compliant were:
    a) Command and Control – Trained on-call staff
    b) Training and exercises – EPRR Training
    c) Training and exercises – Responder Training
    d) Business Continuity – Business Continuity Policy Statement
    e) Business Continuity – Business Continuity Management System
    f) Business Continuity – Business Continuity Audit

6. To address these, we have started to progress a training strategy that will aim to develop the capability of employees that have a role to play in the response to, and/or recovery from an emergency that impacts the Trust by equipping them with the necessary skills, knowledge and behaviours. Underpinning this strategy, a range of courses, both internal and external, are being reviewed to meet the diversity of the roles required to ensure a robust and effective response from East Lancashire Hospital Trust, whenever necessary.

7. The EPRR Committee has started the review of how the Business Continuity Management System will work going forward. Plans are currently being reviewed by their Maximum Tolerable Period of Disruption and each division will review each of their plans and update in the new format over the next few months.

8. We will also seek a peer review from our neighbouring trusts on our plans as well as progressing with MIAA around the feasibility of an external audit.

9. The Deep Dive area (non-mandatory standards) for 2023/24 relate to EPRR responder training. ELHT declared either full or partial compliance with six out of ten standards at the time of submission. Work is now underway to ensure that we will be fully compliant by our next submission in 2024/25.

Industrial Action Response

10. The trust has been responding to the Junior Doctor and Consultant strikes throughout 2023. In line with the nationally recognised NHS command and control structure for responding to major incidents and emergencies, the Trust established virtual Incident Management Meetings (IMTs) with Divisional representation. The IMTs met twice daily throughout each period of Industrial Action.

11. The IMTs provided the overarching co-ordination of the Trust's planning, response and resilience from an organisational and local perspective whilst feeding into system, regional and national response via the Integrated Care Board.

12. The EPRR team continues to act as the single point of contact for the trust. It facilitates communication, coordination and leadership with respect to response and resilience. It provides robust systems to receive and disseminate information, to coordinate and submit situation reports and is formally overseen by the Executive Director of Integrated Care, Partnerships and Resilience as the Trust's nominated Accountable Emergency Officer (AEO) with responsibility for EPRR.

UK Covid-19 Inquiry

13. The Government has established an independent public inquiry to examine the UK's response to and impact of the Covid-19 pandemic and learn lessons for the future. The Inquiry is chaired by Baroness Heather Hallett, a former Court of Appeal judge and commenced earlier this year.

14. The Inquiry has been established under the Inquiries Act (2005). This means that the Chair will have the power to compel the production of documents and call witnesses to give evidence on oath. The inquiry is taking a modular approach as follows:

- **Module 1** - the UK's pandemic preparedness and resilience (commenced on 13 June 2023)
- **Module 2** - core political and administrative decision making in the UK and devolved administrations (commenced October 2023)
- **Module 3** - the impact of the pandemic on healthcare systems (to begin early 2024)
- **Module 4** - vaccines, therapeutics, and anti-viral treatment across the UK (scheduled summer 2024)
- **Module 5** - Government Procurement across the UK (scheduled early 2025)
- **Module 6** - the care sector across the UK (scheduled spring 2025)

15. The Trust is making arrangements and preparations for the provision of information and evidence if this is requested on behalf of the wider NHS's response to the Inquiry in accordance with the guidance and direction of NHS England as well as working with system partners such as our Local Authorities, Public Health and Integrated Care Board in the event of any specific involvement and/or engagement with the Inquiry they may have.

EPRR Update

16. Over the next 12 months, several EPRR related plans and policies will need to be reviewed. This includes the Makor Incident Plan, Adverse Weather Plan, Evacuation and Shelter Plan and Business Continuity Plans and Priority Services

17. Another focus this year will be to address EPRR training and exercising for the trust. The team are currently developing a Training Needs Analysis and training prospectus to cover all response

roles and for staff who have a responsibility for writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity).

