Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

East Lancashire Hospitals NHS Trust Board Meeting

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NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD MEETING (OPEN SESSION)

10 JANUARY 2024, 1.00pm

BOARDROOM, FUSION HOUSE / MS TEAMS

AGENDA

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

OPENING MATTERS				
TB/2024/001	**Chairman's Welcome**	Chairman	v	
TB/2024/002	**Apologies** To note apologies.	Chairman	v	
TB/2024/003	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	
TB/2024/004	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 8 November 2023.	Chairman	d✓	Approval
TB/2024/005	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2024/006	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2024/007	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2024/008	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information/ Approval
QUALITY AND SAFETY				
TB/2024/009	**Patient Story** To receive and consider the learning from a patient story.	Deputy Chief Nurse	p	Information/ Assurance
TB/2024/010	**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/2024/011	**Board Assurance Framework Review** To receive an update on the Board Assurance Framework and approve revisions based on the Executive Risk Assurance Group, Committees' and the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Director of Corporate Governance	d✓	Assurance/ Approval

Agenda

TB/2024/012	**Patient Safety Incident Response Assurance Report** To receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP). This report also includes information on maternity specific serious incidents reporting as required by Ockenden recommendations.	Executive Medical Director	d✓	Information/ Assurance
STRATEGIC ISSUES				
TB/2024/013	**Financial Strategy 2023-27**	Executive Director of Finance	d✓	Approval
TB/2024/014	**Maternity and Neonatal Services Update** *T Thompson to attend for this item.*	Deputy Chief Nurse	d✓	Information/ Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2024/015	**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 Deputy Chief Nurse) c) Caring (Deputy Chief Nurse) d) Effective (Executive Medical Director) e) Responsive (Deputy Chief Operating Officer) f) Well-Led (Executive Director of People and Culture and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2024/016	**Freedom to Speak Up Report** *J Butcher to attend for this item.*	Executive Director of People and Culture	d✓	Information/ Assurance
GOVERNANCE				
TB/2024/017	**ELHT&Me Annual Report and Accounts 2022-23** (The Board is meeting as Corporate Trustee for this item)	Executive Director of Finance	d✓	Approval
TB/2024/018	**Proposal for Revisions to Charity Deed** (The Board is meeting as Corporate Trustee for this item)	Director of Corporate Governance	d✓	Approval
TB/2024/019	**Finance and Performance Committee Summary Report**	Committee Chair	d✓	Information

	To note the matters considered by the Committee in discharging its duties.			
TB/2024/020	**Quality Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2023/021	**People and Culture Committee Summary Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information
TB/2024/022	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
TB/2024/023	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2024/024	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2024/025	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2024/026	**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/2024/027	**Date and Time of Next Meeting** Wednesday 13 March 2024, 12.30pm, Boardroom, Fusion House, Innovation Centre / MS Teams	Chairman	v	

TRUST BOARD REPORT **Item** **4**

10 January 2024 **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 8 November 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:

(4) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 12.30PM, 8 NOVEMBER 2023
MINUTES

PRESENT

Mr S Sarwar	Chairman	Chair
Mr M Hodgson	Chief Executive / Accountable Officer	
Mrs P Anderson	Non-Executive Director	
Professor G Baldwin	Non-Executive Director	
Mr S Barnes	Non-Executive Director	
Mrs M Brown	Executive Director of Finance	
Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive	
Mr J Husain	Executive Medical Director / Deputy Chief Executive	
Mr P Murphy	Chief Nurse	
Mrs C Randall	Non-Executive Director	
Mr K Rehman	Non-Executive Director	
Mrs L Sedgley	Non-Executive Director	
Mr R Smyth	Non-Executive Director	

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

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

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary	
Mr D Byrne	Corporate Governance Officer	Minutes
Miss K Ingham	Corporate Governance Manager	
Mr M Maher	Clinical Director of Obstetrics	Item: TB/2023/142
Mr M Pugh	Corporate Governance Officer	

Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2023/142

APOLOGIES

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

TB/2023/130 CHAIRMAN'S WELCOME

Mr Sarwar welcomed Directors to the meeting. He noted that the meeting would be Mr Barnes' last in his role as Non-Executive Director and thanked him both for the support he had provided to him personally since taking up the role of the Chairman and for his many contributions to the Trust during his tenure.

Mr Sarwar went on to inform Directors that the Trust had successfully appointed a new Associate Non-Executive Director following a recruitment exercise, who would be formally commencing in post from the 1 December 2023.

TB/2023/131 APOLOGIES

Apologies were received as recorded above.

TB/2023/132 DECLARATIONS OF INTEREST

The Register of Directors' Interests was presented to Directors.

Mr Sarwar advised that he had taken up a new role as a member of the Prince's Trust Health and Care Advisory Board and requested that this was noted in the Register.

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

TB/2023/133 MINUTES OF THE PREVIOUS MEETING

Directors, having had the opportunity to review the minutes of the previous meeting, approved them as a true and accurate record.

RESOLVED: The minutes of the meeting held on 13 September 2023 were approved as a true and accurate record.

TB/2023/134 MATTERS ARISING

There were no matters arising.

TB/2023/135 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/2023/136 CHAIRMAN'S REPORT

Mr Sarwar provided a summary of his activities to Directors since the previous meeting. He confirmed that he continued to attend meetings of the Lancashire and South Cumbria (LSC) Provider Collaboration Board (PCB), as well as recently formed System Recovery and Transformation Board, held with colleagues from other provider organisations and the Integrated Care Board (ICB). Mr Sarwar added that he had participated in recent engagements with regional NHS England (NHSE) colleagues and explained that whilst discussions had taken place around the financial challenges facing the Trust, there had also been clear recognition of the significant demands being placed on it and the increased acuity of the patients it was treating. He also informed Directors that it had been recognised that place-based partnerships in LSC were not yet where they needed to be and that the situation had started to evolve more quickly via the Place Board.

Mr Sarwar went on to provide a summary of his activities at Trust level. He advised that he had recently attended a stakeholder event organised by the Trust and that more similar events were planned for the future. Mr Sarwar informed Directors that he had recently visited the East Lancashire Child and Adolescent Service and commended the quality of the service and its leadership. He explained that he had also had the privilege of opening the Trust's Festival of Inclusion event in October 2023 and emphasised that it formed a key part of how it would continue to develop its culture. Mr Sarwar referred to the recent national media coverage around equality, diversity and inclusion and reiterated the Trust's commitment to this, adding that among other benefits, it would ultimately help the organisation to treat everyone who walked through its doors equally.

Mr Sarwar concluded his update by expressing his gratitude to all of the Trust's staff for their ongoing efforts in managing the significant demand and acuity across its footprint. He noted

that many sacrifices were being made by colleagues and that the Trust would not be able to continue to achieve everything that it currently was, without its dedicated workforce.

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

TB/2023/137 **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 made reference to the ongoing national COVID-19 Inquiry and noted that its third module regarding the impact of the pandemic on healthcare, had now gone live. He added that it was likely that requests for evidence would start to come through over the coming weeks and confirmed that preparations were already being made around this.

Mr Hodgson alluded to the unprecedented strike action by junior doctor and consultant colleagues and stressed that, although the Trust would always recognise the right of colleagues to undertake such action, there had been widespread disruption as a rresult. He reported that around 46,000 appointments had been disrupted on a national basis, with 5,000 outpatient appointments and 900 theatre procedures needing to be moved at the Trust alone.

Mr Hodgson explained that Virtual Ward programmes were expected to play a key part in addressing the substantial Urgent and Emergency Care (UEC) pressures currently being seen. He highlighted that the Trust was seen as a national exemplar in this area, with between 160 and 180 virtual ward beds in place.

Mr Hodgson informed Directors that several developments had taken place at a Lancashire and South Cumbria (LSC) system level, including the recent decision to make the Trust the host organisation for the LSC Central Services programme. He noted that the appointment of a substantive Managing Director and underpinning Heads of Service would be key in facilitating the delivery of this programme and indicated that the associated governance and workforce structures were still being developed. Mr Hodgson reported that good progress was being made around developing aspirant clinical models for LSC and advised that a pivotal workshop event would be taking place later in the month to commence development of an associated delivery programme over the coming two-to-five-year period.

Mr Hodgson went on to provide a summary of the developments taking place at Trust level, adding that the number of headlines in his report was testament to the scale of activity taking

place in the organisation. He reiterated that UEC pressures continued to be significant, with an average of over 700 patient attendances per day over recent months. Mr Hodgson highlighted that despite these pressures, improvements had been made in several areas, including reductions in patient length of stay.

Mr Hodgson referred to the ongoing implementation of the Trust's Electronic Patient Record (EPR) and reported that the 'teething issues' seen over recent months were now starting to subside. Directors noted that the Trust was seen as a national exemplar with regard to its EPR implementation and that Mr Hodgson had been invited to speak on this at a national webinar taking place later in the week.

Mr Hodgson informed Directors that the Trust was currently in the middle of its staff survey period for the year and emphasised how pivotal this was in receiving feedback from staff regarding their experiences of working in the organisation and what areas required further improvement. He reported that 37% of staff had provided responses thus far and that every effort was being made to increase this.

Mr Hodgson thanked the organisers of the Trust's recent Festival of Inclusion event and highlighted that several internationally recognised speakers had participated. He agreed with Mr Sarwar's earlier comments that these events formed a key part of the Trust's ongoing cultural development journey. Mr Hodgson added that the Trust had also held a Freedom to Speak Up month through October and stressed the importance of colleagues being able to speak out where they felt it necessary to do so. He highlighted that the Trust's STAR Awards ceremony had taken place a number of weeks prior and extended his congratulations to all 600 staff who had been nominated for an award. Directors noted that the Trust would be featured in two upcoming television documentaries, one regarding the work done by His Majesty's Coroner and another centred around emergency theatres.

Mr Hodgson concluded his update by presenting the latest applications for Safe, Personal and Effective Care (SPEC) 'Silver' status from the Burnley General Teaching Hospital (BGTH) Endoscopy Unit, Pendle West District Nurses, BGTH Day Case Theatre, Rakehead Rehabilitation Centre and Acute Medical Units A and B at Royal Blackburn Teaching Hospital (RBTH). Directors confirmed that they were content for 'Silver' status to be awarded to these areas.

Mr Sarwar reiterated his thanks to all colleagues in the Trust for their ongoing efforts, particularly to Mrs Atkinson and other colleagues who had been closely involved in the

successful launch of the EPR system. He extended his congratulations to Mr Hodgson and the rest of the Board in the Trust becoming a host body for the LSC Central Services Programme, noting that a substantial amount of work had gone into this.

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

TB/2023/138 **PATIENT STORY**

Mr Murphy confirmed that the patient story would again be presented in a video format and noted that this was the third story received by the Board in this manner. He explained that the story would be a difficult one to hear in many ways due to the circumstances involved but stressed the importance of the Board receiving a balance of both positive and negative patient experiences. Mr Murphy advised that the video would also include a section from a member of staff to provide a response to the concerns raised and to outline the lessons learned.

Mr Sarwar acknowledged that the story presented had not made for easy listening. He also stated that he felt the response provided had not sufficiently addressed the concerns raised and enquired if a formal letter of apology had been written and sent to the family.
Mr Murphy confirmed that formal apology had been made and that members of the family had met with Trust colleagues who had also passed on an apology.
Mr Sarwar extended a further apology to the family on behalf of the Board and that there was clear recognition that they had been let down by the Trust.

Mr McDonald stressed the importance of the Trust being able to acknowledge when it didn't get things right and for its responses to reflect the context of how it listened, heard and took note of any concerns not just of patients, but also their loved ones. He added that while there were often significant complexities in relation to discharges, it was important to remember that people were involved and that the Trust had a responsibility to support them and colleagues in managing discharges.

Mrs Anderson agreed with Mr Sarwar's proposal for a further apology to be extended to the patient and their relatives and with Mr McDonald's comments that the Trust should not shy away from acknowledging its failures when they occurred. She stated that she was fully confident that teams and divisional colleagues would look into the situation and update their response accordingly.

Mr Smyth observed that lack of communication had been a key theme in the story and pointed out that if the family's concerns had been listened to initially, the Board would not have had to hear from them regarding their experiences as it had done.

Mr Rehman expressed concern that other similarly complex situations may not be being handled in an appropriate manner and enquired what lessons had been learned from the issues raised in the patient story.
Mr Hodgson explained that the Trust had an Integrated Discharge Team in place to avoid situations like the one described in the patient story. He acknowledged that in this case some things had clearly been missed and that the Trust would need to redouble its efforts in this area.

Mrs Quinn stated that the story clearly showed the importance of partnerships, and that work was still needed across place to ensure that mechanisms were in place to avoid situations like the one described in the patient story. She agreed that a lack of communication seemed to be the key factor in the story, as well as the need to clearly listen to the needs of patients and their families.

Mr Murphy pointed out that the situation described in the story was likely not an isolated incident and agreed that families needed to be listened to as they usually knew patients better than anyone. He confirmed that the lessons learned would be fed through to Divisional Boards and reminded Directors that a new helpline service was being launched across the Trust soon to give families the opportunity to escalate any concerns they may have more effectively.

Mrs Sedgley pointed out that it cost the Trust extra time and money whenever it got things wrong and that a significant amount of both would have been saved in the patient's situation, as well as reducing unnecessary pain and suffering, had matters been resolved better.

Mr Sarwar commented that it would be easy to always have positive patient stories presented to the Board, but pointed out that the greatest lessons were often learned when mistakes had been made. He agreed that communication was a key factor in the issues raised and that more work was needed to ensure better integration. Mr Sarwar also suggested that patient stories could be tracked through the Quality Committee and that more consideration should be given to hearing patient voices in general going forward.

Mr Murphy agreed and confirmed that a library of patient stories was already available to discuss at future Quality Committee meetings.

RESOLVED: **Directors received the Patient Story and noted its content. Further consideration will be given to Patient Stories at future meetings of the Quality Committee.**

TB/2023/139 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, with one risk added (risk ID 9746 - inadequate funding model for research, development and innovation) and one de-escalated (risk ID 5791 - failure to recruit and retain to substantive nursing and midwifery posts) since the previous meeting. He highlighted that the number of open risks held on the Trust's risk register had fallen from 1,709 in 2021-22 to 773 in 2023-24, a decrease of 74%. Mr Husain confirmed that the profiling and mapping of strategic and operational risks in line with organisational strategies and objectives continued and that a risk relating to the embedding of the Trust's EPR system would likely be added to the register for the next meeting. He concluded his update by drawing Directors' attention to the assurances and controls in place around risk ID 9336 (lack of capacity can lead to extreme pressure resulting in a delayed care delivery) and reported that there had been one incident of moderate harm the previous week which the Executive team had since been briefed on.

Mr Hodgson pointed out the healthcare sector carried many inherent risks but acknowledged that the scale of the risks being seen in UEC areas was unexpected. He noted that good progress had been made with the development of the CRR, particularly around strengthening the governance between it and the Board Assurance Framework (BAF).

Mr Smyth observed that the report indicated that the Trust's compliance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) was currently at 44% and requested assurance on the expected timeframe for 95% compliance to be reached.
Mr Husain advised that investments had been made in expanding the capacity of the Health and Safety team to ensure that RIDDOR compliance could be addressed as soon as possible.
Mr McDonald informed Directors that he and Mrs Anderson had visited the Health and Safety team the previous week where they had described the challenges relating to workload and

capacity in more detail. He confirmed that every effort was now being made to address RIDDOR compliance as a priority and that updates would be provided in future reports.

Professor Baldwin agreed that good progress had been made in terms of the CRR and the Trust's overall management of risk, with clear improvements seen in every report. He added that the references made in the report around improved governance were particularly helpful, as it provided assurance that an appropriate amount of attention was being paid to any areas of high risk.

Mr Sarwar agreed that the progress made with risk management should be recognised but stressed that there also needed to be recognition that more trajectories were needed around some of the issues discussed.

RESOLVED: **Directors received the update and assurance about the work being undertaken in relation to the management of risks.**
Updates on the Trust's RIDDOR compliance will be provided in future Corporate Risk Register reports.

TB/2023/140 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, Finance and Performance and People and Culture Committees. She highlighted that the score for BAF risk 3 (Elective Recovery and Emergency Care Pathway) had increased from 16 to 20 following a detailed discussion at the most recent meeting of the Executive Risk Assurance Group (ERAG) and Committees. Directors also noted that risks 3 and 4 had been decluttered, with all 'business as usual' items now removed, and that this work would continue for the other risks.

RESOLVED: **Directors received, noted, and approved the revised BAF risks.**

TB/2023/141 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 the numbers of reported patient safety incidents had steadily increased from May 2023 onwards and that this was reflective of the increased UEC pressures. Mr Husain highlighted that incidents rated as severe comprised only 0.1% of the

total number of incidents, compared to 0.3% nationally and that the number of deaths amounted to 0.14%, compared to 0.25% nationally. Directors noted that Duty of Candour had been completed for all incidents and that all action plans and lessons learned had been shared through relevant forums.

Mr Husain went on to inform Directors that three new local Patient Safety Incident Response Plan priorities had been agreed by key leads and stakeholders: safeguarding patients with learning difficulties where issues with Mental Capacity Act has been identified, anticoagulant medication errors and discharge planning issues/problems from acute hospital beds to Care Homes and the Intensive Home Support Service (IHSS).

Mr Husain concluded his update by reporting that PSIRF training levels were continuing to rise, with level 1a now at 85% and level 1b at 65%.

In response to a query from Mrs Sedgley as to how the findings and lessons learned from reviews of deaths were disseminated across the Trust and embedded, Mr Husain advised that regular patient safety bulletins were circulated by Quality and Safety colleagues and that relevant information was cascaded through Divisional Serious Incident Review Groups and a number of other communication channels. Responding to a further request for clarification from Mrs Sedgley regarding the references in the report to the openness of communications between divisions, Mr Husain explained that every effort was being made to improve this but conceded that communication between different areas was an issue.

Mrs Gilligan added that a new Clinical Director had recently been appointed in the Orthopaedics division to improve communication and agree new escalation routes.

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

TB/2023/142 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson referred to the previously circulated report and advised that it provided a full overview of the Trust's progress in demonstrating compliance against the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5 as well as other neonatal quality and safety programmes.

Miss Thompson provided a summary of the Trust's progress against the CNST MIS. She highlighted that the Trust was compliant with nine of the ten standards for Year 5 and confirmed that work was underway to demonstrate compliance against safety action 8

(Training), including the development of a Core Competency Framework Version 2 Local Training Plan to be presented to the Board in January 2024 and a push to increase Practical Obstetric Multi-Professional Training (PROMPT) rates to the required 80% standard.

Mr Hodgson informed Directors that he had met with the Chairman of NHSE earlier in the week and that he had asked for an overview of the Trust's maternity and neonatal services. He added that this was due in part to the increased national concern around maternity services. Mr Hodgson reported that there had also been a recent article in the Health Service Journal (HSJ) regarding the overly complex nature of maternity updates provided to Trust Boards and stated that he felt the report provided a very clear and comprehensive picture of the Trust's progress against the CNST.

Mrs Anderson highlighted that detailed maternity updates had been provided at meetings of the Quality Committee for a number of years and that there had always been an air of openness and transparency regarding progress and any issues that needed to be resolved.

Mr Sarwar observed that the demands being placed on maternity and neonatal services were continuing to increase without a corresponding increase in resources and requested clarification on the risks associated with this.
Miss Thompson explained that there were some areas of risk, such as the ongoing shortage of midwives, but stressed that work was underway to move things forward. She advised that the capital required for other developments, such as digital monitors needed for Fetal Growth Restriction Assessments, would prove to be more of a barrier and confirmed that bids for external funding were put in whenever they were available.
Mr Murphy pointed out that the Local Maternity and Neonatal System (LMNS) had a significant role to play in some of the national asks and that more work was needed by the system to understand potential risks and mitigate them as much as possible.

Mr Rehman stated that it had been gratifying to see the amount of high-quality work taking place in the Trust's maternity services during his tenure as Maternity Champion. He commented that the CNST MIS was essentially a financial driven quality improvement project and stated that the scope and added value it brought were significant. Mr Rehman also stressed the need to ensure that the work taking place around the CNST was integrated together properly with the wider activity taking place around the Ockenden Review.

Mrs Sedgley observed that there was a national shortage of midwives and that a reliable source of incoming workforce would need to be secured to ensure that progress could be maintained.

Miss Thompson agreed and highlighted that the Trust was in a good position overall with its midwifery workforce, adding that it had held two recruitment events recently which had been very successful.

In response to a query from Mr Sarwar regarding the diversity of the coproduction groups referred to in the report, Mrs Quinn explained that maternity was one of the areas that would be included in a self-assessment exercise around this. She confirmed that she would discuss the matter with Miss Thompson in more detail after the meeting.

Mr Sarwar thanked Miss Thompson and Mr Maher for the updated and stated that he looked forward to their report at the next meeting.

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

An update on the development of the Core Competency Framework Version 2 Local Training Plan will be provided to the Board in January 2024.

TB/2023/143 NEW HOSPITALS PROGRAMME QUARTER 2 BOARD REPORT

The New Hospitals Programme Quarter 2 Board Report was received and noted by Directors.

Mr Hodgson highlighted the increasing connection between the New Hospitals Programme and the LSC Clinical Programme. He added that while realistically any significant opportunities would not be available until 2030 onwards, it would be incumbent on the Trust and the system to prepare to make the most of them in the interim.

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

TB/2023/144 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 September 2023. He informed Directors that work was underway to revise the metrics in the IPR and that these changes would be put before the Board at a workshop session to refine them at a later date.

RESOLVED: **A Board workshop session to consider and revise the metrics included in the IPR will be arranged at a later date.**

b) Safe

Mr Husain referred Directors to the Safe section of the report. He highlighted that there had been no reported cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) since the previous meeting and that the Trust had reported 34 cases Clostridium difficile (C. diff) for the year to date, well under its trajectory of 53. Mr Husain explained that an Infection Prevention and Control (IPC) Week would be held at the end of November 2023 to highlight the importance of IPC principles, particularly in light of the current overcrowding in emergency areas.

Mr Murphy advised that a substantial amount of work was taking place around registered nurse vacancies and confirmed that good progress was being made. Directors noted that the number of pressure ulcer incidents had fallen significantly following a surge earlier in the year and that this had been achieved through both education and dissemination of lessons learned.

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

c) Caring

Mr Murphy referred Directors to the Caring section of the report. He explained that there were no specific items to raise but highlighted that improvements were being seen in the feedback provided for accident and emergency areas.

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) performance remained within expected ranges at 1.11 but reported that its Hospital Standardised Mortality Ratio (HSMR) continued to flag outside of its expected tolerances at 109.7. He noted that the HSMR was lower than it had been over previous months. Mr Husain reported that the main alerting groups were pneumonia, secondary malignancies and cancer of the lung. Directors noted that the Trust still had lower crude mortality rate of 1.8%, compared to the 3% to 4% seen across the rest of the North West.

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

e) Responsive

Mrs Gilligan reiterated that September had been the busiest month on record for the Trust's Emergency Department (ED), with an average of 705 patient attendances per day across its sites. She informed Directors that despite these pressures, the Trust had still achieved 76% for 4-hour performance in September and had also achieved 75.38% in October. Mrs Gilligan confirmed that very long wait times were still being seen in the ED, but highlighted ambulance handover times remained low, with an average time of 27 minutes. She also advised that the Trust was consistently achieving its faster diagnosis standards.

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

f) Well-led

Mrs Quinn informed Directors that sickness rates had risen to 6.6% in September, with the top contributing factors being mental health and musculoskeletal issues. She advised that a number of conversations had taken place over the previous week regarding additional mental health support for staff. Mrs Quinn added that other work was taking place around making necessary adjustments for Trust staff to enable them to work, adding that a colleague story had been provided at the most recent meeting of the People and Culture Committee which had emphasised how urgent this was.

Mrs Quinn went on to highlight that significant improvements were being seen in vacancy rates through a combination of internal recruitment and other activities. She reported that bank and agency spend was still above desired levels but stressed that progress was being made in this area, including the agreement from all main agencies across LSC to a capped rate for staff going forward. Directors also noted that work continued on the development of a collaborative staff bank across LSC.

Mrs Quinn reported that appraisal and core skills training compliance rates had not improved to the extent that was needed and advised that colleagues from the Department of Education, Research and Innovation (DERI) were carrying out a review of appropriate mandatory training for staff as part of the efforts to improve this.

Mr Sarwar commented that the rise in sickness and absence rates, and the lack of improvement in compliance rates, was disappointing and stated that a more robust approach was needed to encourage staff to complete their skills training when required.
Mr Hodgson pointed out that sickness rates had varied significantly over recent months, adding that it had been at 5.3% the previous day. He suggested that a piece of work was needed to better understand the impact of local population health on sickness and absence rates.

Responding to a query from Mrs Sedgley regarding the support mechanisms available to managers around staff sickness, Mrs Quinn explained that the Trust's approach was to ensure that the best possible support was made available to try to prevent staff from taking sick leave in the first instance.

Mrs Brown informed Directors that the Trust remained in a very challenging financial position due to the combination of significant demands on UEC pathways, ongoing industrial action and a significant savings programme. She advised that the revision of the financial strategy was underway to help the Trust to better address its financial position and confirmed that this would be formally presented to the Board in January 2024 for ratification. Mrs Brown added that clear messaging around the need for greater grip and control over finances was also being circulated across the Trust.
Mr Hodgson stated that greater grip and control would be crucial in ensuring the delivery of the Trust's savings plan and advised that discussions were taking place with divisional colleagues via the Finance Assurance Board meetings to determine what else could be done.

Mr Sarwar stressed that the Trust had always been clear that it would not compromise patient safety in any way to meet financial targets. He agreed that the Trust's savings plan would play a significant role in it being able to achieve them, and the quicker that more robust grip and control measures could be implemented, the better.

RESOLVED: **Directors noted the information provided under the Well-Led section of the Integrated Performance Report.**
The links between local population health and staff sickness and absence rates will be explored through future meetings of the People and Culture Committee.

The Trust's revised Financial Strategy will be presented to the Board in January 2024 for ratification.

TB/2023/145 ANNUAL REPORT ON MEDICAL APPRAISAL, REVALIDATION AND GOVERNANCE

The Statement of Compliance for the Annual Report on Medical Appraisal, Revalidation and Governance was presented to the Board.

Mrs Anderson confirmed that a detailed discussion on the full Annual Report on Medical Appraisal, Revalidation and Governance was had taken place at the most recent meeting of the People and Culture Committee and that members had been content to ratify it.

Directors confirmed that they were also content to approve the Statement of Compliance for submission to NHSE.

RESOLVED: Directors confirmed that they were also content to approve the Statement of Compliance for submission to NHSE.

TB/2023/146 EAST LANCASHIRE HOSPITALS NHS TRUST SELF-ASSESSMENT REPORT 2022-23 FOR DEPARTMENT OF EDUCATION, RESEARCH AND INNOVATION

Mr Sarwar confirmed that the DERI Trust Self-Assessment Report 2022-23 had been circulated to Board members prior to the meeting and had been submitted to NHSE via Chair's Action.

Directors confirmed that they were content to ratify the submission.

RESOLVED: Directors confirmed that they were content to ratify the submission of the East Lancashire Hospitals NHS Trust Self-Assessment Report 2022-23 for Department of Education, Research and Innovation to NHSE.

TB/2023/147 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL ASSURANCE STATEMENT AND REPORT 2023-24

Mr McDonald advised that the EPRR Annual Statement described the Trust's position in relation to NHS Core Standards Assurance. He added that in addition to the paper, the Trust had a full work programme that formed another part of its EPRR work.

Directors confirmed that they were content to 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.

RESOLVED: **Directors noted the report and confirmed that they were content to ratify the ratify the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement.**

TB/2023/148 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/2023/149 QUALITY COMMITTEE SUMMARY REPORT

The report was presented to the Board for information.

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

TB/2023/150 AUDIT COMMITTEE SUMMARY REPORT

The report was presented to the Board for information.

TB/2023/151 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/2023/152 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2023/153 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2023/154 OPEN FORUM

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

TB/2023/155 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 noted that staff had been one of the key themes of the meeting, both in terms of valuing them and also through the Trust's ongoing commitment to improving equality, diversity and inclusion.

Mr Hodgson commented that the discussions regarding the ongoing pressures on UEC pathways had been a clear barometer of the challenges facing the LSC system as a whole and had emphasised the need to work together through Place-based partnerships to reduce demand.

RESOLVED: Directors noted the feedback provided.

TB/2023/156 DATE AND TIME OF NEXT MEETING

Mr Sarwar informed Directors that the next Trust Board meeting would be taking place on Wednesday, 10 January 2024 at 12:30.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **6**

10 January 2024 **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:

(6) Action Matrix

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2022/064: Behaviour Framework Implementation Update	A further progress report on the implementation of the Trust's Behavioural Framework will be provided to the Board in 12 months' time.	Executive Director of People and Culture	March 2024	Update: This report will be presented to the People and Culture Committee in March 2024.
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	Q1 2024-25	Update: 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/2023/115: Response to NHSE Letter Regarding Internal	An update on the Trust's implementation of Martyn's Law and how this compares with its	Executive Director of Integrated Care,	March 2024	Agenda Item: March 2024

Item Number	Action	Assigned To	Deadline	Status
Review of Processes in Relation to the Lucy Letby Case	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.	Partnerships and Resilience Executive Director of Integrated Care, Partnerships and Resilience	March 2024	This will be presented to the People and Culture Committee in March 2024.
TB/2023/138: Patient Story	Further consideration will be given to Patient Stories at future meetings of the Quality Committee.	Quality Committee	January 2024 onwards	**Complete**: Patient stories have been added to the Quality Committee agendas as a standing item. The first patient story will be discussed at the Quality Committee meeting taking place in January 2024.
TB/2023/139: Corporate Risk Register (CRR) and Risk Performance Report	Updates on the Trust's RIDDOR compliance will be provided in future Corporate Risk Register reports.	Executive Medical Director	March 2024	Update: Additional information on RIDDOR compliance will be included in the Corporate Risk Register reports from March 2024 onwards.

Item Number	Action	Assigned To	Deadline	Status
TB/2023/142: Maternity and Neonatal Services Update	An update on the development of the Core Competency Framework Version 2 Local Training Plan will be provided to the Board in January 2024.	Divisional Director of Midwifery and Nursing	January 2024	An update will be provided as part of the reporting to the Board in January 2024.
TB/2023/144: Integrated Performance Report - Introduction	A Board workshop session to consider and revise the metrics included in the IPR will be arranged at a later date.	Corporate Governance Team	February 2024	Update. This workshop is being scheduled to take place in late February 2024.
TB/2023/144: Integrated Performance Report – Well-led	The links between local population health and staff sickness and absence rates will be explored through future meetings of the People and Culture Committee. The Trust's revised Financial Strategy will be presented to the Board in January 2024 for ratification.	People and Culture Committee Executive Director of Finance	March 2024 onwards January 2024	People and Culture Committee Agenda Item: March 2024 **Complete**: Agenda Item: January 2024

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT		**Item**	**8**
10 January 2024		**Purpose**	Information

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

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

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 Inquiry

In December, the UK Covid-19 inquiry opened the sixth investigation: the Care Sector across the UK (Module 6). Public hearings are planned for Spring 2025.

Module 6 will investigate the impact of the pandemic on the publicly and privately funded adult social care sector in England, Scotland, Wales and Northern Ireland. It will consider the consequences of government decision-making – including restrictions imposed – on those living and working within the care sector, as well as decisions concerning capacity in hospitals and residents in adult care and residential homes.

It will also address the steps taken in adult care and residential homes to prevent the spread of Covid-19 and examine the capacity of the adult care sector to respond to the pandemic. More details are included in the provisional scope for Module 6, which is published on the Inquiry website.

The Core Participant application window will be open from 12 December 2023 to 19 January 2024.

Data published following junior doctor and hospital dental trainee's strike

NHS England has published data on the recent industrial action by junior doctors and hospital dental trainees.

The data showed a total of more than 73,000 staff were absent from work as a result of industrial action over the three day period. Over 10,000 junior doctors and hospital dental trainees took action in the North West.

Junior doctors and hospital dental trainees began their strike action on Wednesday (20 December) at 7.00am and finished at 7.00am on Saturday (23 December). Further strikes from 7.00am on 3 January until 7.00am on 9 January 2024 will also take place.

Since strikes began, the cumulative total of acute inpatient and outpatient appointments rescheduled is now 1,219,422. Last week's latest action saw 86,329 inpatient and outpatient appointments rescheduled.

NHS sets ambition to eliminate cervical cancer by 2040

Speaking at NHS Providers' annual conference, NHS chief executive Amanda Pritchard outlined how the NHS can achieve the goal for elimination by making it as easy as possible for people to get the lifesaving Human Papillomavirus (HPV) vaccination and increasing cervical screening uptake.

England is among the first countries in the world to set this elimination ambition within the next two decades. As part of new plans to put the NHS one step closer to eliminating the HPV virus, which causes up to 99% of cervical cancers, health and care professionals will be supported to identify those who most need the vaccine, through targeted outreach and offering jabs in more convenient settings.

The NHS will also set out plans to improve access to online vaccination appointments nationally, with millions more people able to view their full vaccination record and book vaccines on the NHS App over the coming months and years.

NHS dementia diagnosis rates at three-year high

Tens of thousands more people with dementia have received a diagnosis since the start of the pandemic, thanks to NHS recovery efforts.

In September 475,573 people with dementia were diagnosed – up more than 52,000 than the same time last year, with diagnosis rates now at a three year high.

The NHS is committed to continuing this diagnosis drive so that more people get the help they need as soon as possible. NHS England launched new pilots in December to increase diagnosis rates with health professionals going into care homes to assess older adults who may have missed checks during the pandemic.

It is hoped the ambition of diagnosing 66.7% of people over 65 will be met in the next year.

New NHS software to improve care for millions of patients

The NHS will roll out new software from spring next year to deliver better joined-up care for millions of patients, help tackle waiting lists and reduce hospital discharge delays.

The software will bring together existing NHS data, making it easier for staff to access key information to provide improved and more timely patient care.

The new tool, known as the Federated Data Platform, will join up key information currently held in separate NHS systems to tackle some of the big challenges the health service faces coming out of the pandemic.

By bringing together real time data, such as the number of beds in a hospital, the size of elective waiting lists, staff rosters, the availability of medical supplies and social care places, staff can plan and maximise resources such as operating theatre and outpatient clinic time to ensure patients receive more timely care.

NHS online GP registration service rolled out to over 2,000 practices

A pledge to roll out a new online GP registration service to 2,000 GP practices by the end of the year has been achieved ahead of schedule.

The online Register with a GP surgery service, managed by NHS England, has been designed to make the process simpler and more convenient for both patients and GP practices. The service allows patients to go online at any time of day to find and register with a local GP without having to visit the practice in person.

More than 750,000 patients have already used the service since its launch in 2022, with one in three GP practices now offering the service. GP practices process 6.8 million registrations a year, with many still using paper forms, often requiring patients to visit surgeries in person to collect and submit paperwork. The online tool has been shown to save GP practice staff admin time.

An ambition of reaching 2,000 GP practices by the end of December 2023 was set in the Delivery plan for recovering access to primary care – a milestone achieved a month earlier than expected, with more than 2,100 surgeries enrolled by the end of November 2023.

Hospital admissions due to smoking up nearly 5% last year, NHS data shows

Smoking-related hospital admissions in England increased by nearly 5% in 2022-23, compared to the previous year, but remain lower than before the Covid pandemic.

The latest statistics released from NHS England showed in 2022-23 there were an estimated 408,700 hospital admissions due to smoking, a rise from 389,800 in 2021-22 (an increase of 4.8%).

The figures published in NHS England's Statistics on Public Health, 2023 report also cover 2020-21, when there were 314,100 admissions attributed to smoking, which was consistent with fewer hospital admissions overall that year. Smoking-related admissions in each of the past three years were lower than in 2019-20, prior to the pandemic, when there were 446,400.

Around one in six (16%) of all hospital admissions for respiratory diseases in 2022-23 were estimated to be related to smoking, while it also caused 8% of all admissions for cancers and 7% of admissions for cardiovascular diseases.

Home testing trials for chronic kidney disease

Tens of thousands of patients at risk of kidney disease will be able to get tested from the comfort of their own homes as part of a £30 million tech and AI innovation fund this winter.

The Healthy.io early detection device will initially be sent to 30,000 patients who are considered most at risk for kidney disease.

Analysis suggests the device could help detect 1,300 cases of undiagnosed chronic kidney disease (CKD) over the coming months, as well as stopping some patients from developing end-stage renal disease – improving outcomes for individuals and reducing pressure on the NHS by preventing unplanned hospital admissions.

New NHS energy deal to cut bills by up to £100 million a year

As part of a major drive to find further efficiencies and improve care, the NHS will roll out a new centralised approach to buying energy which could help slash its energy bill nationally by up to £100 million a year.

From January, the NHS will use its buying power to purchase energy nationally, driving down costs to reinvest into frontline patient care. There are currently 200 different energy contracts in place in Trusts across England, each with varying value that have been purchased in different ways.

NHS commercial leaders worked alongside Crown Commercial Service (CCS), the biggest public procurement organisation in the UK, to develop a national approach to buying energy, which means the NHS can achieve greater value for money and find efficiencies.

Over the coming weeks, CCS will contact Trusts to support them with the transition to the new way of buying energy from the specific NHS energy 'basket', depending on their current energy agreement.

It is anticipated that all existing CCS contracts will move to this new agreement between January and March 2024. All other NHS Trusts are asked to commit to joining the CCS NHS energy basket once their current contracts expire.

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 8 November 2023. A recording of the meeting is available to watch online here: LSC ICB: 8 November 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 2.*

PCB meeting - 16 November 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 and 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 3*.

Provider Collaborative colleague briefing

A colleague briefing took place on 8 December updating attendees of the work being carried out by the local NHS Trusts to improve health and care across Lancashire and South Cumbria.

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

The date and time of next briefing is 5 March 2024, 12:30pm-13:30pm

Introducing Patient Engagement Portal Plus

Hospital Trusts in Lancashire and South Cumbria will soon be rolling out PEP+ (Patient Engagement Portal Plus) to patients. PEP+ is an online platform that gives patients more control of

their hospital care experience. It allows them to access relevant information at the touch of button, schedule appointments when they need them and communicate with their clinical team if needed.

The national ambition is for all acute hospitals to provide a secure digital solution for patients to access personal health information, arrange appointments and other administrative functionalities that will be linked to the NHS app.

New funding for women's health hubs

Lancashire and South Cumbria has been awarded funding to develop women's health hubs to support women's health needs. Women's health hubs bring together healthcare professionals and existing services to provide integrated women's health services in the community, centred on meeting women's needs across the life course. Hub models aim to improve access to and experiences of care, improve health outcomes for women, and reduce health inequalities.

NHS director visited communities to discuss health inequality issues

Professor Bola Owolabi met with health colleagues and charities in the region last week to see how the national Core20PLUS5 strategy is being implemented in a bid to reduce health inequalities. Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Professor Owolabi's visit began at New Neighbours Together in Burnley, where refugees and asylum seekers attend drop-in sessions for food, clothing, English lessons, and various support services, including health checks. Approximately 600 out of 6,000 refugees in Lancashire live in Burnley. She also visited Little Harwood Family Hub to discuss local challenges with leaders and to speak with parents about local services. At the hub's nursery, operated by Blackburn with Darwen Local Authority, Professor Owolabi learned about the children's oral health programme. The visit included a vaccination session by North Blackburn PCN, addressing flu vaccine challenges in the area.

Young people can get smart about asthma

Lancashire and South Cumbria Integrated Care Board is one of the first in the country to launch the asthma Digital Health Passport app, which helps children, young people and carers with self-management of asthma, and provides learning resources and education to improve knowledge and confidence.

New Engagement Hub for colleagues launched

A new colleague-only website will provide a central place for information and collaboration for the five NHS Trusts in Lancashire and South Cumbria and the Integrated Care Board. The Engagement Hub includes the most up-to-date information about changes planned across central and clinical services. The site has loads of ways for you to engage with projects and with each other, hopefully making it much easier to connect, share best practice and let colleagues know what's going on.

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:

-

Site pressures

Considerable work continues to take place to deliver safe, personal and effective care as the Trust faces sustained pressure in urgent and emergency care pathways. The Emergency Department has seen a record number of patients, which is impacting waiting times.

The Trust has looked at ways to improve the situation and the experience being provided to patients and their loved ones. This has included:

- Creating additional bed capacity by making better use of space in the hospital, including making the Discharge Lounge space multi-purposed so it now also supports the Older People's Rapid Assessment Unit
- Additional in-reach activity from the community services and acute medical team to support timely acute medical reviews and senior decision making
- The opening of a winter escalation ward to help ongoing efforts to improve patient flow
- A consultant working at the front door of Urgent Treatment Centre, weekdays between 10am-6pm, to identify patients for Same Day Emergency Care (SDEC), clinic appointments and those who may be suitable to go to Accrington Minor Injuries Unit for assessment

Spotlight on ambulances

A team from ELHT has been working with key partners to analyse reasons patients come to our Emergency Department and whether there are more appropriate alternatives that could help them receive the treatment and care they need more easily and quicker.

Part of this activity has involved a short-term review of people arriving by ambulance. This was to identify anyone who could have been looked after in their usual place of residence by a community support team and reducing the need for patients to come to hospital.

It is just one part of a programme of work to maximise the excellent out of hospital services available in the East Lancashire area. Further work is being undertaken to analyse and understand the data collected which will then be fed back to all involved to agree improvement actions and next steps.

Industrial action

Further periods of industrial action have taken place since the last Board meeting as part of a national dispute over pay. Junior doctors took action from 20-23 December and 3-9 January. Colleagues continued to work tirelessly to provide patients with the best possible care under the circumstances.