18. Business Continuity incidents this year include phone failure, suspect package, sewage blockage and Cerner downtime. Responses to each incident were managed through the timely establishment of effective incident response teams. After each incident, facilitated debrief are undertaken to identify any lessons to be learned and good practice that can further improve our responses to such incidents in the future and these are shared formally through the EPRR Committee.

Recommendations

19. The Trust Board is requested:

a) To receive the action plan contained within this report to provide assurance that the trust is committed to declaring full compliance against the EPRR Core Standards by June 2024.

b) To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it substantially fulfils its statutory and non-statutory duties and obligations.

Tony McDonald
Executive Director Integrated Care, Partnerships and Resilience
Accountable Emergency Officer
October 2023

Lancashire and South Cumbria Provider Collaborative

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TRUST BOARD REPORT **Item** **148**

8 November 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 meetings held on 31 July, 13 and 25 September 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: **31 July 2023**
Committee Chair: **Stephen Barnes, Non-Executive Director**

ITEMS APPROVED

- Members approved the minutes from the meeting held on 12 June 2023 as a true and accurate record.
- Members supported the presentation of the Terms of Reference to the Trust Board for ratification.

ASSURANCE RECEIVED

1. Finance Reporting

Members were updated on the Trust's financial position as at the end of Month 3 and Quarter 1, noting that the Trust was away from plan due to issues including the ongoing industrial action, financial slippage, and the impact of the pay award.

Members were informed that the provider Trusts had been asked to produce a forecast, including no mitigations, for where they would be positioned at the end of the financial year. Members were informed that the Trust was still currently forecasting it would meet the deficit it had submitted earlier in the year.

Members were updated about the System Finance Group and the ELHT assurance meetings that had been held at which the feedback from NHS England (NHSE) had been discussed regarding the Trust's run-rate. Members were advised that the recovery plan for 2024-25 onwards needed to be submitted in September and that work had commenced on the 3–5-year plan.

An update was provided on capital funding, and the current schemes taking place. In addition Members were informed that a full review of the Trust wide risk register had been completed and that the additional assurance structures now in place meant that Executive colleagues had a closer oversight of the most high-level risks affecting the organisation.

2. Improvement Update

Members were provided with an update on the Electronic Patient Record (EPR), noting that the Trust was now 6 weeks post go-live of the EPR and that this would be the basis of improvement work to the Trust over the coming years. Members were advised that the Trust was now in a transitional phase, with diagnostic work being completed and the focus moving to support the Trust with the adoption of the system. Members noted that the Trust continued to work with Cerner and was working through issues.

It was noted that Cerner had expressed they were impressed that the Trust had already identified early issues. Members were informed that the number of issues being identified was reducing, however there was a lot of work to address to be able to meet the 109% target for the Elective Recovery Plan. Members were informed that several improvement workshops would be held over the coming weeks relating to prescribing, and that the ambition was to update the current EPR risk on the Corporate Risk Register to a rating of 16 by the end of September, before reducing to 12 and then removing from the register.

Members were informed that the Change Strategy Group had been re-established and had now become the Lancashire Improvement and Optimisation Group. Furthermore, that Cerner would be holding a health check event in October for 2 weeks where they would visit the site and observe how the system is being used and what the Trust can do to maximise the value of the system.

3. Integrated Performance Report (IPR)

Members were informed that despite the introduction of the EPR and differences in working this had introduced, the Trust was not only achieving trajectory but was also achieving the end of March 2024 ambition for the 4-hour Emergency Department (ED) target.

Members noted that the Trust was off trajectory for June and July for patients waiting more than 65 weeks for treatment. It was explained that this was in part due to the implementation of the EPR, and partially due to the cumulative effect of industrial action. Members were advised that the Trust would not hit trajectory for July, however it was expected that the current number of patients would reduce from 475 but would still remain high.