The Trust took steps to minimise the impact on patients, however the action lead to a reduced level of clinical capacity across our services and some procedures had to be cancelled as a result.

Collaborating with the wider healthcare system, consistent messages were shared with the public asking people to attend appointments unless told not to and signposting to appropriate pathways for health care and support.

EPR update

The Electronic Patient Record system has been live across the Trust for seven months and a significant amount of work is ongoing to improve and enhance colleagues' experience with using the system.

One to one coaching from Cerner Oracle began in October and has received positive feedback. Clinical colleagues have reported taking their learning to their teams and upskilling each other across the organisation as a direct result of the coaching.

Clinical Informatics continue their walkabouts at all Trust sites to educate colleagues on how to create discharge letters properly and to capture feedback from teams to support any further

improvement work. The feedback has led to various technical issues being resolved based on change requests.

Since the implementation of EPR in June there have been over 14,000 IT tickets raised specifically in relation to Cerner Millennium. The data and digital teams continue to work behind the scenes to resolve these. Out of these 14,000 tickets, approximately 300 remain open. 60,000 tickets have been raised in total, including non-EPR related tickets, since go-live.

The Trust has recently implemented a robust procedure to manage changes required across the Data and Digital Infrastructure and Systems. This incorporates a weekly meeting with clinical, operational and data and digital colleagues across the organisation to ensure that all changes are evaluated and implemented safely. At present, there are over 200 changes working their way through the process.

CEO of NHS Employers visit

The Trust recently welcomed Danny Mortimer, Chief Executive of NHS Employers. Danny has been chief executive of NHS Employers since November 2014, leading work relating to workforce policy and practice.

During his time at the Trust he met with senior leaders and heard about ELHT's innovative approach to people and culture, innovation and health equity.

Getting patients Ho Ho Home for Christmas/winter planning

The Trust ran its popular internal campaign focusing on patient flow and discharge, Ho Ho Home for Christmas, encouraging colleagues to do all they could to help people spend Christmas in their own home or usual place of residence, where appropriate. This included regular updates in internal communications channels sharing best practice and guidance.

Meanwhile, key messages were shared with patients, families, stakeholders and partners across the healthcare system as part of a communications campaign co-produced by the Lancashire and South Cumbria Provider Collaborative Board communications teams. The campaign focused on three key areas: prevention, signposting and self-care, with the following objectives:

- Reducing non-urgent attendances to emergency pathways
- Increasing take-up of vaccinations
- Increasing public awareness of the appropriate health and care services
- Keeping the public up-to-date

As a co-produced campaign, all five local NHS Trusts plus the ICB continued to share and reinforce a selection of focused, agreed key messages.

ELHT's updated OPEL framework

In December ELHT became part of the new national Operational Pressures Escalation Levels (OPEL) framework. OPEL is designed to support accident and emergency departments, helping to manage everyday variations in demand and outline procedures when there are significant surges.

Specialist Palliative Nurses launch seven-day service

The Trust's Specialist Palliative Care teams are now working seven days (8.30am-4.30pm) across the hospital and community. They are available to assess and review patients on the wards and out in the community who require urgent interventions. This may include patients with unstable and complex symptoms who would benefit from daily input to ensure their situation remains stable and/or to avoid unnecessary conveyance to hospital.

New referral pathway in ED to community pharmacists launched

Patients visiting the Urgent Treatment Centre at Royal Blackburn Teaching Hospital (RBTH) with minor illness symptoms or needing an urgent regular medicine now have the option to have a same day clinical consultation with a community pharmacist as part of the NHS Community Pharmacist Consultation Service (CPCS). The scheme is being piloted, with two pharmacies currently involved, both within a short distance from RBTH.

Patient Initiated Digital Mutual Aid System

Patients who have been waiting over 40 weeks for treatment and do not have an appointment date within the next eight weeks, could now be eligible to request to move to a different hospital to be treated sooner.

The alterative choice programme or Patient Initiated Digital Mutual Aid System (PIDMAS) went live at the end of October 2023. As part of this national initiative, those eligible are being contacted by the hospital they are under the care of and given a weblink and telephone number to submit a request to explore their options. To support this, ELHT has been contacting eligible patients with information.

Smoke-free pledge

As part of the Trust's commitment to helping smokers quit and providing smokefree environments that support them, Chief Executive Martin Hodgson signed the NHS Smokefree Pledge. The pledge is designed to be a clear and visible way for NHS organisations to show their commitment

to provide healthier smokefree environments and to provide people with the opportunity to consider options around stopping smoking.

In England alone, almost 75,000 people die from smoking related diseases each year. Smoking accounts for over one-third of all deaths from respiratory disease, one quarter of all deaths from cancer and over one tenth of all deaths caused by circulatory diseases. On average, smoking reduces life expectancy by 10 years. If hospitalised, people who smoke are more likely to require longer stays and need intensive care after surgery.

Delivering the commitments in the NHS Smokefree Pledge will not only bring us closer to national targets and the Government's ambition for England to be smokefree by 2030 but can ultimately save tens of thousands of lives and billions of pounds in NHS resources.

Tobacco Inpatients Service open for referrals

A new Tobacco Inpatient Service Team opened for referrals in November. The service supports nicotine dependent patients at ELHT and offers referrals to their service via the Care Plan or New Order Entry on Cerner.

The service also offers advice about nicotine replacement therapy and VBA – known as Very Brief Advice on Smoking, a life-saving intervention delivered by health and social care practitioners that triggers quit attempts.

Adult lung function testing at Rossendale Community Diagnostics Centre

Rossendale Community Diagnostics Centre, based in Rossendale Primary Care Health Centre, is now taking referrals from primary care for adult lung function testing. Tests can be requested for COPD, asthma and chronic cough.

The new Rossendale CDC became operational in October 2022 following a £1.2m investment from national funding allocated to reduce diagnostic waiting times and to bring services closer to patients' homes.

It All Adds Up

A new campaign called It All Adds Up has been launched encouraging colleagues to think about ways to reduce spending. The aim is to reduce expenditure where possible with immediate effect, without impact on patient safety or the quality of services.

To help, colleagues have been encouraged to put forward ideas for reducing costs and saving money – either in their own area or anywhere else in the Trust.

12 days of Christmas

This year as part of our charity's Christmas Hug to colleagues, £15,000 of vouchers were given away. It served as a token of appreciation for the unwavering dedication of our hardworking colleagues.

Each weekday from Monday 11 December, the names of 12 colleagues, were drawn at random to receive a voucher worth £100, courtesy of our hospital charity ELHT&Me.

Colleagues also had the opportunity to nominate a team to be named as a 'Christmas Cracker' and win one of 12 towers of treats, also donated by ELHT&Me. More than 1,00 nominations were submitted to be a Christmas Cracker.

Examples of Christmas Cracker winners are:

> **Paediatric Audiology, St Peter's Centre**
>
> "The Paediatric Audiology team have come together through a period of significant change and increased demand this year, while battling with estates issues and implementation of a new patient management system (as well as Cerner). Through the whole of 2023 the team have remained resolute and dedicated to the deaf children and families of East Lancashire we serve and made the service a really pleasant place to work. I am so blessed to have a fantastic team to work with and our amazing colleague wellbeing champion (Charlene Richardson) deserves a special mention in her commitment to supporting our wellbeing."
>
> **Keira Butler – A&E**
>
> "This nurse personifies what it is to be a nurse. My father-in-law was a patient on A&E. Despite it being very busy Kiera was very kind, explained everything to my father-in-law and the family. The care was amazing. She maintained his dignity. Despite my father-in-law passing away I will always remember this very special nurse with fondness and how caring and kind she was."

You're not OK, let's talk about it

A new campaign was launched in December to support colleague wellbeing. 'I know you're not okay, let's talk about it' aimed to encourage colleagues to reach out to one another and to raise awareness of the support available.

Following on from feedback from a survey carried out by the Trust's staff Mental Health Network, a review of mental health information was undertaken. All key details including waiting times were collated into a central hub providing ease of access for those in need seeking help and advice.

Wellbeing and adjustments passport

A wellbeing and adjustments passport is now available as part of ongoing and easy access support for colleagues. It can be used by any colleague who feels that they may need some additional support at work, for example, someone with a disability or long-term condition, someone with caring responsibilities, parents with young children, colleagues who observe religious festivals or daily prayers and colleagues who are in the process of gender reassignment. The Passport is completely voluntary, however all colleagues have the opportunity to have one completed and it can be at any point during their employment.

Mobile breast screening for colleagues

A new Trust initiative is offering colleagues who have missed their breast screening mammogram to access the mobile breast screening service. The service has been available at Burnley and Blackburn. The team has also been providing a drop-in service for any colleague who wishes to learn more about breast awareness, signs and symptoms, and breast self-examination.

Royal visit for John

Trust colleague John Mathew met King Charles III during a special event at Buckingham Palace.

John, a charge nurse at Royal Blackburn Teaching Hospital, was one of 25 international nurses from the North West to be invited to meet His Majesty at a celebration of the contribution of international nurses and midwives. The event was part of the NHS75 celebrations coinciding with the King's 75th birthday.

The Prince's Trust celebration event

The Trust continues to provide opportunities through the Prince's Trust for young people who are looking for employment.

The Prince's Trust began in 1976 by His Majesty King Charles III when he was His Royal Highness The Prince of Wales. The Trust helps young people from disadvantaged communities and those facing the greatest adversity by supporting them to build the confidence and skills to live, learn and earn.

Working with NHSE and the Department for health and Social Care, The Prince's Trust provide two pre-employment programmes "Get Into" and "Get Started".

A celebration was held last month showcasing the latest group who have completed the “Get Into” Hospital’s training. The event praised the group of young people who completed training and work placements as Healthcare Assistants and within the Catering Department and as a result have all secured bank employment within the Trust.

ELHT partnered with The Prince's Trust in 2017 and since then has employed 98 young people through the programme.

ELHT accredited to deliver teacher training

The Trust has been approved as an accredited training centre to deliver teacher training qualifications – the first in Lancashire and South Cumbria to do so.

The Level 3 Award in Education and Training is accredited through Qualsafe. The qualification provides an introduction for those new to teaching and training or those wishing to teach or train and is designed to equip a wide range of teachers and facilitators with the basics they need.

The course will be delivered internally by an experienced team of qualified teachers.

Chef of the Year 2023

Darby Hayhurst and Dylan Lucan have been crowned the winners of the NHS Chef 2023 competition. The is now in its third year and this is the second time ELHT chefs have won.

Competitors create restaurant standard food using an NHS budget – helping to showcase how rewarding a career as an NHS chef can be, supporting patients in their recovery while working as part of a team.

During the final held at the Lainston House Cookery School near Winchester finalists had to cook a four-course menu in four hours. Darby and Dylan’s winning menu consisted of cauliflower three ways, Moroccan spiced cakes, pan fried duck as well as choc, rock and pop crumble.

Award win for Critical Care Research Team

The Critical Care Research Team were named winners of the ‘Research’ Future of Intensive Care Awards category at the Intensive Care Society Awards 2023. The awards recognise and celebrate the exceptional achievements of individuals and teams in delivering the best quality care.

Nurses recognised with Queen's Nurse title

Five nurses at the Trust have been recognised for their commitment to high standards of person-centred care with the Queen's Nurse title. Advanced Nurse Practitioner Helen Stubbs, Clinical Team Leader Laura Milner, Community Practitioner Joanne Cranham, and District Nursing Matrons Sam Head and Hayley Hudson have been recognised for demonstrating a high level of commitment to patient care and nursing practice.

The Queen's Nurse programme brings together community nurses to develop their professional skills and is a formal recognition that you are part of a professional network of nurses dedicated to delivering and leading outstanding care in the community. The title is a formal recognition of nurses' commitment to improving care for patients and provides further learning and leadership opportunities, as well as giving access to developmental programmes, bursaries and networking.

Top-quality accreditation by the Royal College of Psychiatrists

Colleagues who support young people with their mental health across East Lancashire have again been recognised for the quality of the service they provide. The Trust is one of just six NHS Trusts in the country to be recognised with accreditation by the Royal College of Psychiatrists.

It was presented by the Quality Network for Community CAMHS (Child and Adolescent Mental Health Services) in recognition of the care delivered by ELCAS, a community mental health service that supports children and young people up to the age of 18 who are experiencing a range of mental health difficulties. ELCAS was first accredited by the Royal College of Psychiatrists in this way in 2017, and again in 2020.

ELHT excellence in pharmacy recognised

Two Senior Pharmacy Technicians have been presented with the 'Excellence in Pharmacy Education and Development Award'. Jane Shanahan and Alison Marshall from ELHT's Specialist Medicines Optimisation Care Home (SMOCH) Team were presented with the award, at the APTUK Pharmacy Technician Awards.

Over the last 12 months Jane and Alison have networked, extensively studied research papers, presented anticholinergic awareness sessions to multiple healthcare professionals of all levels and all disciplines, as well being invited to present at University of Central Lancashire and the British Geriatrics Society Conference.

Their work has also been nationally recognised and expanded to clinical pathways where their work is now embedded across both primary and secondary care in East Lancashire and has helped improve the quality of life of East Lancashire care home residents.

Memory bench to remember Jasper

ELHT colleagues and visitors joined together for the unveiling of a memorial bench in honour of Jasper, the Trust's therapy dog who sadly died last year. The bench sits outside Royal Blackburn Teaching Hospital and was kindly commissioned by GMB M53 East Lancs Health Branch and lovingly made by York Disabled Workers Co-Operative. The chosen spot for the bench was where Jasper used to have his lunchtime walk and where he loved to meet colleagues and patients.

Cause of Death documentary

ELHT featured in the second series of Candour's remarkable Cause of Death documentary for Channel 5. The insightful exploration of coronial investigations, aired from 8 November, explaining how unexplained or suspicious deaths are investigated.

The third series is now being filmed and again features ELHT alongside Lancashire Teaching Hospitals.

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:

- Armistice Day remembrance events
- Annual baby loss remembrance service
- World aids day
- World COPD day
- Nursing support workers day
- National grief awareness week
- International fraud awareness week
- World antimicrobial resistance awareness week
- Adult safeguarding week
- Advanced Practitioner week
- Radon awareness week
- White Ribbon Day - 16 days of activism against gender-based violence
- Disability history month

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 Integrated Care Board

Integrated Care Board

Date of meeting	8 November 2023
Title of paper	Report of the Chief Executive
Presented by	Kevin Lavery, Chief Executive
Author	Hannah Brooks, Communications and Engagement Manager and Executive Team contributions
Agenda item	5
Confidential	No

Executive summary

This report sets out the current challenges that the ICB is facing in relation to delivering an ambitious recovery and transformation plan, and focuses on what needs to be in place in order for the plan to be achieved.

Major change will require strong commitment and leadership, and the right culture. This will be even more key as more complex programmes of transformation are developed.

There has not been enough progress in relation to the agreed recovery plan and the month six position means that it is now necessary to prepare for intervention from NHS England. Intervention should add value and help to improve the year-end position and future transformation.

Recommendations

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

Which Strategic Objective/s does the report relate to:		Tick
SO1	Improve quality, including safety, clinical outcomes, and patient experience	**x**
SO2	To equalise opportunities and clinical outcomes across the area	**x**
SO3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	**x**
SO4	Meet financial targets and deliver improved productivity	**x**
SO5	Meet national and locally determined performance standards and targets	**x**
SO6	To develop and implement ambitious, deliverable strategies	**x**

Implications

	Yes	No	N/A	Comments
Associated risks			x	
Are associated risks detailed on the ICB Risk Register?			x	

Financial Implications			x	

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
Executive Management Team	31 October	Draft reviewed for agreement.

Conflicts of interest associated with this report
Not applicable.

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

Report authorised by:	Kevin Lavery, Chief Executive

Integrated Care Board – 8 November 2023

Report of the Chief Executive

1. Introduction

1.1 We are acutely aware that we face some major challenges around the Integrated Care Board (ICB). There are even bigger challenges within our system. We are working hard to respond to those challenges, and we have a good plan in place for recovery and transformation, which we covered in detail at the last board meeting in September.

1.2 Since the last formal board meeting, we have held the first two meetings of the System Recovery and Transformation Board, which brings together the leadership of all of our NHS trusts, the ICB and local government.

1.3 We do, however, have some real risks around the speed of implementation of our recovery plan. In the NHS, we are not used to transformational change, and we are encountering some resistance to change. Lancashire and South Cumbria has low turnover and a conservative culture, so major change is a challenge in our system. We need to work closely with our senior and middle managers in the system to build on the positive work that is already taking place and ensure they have what they need to go further, faster and truly embed change.

2. The challenge of execution against our recovery plan

2.1 We have got a good plan, but it is high risk and requires trusts to work closely together, major hospital reconfiguration and a switch to community services. This is nothing short of a revolution. It is not surprising that execution of such an ambitious plan is challenging. It means a major change to how we do things around here and not all the relevant staff have the necessary experience and skills.

2.2 As American novelist Larry McMurtry describes, “what needed to be done was simple, if not easy”. We need to make progress and move forward. To do this, we need to gain momentum. There is a lot that needs to happen and as a system we need to be on the same page.

2.3 The challenge is not going to go away, and as leaders we will need to be decisive in the difficult decisions that we will face over the coming years. It is likely to be a difficult experience if we are going to achieve a real step change across the system.

2.4 It is important that we do not come up short in this respect. One of the things that we can really focus on is getting the culture and leadership right at every

level of our healthcare system, so that we can make big and difficult decisions for the overall benefit of the people of Lancashire and South Cumbria (LSC).

2.5 Our central services programme is one of the more mature and well-developed programmes. The Provider Collaborative joint committee has determined what is in store, set a joint timetable and agreed that East Lancashire Hospitals Trust (ELHT) will be the host organisation.

2.6 However, we are now encountering some slippage which is concerning. This is a perfect example of a programme that has achieved a lot in a short space of time, but now we must ensure that the environment around the programme is right, so that we can continue to meet the challenging and ambitious objectives of the programme. This will require strong commitment and leadership and the right culture. This will be even more key as we move onto more complex programmes of transformation, like clinical service reconfiguration.

2.7 I am keen, therefore, that we get some strong earthed leadership development for the system – for senior leadership and high-potential managers, focused on hard skills around our agenda, such as how to roll out virtual care and zero-based budgeting, soft skills such as collaboration and engagement with clinicians as well as building a community of leaders within our system. In doing so, we will reap the rewards for years to come for people living and working in Lancashire and South Cumbria.

3. Preparing for intervention

3.1 So far, we have been using a range of NHS England (NHSE) financial controls around discretionary spend, consultancy, contract renewals and staff vacancies across the LSC NHS system. We voluntarily adopted these measures in an attempt to improve our financial position.

3.2 Although the three-year recovery plan that we agreed with NHSE is a good one, the execution of the plan has fallen short of what we expected. There is a lot of risk within the plan, due to the underlying deficit.

3.3 Unfortunately, we are not making enough progress and our month six position means that we are now preparing for intervention from NHS England.

3.4 Intervention is not how it should be done. It is much better to get it right first time, rather than intervene after the event.

3.5 We need to make sure that any intervention adds value and helps improve our year-end position and our future transformation.

3.6 We need targeted support from specialists and experts from the national team, who are able to take an objective view of specific areas that would benefit from intervention. We will therefore ask for support in relation to certain areas of commissioning, transformation programmes that are encountering barriers, and the trusts in our system that are most financially off-plan.

4. Organisational development: a way to go

4.1 We are currently in the annual NHS Staff Survey period and in July we ran one of the quarterly NHS Pulse Surveys. This, alongside our monthly wellbeing check-ins with staff has shown that staff satisfaction and morale remains low.

4.2 As chief executive of the organisation, I take responsibility for the results of our surveys and have already begun working with our leadership team to look at how we can improve the experiences of our staff.

4.3 We have a way to go to get some of this right, but we are committed to listening to our staff and are making our organisation a great place to work for everyone.

5. Chief operating officer

5.1 We have updated the job title for Craig Harris to better reflect his portfolio. Although there is no change to Craig's portfolio or responsibilities, his job title is now chief operating officer, or COO. The updated job title is more akin to what is used in other NHS organisations and is intended to help people better understand Craig's role and portfolio.

6. Continuing Healthcare transfer of staff and new model

6.1 On 1 October the All Age Continuing Care (AACC) and Individual Patient Activity (IPA) service provided by Midlands and Lancashire Commissioning Support Unit (MLCSU) transferred into our ICB. This means that the AACC and IPA service has now become a team of circa 250 staff. This also includes existing ICB staff and 75 new starters.

6.2 Four place-based Continuing Healthcare (CHC) teams will operate across the ICB. Discharge to assess, children and young people's continuing care and IPA teams will operate at system level with place-based links.

6.3 A senior leadership team has been established within the ICB led by the director of adult health and care and the associate director of AACH and IPA.

6.4 This has been a significant milestone for the service and many compliments have already been received from external stakeholders and staff who have transferred over about the improved quality and responsiveness.