4. Quarterly Workforce Update

Members were updated on recruitment and retention, noting that the number of open vacancies continued to reduce. It was noted that the number of registered nurse vacancies had reduced from 237 to 207, with the aim that 240 additional nurses should be recruited by March 2024. Members were advised that the turnover levels had reduced with staff choosing to stay with the Trust. Members were informed that the Trust had a significant focus on recruitment with peer trajectories now in place. Furthermore, retention of staff was now a significant focus for the Trust.

An update was provided about the work to improve flexible working and the ambition that this will move bank workers into substantive posts. It was explained that the Trust was moving away from flexible working to only mean flexible hours, and instead would look at all possibilities.

Members were updated on the work to reduce Bank and Agency spend, noting that the collaborative work across the system was starting to show results.

Members were updated about the new core pathway that had been introduced as part of the work to improve leadership in the Trust. Members were updated about the work taking place within the staff networks, the reduction in staff sickness, and the recruitment of a number of apprentices into the Trust.

5. Private Finance Initiative (PFI) Update

Members were provided with an update regarding the PFI schemes at the Blackburn and Burnley sites. Members were informed that a joint appointment to check the remedies had been undertaken to the required standards was being developed for the Burnley site. In addition, Lancashire Fire and Rescue Service (LFRS) had visited the site and were pleased with the Renal position, however they wanted to know more about the next steps.

Members were updated about the Blackburn site, noting that plans were being implemented for regular meetings to review the action plans.

6. Terms of Reference

Members were advised that the Finance and Performance Committee Terms of Reference had been reviewed and updated with the comments provided from the Committee. It was explained that all items received by the Committee had now been included and that items that were to be presented to the new People and Culture Committee had been removed. Members were informed that the Terms of Reference were being presented for discussion and for the Committee to provide their recommendation for ratification by the Trust Board. Members supported the presentation of the Terms of Reference to the Trust Board for ratification.

ITEMS TO REFER TO THE AUDIT-COMMITTEE OR ESCALATE TO THE TRUST BOARD

Members suggested that an update regarding internal audit on the Electronic Patient Record, and an update on Health and Safety be provided to a future Audit Committee. 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.

Meeting: **Finance and Performance Committee**
Date of Meeting: **13 September 2023**
Committee Chair: **Stephen Barnes, Non-Executive Director**

ASSURANCE RECEIVED

1. Finance Reporting

Members were updated on the Trust's month 4 position and key risk faced that could be faced by the Trust. Members were updated on agency spend, noting that the Trust was running at an agency threshold of 3.8% against a target of 3.7%. Members were updated on the Trust's Waste Reduction Plan (WRP), noting that as of month 4, £10 million had been delivered and £39 million had been identified, of which £28 million was recurrent.

2. Improvement Update

Members were provided with an update on the Outpatient Improvement Plan and the performance improvements and opportunities that could be applied across the organisation. It was noted that the Trust had attempted to align the plan to the system priorities and that good governance was in place. Members were informed that the Improvement team was still providing support to teams across the Trust for the adoption of new systems, including the EPR, and working on getting back to pre-EPR go live activity levels. Furthermore, a significant area for improvement was patient initiated follow ups.

3. Integrated Performance Report (IPR)

Members were informed that the Trust was achieving the 76% target for the 4-hour ED target. Members noted that the department was experiencing high volumes of attendances with an average of 630 per day in July and August, and increasing numbers in September.

Members were informed that the number of 12-hour breaches had slightly increased in August due to capacity related issues around flow, however this was being managed in September. Members were advised that ambulance handovers had improved following the Cerner implementation, with further improvement recorded for August. It was noted that there had been challenges due to the volume, however the teams had managed to stay on the fringe of 60 minutes. Members were advised that cancer performance was being micromanaged due to challenges in August resulting from industrial action and annual leave.

Members were informed that work was taking place to track every patient that had the potential to breach the 65 week waiting time for Referral to Treatment (RTT).

Members were informed that the cancer standards would be changing from 1 October 2023 and would focus on 3 standards – 28 day fast diagnostic standard, 85% of patients to be treated within 62 days, and achieving the 96% target for 31 days from decision to treat to treatment and noted that the IPR would be updated and be reflective of the new standards.

4. Private Finance Initiative (PFI) Update

Members were informed that the Trust had met with Lancashire Fire and Rescue Service (LFRS) to discuss the Blackburn and Burnley sites. Members were informed that lifecycle and fire improvement works would continue, although it was understood that there could be some delays to rectification works due to Winter pressures.

6. Board Assurance Framework

Members were presented with the Board Assurance Framework (BAF) and advised that this would continue to grow as further assurance was required. Members noted that a session to discuss the BAF was being held in October and that the Chairman had suggested using the session to discuss how the BAF could be used to manage both system and Trust risks.

ITEMS TO REFER TO THE AUDIT-COMMITTEE OR ESCALATE TO THE TRUST BOARD

Members suggested that the Audit Committee could ask the auditors how reporting was undertaken at a system level of providers. 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.

Meeting: **Finance and Performance Committee**
Date of Meeting: **25 September 2023**
Committee Chair: **Stephen Barnes, Non-Executive Director**

ITEMS APPROVED

- Members approved the minutes of the meeting held on 31 July 2023 as a true and accurate record.

ASSURANCE RECEIVED

1. Finance Reporting

Members were updated on the Trust's month 5 position and any current risks that had the potential to affect the Trust's financial position. Members were updated on the Trust's forecast outturn and informed about the best case, worst case and likely end of year positions.

An update was provided on the National Cost Collection and the work taking place with the Patient Level Information and Costing System (PLICS) data.

2. Improvement Update

Members were provided with an update on UEC, covering the 2023/24 UEC activity and performance plan, the 2023/24 Improvement Hub Team priorities and focus updates on the ED Improvement Plan, North West Ambulance Service (NWAS) Collaborative, Electronic Patient Record (EPR) Discharge Process, and the Clinical Quality Academy.

3. Integrated Performance Report (IPR)

Members were informed that the Trust was achieving 76% for the 4-hour ED target. Furthermore, the department was experiencing high volumes of attendances with an average of 648 per day and with increasing acuity.

Members were informed that Cancer performance was on trajectory up to the end of July, however industrial action and annual leave had impacted delivery resulting in September being off target. It was confirmed that the Trust would be closer to trajectory at the end of September through a combination of micromanagement and daily updates being provided.

4. Private Finance Initiative (PFI) Update

Members were provided an update on the PFI work taking place at the Blackburn and Burnley sites.

ITEMS TO REFER TO THE AUDIT-COMMITTEE OR ESCALATE TO THE TRUST BOARD

Members suggested discussing work on cost proportion allocation at a future Audit Committee meeting. 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** **149**

8 November 2023 **Purpose** Information

Title	Quality Committee Summary Report
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mrs C Randall, Committee Chair

Summary: The report sets out the summary of the papers considered, and discussions held at the Quality Committee meeting held on 30 August and 27 September 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: **30 August 2023**

Committee Chair: **Naseem Malik, Non-Executive Director**

ITEMS APPROVED

The minutes of the previous meeting held on 28 June 2023 were approved as a true record of the meeting.

ASSURANCE RECEIVED

1. Patient / Staff Safety

Members were informed that a Patient Safety Congress Event had taken place earlier in the week with divisional and senior leadership colleagues to discuss and reflect upon the recent Never Events reported by the Trust. Members noted that several learning and action points had come out from this event and confirmed that an update would be provided at a future meeting.

2. Professional Judgement Review Update

The Committee received a report summarising the latest round of Professional Judgement Reviews in relation to its safe staffing levels. It was highlighted that the majority of areas across the Trust did have confirmed safe staffing in place, both in acute and community-based settings and that no additional funding was required at the current time.