6.5 It should also be noted that the AACC team has met their NHSE quality premium trajectory and aim to achieve this consistently across all place teams from Q4 as approved by NHSE, which is another milestone achievement.

6.6 The board will be aware that we have got significant financial challenges in the CHC area, with high inflation on packages and increased volumes and some of that is associated with the transfer from MLCSU to us. At the same time, we are confident that that the new model is working really well. Already, we have eliminated the backlog and we are close to hitting our target for the time requirements for assessments. The new model has already received numerous compliments from stakeholders from across the system.

7. National Allied Health Professional Day

7.1 In the week leading up to Allied Health Professionals (AHPs) Day on Saturday 14 October, our AHPs showcased the breadth and depth of their system working innovation through events and social media, with a focus on 'AHPs in the right place, at the right time, with the right skills'.

7.2 AHPs represent our third largest workforce across the ICB. They are integral to helping us move forward with new multi-professional clinical and care models that will holistically support the needs of our communities both now and in the future.

7.3 It is important to acknowledge the impact that AHPs have in patient care, inspire the future workforce and ensure AHPs play a central role in health and care transformation. Our allied health professions are art therapists, dramatherapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, osteopaths, prosthetists and orthotists, paramedics, physiotherapists, diagnostic radiographers, therapeutic radiographers, speech and language therapists.

7.4 Katherine Simcock, principal speech and language therapist at Lancashire and South Cumbria NHS Foundation Trust won the 'AHP leadership for equality, diversity and inclusion award' the prestigious Chief AHP Officer Awards, announced as part of the national celebrations.

7.5 Katherine's work included a focus on the evidence base for language used to talk about autism. Through co-production with people in Lancashire and South Cumbria, Katherine produced a language guide to help professionals talk to autistic people about their preferences for language whilst continuing to recognise that every person is an individual and language is not 'one size fits all'. This is a great example of the way in which we are keen to see our teams work across Lancashire and South Cumbria, and rightfully so, has earned national recognition.

8. Our ambition to become a truly anti-racist organisation

8.1 Every October marks Black History Month, which is a time to promote and celebrate Black contributions to British society, including our NHS colleagues across Lancashire and South Cumbria. While this is a time of celebration, it also shines a spotlight on some of differences and issues experienced by Black

people and people from other ethnic backgrounds.

8.2 Nationally, we know that NHS staff from ethnically diverse backgrounds experience disproportionately higher rates of bullying, harassment and discrimination when compared to their white counterparts and are less likely to be represented at senior levels within our workforce. We cannot allow this to be the experience of our people, and therefore we are committed as a senior team to challenge this behaviour and pave the way for equal opportunities for all of our people across the system.

8.3 Through our annual work on the NHS Workforce Race Equality Standard (WRES), we know that our ICB and provider trusts still have a long way to go to ensure that we have a representative workforce and that our people from ethnically diverse backgrounds are able to thrive in a workplace free from discrimination. We have recently completed our WRES System Report for 2023 and will be using this to formulate clear actions to improve the workplace experience of our ethnically diverse staff.

8.4 We are also in the process of engaging with the North West BAME Assembly's Anti-Racist Framework which will help us further in improving workplace experiences and amplifying the voices of our people from ethnically diverse backgrounds.

8.5 As part of our commitment to the Anti-Racist Framework, we will soon be publishing our anti-racism statement which will outline our organisation's stance. Our ambition as an ICB is to become a truly anti-racist organisation and we are fully committed to taking appropriate steps to ensure this happens.

9. Provider Selection Regime

9.1 The Provider Selection Regime (PSR) regulations have been introduced into Parliament by the Department of Health and Social Care (DHSC), and subject to scrutiny by Parliament, the DHSC intends for the new regulations to come into force on 1 January 2024.

9.2 The PSR will be a set of new rules for procuring health care services in England by organisations termed relevant authorities and will replace the existing procurement rules for NHS and local authority funded health care services. Relevant authorities are:

1. NHS England
2. Integrated Care Boards
3. NHS trusts and NHS foundation trusts
4. Local authorities and combined authorities

9.3 The PSR introduces greater flexibility when making decisions about how best to arrange healthcare services, with competitive tendering one of several potential

processes that may be followed.

9.4 To support implementation, NHS England have published draft statutory guidance (subject to parliamentary approval of the regulations) which will be supported by a set of resources including more detailed implementation tools such as process maps and template documents.

9.5 This will require a significant amount of planning for the ICB over the next eight weeks to ensure that we have our internal processes, contract reviews, and decision-making arrangements in place to implement the new regime. We will keep the board informed of any relevant updates in the lead up to anticipated implementation date.

10. Awards and recognition for our staff

10.1 I would like to finish by acknowledging some awards that our ICB staff have recently received.

10.2 Our ICB won an award at the HSJ Patient Safety Awards in the 'Improving Medicines Safety' category for our joint work with Midlands and Lancashire Commissioning Support Unit on enhancing inhaler prescribing practice.

10.3 Louise Hamer was also recently presented with the first ever 'Lads like Us' Ask Why award at the Institute of Health Visiting Evidence-based Practice Conference for showing tremendous trauma informed practice, and exercising professional curiosity.

10.4 Alison Marshall and Jane Shanahan won the Excellence in Pharmacy – Education and Development award at the National Conference for the Association for Pharmacy Technicians, after they collaborated across organisations and professions to share their learning and upskill the workforce in reducing harms and improving quality of life and outcomes for our most vulnerable patients.

10.5 Finally, Dr Andy Knox, associate medical director for population health, received an MBE last week in recognition of his services to primary care and tackling health inequalities across the region, awarded as part of The King's first birthday honours list. Dr Knox has been a leading figure in developing our population health model and the population health equity leadership academy, which launched last year.

10.6 As an ICB, we are keen to recognise and celebrate the hard work and dedication of our staff, and one of the ways that we plan to achieve that is through our new internal awards process.

10.7 In mid-September, we launched our first ever ICB Staff Excellence Awards, which centre around our new 'PROUD' values. During the nomination period we received over 175 nominations for the nine categories, and we will hold an

afternoon celebration event to announce the award winners on 6 December, which board members have been invited to.

Kevin Lavery

1 November 2023

Provider Collaborative Board – 16 November 2023

The Provider Collaborative Board (PCB) met on 16 November 2023. It received updates on the following standing items: system pressures and performance updates within Urgent/Emergency Care and Elective Care; Mental Health and Learning Disabilities, and Finances.

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

The Joint Committee has been established to give the PCB a mechanism via which to make decisions on several key programmes of work as agreed with Trust Boards. Updates on the One LSC leadership team, the Clinical Programme Board and the Pathology Network Board were discussed under Joint Committee Working items.

System pressures – acute

September saw an increase in overall attendances across Lancashire and South Cumbria (LSC) Emergency Departments despite all the public messaging around industrial action. The trend continued into the first part of October, however towards the end of the month overall attendances started to fall and overall, there were -2% fewer throughout October than the month before. Ambulance handover delays rose by nearly 85% in October and averaged 50 per day.

Patients being seen in urgent care within LSC had high levels of acuity which impacted on length of stay and admissions and this alongside a lack of flow and high number of patients not meeting the criteria to reside (NMC2R) had added to pressures and impacted on performance. There is an issue with data reporting and collection within some Trusts which needs to be addressed as this is impacting on the integrity of comparisons of some metrics.

Although LSC are performing well against both North West and national peers, we do have various points of pressure in the system which require mutual aid and diverts. The ICB and Chief Operating Officers had a planned workshop to discuss winter plans and tactical and operational approach to managing pressure through the coming months.

In recent months there has been a steady reduction in the number of patients waiting over 78 weeks at the end of the month, however the number of 65-week waits is continuing to grow and is above plan. 52 week waits are also continuing to increase across LSC, however the rate of growth has reduced in the last month.

There is still a required focus on longest waits to reduce the Cancer backlog – those waiting over 104 days. Skin, lower and upper GI and Urology continue to be challenged across all providers.

As with all Trusts the system needed to find the right balance between reductions in waiting times and elective recovery and the requirement to deliver savings. Board members had a development workshop following the PCB meeting and as part of this were going to discuss how to set aside time on a regular basis to discuss some of these issues in detail.

System pressures – mental health and learning disabilities

The total bed request rate remains within normal range, with no indications of the extraordinary demand of January - April 2023. A&E bed requests also show more stability. A&E 12-hour breaches are trending downwards from the May 2023 peak and overall bed demand has been in the established range for the last three months.

Actions for the Mental Health Learning Disability and Autism (MHLDA) performance include: admissions management to review all informal patients awaiting admission each day to identify community support or alternatives; a review of all community waits to ensure risks are escalated; Health Based Place of Safety (HBPoS) meetings to take place to review learning from A&R and HBPoS breaches; Clinically Ready for Discharge meetings taking place daily with a 'Perfect Week' event planned for the first week in December, and there is planned to be a future focus on reducing the number of patients in Spot Purchased (inappropriate) Out of Area Placements (OAPs).The Woodview site is due to open in November to provide 32 more inpatient beds to support the local bed base and reduction of OAPs.

The proposal for Blackburn with Darwen transfer of physical health and mental health services would be going to the Integrated Care Board (ICB) board in January. A positive alliance was being formed with Lancashire and South Cumbria NHS Foundation Trust (LCSFT), Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) and Primary Care.

The tender for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) had now been awarded. This is only for assessment, not for treatment and a fully funded pathway would be required from April.

The longest waits within Mental Health are in Childrens' services, and a Quality Impact Assessment was being completed. This issue was a matter of concern for the Trust and for stakeholders, particularly Members of Parliament.

The lead Chief Executive Officer for the PCB is meeting the ICB to ensure that Mental Health strategy was given as much scrutiny and support as the acute.

Blackpool Teaching Hospitals NHS Foundation Trust (BTH) passed on their thanks for the support of all partners after they declared a critical incident level 2 the previous week. There had been a whole system response and leadership quality shone through.

Financial Update

LSC was required to submit an updated and more ambitious financial plan. The Senior Responsible Officer for Finance thanked all organisations for their support on pulling this together and acknowledged that the benefits of collaboration across the system which were becoming increasingly obvious.

There had been a significant improvement in the exit run rate in the last 10 days. Whilst the 5.5% CIP target had not yet been made, plans were in place for over 5% which is significant and demonstrates the scale of the stretch that organisations were making. The £149.49m deficit had been confirmed and Directors of Finance have identified a range of opportunities to manage the risks associated with this.

Financial sustainability plans and metrics need to continue to be undertaken as part of a coordinated system response and it was important that services, outcomes, and safety needs to also be incorporated into the messaging to internal and external stakeholders.

It was vital to ensure we have plans for 2024/2025 in place at an early stage and that Trusts don't lose sight of this as they focus on delivering the year end position. External intervention was still a strong possibility.

LSC didn't fare well under the most recent financial allocation. The ICB had a number of ideas about how things could be done more creatively, however there needed to be a sustained focus on the whole issue of recruitment as some organisations had significantly increased their workforce during the pandemic. A lot of work had been done on the collaborative bank and job and role designs could be an important way of reducing costs in future years.

One LSC leadership team – approval to hire initial roles

Approval was sought to recruit the initial leadership roles for One LSC. These roles were approved by PCB Joint Committee in June 2023 as part of the agreement to next steps for the programme. Now we have the host trust in place, the recruitment to these key roles is a critical next step in moving to our One LSC model.

The roles included for initial appointment are as follows:

1. One LSC Managing Director
2. Director of Procurement (who will be our One LSC Chief Procurement Officer)
3. Director of IM&T (Who will be our One LSC CIO)
4. Director of E&F (Who will be out One LSC Chief Estates & Facilities Officer)

The other programmes are at a less advanced stage, so those appointments would be made at a later time. It is not possible to determine the final impact because we cannot determine who will be appointed to each role. Were it to be an appointment from a role encompassing the current SRO, it may not require backfill as we are moving into a new way of working with this structure in situ. It will also depend on start date that can be agreed. This has been exemplified in terms of several scenarios to show the likely cost. A budget provision had been set aside for this financial year only, specifically to fund the part year cost. For next year we will need to recover the cost of the leadership of One LSC as overhead against savings to be made.

The PCB JC approved the above roles and agreed that they should be recruited to via open internal advert (for colleagues currently working within LSC) as soon as possible.

Clinical Programme Board Update

At the last Provider Collaborative Board meeting, a shortfall of funding was highlighted within the clinical programme. A process is being led through the System Recovery and Transformation Board (SRT) around allocating resource. This process should ensure that the clinical programme receives the correct amount of additional funding, however this process is unlikely to be complete until the SRT board in December. As a result of this, on 1st November, project support provided by the NHS Transformation Unit to the following programmes was suspended: Urology, Musculoskeletal Trauma

and Orthopaedics, Haematology, Ophthalmology, Integrated Mental and Physical Health, and Stroke networks.

Working with other system programme areas we have tried to retain the administrative support to the networks so they can continue meeting, however the ability to progress programme plans has been severely restricted until the resourcing process has been completed. As anticipated, this news has caused some consternation within the networks and has the potential to reduce morale and engagement.

A lot of positive engagement had taken place to get to agreed clinical models in the priority areas and a further clinical workshop was due to take place on 17th November which would cover fragile services, reconfiguration specialities, and the PCB Clinical Service Configuration Plan.

The urology case for change was also presented at the last clinical programme board, with comments from the ICB around us being clearer on the aim of moving to a single urology cancer surgery service for the system.

Pathology Network Board

Updates included the new Laboratory Information Management System (LIMS), the Capital Business Case, and the Pathology Network Board Terms of Reference.

Deployment of the Magentus system at BTH is currently underway, with several critical issues relating to the configuration of the system being addressed with support from an ICB senior digital leader who is reviewing the project and the potential solutions. The timeline remains a challenge with an intended go live date for February 2024 – the contract with the current supplier has been extended to March 2024 using additional funding from NHS, however the availability of staff to undertake the current and future testing phases remains a future problem.

As reported to the last meeting, a programme plan has been developed that aligns with the need to draw down the national capital money of £31.2m by March 2025. Key issues that have emerged in the development of the case were identified, including that the current funding would only support a hub of 2600sqm which would not be sufficient to accommodate more than microbiology, virology, and immunology. There were also significant concerns about the clinical viability of such a facility. PCB Board members and the ICB agreed that we needed a larger viable facility and were committed to finding ways of resourcing the gap, particularly as the new facility would achieve significant annual savings.

Given tight timeframes for the business case, a site needs to have been identified and planning consent obtained by the end of June 2024. In the intervening period, the design team are progressing with the design based on a potential site with a final decision expected by December.

The Terms of Reference for the Pathology Network Board are currently being reviewed and updated to reflect what was discussed at the last PCB meeting, specifically that the Pathology Board would review and make recommendations on any Pathology capital business case to the PCB. In addition, a further request has been made to consider the membership of the Pathology Network Board.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD MEETING REPORT **Item** **10**

10 January 2024 **Purpose** Approval / Assurance / Information

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

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

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

Report linkages

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

	5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptors on Board Assurance Framework. Risk 2 (Risk Score 20 (C5 X L4)) The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. Risk 3 (Risk Score 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. 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	Assurance Framework, Risk Management Core Controls, 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) 20 risks are held on the corporate risk register. 2 are new, 2 have reduced risk scores of 12 awaiting approval to be removed, 7 have projected risk scores <15 in the next reporting period and 1 risk has been removed.
   b) Numbers of open risks continue to reduce from 1,709 risks in Q4 2021-22 to 733 in Q3 2023-24 to date, a reduction of 57%.
   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 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, enhances decision making and improves organisational resilience.
   b) Supports legislative and regulatory compliance and license to operate requirements.
   c) Facilitates strategic and operational planning, improves organisational efficiency and promotes innovation.
   d) Reduces financial, legal and insurance costs.
   e) Enhances stakeholder confidence.
   f) Improves credibility, reputation and commercial viability.

Corporate Risk Register (CRR) Performance Activity

5. A summary of key points to note.
   a) 20 risks are held on the corporate risk register. 2 are new risks, 2 have reduced risk scores of 12 awaiting approval to be removed, 7 have projected risks scores <15 in the next reporting period and 1 risk has been removed.
   A more detailed summary and breakdown is included within the appendices.

b) Matters to avoid duplication, improve standardisation and the quality and quantity of risks arising from the implementation of Cerner e-PR remains in progress.

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 733 in Q3 2023-24 to date, a decrease of 57%.

b) Risks identified as being significant or moderate are down from 1,368 risks in Q4 2021-22 to 232 in Q3 2023-24 to date, a decrease of 83%.

c) Risks remaining open over 3 years old are down from 1,035 risks in Q4 2021-22 to 429 in Q3 2023-24 to date, an 59% decrease.

d) Overdue risks are down from 230 in Q4 2021-22 to 67 in Q4 2023-24 to date, a 71% decrease.

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

f) Clinical risks (63%) remain the highest risk type category followed by health and safety risks (17%).

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 (35%) followed by radiation risks (21%).

i) Highest numbers of open risks on the risk register are held within Diagnostic and Clinical Services (DCS) (31%) followed by Surgical and Anaesthetic Services (SAS) (23%).

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 and improves 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 e-PR 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) Ongoing 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) A review of the effectiveness of Divisional Quality and Safety Board meetings regarding the review and scrutiny of risks.

h) Supporting services in addressing the 455 foreseeable risks due for review over the next three months.

i) Although a number of wide ranging measures have been put in place to improve risk management competencies of managers and staff, work to address risk management and assessment training, as part of the competency framework of managers, remains challenging. 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 assessment, training plans, resources and roll out required for delivery and of monitoring competencies and training compliance of

staff is to take place, along with the development and issue of management guidance will help provide a short term solution.

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 within DATIX.

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 improvement works made to DATIX.

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, 29 December 2023

Summary of the CRR

Corporate Risk Register						
No	ID	Where is the risk being managed	Title	Risk Score (current)	Effectiveness of Controls (taken from Datix)	Changes since last report
1	9771	Trust Wide	Failure to meet internal and external financial targets for the 2023-24 financial year	25	Adequate	⇔
2	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	9545	SAS	Failure to provide surgery due to breakdown of equipment	20	Limited	⇧
5	9336	MEC	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery	20	Limited	⇔
6	8126	Corporate	An electronic patient record system may compromise clinical management systems and processes, impact on patient safety, care and service provision	20	Adequate	⇧
7	9746	Corporate	Inadequate funding model for research, development and innovation	16	Limited	⇔
8	9705	SAS	Inability to provide a robust hepatobiliary (HPB) on call service	16	Limited	⇔
9	9367	Family Care	ECHO Images Transfer	16	Inadequate	⇔
10	8941	DCS	Potential delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology	16	Limited	⇔
11	8033	Trust Wide	Complexity of patients impacting on ability to meet nutritional and hydration needs	16	Limited	⇔
12	7165	Corporate	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	16	Limited	⇔
13	6190	SAS	Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales	16	Limited	⇔
14	8725	CIC	Lack of senior clinical decision making and inconsistent medical cover for Community Intermediate Care Services	15	Inadequate	⇔
15	8808	Corporate	BGTH - breaches to fire stopping and compartmentalisation in walls and fire door surrounds	15	Adequate	⇔
16	7764	Corporate	RBTH - breaches to fire stopping and compartmentalisation in walls and fire door surrounds	15	Adequate	⇔
17	7008	Trust Wide	Failure to comply with 62 day cancer waiting time target	15	Limited	⇔
18	4932	Trust Wide	Patients who lack capacity to consent to placements in hospital may be being unlawfully detained	15	Limited	⇔
19	8839	SAS	Failure to achieve performance targets	12	Limited	⇩
20	8061	Trust Wide	Tolerated Risk - 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

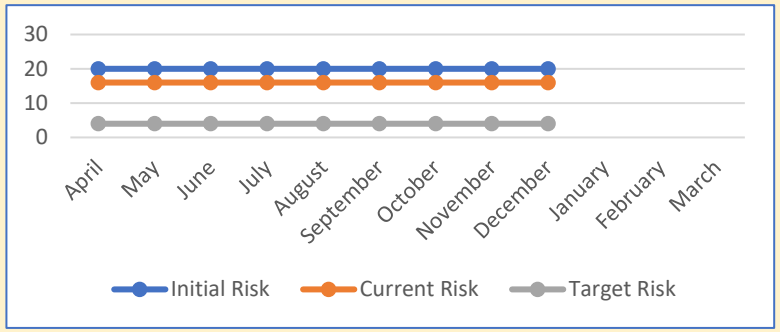
Strategy: Quality Strategy

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: 08 December 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.

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.