3. NHSE Letter Regarding the Verdict in the Trial of Lucy Letby

A letter recently received by the Trust from NHSE following the conclusion of the Lucy Letby Trial was presented to the Committee. Members were informed that there was a substantial focus on learning in the letter as well as a clear emphasis on ensuring that any concerns raised were properly investigated. It was confirmed that robust processes were in place at the Trust in relation to medical colleagues via the Trust's Patient Safety Group and incident reporting mechanisms. Members also noted that similar measures were also in place for nursing staff when any concerns were raised through professional bodies.

4. Quarterly Mortality Update

A Quarterly Mortality Update was provided to the Committee. Members noted that there had been several improvements in the Trust's Hospital Standardised Mortality Ratio (HSMR) measure and a slight rise in its Summary Hospital-level Mortality Indicator (SHMI). The Committee was also informed that a new process had been introduced to address the issues with palliative care coding raised in previous meetings and that the Trust's Electronic Patient Record (EPR) system would enable better capture of patient co-morbidities going forward. A rise in overall neonatal mortality rates over the previous 12 months was reported but it was noted that a significant contributing factor to this had been an accompanying rise in congenital abnormalities.

5. Floor to Board for Maternity Services

The Committee received the latest iteration of the Floor to Board for Maternity Services. It was highlighted that good progress was being made with proving compliance against the ten safety actions outlined in the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) and that additional funding had recently been received through the Local Maternity and Neonatal System (LMNS).

The Committee:

Agreed for an update on the Trust's pharmacy services to be provided at a future meeting.

6. Quarterly Report on Safe Working Hours: Doctors and Dentists in Training

Members received a quarterly report on safe working hours from the Trust's Guardian of Safe Working. It was noted that no serious concerns had been raised since the previous update provided to the Committee and that work was underway to better incorporate non-training posts to enable colleagues to better communicate any concerns that they may have.

7. Corporate Risk Register (CRR)

The Committee was informed that four new risks had been added to the CRR, and another six deescalated from it, since the previous meeting. Members agreed that the number of risks deescalated showed that real progress was being made by the Trust in managing its overall risk levels. The Committee was also informed that the implementation of a new RADAR total quality management system had been delayed from the initially planned date of October 2023 to April 2024 at the earliest.

8. Board Assurance Framework (BAF)

The revised BAF was presented to members for approval. It was noted that no changes had been made to any of the scores assigned to each risk but that preliminary discussions had taken place around potentially revisiting some of their tolerated and target risk scores. Members were informed that externally provided training around risk management was being developed and was expected to be available later in the year.

Meeting: **Quality Committee**
Date of Meeting: **27 September 2023**
Committee Chair: **Trish Anderson, Non-Executive Director**

ITEMS APPROVED

The minutes of the previous meeting held on 30 August 2023 were approved as a true record of the meeting.

ASSURANCE RECEIVED

1. Patient / Staff Safety

The Committee received a detailed overview of the ongoing extreme pressures being placed on urgent and emergency care pathways both at the Trust and across the country. It was reported that two serious incidents had recently occurred in the Trust's emergency department and that these were being investigated in detail. Members were informed that a number of actions had been considered and agreed to by the Trust's Executive team to try and alleviate the pressure on staff.

The Committee:

Agreed for a full report on the pressures being seen on urgent and emergency care pathways and the additional support measures put in place for Trust staff to be provided at a future meeting.

2. Lancashire Diabetic Eye Screening Programme Quality Assurance Recommendations Progress Report

Members received an overview of the activities of the Lancashire Diabetic Eye Screening Programme, following a recent Screening Quality Assurance (QA) visit. It was confirmed that this visit had been a positive one overall and that ten recommendations had been made to further strengthen the service, with the majority of these now approaching completion.

The Committee:

Agreed for a further update on the progress made by the Lancashire Diabetic Eye Screening Programme against the ten recommendations made following its assessment by Quality Assurance colleagues to be provided in another six months' time.

3. Electronic Patient Record (EPR) Progress Overview

An update on the Trust's implementation of its EPR system was provided to the Committee. It was confirmed that a substantial amount of progress had been made since the initial 'go live' of the system but that a number of issues would still need to be resolved over the coming months.