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. 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. RIDDOR reportable occupational diseases more explicitly included within performance reporting. 5. RIDDOR performance included as part of Quality and Safety KPI performance metrics for Senior Management overview. 6. Continuous reduction in numbers of RIDDOR reportable incidents from 45 in 2021/22 to 38 in 2022/23 to 32 in 2023/24 to date. 7. Work to increase compliance with RIDDOR reporting timescales has improved from 12% in 2021/22 to 47% in 2022/23 to 41% in 2023/24 to date. <u>Specialist support, policy and procedure setting, oversight responsibility:</u> 8. RIDDOR reporting requirements are contained within the scope of incident management policy and procedures. 9. Responsibilities of staff to report any health concerns embedded within scope of organisational health and safety at work policy. 10. Specialist advice, support or guidance readily available from the health and safety team. 11. 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. 12. 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> 13. 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.	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	G

		Include RIDDOR performance as part of Quality and Safety KPI metrics Improve communication and strengthen collaborative working partnerships. Better utilisation of Quality and Safety Leads to relay and enact upon important safety critical information across Divisions			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 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 = 6,708 incidents 2023/24 = 4,293 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. Strategy completed Completion of regulatory gap analysis will support the action plan of the Health and Safety Committee in seeking assurances of legislative compliance due for presentation in Jan-24	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 33% increase in RIDDOR reportable incidents when comparing previous FTYD from 24 in Q1-Q3 2022/23 to 32 in Q1-Q3 2023/24	Health, Safety and Risk Manager	Q4 2024	Current compliance levels remain at 58% and remain 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 13/12/2023** **Risk reviewed. No change in risk score** At M8 the Trust is reporting a £29.5m deficit for the 2023-24 financial year to date, £11.9m behind the £17.6m planned deficit, a movement of £0.7m in the month. 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. The Lancashire and South Cumbria system submitted a revised forecast deficit on the 22-Nov-23 at £198.5m which is made up of £149.5m deficit for provider Trusts and £49m deficit for the Integrated Care Board, an increase to £80m initial planned deficit of £118.5m. ELHT has submitted a revised £39.1m forecast deficit. This is an extremely challenging target to meet and will require a large reduction in expenditure in the final four and half months. **Next Review Date 12/01/2024**	**Date last reviewed**	**13/12/2023**
		Risk by quarter 2023-24	**Q1**: 25 / **Q2**: 25 / **Q3**: 25 / **Q4**:
		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 09/12/2023** 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 09/01/2024** **Awaiting review of risk at next Executive Risk Assurance Group meeting and approval for risk to be removed from the Corporate Risk Register.**	**Date last reviewed**	**09/12/2023**		
			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 06/12/2023** 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. Collaborative working with urgent and access care pathways across LSCFT in progress. **Next Review Date 08/01/2024**	**Date last reviewed**	**06/12/2023**
		Risk by quarter 2023-24	Q1: **20** | Q2: **20** | Q3: **20** | Q4:
		8-week score projection	**20**
		Current issues	External influences regarding mitigation of risk beyond the control of the Trust

No	ID	Title				
4	9545	**Failure to provide surgery due to breakdown of equipment**				
Lead		Risk Lead: Joanne Preston Exec Lead: Michelle Brown	**Current score**	**20**	**Score Movement**	⇧
Description		There are over 130 theatre items that are out of service / obsolete, posing a significant risk for complete failure and impact on service and patient safety. This includes theatre stack systems and 2 x OR1 NEO Integrated theatre solutions which are now out of service contract. There are additional critical items which are due to be out of support in the short to medium term. The capital cost of the equipment (if replacing) is over £1.1million.				
Controls and Assurances in place		Controls 1. Service contract jointly managed between EBME and Theatres 2. Organisational policy in place for lifecycle management of medical devices 3. Loan kit ordered where available (parts/items dependent) when medical devices are broken 4. Theatre staff fully trained and competent in using medical devices Assurances 1. Specialty scheduling and theatre oversight 2. Regular communication and support provided by EBME and supplier 3. Discussed and monitored at theatre and divisional governance/directorate/DMB meetings			**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Awaiting outcome of capital bids process and written business case for movement to a managed service and potential solution. 2. Policy covering lifecycle management of medical devices may require review to ensure robust process in place. 3. No spare parts availability internally or with supplier. Supplier has confirmed that items are now obsolete and replacement parts are not available. 4. Possibility for loan kit to be unavailable. 5. Potential for equipment to break. 6. Equipment not available due to breakages 7. Service contracts have expired for obsolete items 8. Failures of equipment are due to age and are not MHRA reportable. Field Safety notices are not applicable - failure due to age of equipment. 9. Servicing / maintenance is the responsibility of the company - however these items are now out of contract so there is no servicing / maintenance for the obsolete items. **Gaps / weaknesses in assurances** 1. Potential for unavailability of company representative support. 2. Increasing incidents being reported. 3. Medical Devices Committee not currently in place. No forum has been in place for systematically raised equipment issues, and to allow the overview of expiring service contracts and equipment. 4. Potential failure to report incidents of equipment issues / breakages. 5. Breakages of choledoscoscopes has been fully investigated with Theatres, EBME and Supplier. Additional rep support implemented. Outcome of investigation found no particular trend, and some breakage is expected due to fragility of equipment and increased complexity of cases
Update since the last report		**New Risk**. Task and Finish Group in place with Procurement and Finance to progress replacement of medical devices and managed service option. **Next Review Date 06/01/2024**			**Date last reviewed**	**06/12/2023**
					Risk by quarter 2023-24	Q1: ; Q2: ; Q3: 20; Q4:
					8-week score projection	20
					Current issues	Management of Medical Devices

No	ID	Title				
5	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 27/11/2023.** Risk reviewed. No change in risk score. Increased demand, multiple long waits and the continuation of NWAS handover delays are still being experienced. Appointed UTC patients remain in outpatients along with regular utilisation of the fracture clinic to help mitigate overcrowding. Incidents associated with overcrowding remain. 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 30/12/2023**	**Date last reviewed**	**27/11/2023**
		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
6	8126	**An electronic patient record system that is not fully implemented or optimised may compromise clinical management systems and processes, impact on patient safety, care and service provision**

Lead	Risk Lead: Daniel Hallen Exec Lead: Jawad Husain	Current score	20	Score Movement	

Description	A lack of continuous optimisation and investment may lead to frustration and create disillusionment, leading to poor usage and productivity, unsafe workarounds, substandard data and ineffective clinical decision making.	**Gaps and potential actions to further mitigate risk**	Gaps / weaknesses in controls
Controls and Assurances in place	Controls general • significant resource in place to support improvement opportunities and deliverables • dedicated senior consultant identified by Cerner to undertake work to review issues identified and support further development and actions required • recruitment of e-PR champions, super users and floor walkers to support system implementation • development of e-PR SharePoint one stop shop site of readily available resources e.g. workflow sheets, 'hot sheets' outlining brief instruction on how to complete tasks on Cerner and FAQ's covering general, clinical, administrative, IT, pharmacy and discharge processes clinical management • improvement plan in place with identified learning outcomes spread across the Trust • initial focus on outpatient areas i.e. head and neck, cardiology, urology, fracture clinical, gynaecology, respiratory and dermatology • completion of project to identify all policies, procedures and guidance affected by system implementation • prescribing is structured and follows a digital process with appropriate auditing capabilities • replacement of ICE with Order Entry Catalogue and Order Entry Form to place requests and ordering of all surgical procedures and medications communication • regular updates using a variety of trust wide communication systems, digital and social media platforms • use of roadshows and walkabouts to raise awareness and demonstrate system use • issue of role specific posters, flyers and key contacts • use of displays across inpatient and staff areas education, training and competency • registration process and extensive roll out of end user training and support • development and issue of staff handbooks • library of quick reference guides developed and available on SharePoint and e-Coach and organised by job role describing how to use particular tools or complete set workflows e.g. admission, transfer, discharge, prescribing etc. • a series of patient journey demonstration and training videos have been created and available to view on the learning hub and YouTube channel to help navigate the new system • personalised demonstrations for doctors, nurses and allied health professionals • clinician RTT training • virtual discharge masterclasses held to demonstrate discharge processes for inpatients, outpatients, emergency department and same day emergency care to assist staff to successfully discharge a patient using the e-PR system and create full discharge summaries, with recordings routinely available from the e-PR hub on OLI • power chart and revenue cycle (RPAS) e-learning videos covering a wide range of patient journey demonstrations such as; - ED triage covering patient summary, staff check in to shift and work location, adult triage and assessment forms, Manchester triage, discriminators and dictionary, presenting complaints, nursing notes and observations - ED doctors covering clerking, ordering tests and medication, patient status view, specialty referrals, documentation of decision to admit, bed requests, ED discharge workflow		general • limited capital budget to invest in additional hardware or software as clinical requirements develop • the lack of sufficient administrative resource • lack of effective clinical management to support and maintain implementation may impact on service provision and delivery leading to a secondary impact on patient safety • inability to rapidly flex current system to respond to emerging demands from 'external' NHS bodies for additional information clinical management • key control issues identified regards elective outpatient and inpatients i.e. clinic set up and bookings; flow and discharge i.e. admission, discharge and transfer processes and discharge workflows; encounters; radiology integration; equipment and prescribing • other issues identified relate to endoscopy booking issues; GP discharge summaries and reporting • clinical management policies, procedures, systems and processes may not be in place or updated to reflect system changes following go live • clinical management policies, procedures, systems and processes may not be followed by clinicians or are being effectively monitored by policy authors, committees and or groups • there is more than one method of recording the same piece of information • pharmacy medicines dispense system requires updating emergency preparedness, response and resilience • limited assurance policy and or procedural requirements remain effective, are being monitored, reviewed or followed governance • there is no robust document management solution currently in place e.g. imaging, documentation etc. digital • local data and digital strategy in development to help drive successful implementation of e-PR system • network instability which may lead to intermittent crashes • extended contracts on existing digital systems that provide current cover causing unexpected, additional financial pressure • no functioning information governance service at present • impact on infrastructure if technology, clinical management and techniques are developed in isolation from main e-PR • not all digital and clinical management systems are registered or known about • current system contracts do not identify specific switch over dates and are being rolled over annually • community services system is not connected to acute setting • scanning solution not consistent across all specialties and case note groups

- nursing inpatient admissions covering care compass, patient status overview and activity timeline, tasks to complete, admissions assessments including observations, pain assessments, EWS scoring, medicines administration and drug charts, discharge care plans, day of admission checklist, discharge planning risk assessment
- inpatient admission – doctor covering doctors worklist, admission documentation including auto text example, book patient for theatre, admission clerking notes including ability to forward to other recipients and available previous documentation within record
- inpatient preoperative checklist and discharge care plan (nursing) covering preoperative checklists, prior to discharge plan and discharge dashboard
- discharge (doctors) covering fit for discharge, discharge documentation and summary, discharge medication and discharge letter
- discharge (nursing) covering day of discharge checklist, key discharge information and PM conversation discharge of patient

emergency preparedness, response and resilience
- policy and procedural controls in place relating to emergency preparedness, response and resilience, major incident and business continuity planning
- paper based contingencies remain in place to allow and record data capture

governance
- e-Lancs managed from one command centre

digital
- national data and digital strategy in place to help drive successful implementation of e-PR system
- stability of existing systems i.e. clinical and patient flow system (including capture of nursing documentation), digital dictation and scanning
- improved digital infrastructure, network upgrades and digital solutions including storage to maintain and manage existing systems in place to help best utilise data sets and information from e-PR system
- extended contracts on existing digital systems that provide current cover
- register of non-core systems capturing patient information (feral systems)
- decommissioning programme of digital systems underway
- IT helpdesk and self-service portal in place to help resolve technical and general issues

patient and staff safety
- staff access to a wide ranging staff health and wellbeing support mechanisms e.g. occupational health and wellbeing teams, employee assistance programmes, external organisations, staff side, freedom to speak up guardians etc.

task based
- improved digital infrastructure and investment in new technology and equipment e.g. connectivity, large screen monitors for status and track boards, bed planning and control centres, use of barcode scanners for medication, patient wristband supply and scanning, workstations on wheels, laptop trolleys for ward and bedside usage, medicine trolleys specifically built for ward medication dispensing, anaesthetic machines within theatres, badge readers for logging within inpatient and theatre areas, use of 24/7 device computers with access viewer software installed in clinical areas etc.
- use of personalisation lab to allow customisation of system to suit individual needs e.g. doctor, allied health professional, nurse etc.

Assurances

general
- digital solution meets regulatory and data set compliance requirements
- system designed around national clinical requirements
- back office and application support teams triage, troubleshoot and resolve issues
- support with staff familiarisation and confidence on clinical management systems readily available from Cerner e-PR and e-Lancs expertise
- rolling replacement of hardware and regular audits of IT service desk issues to identify challenges around themes such as reliable Wi-Fi etc.
- clinical incidents relating to system implementation and use to identify challenges
- integration architecture skills set is not native to the trust

patient and staff safety
- limited assurance staff related health and wellbeing support systems are being used, monitored or reviewed for Cerner related issues

Gaps / weaknesses in assurances

clinical management
- staff familiarisation and confidence with the new system to support safe clinical pathways e.g. admission, transfer, discharge and prescribing etc. which in turn may lead to backlogs and delays in patient flow
- limited assurance clinical pathways including assessments and workflows remain robust, are the most appropriate method of control, are being followed by staff or are being monitored and reviewed

communication
- human factors and behaviours may be as a result of information fatigue and or culture/change acceptance

education, training and competency
- accessing e-Coach may not be clearly understood or being utilised effectively by staff

emergency preparedness, response and resilience
- limited assurance major incident and business continuity plans covering digital and clinical management systems may not be reviewed, tested, updated or followed to reflect e-PR implementation

governance
- work underway to review longer term governance structure and arrangements to support the digital transformation journey
- limited assurance monitoring and review of data within e-PR is being assessed to determine how well it is being used and of driving improvements
- impact on mandatory national and local audit activity i.e. coding timelines, delays and observed changes in coded diagnosis reducing numbers of expected cases for submission
- data behind GIRFT metrics and model hospital data is not being updated in a timely manner

staff safety
- limited assurance HR/occupational health systems are being monitored against implementation to determine whether major system change is having a negative impact on staff health and wellbeing

- business as usual support roles from executive team, directors, on call senior managers, matrons, enhanced service desk and self-service portal
- early go live period identified has identified a number of issues relating to the technical design and adoption by staff which is expected due to the size and scale of implementation

clinical management

- a stop, start and continue project, led by a clinical lead in improvement practice involving cross divisional engagement, has reviewed working practices across all clinical, operational, administration, human resources and governance processes
- key control issues identified are being closely monitored with executive leads and through working groups
- clinical document library outlining electronic and paper based systems covering policy and procedures, clinical risk assessments, bundles, care plans etc.
- patient and statutory data sets captured in Bedrock Data Warehouse with reports in place
- patient flow monitored through Alcidion MiyaFlow
- patient care is visible and monitored through e-PR
- patient activity is captured leading to accurate income reports
- digital medical record capability shared within treatment and support teams

communication

- regular webinars and team brief sessions held

education, training and competency

- use of access fairs to ensure smooth staff logins
- additional 940 hours available to support adoption and optimisation of system provided by Cerner for individual and team coaching

emergency preparedness, response and resilience

- the EPRR committee benchmarks performance against national standards and provides assurances of organisational compliance

governance

- weekly e-PR Programme Board meetings chaired by Medical Director
- weekly incident management meetings chaired by Chief Operating Officer and Director of Service Improvement
- weekly e-Lancs Improvement and Optimisation Group
- use of specific working task groups as required
- e-PR programme included as standing agenda item at Executive and Senior Leadership Group meetings
- progress on those key control issues identified undertaken at weekly Cerner incident management team meetings
- monitoring and performance management of incidents reported through DATIX and IT helpdesk following system go live
- learning from themes and trends converted into videos or quick reference guides and uploaded onto e-Coach
- operational teams monitoring and reviewing clinical pathways
- escalations, monitoring and performance discussed at ICB assurance meetings
- governance arrangements to be reviewed in Jan-24
- ongoing assessment of staff feedback, incidents and problems raised through operational teams are assessed to look at change requests and training requirements

digital

- completion of build work and excessive technical testing
- all critical systems directly and indirectly managed by data and digital
- 24/7 systems support in place
- significant amount of business intelligence system data quality and usage reporting
- consistent monitoring of clinical management systems and support via IT helpdesk
- service desk e-PR tickets are continuously monitored
- robust process in place for change requests

patient and staff safety

- no patient or staff harm at present

task based

- evaluation of issues undertaken by multi-disciplinary teams e.g. digital, clinical operational teams, learning and development, improvement hub, system support and leadership etc. through in person and observations utilising SPE+ improvement methodology

<table>
<tr><td rowspan="4">Update since the last report</td><td rowspan="4">New Risk
Next Review Date 12/01/2024</td><td>Date last reviewed</td><td colspan="4">12/12/2023</td></tr>
<tr><td rowspan="2">Risk by quarter 2023-24</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td></td><td></td><td>20</td><td></td></tr>
<tr><td>8-week score projection</td><td colspan="4">20</td></tr>
<tr><td>Current issues</td><td colspan="4">System wide external influences</td></tr>
</table>

No	ID	Title				
7	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 11/12/2023** Risk reviewed. No change in risk score. Update paper drafted ready to be sent to the Trust board with actions taken to date but the risk remains as to what the funding model is for R&I. Waiting to see the impact of having Study Coordinators trained to undertake some finance functions with them working closely with sponsors. Women's & Children's Team are the first to be trained. This work will be reflected in the drafted paper. Pharmacy continues to have limited capacity which impacts on CTiMPs trials and with that the potential to generate income. R&I Finance Officer post interviews are on 14/12/23 and are hopeful that this post can be recruited to. **Next Review Date 15/01/2024**	

Date last reviewed	**11/12/2023**			
Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
		16	**16**	
8-week score projection	**16**			
Current issues	System wide external influences			

No	ID	Title
8	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 28/12/2023** 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 31/01/2024**	**Date last reviewed**	**28/12/2023**		
		Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
				16	16	
		8-week score projection	16			
		Current issues	System wide external influences			

No	ID	Title
9	9367	ECHO images transfer

Lead	Risk Lead: Victoria Hampson Exec Lead: Peter Murphy	**Current score**	**16**	**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** **Awaiting review of risk at next Executive Risk Assurance Group meeting and approval for risk to be removed from the Corporate Risk Register.**	**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
10	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 22/12/2023** Risk reviewed. No change in risk score. Potential for review of risk score to reflect additional recruitment and additional controls. **Last Review Date 26/01/2024** **Awaiting review of risk at next Executive Risk Assurance Group meeting and approval for risk to be removed from the Corporate Risk Register.**	**Date last reviewed**	**22/12/2023**
		Risk by quarter 2023-24	Q1: 16 | Q2: 16 | Q3: 16 | Q4:
		8 week score projection	12
		Current issues	External influences regarding mitigation of risk beyond the control of the Trust. National shortage of histopathologists.

o	ID	Title
11	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 04/12/2023** 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 05/01/2024** **Awaiting review of risk at next Executive Risk Assurance Group meeting and approval for risk to be removed from the Corporate Risk Register.**	**Date last reviewed**	**04/12/2023**
		Risk by quarter 2023-24	Q1: **16** · Q2: **16** · Q3: **16** · Q4:
		8 week score projection	**12**
		Current issues	Recovery and restoration pressures, recruitment and retention

o	ID	Title
12	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 4,293 in 2023/24 to date. 4. Current trend analysis highlighting a 33% increase in RIDDOR reportable incidents
Controls and Assurances in place	Controls 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. Assurances 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 45 in 2021/22 to 38 in 2022-23 to 32 in 2023/24 to date. 9. Work to increase compliance with RIDDOR reporting timescales has improved from 12% in 2021/22 to 47% in 2022/23 to 41% in 2023/24 to date.		

<table>
<tr><td></td><td></td><td></td><td colspan="4">compared to previous financial year to date, from 24 in Q1-Q3 2022/23 to 32 in Q1-Q3 2023/24
5. Current compliance levels remain way below the threshold level of achieving and maintaining 95% compliance.</td></tr>
<tr><td rowspan="5">Update since the last report</td><td rowspan="5">Update 08/12/2023
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 05/01/2024</td><td>Date last reviewed</td><td colspan="4">08/12/2023</td></tr>
<tr><td rowspan="2">Risk by quarter 2023-24</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>16</td><td>16</td><td>16</td><td></td></tr>
<tr><td>8 week score projection</td><td colspan="4">16</td></tr>
<tr><td>Current issues</td><td colspan="4">Systems, capacity and workforce pressures</td></tr>
</table>

No	ID	Title
13	6190	**Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale**

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

Description	Insufficient clinic capacity for patients to be seen in outpatient clinics resulting in unbooked new patients and a very large holding list of overdue patients. In some cases, there is significant delay and therefore a risk to patients. Demand far outweighs capacity, and this has been exacerbated since the COVID-19 pandemic. All patients are risk stratified (red, amber, green) but still cannot be seen within timescales with additional risk that amber patients could be become red over time etc.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Funding and insufficient staff numbers, competencies and skills mix to provide capacity. 2. Limited estates capacity and outpatient space to provide required clinics. 3. Limited opportunity to flex theatre to outpatient departments and vice versa. 4. Use of locums to support capacity sessions no longer in place due to lack of available space, gaps in competency, expertise and skills and challenges in practice regarding discharge, adding to holding list concerns. **Gaps / weakness in assurance** 1. Getting It Right First Time (GIRFT) report not yet created for patient waiting times above 25% within recommended timescales for review.
Controls and Assurances in place	Controls 1. An integrated eye care service is in place for specific pathways to help steer patients away from out of hospital eye care services. 2. New glaucoma virtual monitoring service in place to manage reviews and support the service. 3. Use of capacify sessions where doctors are willing and available. 4. Use of clinical virtual pathways where appropriate. 5. Action plan and ongoing service improvements identified to reduce demand. 6. A failsafe officer has been recruited to validate the holding list and focus on appointing red rated patients and those longest waiting. 7. Expanded non-medical roles e.g. orthoptists, optometrists, specialised nurses etc. 8. Additional ST's rotated for use one day per week from Aug-23 with 1 ST able to operate independent clinics. Assurances 1. Capacity sessions held where doctors are willing and available. 2. Increased flexibility of staff and constant review and micro-management of each sub specialty. 3. All holding list patients reviewed weekly by administrative staff with patients highlighted where required to clinical teams. 4. Weekly operational meetings challenge outpatient activity and recovery. 5. Arrangements made with college to support a further two ST's one day per week each.		
Update since the last report	**Update 14/11/2023** 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 15/12/2023**	**Date last reviewed**	**14/11/2023**
		Risk by quarter 2023-24	Q1: **16** | Q2: **16** | Q3: **16** | Q4:
		8 week score projection	**16**
		Current Issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title
14	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 18/12/2023
Work remains ongoing to look at the medical model within the division. Agreement reached to recruit a medical lead with recruitment underway in Dec-23. No major incidents have been reported to date.

Next Review Date 31/01/2024

Date last reviewed	**18/12/2023**			
Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
		15	**15**	
8 week score projection	**15**			
Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
15	8808	**BGTH - breaches to fire stopping and compartmentalisation in walls and fire door surrounds**

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

Description	Phase 5 breaches to fire stopping compartmentalisation in fire walls and fire door frame surrounds due to poor workmanship or incorrect product usage may result in faster spread of smoke or fire between compartments within a timescale <1 hr or 30 mins that compartments and doors are designed to provide.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Refurbishment of Renal Unit including fire compartmentalisation and fire doors completed and review undertaken by Lancashire Fire and Rescue Service. Minor snagging remains ongoing with fire doors installed but not signed off by third party accreditor. **Gaps / weaknesses in assurances** 1. Assurances required regarding integrity of fire stopping in compartment walls throughout Phase 5. A sequence programme of ward closures to be agreed with an estimated duration of 20 weeks for completion of remedial works.
Controls and Assurances in place	Controls 1. Contractual arrangements in place between the Trust and its PFI partners in establishing duty holder responsibilities of building controls, servicing of alarm systems and planned preventative maintenance programme. 2. Upgrade of suitable building fire detection systems in place to provide early warning of fire. 3. Fire safety awareness training forms part of core and statutory training requirements for all staff. 4. All relevant staff trained in awareness of alarm and evacuation methods. 5. Emergency evacuation procedures and business continuity plans in place across services. 6. Project team established to manage passive fire protection remedial works. 7. Random sampling and audit of project works being undertaken. 8. Find and fix process in place for fire remedials. Assurances 1. Weekly IMT meetings and Fire Safety Committee led by Executive Leads set up to seek assurances and monitor progress with project. 2. Fire safety management performance forms part of standing agenda item of Health and Safety Committee. 3. Collaborative working between the Trust, Albany and third parties to identify / prioritise higher risk areas, address remedial works and defect corrections to fire doors and frame sealings. 4. All before and after photographic evidence of remedial works recorded and appropriately shared. 5. Arrangements and responsibilities of managers and staff contained within fire safety policy. 6. Fire wardens in place and additional fire wardens provided by Albany to maintain extra vigilance, patrol common areas across hospital sites and undertake fire safety checks. 7. Provision of on-site fire safety team response. 8. External monitoring, servicing and maintenance of fire safety alert system and suitable fire safety signage in place. 9. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England. 10. Independent consultant employed to review and oversee project.		

Update since the last report	**Update 14/12/2023** 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 05/01/2024**	**Date last reviewed**	**14/12/2023**			
		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	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 14/12/2023** Risk reviewed. No change to risk scoring. LFRS have issued enforcement action. **Next Review Date 05/01/2024** **Risk score is to be reviewed at the next Fire Safety Committee following completion of improvement works.**	**Date last reviewed**	**14/12/2023**		
		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	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.	**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
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.		
Update since the last report	**Update 18/12/2023** Risk reviewed. No change in risk scoring. Endoscopy actions are well underway. IT supporting implementation of skin e-Derm planned for end Dec-23 with improvements against performance expected Jan-24. Urology robot capacity actions stalled due to lack of mutual aid availability with funding not yet released to support. 62 day backlog trajectory reached in Nov-23. **Next review date 18/01/2024** **Awaiting review of risk at next Executive Risk Assurance Group meeting and approval for risk to be removed from the Corporate Risk Register.**	**Date last reviewed**	**18/12/2023**
		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
18	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 22/12/2023** Risk reviewed. No change in risk score. Approval status changed to a tolerated risk. 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. **Next review date 21/01/2024** **Awaiting review of risk at next Executive Risk Assurance Group meeting and approval for risk to be removed from the Corporate Risk Register.**	**Date last reviewed**	**22/12/2023**

Risk by quarter 2023/24	Q1	Q2	Q3	Q4
	15	15	15	
8-week score projection	12			
Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

No	ID	Title
19	8839	Failure to achieve performance targets

Lead	Risk Lead: Leah Pickering Exec Lead: Sharon Gilligan	Current score	12	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 12/12/2023** Risk reviewed. Risk score reduced to 12 Active RTT pathways = 39,015 >18 weeks = 18,693 of which 1,528 are >52 weeks, 356 are >65 weeks, 4 are >78 weeks and 2,339 at risk of breaching 65 weeks by end of Mar-24 The current milestone regards elective recovery is eradication of patients waiting >65 weeks by end 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. Recovery of activity lost due to industrial action and Cerner implementation continues to remain very challenging. Further industrial action has now been announced and is scheduled to take place in Dec-23 and Jan-24 **Next Review Date 12/01/2024** **Despite a reduction in risk score to 12, the risk remains on the corporate risk register awaiting review and challenge at next Executive Risk Assurance Group**	**Date last reviewed**	**12/12/2023**
		Risk by quarter 2023-24	Q1: 15 | Q2: 15 | Q3: 12 | Q4:
		8 week score projection	12
		Current issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title				
20	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.				
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.	**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.	
Update since the last report		**Update 12/12/2023** Risk reviewed. Risk score reduced to 12. 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 13/02/2024** **Despite a reduction in risk score to 12, the risk remains on the corporate risk register awaiting review and challenge at next Executive Risk Assurance Group**	**Date last reviewed**	**12/12/2023**		
			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** **11**

10 January 2024 **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 December 2023. In addition, the Finance and Performance Committee has received the risks relevant to the Committee at its most recent meeting on 18 December 2023 and agreed to recommend the BAF risks within their remit to the Board for ratification.

Members of the People and Culture Committee and Quality Committee, as well as the Finance and Performance Committee have received the whole BAF outside of the Committee cycle for review and comments. Any comments received will be shared with the Board members at the meeting on 10 January 2024.

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 have been no proposed revisions to the scoring of the risks or tolerated risks during this review period.

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.

(11) Board Assurance Framework (BAF)

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, December 2023

Executive Risk Assurance Group, December 2023

Finance and Performance Committee, 18 December 2023 and via email on 3 January 2024

To be considered at Quality Committee, via email on 3 January 2024 (as there was no meeting in December 2023)

To be considered by the People and Culture Committee, 8 January 2024 and via email on 3 January 2024

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 November 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 5 of the actions (3, 4, 7, 8 and 9), the details of which are also included in the detailed BAF sheet. Action 5 is noted to have been completed, but reporting to the Board will not take place until later in quarter 4 of the year (January to March 2024).

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 current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
5. The section detailing the links to the Corporate Risk Register (CRR) has been updated to reflect the revised CRR risks. For clarity, there have been 2 new addition to the CRR which relate to this risk (ID 9545 and ID 8126).
6. There have been 3 new additions to the controls section of the risk, which are detailed in the BAF sheet.
7. A number of updates have been made to the assurance section of this risk, which are also detailed in the BAF sheet
8. With regard to the actions section of the risk, there have been additional updates added to the progress section for actions 1, 2, 3, 4, 5a and 6. These additions are in the detailed BAF sheet, as are the revisions to the due dates for actions 1, 3 and 4 with reasons for the revisions.

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.

9. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
10. The section detailing the links to the Corporate Risk Register (CRR) has been updated to reflect the revised CRR risks. For clarity, there have been 2 risks removed from the CRR which relate to this risk (ID 8061 and ID 8839).
11. There has been 1 addition to the controls section of the risk, which is highlighted in the BAF sheet.
12. In relation to the actions section of the BAF risk, there have been updates provided for risks 4, 5, 10 and 11.
13. There have also been a number of revisions to the actions, including to the due dates (for actions 4, 5, 9, 10 and 11). The rationale/explanation for the revised dates is included within each update.

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.

14. 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).
15. There have been 4 new sources of assurance included the details of which are set out in the detailed BAF sheet.
16. There have been updates to all of the actions and there has been a revision to the due date for action 6, to confirm that an update will be provided to the Board meeting in January 2024.

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.

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

18. 2 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. In addition there have been updates to 3 of the actions. All of which are highlighted in the BAF sheet.

Recommendation

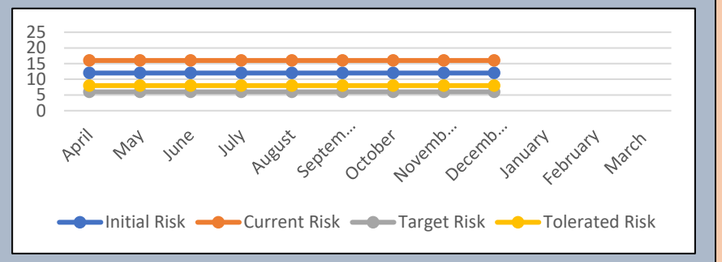
The Board is asked to review, discuss and approve the revised BAF.

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: December 2023 ERAG: December 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:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

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.
- The System Recovery and Transformation Board is established with a focus on delivery of key priority programmes and Financial Recovery
- Limited mechanisms yet developed in the system Programme Management Office to support delivery and monitoring of benefits realisation of system-wide programmes.
- ELHT has strong representation at all levels across existing ICB structures and working groups and the newly formed System Recovery and Transformation Board. 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.

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, representation at all other functional Director co-ordination groups and senior clinical and operational staff represented at clinical and non-clinical programme and working groups.
- The Clinical Services Programme Board, chaired by ELHT Chief Executive. oversees a programme of work focussed on clinical services configuration including fragile services.
- Central Services Programme Board oversees potential savings and other benefits of Central Services programmes opportunities.

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, with associated programme board and working groups, 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.
- PCB Programme Update reports to the PCB Joint Committee.
- Weekly monitoring of Key Delivery and Improvement 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 from 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 and Improvement 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

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 finalised in July. System-wide programmes reporting to Recovery and Transformation Board. ICB/System Programme Management Office (PMO) leadership has now been appointed to and the PMO is being established.	A
2.	PCB Clinical Strategy/Programme development and implementation process needs 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	Clinical Programme Board in place alongside priorities for 23/24 agreed to deliver key clinical change programmes. Review of Clinical Programme undertaken in November 2023 to identify a 1000-day plan for service configuration and plans for fragile services aligned to New Hospital Programme and future development of New Models of care as part of wider ICB strategy. Delivery plans now in development.	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~~ April 2024	Ongoing participation by ELHT leads/teams in agreed workstreams with regular updates being provided to Trust Board. Revision of date due to slippage of project at system level. Work is now underway to develop the plan for the hosting of One LSC at ELHT. A full transition plan currently in development and work underway to agree approvals via Trust Boards and JCPCB for 2024-25.	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	~~October/November 2023~~ April 2024	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. For East Lancashire, each of the District Councils have also re-established their health and wellbeing partnerships and identified priorities which also align to the Trust and Lancashire PLACE priorities. Work ongoing to establish effective working structures to progress priorities.	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 (complete but reporting to Board in quarter 4)	Work has been completed as planned by the end of September and will be presented to a future Board meeting for information (March 2024). Initial plans and priorities for 2024/25 currently in development and were presented at a Board Development workshop in November 2023. The 2024/25 planning round will enable full alignment of priorities to generate 1 system plan.	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~~ April 2024	Improvement Hub has clear priority programmes of improvement work that it is supporting and reporting to relevant Trust sub-committees. Trust Board development session arranged for 30 January 2024 to review and update SPE+ Improvement Practice development plan in line with national NHS Impact requirements for 2024-25.	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	~~December 2023~~ April 2024	System Programme Management Office and programme methodology in development. PMO leadership now in place to enable progression. Ongoing review of ELHT capacity requirements.	A
9.	Full implementation of ELHT Accountability Framework	Full implementation of Trust Accountability Framework	Director of Finance/Director of Service Development and Improvement	~~October 2023~~ February 2024	Final review of framework completed, but socialising with senior leadership group planned during Autumn 2023 (due date extended due to operational pressures) Quarterly review meetings commenced in July and continue.	A

BAF Risk 2 – Quality and Safety

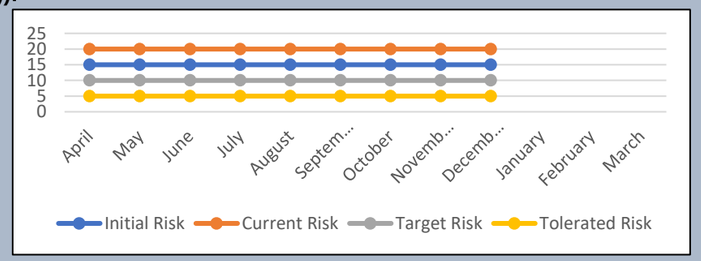
Risk Description: The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.		**Executive Director Lead:** Executive Medical Director and Chief Nurse	
Strategy: Quality Strategy	**Links to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

Links to Corporate Risk Register:

Risk ID	Risk Descriptor	Risk Rating
9570	No capacity for the storage of legacy ECHO images	**20**
9557	Patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provision.	**20**
9545	Failure to provide surgery due to breakdown of equipment	**20**
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**20**
8126	An electronic patient record system may compromise clinical management systems and processes, impact on patient safety, care and service provision	**20**
9705	Inability to provide a robust hepatobiliary (HPB) on call service	**16**
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**
8725	Lack of senior clinical decision making and inconsistent medical cover for Community Intermediate Care Services	**15**
8808	Burnley General Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke.	**15**
7764	Royal Blackburn Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke.	**15**
4932	Patients who lack capacity to consent to placements in hospital may be unlawfully detained	**15**

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

Current Risk Rating: **C5 x L4 = 20**
Initial Risk Rating: C5 x L3 = 15
Tolerated Risk C5 x L2 = 10
Target Risk Rating: C5 x L1 = 5



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Minimal

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

Strategy and Planning:

- The Quality Strategy contains 14 core priorities which are routinely reported and monitored through the Quality Committee. These will be reviewed and updated annually through workshops with key partners.
- The Quality Strategy priorities for 2023-24 have been confirmed, with associated KPIs. Progress against the 2023-24 priorities is reviewed by the Executive team 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, led by the Improvement team. New priorities for 2023-24 have been agreed following engagement with key stakeholders, including the PPP and Healthwatch. following presentation at the Trusts Quality Committee and at the ICB Quality Committee in November 2023
- Learning from the first year of implementing PSIRF has acknowledged priorities for 2022-23 were implemented over 18 months and therefore the 23-24 priorities are anticipated to cover until mid-2025.

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, People and Culture 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.

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

- 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 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 ongoing industrial action and 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.
- A&E improvement group lead by Chief Nurse, monthly meetings
- Quarterly Divisional performance meetings where all elements of quality and performance are discussed

- 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.
- 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.
- New model for patient safety culture reflecting the Insight/Involve/Improve model – integrating patient and staff safety data (in line with the National Patient Safety Strategy) has been agreed in principle with the Quality and Safety team.
- Patient safety specialists are working with Deputy Director of HR to integrate staff safety metrics alongside patient safety.
- Patient Safety 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.
- New Clinical Lead for Retention, Resilience and Experience commenced in post on 1 August 2023 with a focus on nursing and AHP workforce.
- Work is being undertaken with ward managers and team leaders to review and learn from observations of patient care to improve patient care, outcomes and experience.

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

- Integrated Care Board (ICB) have confirmed their contract requirements in relation to Quality reporting. Internal systems have been updated to ensure timely data and exception submission. First submission completed at the end of Q2. The Trust has continued to strengthen reporting against the updated Quality contract requirements and is proposing updates to the Quality metrics contained within the IPR to further strengthen internal assurance and visibility of these metrics
- ICB has split the assurance and safety functions with new leadership and focus.
- Monthly Quality Review Meetings with ICB Quality Team continue.
- 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 The Trust is supporting the adoption of PSIRF across the system as an active member of the implementation group.
- 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)

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

- Annual organisational appraisal report.
- CQC inspections and preparation/evidence gathering ongoing. Internal assurance processes evidencing performance against CQC Quality Standards have been aligned to the updated regulatory framework.
- 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.

BAF Risk 2 – Quality and Safety

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 Ongoing industrial action	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~~ March and June 2024	This has been partially achieved and the Governance Assurance structure review completed. Despite systems working the fragility of the workforce across LSC doesn't enable sufficient mutual support for fragile services. 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. Nursing professional judgment review process completed will be presented to January or February Quality committee and to the Trust Board in March 2024. There has been a significant reduction in the vacancy rates for Registered Nurses. In the main this has been through overseas recruitment which , whilst mitigating the vacancy gap, had led to a reduction in experience and available skill mix. However, comprehensive plans have been drawn up to address this risk. Due for review June 2024.	A
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. There is no significant change to the narrative for this risk. The situation continues to be stable however the workforce challenges remain. LIMS project to help digitise pathology has had a setback which will lead to delays in ensuring digital platform for the region.	G
3	Lack of effective electronic governance management system	Update Datix system to ensure best use of resource within current contract Update Datix incidents module to ensure readiness for mandatory requirement to externally report incidents in line with the Learning from Patient Safety Events (LfPSE), by April 2024. (NRLS being phased out).	Executive Medical Director	Further delay in implementation due to lack of resource April 2024 to meet LfPSE	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.	R

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					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. RADAR will not be taken up by the Trust due to a number of logistical and data governance issues. The Trust will continue to utilise DATIX until a time where an ICS-wide solution is procured and implemented. The Trust has not met the initial deadline to enable incident reporting to the new national LfPSE system from Sept 2023. NRLS has been confirmed as still enabling reporting but some national suggestion that this will be closed from April 2024. Datix manager prioritising the required update in line with this deadline. Temporary post ended Dec 2023. Business case being worked on by Datix manager and Deputy Medical Director to support long term improvements in the analysis and learning from Quality metrics, in line with the National Patient Safety Strategy.	
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~~ June 2024 for non-emergency patients	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. Registration visit completed by CQC in October 2023. Joint presentation by ED and LSCFT liaison team to CQC, who then walked the pathway through the emergency department. Significant pack of evidence re MH management within the emergency department provided to CQC. Verbal feedback from CQC Dec 2023 that application to register the emergency pathway for the assessment and treatment of patients subject to the MH Act has been successful. Specifically, that the evidence provided was of a standard that demonstrated we could provide safe care to this patient group of a standard that could be inspected against. CQC will write to formally notify the Trust of their decision in Jan 2024, after which we will have 28 days to accept the proposed extension to our regulated activities. This registration should have been in place to support the management of patients subject to Section 136 brought to our ED as a place of safety whilst awaiting assessment and will enable ELHT nurses to use Section 5 (2) and (4) to hold patients who may be a danger to themselves or others if they leave the department.	A

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					A further extension of this regulated activity (to enable non-emergency treatment to MH patients on specific wards across the Trust) will be made once the additional support and resource is in place to enable the Trust to ensure this can be provided safely outside the emergency pathway. 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	
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 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. This has now been stood down with key contacts monitoring the national situation for any escalation 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. The governance team receive regular updates from Hempsons on the Covid Inquiry. No individual trust has yet received a direct request for information. ELHT has now confirmed and locked down information at both corporate and divisional levels (from ICC and OCC groups) detailing decisions taken at the time. A template in line with the phased approach to the Inquiry has been developed but no further action to transfer the identified info into this template needed at this stage. Patient experience and complaints moved over to the Corporate Lead Nurse portfolio which will help to reduce demand on the Quality Governance team. The Governance team is currently reviewing the now persistent change in demand post Covid, eg ELHT now routinely has 23% more incidents reported monthly than pre-pandemic and the increased mortality rates nationally is resulting in high levels of investigations which are significantly higher than the 4 PSIRF investigators can manage within timescales.	G

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
		B. Introduction of Liberty Protection Safeguards. (LPS)	Executive Director of Nursing/ Executive Medical Director	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
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. New Patient Experience Strategy task and finish group has been set up – including service user experts – and work is due to be completed by March 2024 after which it will be presented to the Quality Committee and then to the Board.	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: December 2023
ERAG: December 2023

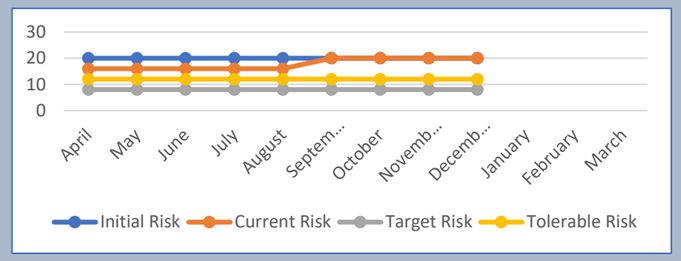
Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register

Risk ID	Risk Descriptor	Risk Rating
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**
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).