4. Pressure Ulcer Progress Update

The Committee received an update on the Trust's management of pressure ulcers, following the previous update that it had received earlier in the year. Members noted that a range of measures had been implemented over recent months and that there had been some positive progress made. They were also informed that new national guidance around reviewing pressure ulcers was expected in the near future.

The Committee:

Agreed for a further update on the Trust's management of pressure ulcers to be provided to in six months' time.

5. Patient Safety Incident Response Framework Report

Members received a summary of the latest figures from the Patient Safety Incident Response Framework. It was reported that although there had been a rise in the numbers of incidents reported, this had not translated into additional levels of harm. Members noted that the significant pressures being seen in the Trust, and a rise in incident caseloads, were leading to delays in incident reports being completed in a timely manner.

6. Nursing Assessment and Performance Framework (NAPF) Update

The Committee received a summary of the assessments undertaken by the Trust's NAPF team over the previous two-month period. It was highlighted that out of the 68 total areas assessed by the NAPF team, 54 were rated as either green, silver or gold.

7. Infection Prevention and Control Report

The Committee was informed that there had been a recent outbreak of Clostridium difficile (C. diff) on one of the Trust's Digestive Diseases Unit, affecting nine patients in total. It was noted

that poor hand hygiene scores had previously been observed on the same unit and that extra support had been put in place from IPC colleagues.

8. Annual Report of the Director of Infection Prevention & Control

The annual report from the Director of Infection Prevention & Control was presented to members. It was noted that the Trust would be given stricter trajectories for gram-negative bacteria and that an additional emphasis would be placed on catheter tracking tools and passports to help to facilitate this.

9. Quality Improvement Update

A series of slides were presented to the Committee that summarised the recent activities of the Trust's Quality Improvement team. Members noted that work was underway to link the Trust's Strategic Framework to the improvement programmes already in place across the organisation and that a refresh of its improvement priorities had taken place as part of this. The Committee was also informed that a Harms Reduction Closure Report was currently being developed and would be provided at a future meeting for consideration.

The Committee:

Agreed for a Harms Reduction Closure Report to be provided at a future meeting.

ITEMS TO ESCALATE TO THE AUDIT COMMITTEE AND TO THE TRUST BOARD

None.

ITEMS RECEIVED FOR INFORMATION

None.

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **150**

8 November 2023 **Purpose** Information

Title	Audit Committee Summary Report
Report Author	Mr M Pugh, Corporate Governance Officer
Executive sponsor	Mr K Rehman, Committee Chair

Summary: The report sets out the summary of the papers considered, and discussions held at the Audit Committee meeting held on 10 July 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: **10 July 2023**
Committee Chair: **Richard Smyth, Non-Executive Director**

ITEMS APPROVED

- Members approved the minutes from the meetings held on 17 April and 22 June 2023 as true and accurate records.

ASSURANCE RECEIVED

1. Management Response to Internal Audit on Risk Management – Update on Progress

Members were informed that the paper had been included as an update, noting that a significant amount of work had been undertaken around the clarity of the risks and how they were described. Furthermore, the report detailed a number of process issues still to be addressed. Members were informed that a full review of the Trust wide risk register had been completed and that the additional assurance structures now in place meant that Executive colleagues had a closer oversight of the most high-level risks affecting the organisation.

2. Consultant Job Planning Update

Members were informed that the Trust's Consultant Job Planning Policy had been updated and additional training packages were available for colleagues to access via the Sharepoint system. Members were informed that there had been a reduction in the percentage of Job plan sign-offs, however this was potentially linked to the significant ongoing impacts of industrial action and the implementation of the Trust's Electronic Patient Record (EPR) system.

3. NHS Green Plan

Members were informed that the Trust had achieved a reduction in its tonnes of carbon dioxide equivalent (tCO2E) of 3,271 in the first year of its Green Plan, narrowly missing the target of 3,281. Members were advised that similar levels would need to be achieved over the coming years in order to meet the Trust's Net Zero goals. Members were advised that more work needed to be undertaken on aligning governance and processes, and that work was underway with the Executive team to facilitate improvements in these areas.