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

- Robust annual planning processes and review processes in place to continually assess clinical and operational demand and capacity across all specialities, modalities and points of delivery.
- 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.)

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

- The Trust met its trajectory to achieve the target in relation to 78-week waiters by 31 March 2023. There is further focus on preventing build up and reduction of >65 weeks in 2023/24 towards eliminating over 65 week waits by March 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.

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

- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital.
- Cancer Alliance support on focussed areas requiring improvement.
- Integrated Performance Report and remedial and improvement plans reviewed at Senior Leadership Group, Quality Committee, Finance and Performance Committee and Trust Board.
- 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.

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

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. • Monthly Emergency Care Improvement Programme (ECIP) meetings are 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. Monthly SDEC meetings now in place with involvement from NWAS colleagues. • 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 include the opening of a further escalation ward in December 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~~ February 2024	As of December 2023 outpatient utilisation reporting has been developed, further testing will take place throughout December to ensure its accuracy. Further areas of improvement identified with additional improvement resource being made available to outpatient booking from January 2024. 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~~ February 2024	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.	**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
					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 theatre utilisation report has now been built. As it has only been recently built, it is currently being tested.	
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	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	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 and outpatient area for booked appointments	A
8	Strengthen ward discharge bundle and clinical ownership for timely discharges	Embed the discharge bundle across all wards with clinical champions to promote best practice. Release the discharge matron colleagues from community bed management functions to enable a dedicated focus on pathway 0 discharges and ward support for preparing pathways 1, 2 and 3 patients for the community teams to case manage.	Executive Medical Director/ Executive Chief Nurse/Executive Director of Integrated Care Partnerships and Resilience	End of March 2024 New deadline set due to the ongoing	The discharge bundle has been introduced across all wards. Initial internal audit (draft) suggests low compliance. Plans in place to re-establish the discharge matron focus on pathway 0 discharges by 17th April 23. Safe Discharge Multi-disciplinary team (MDT) steering group established in May 23 to drive through clinical changes at ward level. NHSE visit in May 23 following the	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
				implementation and learning from Cerner and refocusing on Everyday Matters to support safe and timely patient flow/discharge.	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.	
9	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 ~~December 2023~~ January 2024 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**
10	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~~ March 2024	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. As part of the 2024-25 planning, the Trust has committed to achieving 80% of ambulance handovers in less than 30 minutes by March 2024.	A
11	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~~ January 2024	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. There is considerable work ongoing and mitigation in place around the UEC pathways, particularly with regard to redefining datasets. An Executive Director led assurance meeting has been established and is chaired by the Chief Nurse to consider improvements within ED In January a triple A system is being established which will also consider datasets and will be led by the Chief Nurse, Executive Medical Director and Chief Operating Officer.	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: December 2023
ERAG: December 2023

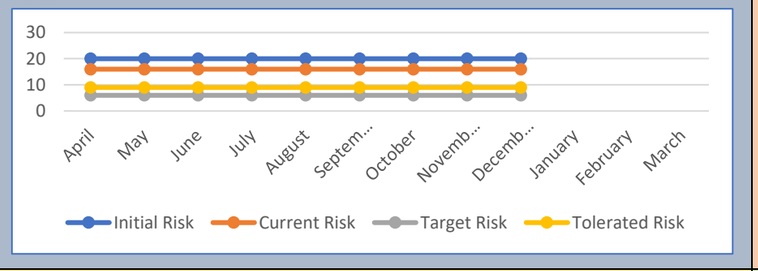
Lead Committee: People and Culture Committee

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.)

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

- 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 and Anti-Racism Framework.
- 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 since 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.

- 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
- Project M: support for managers due to be launched in January 2024.
- 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 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.
- Executive Director of People and Culture is the health member on the Lancashire LEP Skills Advisory Panel.

<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.
- 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.
- 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).
- 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.
- Internal and ICB vacancy control panels provide oversight on recruitment.
- Monthly IAG meetings with the ICB which scrutinise the workforce KLOE.

BAF Risk 4 – Culture Workforce Planning & Redesign

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Full roll out of the behaviour framework	Additional communications and OD support with individual teams inclusion in the recruitment process.	Executive Director of People and Culture	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. It is anticipated that the initial work will be completed by the end of January 2024, and would then become business as usual and move to the assurances section at the next review.	G
2	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. International recruitment is on track to deliver more than the originally planned numbers of nurses and we are confident that this will be achieved by the July 2024 deadline.	G
3	Improve Trust retention levels / Develop Retention Strategy	Implementation of targeted plan to deliver the national People Promise of Flexible Working and development of a Trust Retention Strategy.	Executive Director of People and Culture	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 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	G

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					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. Secured funding for a Band 8a People Promise Exemplar lead through NHSE for 12 months to support the retention agenda.	
4	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	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 and 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. Work continues to progress to develop the clinical services workstream across the PCB and there will be opportunities for workforce transformation as part of this work.	A
5	Risk of staff leaving the NHS due to burnout.	Delivery of the Enhanced Health & Wellbeing offer to the ICS. Next steps are to revise the model and proposition.	Executive Director of People and Culture	End of March 2024	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. 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	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					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. Launching Colleague Care month in January 2024 to support colleagues at the most challenging time of the year and Project M which is designed to support managers.	
6	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~~ January 2024.	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. The BMA have agreed to put an offer to consultant and SAS members and the outcome is awaited. However junior doctors continue to be in dispute.	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: December 2023
ERAG: December 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, weekly Executive led meetings with each Division, Executive led workforce control, vacancy freeze and current stop on all non-essential spend
- Medium term financial strategy to Finance and Performance Committee in October 2023 and Trust Board in November 2023
- Financial plans for 2023-24 developed via annual planning process, signed off at the Trust Board in July 2023.
- Revised forecast for 2023-24 submitted to ICB and national team (early December 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.
- Central services collaborative programme underway with ELHT confirmed as hosts
- 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:

- 2023-24 revised forecast outturn submitted to ICB and national team.
- 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, QIRAs will be completed for all schemes.
- Additional financial controls are in place to reduce spend.
- 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
- ICB level financial governance through System Finance Group and ICB proposals being reviewed by provider governance.

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.

BAF Risk 5 – Financial Sustainability

	• 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. 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	Financial plan will not be formally agreed. Contract – end March 2024 ~~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. There are a number of outstanding queries between the Trust and ICB, the Trusts' contracting team are working to address these	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 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	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	~~Q3 2023-24~~ Q4 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 There is no further update at this time, a further update will be provided at the March Board meeting.	R
4	ICB/PCB workplan identification and capacity	Work with system to ensure plan developed and capacity gaps rectified and mitigated	Executive Director of Finance	In progress Updates due in January and March 2024	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 January and to the Board in March 2024.	R

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

10 January 2024

Item	**12**
Purpose	Information Decision

Title	Patient Safety Incident Response Assurance Report
Authors	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 Patient Safety Incident Response Plan (PSIRP) and the outcome of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel decision-making process on high level investigation reports.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do. Invest in and develop our workforce. Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

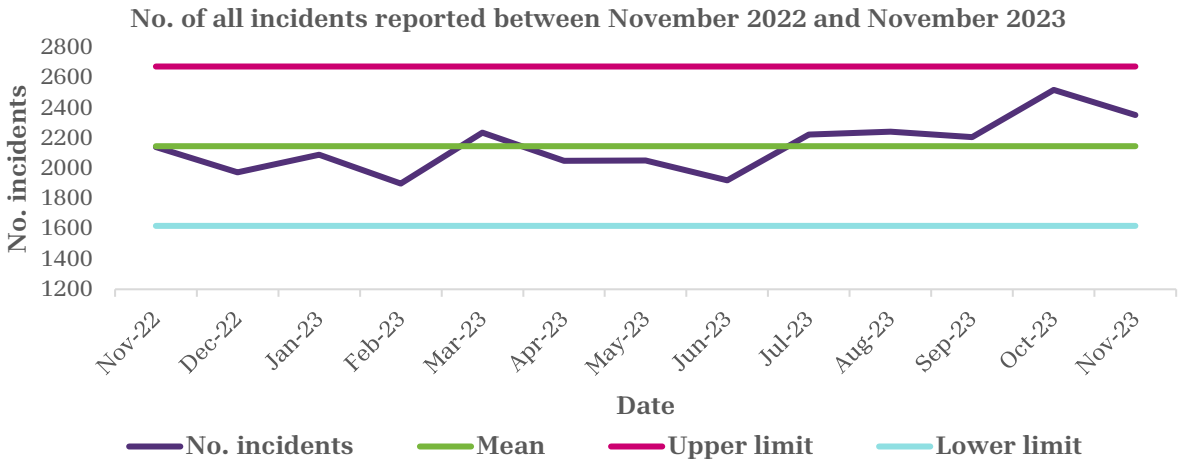
Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: No formal Committee

1. Incident Reporting

1.1 The Trust reports and manages incidents in line with the New National Patient Safety Incident Response Framework. Over the last year, reporting of incidents has remained within control limits, as seen in graph 1. However, there is some variation around the mean, which can be expected with incident reporting and can be subject to natural variation.



Graph 1: Incidents reported over last 12 months.

1.2 All harms levels remain below national levels.

1.2.1 Moderate harms have been above or similar to the Trust 2022 average level since May 2023 and have seen an increase in the last two months.

1.2.2 Incidents resulting in death whilst low reported numbers, these have been consistently above the Trusts 2022 average since May 2023, and have remained at a consistent level since September 2023. However, the numbers remain within control limits, suggesting there is a system/process issue causing the variation rather than a single cause/incident type. Further investigation of the incidents is required to understand the influencing factors to enable a change to the system.

2. Duty of Candour

2.1 There have been 38 reported incidents of moderate and above harm reported in October 2023 and November 2023, of which Duty of Candour applies, as set out in CQC Regulation 20. The Trust has continued to demonstrate 100% compliance with no breaches reported in October 2023 and November 2023.

Table 1: Breaches of Duty of Candour

Duty of Candour	KPI	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
No. of breaches	0	0	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 Patient Safety Response, or a 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 currently achieving the 95% KPI target, however, there has been improvement in most Divisions except for DCS. CIC Division have achieved 92% and both MEC and Family Care Divisions are moving towards achieving 80%. Work is continuing across all Divisions to continue the improvement.

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 3 months.

4.2 Each Division continues the work to improve the position of overdue PSRs, and there has been a continued reduction in the number of overdue PSRs in most Divisions.

4.3 A new process for Pressure Ulcer Checklists has been implemented in MEC and is being launch within CIC Division in January, with the aim to reduce the investigation burden and improve the amount of time required to complete investigations. Pressure Ulcer Checklists were previously recorded as PSRs however under the new process are investigated as an IR2 with additional Pressure Ulcer specific questions to be completed, these will identify any lapses in care and influencing factors. The investigations are all still reviewed by the Pressure Ulcer Review and Learning Panels within the Divisions, themes and trends are now more easily identified as the investigation is completed within Datix. On completion of the backlog and there is sufficient data available regular theming and trending, a review of DATIX will take place, to identify hotspots and areas for possible improvement.

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

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

5.1 In October 2023 and November 2023, the Complex Case meeting reviewed 56 incidents of which 3 met the PSIRF National Priorities for reporting and require a PSII, these have been allocated to lead investigators within the Patient Safety Team. All PSII reports and safety improvement plans are presented at the Trusts Patient Safety Incidents Requiring Investigation (PSIRI) Panel for Trust approval and signoff.

5.2 A KPI dashboard of PSIIs is provided is appendix D. At the end of November, the Trust had 26 open PSII incidents of which 6 were being investigated by MNSI.

5.3 There are currently 4 PSIIs which have been open longer than 6 months and 2 external Maternity and Neonatal Safety Investigations (MNSI) reports. The Trust has no control on timescales for MNSI reports.

- 5.3.1 2 x MNSI reports have been received by Family Care Division on23rd Nov who are currently developing safety Improvement plans before going to PSIRI in January.
- 5.3.2 1 x PMRT (Family Care Division) was presented at PSIRI and awaiting amended report before approving closure.
- 5.3.3 1 x PSII report has been approved by PSIRI but still awaiting Family feedback, report has been shared with the Coroner for Inquest.
- 5.3.4 1 x presented at DSIRG for divisional approval 6th Dec due to go to PSIRI.
- 5.3.5 1 x PSII report approved by PSIRI but still awaiting divisional safety improvement plan.

5.4 In October 2023 and November 2023, 7 PSII reports, have been approved by PSIRI and closed.

6. Never Events PSIIs

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

6.1.1 *Wrong site Surgery (Nerve Block) – Investigation completed, and report and safety improvement plan approved by PSIRI.*

6.1.2 Transfusion of ABO incompatible blood component – Investigation completed, and report and safety improvement plan approved by PSIRI

6.1.3 Wrong site surgery (injection) – Investigation completed, and report and safety improvement plan approved by PSIRI. This incident has been de-escalated as a Never Event and approved by NHS England.

6.1.4 Wrong Implant –investigations completed; report drafted awaiting approval at DSIRG before going to PSISI.

6.1.5 Misplaced NG Tube – investigations completed; report drafted awaiting approval at DSIRG before going to PSISI.

7. PSIRI Panel Approval and Learning from Reports

7.1 During October 2023 and November 2023, 11 new PSII reports were presented at the Trusts PSIRI panel.

7.1.1 9 reports were approved by the panel with some minor amendments required, and revision of the improvement plans.

7.1.2 1 report was not approved and required resubmission to the panel following amendments.

7.1.3 1 report was approved with no amendments required.

7.2 Never Event - *Transfusion of ABO incompatible blood component* (eIR1254681) – The areas highlighted for improvement were:

- Division to issue a Patient Safety Alert to address the issues raised in the investigation.
- Review of policies and SOPs in relation to blood transfusion, to remove ambiguity surrounding side by side checks.
- Hospital transfusion committee and blood transfusion practitioners to consider how they can best support clinical staff undertaking blood transfusions.
- Review of the blood transfusion provisions in place on Cerner and establish whether the excepted/required transfusion prompts, guidance and/or checklists are on the system.

7.3 Incident resulting in death (eIR1244115) – The areas highlighted for improvement were:

- Improvements related to the management of women who are experiencing vomiting in pregnancy/Hyperemesis Gravidarum
- How information on prescribing is managed and detailed in the electronic patient record.
- Face to face or telephone contact to take place with women when they weaned of medication that is not routinely used.
- Share the learning with staff related to how comments made to patients may be received/perceived by patients.
- Review of guidance and education related the management of Hyperemesis Gravidarum.
- The service to request the Whooley questions are added to the antenatal assessment forms.
- Link with the Northwest Coast Strategic Clinical Network to review the guidance in relation to perinatal mental health.

7.4 Never Event – Nerve Block (eIR1250223) – The areas highlighted for improvement in the report were:

- The Theatre Department have implemented the Prep, Stop, Block procedure.
- Develop a continual schedule of mandated multidisciplinary in person simulation training for all staff involved in anaesthetic procedures.
- Multidisciplinary attendance at the clinical effectiveness speciality meeting for anaesthetic and theatres, linking to the measurement forward plan, with outcomes disseminated to share to care meetings.

7.5 Vulnerable adults – nil by mouth (eIR1240992) –The areas highlighted for improvement in the report were:

- Consideration given to making Dysphagia SLT e-learning mandatory.
- Review of long-term funding for SLT including weekend cover.
- Review of process for all new ward admissions who are nil by mouth to be reviewed by a senior clinician at the weekend.
- Further development of the MDT discussions to encourage sequential care planning.

7.6 Incident resulting in death (eIR1259092) – The areas highlighted for improvement in the report were:

- Reiteration of the importance of following the Heparin Protocol and to provide further training to staff who are unsure of the policy in theatre and recovery.

7.7 Never Event Wrong Site Injection (eIR1255315) – The areas highlighted for improvement in the report were:

- Consider developing a procedure for all staff listing patients for elective cases on Cerner to provide standards/guidance on how to list patients for procedures.
- New Deputy Directorate Managers should be provided with training on the management of rota changes and clear guidance developed to support staff in this role. The guidance should include if a patient is listed for consultant they should not be moved to another consultant without a discussion with the primary consultant.
- Ensure timely completion of allocation to theatre lists.
- Consent should be reviewed with the patient at the time of the procedure and checked against the clinic letter.
- All information on the operating lists should be discussed in the brief and all comments taken into consideration.
- When booking procedure, the reason for booking with a named consultant should be stated if only this consultant can complete the procedure.
- This incident has been de-escalated as a Never Event and approved by NHS England.

7.8 Delay in cancer treatment which caused moderate or above harm (eIR1207816) – The areas highlighted for improvement in the report were:

- Develop and improve the investigation of 104-day cancer pathway breaches across the ICS to be in line with PSIRF.
- Ensure that psychological impact is assessed as part of clinical harm reviews.
- Implement a formal process for the scrutiny of 104-day breach clinical harm reviews.
- Review the oversight of 104-day clinical harm reviews at a Divisional Management Board (DMB).
- Directorates to provide assurance to the directorate meetings and DMB meetings.

7.9 Internal transfer/handover of patients from ED to other areas of the Trust (eIR1253854) – The areas highlighted for improvement in the report were already addressed in another PSII report that had previously been approved by the panel.

7.10 Child Death (PMRT) (eIR1252045) – The areas highlighted for improvement in the report were:

- The case highlighted the need to update local guidance for women booking late in pregnancy and to increase awareness of British Association of Perinatal Medicine and Trust guidance in relation to the management of babies born at the extremities of prematurity. An education package had been made for local dissemination regarding the guidance.

7.11 Child Death (PSR) (eIR1262803) – The areas highlighted for improvement in the report were:

- NICU staff to be reminded of process for sending MCCD following a Neonatal Death.
- Registry office to be contacted by phone following a Neonatal death to ensure they are aware of the death.
- Registry office to contact CBS managers inbox via email for any queries relating to birth/death registration.

7.12 Incident resulting in death (eIR1246958) – The areas highlighted for improvement in the report were:

- Support to be offered to the GP surgery involved for training and education in respect to referral pathways, and the learning to be shared with Lancashire and South Cumbria Cancer Alliance.
- The GP surgery is recommended to review their oversight and management of rejected and cancelled referrals.
- The GP surgery is recommended to review their processes for maintain oversight of patient pathway when a patients have multiple pathways running concurrently to ensure the wider clinical picture is considered.
- Endoscopy service to review processes in place for booking of direct to test procedures from primary care for urgent and routine referrals, to ensure clinical triage.
- Endoscopy service to review East Lancashire Hospitals NHS Trust Operational Policy Endoscopy and the Standard Operating Procedure for Clinical Prioritisation and Vetting of Endoscopy Procedures to ensure it is reflective of the above recommendation.

- Endoscopy booking team to review training program for booking staff to ensure it is formalised, robust and provides staff with the required skills and knowledge to undertake their roles.
- Endoscopy service to review all processes in place with the insource team to ensure they are robust, provide equitable service for patients, provide the required standard of documentation and effective communication to the Trust.
- Endoscopy service to review the cancellation avoidance algorithm to ensure that the escalation process is appropriate for staff to follow out of hours and at the weekend.
- Endoscopy service to formalise the process for how information is on cancellations is communicated to the relevant people.
- Endoscopy service to continue monitor cancellations due to booking errors.
- Radiology department to share the experience of the GP surgery in respect of the patients care pathway and to consider how the reporting and imaging of results to external organisations can be improved.

7.13 Six reports that were previously reviewed by the panel, were returned for approval of amendments and the safety improvement plans. All the reports were approved.

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

8.1 In November 2023 the updated PSIRP with the three new recommended local priorities for the Trust was presented at the Trust Quality Committee and the ICB Quality Board and approved. The updated PSIRP is now available on Oli for all staff to access.

8.2 The new Local priorities for Patient Safety Incident Investigations approved from 1st December 2023 are:

- 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

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, all staff are required to complete level 1a. The target is for 95% of staff to have completed training by the end of March 2024.