4. Private Finance Initiative (PFI) Update

Members were provided an update on the work taking place with PFI partners at the Burnley General Teaching Hospital (BGTH) and the Royal Blackburn Teaching Hospital (RBTH) sites.

5. Internal Audit Progress Report – Insight Report

Members were advised that majority of planned activity in the Trust's 2022-23 internal audit plan had been completed and finalised, and were informed that two audit reviews were currently at the draft report stage, with a further two still in progress. Members were referred to the four final audit reports detailed in the Executive summary of the report and noted that two (Medical Sickness and Safety Standards for Invasive Procedures (LOCSSIPs)) had received 'Limited Assurance' ratings. Members noted that adequate controls had been found to be in place around Medical Sickness but were not always operating effectively. It was explained that the audit on LOCSSIPs had taken place in a period of transition and that a number of subsequent recommendations had been made which the Trust had accepted. In addition, a re-audit of this area was also planned to take place in 2023-24. Members commented that the Trust was one of a small number of organisations that had decided to proceed with implementing new guidance around LOCSSIPs and that the re-audit planned in 2023-24 would provide a number of opportunities for additional learning.

6. External Audit Annual Report

Members were informed that a reformatted version of the Mazars Audit Completion Report presented at the last meeting would be circulated separately after the meeting for information, confirming that no changes had been made to the main content of the paper.

7. ELFS Shared Service Independent Services Auditors Report

Members noted that the report covered the period from 1 April 2022 to 31 March 2023 and confirmed that all material aspects and controls are accurately described, suitably designed and were operated effectively. Upon a request for clarification for the length of membership for Board members of ELFS Shared Services, it was explained that there was uncertainty to the length of tenure of the wider circulation of members on the ELFS Board, however the Trust's Director of Finance and previous Directors of Finance at the Trust had been members

for a number of years. Furthermore, there was a degree of independence provided both through an independent Chair and the presence of a Non-Executive Director from the Northern Care Alliance.

8. Anti-Fraud Service Annual Report

Members were advised that the annual Government Counter Fraud Standard Return for the Trust had been successfully submitted following approval from Director of Finance and the Audit Committee Chair, and that 10 of the 12 components had been rated as green. Members noted that the remaining two areas had been rated as amber, with one related to completion of training and the other relating to policies, registers, and declarations of interest (DOIs). It was confirmed that work was taking place to address the first and that ideas on how to increase DOI compliance rates were being explored.

Members were informed that the Government was in the process of creating new 'failure to prevent fraud' offences to better hold organisations, including the NHS, to account if they profited from fraud committed by their employees.

Members were informed that three referral queries had been carried forward into 2023-24 and that seven further queries had been received during the current reporting period. It was noted that, of these seven, three had been progressed to investigations following initial enquiries and the other four remained open, pending further information from the Trust.

9. System Issues

Members were advised that the main system level issue for the Committee to be aware of related to the approval of the corporate collaboration business case at Integrated Care Board (ICB) level. An overview of the case was provided, including the desire to bring together some of the back-office functions from across the Lancashire and South Cumbria (LSC) area, including finance, HR, and some areas of governance.

Expressions of interest have been sought from Trusts who are interested in taking on the lead employer role, which the Trust had responded to.

It was reported that an agreed model for temporary staffing had been agreed via the ICB and a staff bank would be set up across the LSC area. Internal governance arrangements were in the process of being set out and it had been agreed to provide update reports to the Audit Committees and Trust Boards.

10. Waivers Report

Members noted that there were five waivers included within the report, with most being unavoidable as they elated to work being carried out across the LSC area. It was suggested that it was likely that there would be an increasing number of such waivers being required in the future as work continues on a partnership/LSC basis.

11. Corporate Risk Register

Members were informed that the Trust was utilising the improvement methodology to address the risks on the register, particularly those risks where capacity within teams was an issue. Members noted that whilst the Trust would not compromise on quality and safety, by utilising the improvement methodology to improve processes, further resources may not be required in all cases.

12. Board Assurance Framework (BAF)

Members were informed that the proposed new BAF, including new risks, risk tolerance and risk scores had been developed through a series of meetings with Executive Directors, a Board workshop and feedback from the other Committees had been gained. Members noted that there continued to be a large number of items within the assurance and controls sections of each BAF risk that could be seen as 'business as usual' and therefore further work was required to refine these sections over time.

Members commented that the links between the BAF and Corporate Risk Register had improved in this iteration of the document and suggested that consideration could be given to the wording of some of the assurances within the risks, particularly BAF risk two (Quality

and Safety) to ensure they provided the required levels of assurance as opposed to merely being statements.

13. Register of Interests

An update was provided on the work being undertaken to improve compliance with declarations of interests across the Trust. Members were informed that the conflicts of interest mandatory training module had been launched on 17 July 2023 with all staff being required to undertake the training module on a two-yearly cycle.

Members noted that whilst some progress had been made against the actions resulting from the MIAA audit, it had not been possible to undertake the updates to the declarations system, as a result of capacity limitations associated with the implementation of the Trust's Cerner system.

14. Terms of Reference

Members were advised that the Terms of Reference had been reviewed and revised in line with the current workings of the Committee, and in line with the new Code of Governance for the NHS.

Comments were received that the section that had been included regarding system working had set out the work of the Provider Collaboration Board, but not the expectations for the Audit Committee. Members were advised that the requested revisions would be made prior to being presented to the Board in September for ratification.

15. Update from the Lancashire and South Cumbria Audit Chairs Network

Members noted that the network was helpful in regard to enabling the Committee Chairs to meet, share information and develop positive working relationships.

16. Quality Committee Minutes

This item was presented for information only.

17. Finance and Performance Committee Minutes

This item was presented for information only.

18. Information Governance Steering Group Minutes

This item was presented for information only. Members were informed that following the Information Governance meeting in May 2023, training compliance had improved with the Trust compliance being at 94.2%, although a number of areas had over 95% compliance.

ITEMS TO REFER TO THE SUB-COMMITTEES OR ESCALATE TO THE TRUST BOARD

Members agreed to refer the issues regarding LOCSSIPs to the Quality Committee for further review. 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** **151**

8 November 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 13 September 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	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:

Meeting: **Trust Board (Closed Session)**

Date of Meeting: **13 September 2023**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 12 July 2023 were approved as a true record of the meeting.

ITEMS DISCUSSED

At the meeting of the Trust Board on 13 September 2023, the following matters were discussed in private:

a) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.
b) Round Table Discussion: Central Services
c) Round Table Discussion: PCB Clinical Programme
d) Community Services Update: Blackburn with Darwen and Lancashire East Community Services Alignment Update
e) Community Services Update: Albion Mill
f) Protecting and Expanding Elective Activity Self-Certification
g) Car Parking Charge Increase
h) Provider Revenue Support
i) Never Events Update
j) Fire Remediation Programme Update: Burnley General Teaching Hospital
k) Fire Remediation Programme Update: Royal Blackburn Teaching Hospital
l) Electronic Patient Record Progress Overview

ITEMS RECEIVED FOR INFORMATION

None.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**152**
8 November 2023		**Purpose**	Information
Title	Remuneration Committee Summary Report		
Executive sponsor	Mr S Sarwar, Chairman		

Summary: The list of matters discussed at the Remuneration Committee meeting held on 15 September 2023 are presented for Board members' information.

Report linkages

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

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	Yes

(152) Remuneration Committee Summary Report

Meeting: **Remuneration Committee**

Date of Meeting: **15 September 2023**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 8 March 2023 were approved as a true record of the meeting.

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 15 September 2023, the following matters were discussed in private:

a) Executive Salary Benchmarking Report and Remuneration Policy
b) Fit and Proper Persons Test Report