Table 2: Patient Safety Syllabus Training (as of 30th Nov 2023)

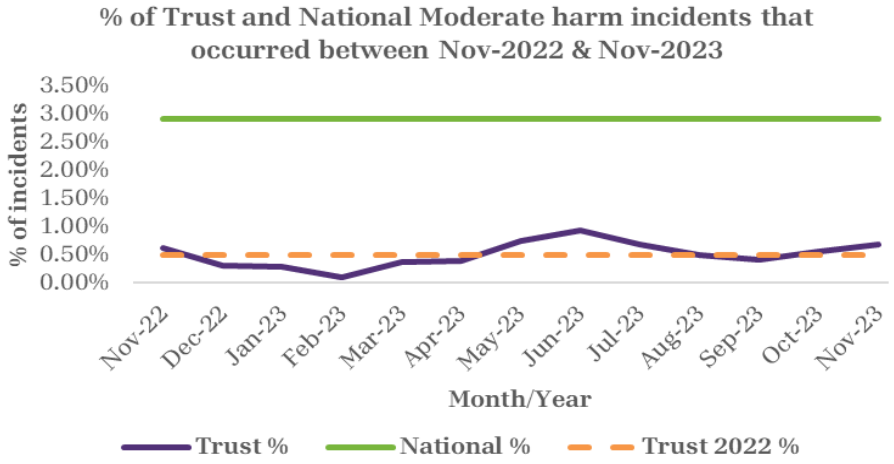
Patient Safety Training Modules	KPI Target Q3	% of staff completed training
Patient Safety Level 1a – all staff	85%	88.8%
Patient Safety Level 1b – Boards and senior leadership	85%	68.3%
Patient Safety Level 2 – Essential to role	85%	81.9%

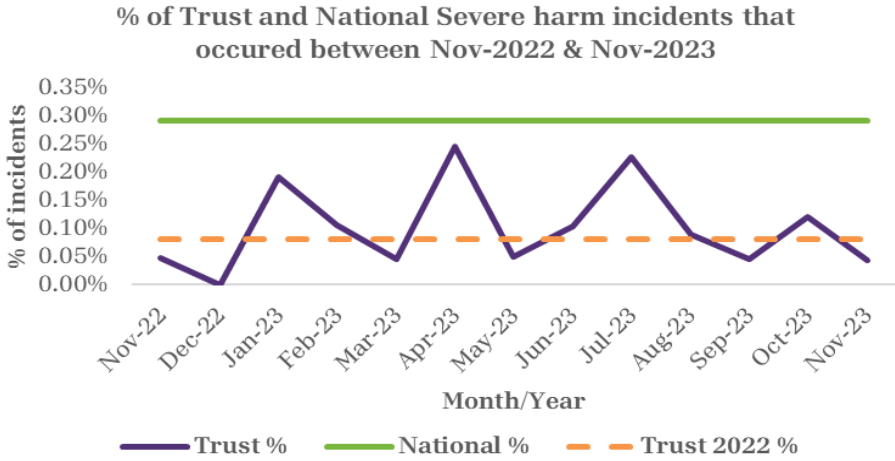
10. Maternity specific serious incident reporting in line with Ockenden recommendations

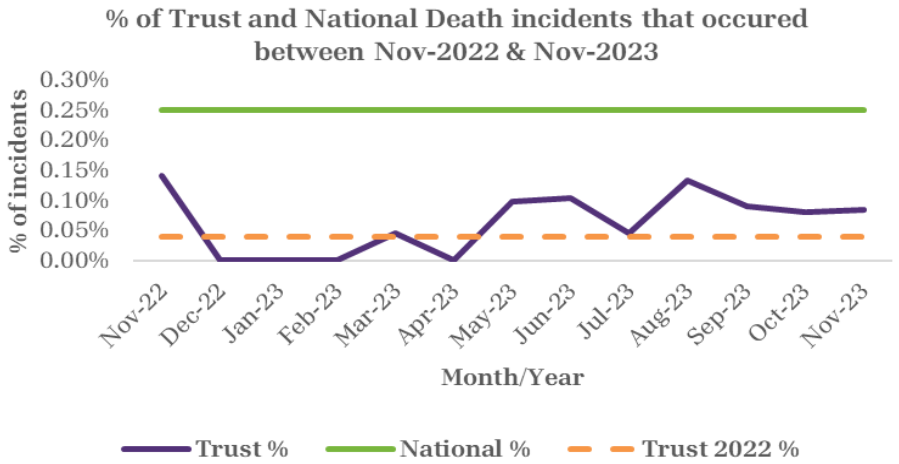
10.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 55 maternity related incidents have been reported on StEIS of which:

- 31 have been closed by the ICB with learning.
- 14 have been agreed for de-escalation from StEIS.
- 6 are currently being investigated by HSIB.
- 4 are currently under investigation by the Trust.

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	Oct	Nov	Trend
CIC	Total IR2 reported	303	328	336	368	391	331	306	
	(total number investigated) % complete within 30 calendar days	(245) 80.86%	(267) 81.40%	(284) 84.52%	(303) 82.34%	(348) 89.00%	(300) 90.63%	(283) 92.48%	↑
DCS	Total IR2 reported	153	143	122	141	128	139	174	
	(total number investigated) % complete within 30 calendar days	(91) 59.48%	(81) 56.64%	(77) 63.11%	(91) 64.54%	(76) 59.38%	(75) 53.96%	(99) 56.90%	↑
FC	Total IR2 reported	185	199	238	330	253	252	348	
	(total number investigated) % complete within 30 calendar days	(119) 64.32%	(131) 65.83%	(154) 64.71%	(225) 68.18%	(201) 79.45%	(171) 67.86%	(259) 74.43%	↑
MEC	Total IR2 reported	998	959	796	883	885	877	926	
	(total number investigated) % complete within 30 calendar days	(751) 75.25%	(642) 66.94%	(578) 72.61%	(629) 71.23%	(624) 70.51%	(601) 68.53%	(732) 79.05%	↑
SAS	Total IR2 reported	367	374	386	457	385	391	542	
	(total number investigated) % complete within 30 calendar days	(207) 56.40%	(213) 56.95%	(252) 65.28%	(332) 72.65%	(248) 64.42%	(264) 67.52%	(366) 67.53%	↑
Corp	Total IR2 reported	48	68	40	70	53	78	79	
	(total number investigated) % complete within 30 calendar days	(13) 27.08%	(28) 41.18%	(16) 40.00%	(34) 48.57%	(20) 37.74%	(55) 44.87%	(44) 55.70%	↑

Total number of IR2s open on DATIX over 30 calendar days old	
Division	Total No.
CIC	20
DCS	144
FC	161
MEC	141
SAS	310
Corporate	188

Appendix B: KPI Dashboards for PSRs

Division	Number of PSRs open	Jun	Jul	Aug	Sep	Oct	Nov	Trend >90
CIC	No. open	41	41	43	26	47	51	↓
	No. open more than 90 calendar days	15	5	7	6	7	2	
DCS	No. open	6	8	11	11	17	19	↓
	No. open more than 90 calendar days	1	1	4	6	9	4	
FC	No. open	28	35	33	27	36	43	↑
	No. open more than 90 calendar days	13	13	14	15	11	13	
MEC	No. open	83	118	135	157	168	141	↓
	No. open more than 90 calendar days	25	25	36	39	45	28	
SAS	No. open	44	49	41	49	55	57	↓
	No. open more than 90 calendar days	1	9	12	11	13	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 B: KPI Dashboards for PSIIs

PSII reports (including HSIB/PMRT)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total / Trend
No. incidents at Complex case	32	21	22	20	21	22	31	25		194
No. incidents agreed as PSII including (HSIB/PMRT)	5 (1)	4 (0)	5 (2)	2 (0)	1 (0)	6 (0)	3(2)	0		26 (5)
No. over 6 months	N/A	N/A	3	6 (2)	10 (2)	10 (2)	8(2)	6(2)		↓
Total No. of PSIIs Open	N/A	N/A	30 (6)	29 (4)	29 (4)	32 (5)	28(6)	26(6)		↓
No. approved/closed by PSIRI and of StEIS	0	4 (1)	3 (1)	3 (1)	0	3 (0)	5(0)	2		20 (3)

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

10 January 2024

Item	**13**
Purpose	Approval

Title	Financial Strategy 2023-27
Executive sponsor	Mrs M Brown, Executive Director of Finance

Summary: This paper outlines the Trust's medium term financial strategy and a financial sustainability plan over the next three years.

Recommendation: To approve the Trust's Financial Strategy for 2023-27.

Report linkages

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

Executive summary

1. This paper outlines the medium term financial strategy of the Trust and the role it must play in enabling the delivery of the Trust's Strategic Framework. In addition, the paper sets out the recommended shape and form of the financial recovery and sustainability plan.

Medium Term Financial Strategy

2. The Trust's financial strategy is twofold, one as an enabler to the Trusts Strategic Framework and secondly in working collaboratively across Lancashire and South Cumbria in shaping the financial framework as a system.

3. The Trust's strategic framework details the overarching approach, summarising the key goals and how these are delivered throughout the organisation. The framework helps to 'join the dots' of our detailed strategies, plans, delivery programmes and improvement practice, and thus provides a clear organisational framework for delivery.

4. The Trusts behavioural framework is supported by four supporting strategies being the Clinical Strategy, Quality Strategy, People Plan and the Green plan. These are the four Trust Strategies that form the cornerstones of our Trust plans. These are approved and monitored regularly at Trust Board. The strategies are aligned together so that they fit the pieces of the Trust jigsaw in terms of our plans and ambitions as an organisation. (*Appendix A*)

5. In addition, there are four Enabling strategies being the Financial Strategy, Digital Strategy, Estate Strategy and Education, Research, and Innovation Strategy. These are critical to ensure delivery of the Trust's Strategic Framework.

6. The Financial Strategy encompasses mandatory requirements, whilst ensuring the financial envelope, (a limiting factor in providing healthcare services), is spent wisely with the quality of care, at the heart of every decision made to maximise the benefit to the population of East Lancashire.

7. The Financial Strategy includes ten main principles: -

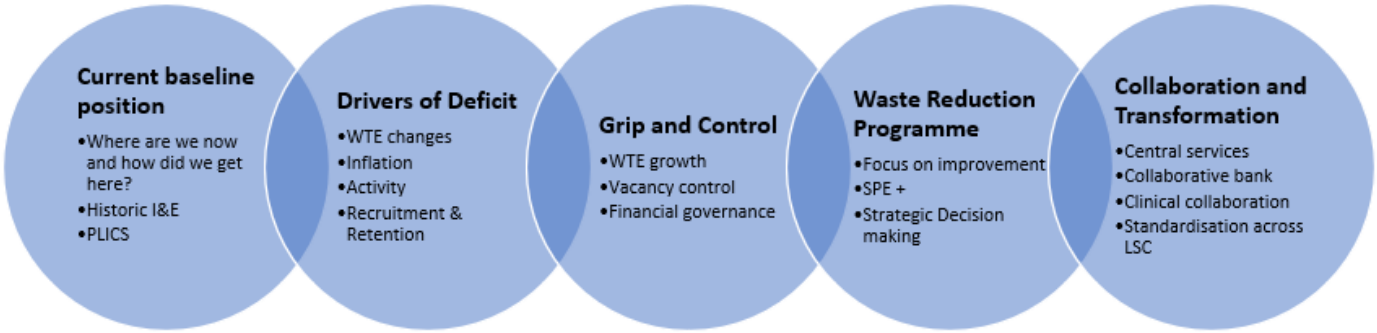
   - Ensure the Trust carries out its business of providing healthcare within sound Financial Governance arrangements that are controlled and monitored through robust audit and accounting mechanisms that are open to public scrutiny on an annual basis.
   - Meet all statutory financial responsibilities.
   - Deliver an accurate financial plan triangulated with activity and workforce plans forming the Trusts Business plan, incorporating any objectives that are part of the Trusts strategies.
   - Support the delivery of the Trusts Waste Reduction Programme.
   - Financial recovery and sustainability, working to improve the Trusts underlying financial position.
   - As we mature as a Lancashire and South Cumbria system, continue to support a system-based approach to planning and delivery; working collaboratively with system partners to standardise practice and maximise opportunities.

- Work to shape the financial framework for Lancashire and South Cumbria ICS and achieve system financial balance
- Enable delivery of the NHS planning priorities for 2023-24+
- Engage all finance staff in improving NHS finance, to support the delivery of quality services for patients, supported by the vision of One NHS Finance (*Appendix B*)
- Maintain Future-Focused Finance Towards Excellence Accreditation Level 3, recognising organisational excellence.

Financial Recovery and Sustainability

8. The Trust is committed to establishing a three-year financial recovery and sustainability plan to improve the Trusts underlying financial position and ultimately the systems underlying financial position. There are several risks in the financial position as it currently stands.

9. The Trust will focus its financial recovery in the following key domains



Current baseline position – NHS Trusts have a statutory duty to achieve their breakeven duty. ELHT has never, at any point since its formation in 2003 breached this duty. At the beginning of this financial year, the Trust had a cumulative surplus of £29m. Our likely deficit position in 2023-24 will erode this cumulative surplus, however under the current rules, the Trust will have another 2 years to address this, without breaching its break-even duty. As detailed further in this paper, the Trust currently has an exit run rate recurrent forecast deficit of £78.9m.

Drivers of Deficit – We will continue to review our drivers of our deficit and our resultant income and expenditure position. It is important to understand this in detail to consider any mitigating strategies.

Grip and Control – The Trust takes its stewardship of tax payers money very seriously. We will focus on ensuring expenditure is through appropriate delegated authority and in line with the Standing Financial Instructions of the Trust.

Waste Reduction Programme – The Trust's waste reduction programme is aligned to the key deliverables of its strategic objectives. It is important that the programme is not seen as purely finance focussed and separate to the day to day operations of the Trust.

Collaboration and Transformation – As we work towards increased system working, there are opportunities for collaboration which must be realised. The Trust will actively participate and influence decision making in respect of our services, ensuring all decisions aim to improve quality, delivery, impact on staff and patients and our financial recovery. It is recognised that there may be individual service changes that result in a higher cost to ourselves but a reduction to the system overall. In these circumstance we would still expect improvements to the other indicators.

Financial context

10. The Trust reported a £4.1 million deficit financial performance for the 2022-23 financial year, in line with the agreed financial plan. The Trust is currently not breaching its break-even duty.

11. The 2021 Spending Review (SR21) provided the NHS with a three-year revenue and capital settlement covering 2022-23 to 2024-25. The ICS has been highlighted as receiving more than its expected funding throughout the pandemic. The system will be reduced over the coming years to converge the funding back into the expected funding envelope. This will be in addition to any national efficiency requirements. Convergence will be a further 1.34% reduction in 2024-25.

12. The NHS Financial Framework requests all systems to breakeven in 2023-24.

13. That said, the Trust has submitted a £24.2 million deficit financial plan for 2023-24, the deficit includes a waste reduction target in year of £54.6 million; it must be noted this is high risk as the Trust has never achieved a target of such a scale.

14. This is in line with the Lancashire and South Cumbria system plan of a £80 million deficit, which has been received by the national team, but not approved.

15. The Trust is facing a significant financial challenge in 2023-24 onwards, and there remain significant risks to its current forecast outturn position.

16. On the Trusts corporate risk register, the financial sustainability risk is scoring at 25, and will likely remain at 25 until we have some level of certainty around the current financial risks.

17. The Trusts 2021-22 National Cost Collection Index is 104.

Underlying financial position and core drivers of deficit

18. The Trust faces a gross underlying financial deficit of c£79 million at the end of 2023-24.

19. The Trusts underlying deficit has resulted from a combination of factors. These includes national and local drivers of deficit detailed below, non-recurrent achievement of the waste reduction programme and non-recurrent funding allocations.

20. National drivers of deficit include:

Exit from Covid

Whilst Covid remains, both primary and secondary based services face the combined challenge of maintaining social distancing and Protective Personal Equipment (PPE) in higher risk settings, together with restarting normal levels of elective and non-elective service provision. This presents risks where services have had to adapt and ultimately a financial pressure. The financial strategy aims take an agile approach to responding to the pandemic but stepping down measures when safe and practicable to do so.

In addition, large numbers of patients waiting for elective care require a proactive approach both nationally, regionally and locally. Resources are likely to be targeted toward providers who can make significant improvements within their systems. As such the financial strategy will support the development of systems and tools to support operational teams to optimise elective and non-elective pathways and identify areas where the Trust can use capacity to support the wider system.

Changing Structure of the NHS

The Department of Health and Social Care's White Paper "Integration and innovation: working together to improve health and social care for all," sets out the legislative proposals that will shape the NHS for the next decade. Alongside this we are also seeing changes in the way we do business. Integrated Care Boards are now in place, resulting in the need as part of the Trusts financial strategy to think differently about the commissioning of healthcare and reappraise that our commissioners are and how we engage with them.

21. Local drivers of deficit are shown below against the Trusts twelve Key Delivery Programmes. The Key Delivery programmes are led by an Executive team member and have been linked to related strategies.

Key Delivery Programme 1 Related Plan/Strategy Drivers of deficit/change in cost	Urgent & Emergency Care Improvement UEC Improvement Plan ED throughput Pressures, Corridor pressures, Workforce vacancies, NMC2R, rec impact of Covid
Key Delivery Programme 2 Related Plan/Strategy Drivers of deficit/change in cost	Elective Pathway Improvement Elective Care Improvement plan Unfunded Critical care beds, productivity reduction, under bedded
Key Delivery Programme 3 Related Plan/Strategy Drivers of deficit/change in cost	People Plan Priorities People Plan Strategy High workforce gaps and premium rates paid/patient safety, H&WB, International recruitment Increased support for H&WB agenda
Key Delivery Programme 4 Related Plan/Strategy Drivers of deficit/change in cost	Quality & Safety Improvement priorities Quality Strategy CNST increase out of line with inflation funding streams
Key Delivery Programme 5 Related Plan/Strategy Drivers of deficit/change in cost	eLancs Programme ePR Cerner Programme Implementation slipped from 2022-23 to 2023-24, resource heavy, activity recording risk
Key Delivery Programme 6 Related Plan/Strategy	Care Closer to Home/PLACE based partnerships Healthier Pennine Lancashire delivery plans

Drivers of deficit/change in cost	Community site excess costs i.e., AVCH, PCH
Key Delivery Programme 7 Related Plan/Strategy Drivers of deficit/change in cost	Provider Collaborative PCB Clinical Strategy Contribution towards Collaborative workstreams
Key Delivery Programme 8 Related Plan/Strategy Drivers of deficit/change in cost	Tackling Health Inequalities Health Equity Plan Local depravation, costs incurred supporting Mental Health patients A&E, security on wards
Key Delivery Programme 9 Related Plan/Strategy Drivers of deficit/change in cost	R&D, Education & Innovation DERI strategies The number of Trust funded Junior Doctors, dedicated sessions for research and education, Double running of workforce transformation, Physician and Nurse Associates
Key Delivery Programme 10 Related Plan/Strategy Drivers of deficit/change in cost	Waste Reduction Programme WRP plan PFI contract premium costs in addition to contract related additional costs i.e., Fire/security and small works costs, increased non recurrent schemes
Key Delivery Programme11 Related Plan/Strategy Drivers of deficit/change in cost	Sustainability Net Zero Plan, Financial Strategy
Key Delivery Programme 12 Related Plan/Strategy Drivers of deficit/change in cost	Income and Contracting Financial Strategy Impact of System Funding Allocation, System top-up, UEC Fund, Incomplete Contract Position Impact of system convergence funding reduction

22. Local financial pressures include: -

- High-cost emergency medicine department dealing with increasing number of patients attending the department, with increased complexities, together with longer wait times.
- The premium cost of PFI Contracts and monitoring thereof
- Unfunded capacity that is required to ensure a safe environment for patients
- Workforce gaps and the use of agency staff and Trust funded junior doctors

23. Our drivers of deficit include:-

- Services where current activity levels are not capable of sustaining financial balance but are essential
- The loss of funding for services deemed as necessary for patient safety reasons
- Allocative inequalities
- A fall in productivity whilst the cost of delivery has increased.

Governance

24. The Trust must balance the quadruple aim of quality, workforce and patient needs, performance targets and finance across the organisation, and everyone has a role to play in this.

25. The Trust Board is ultimately accountable for all aspects of the Trusts performance. This is documented in the Trusts Accountability Framework. Assurance is delegated to the Finance and Performance Committee to oversee the detailed financial plan and performance against the plan and waste reduction programme.

26. In addition, a more granular level of accountability takes place within the Financial Assurance Board, which feeds into the Financial and Performance Committee, this is chaired by the Chief Executive.

27. The Capital Planning Board monitors performance against the capital plan, again which feeds into the Financial and Performance Committee., this chaired by the Director of Finance.

28. The ICB will in addition monitor our performance and play a crucial part in supporting the Trust to deliver the financial strategy, particularly where our plans extend into areas not totally within our control such as commissioning arrangements and provider collaboration.

Financial Recovery Scenarios

29. The Trust has created three recovery scenarios

    Do Minimum – this assumes that the Trust delivers an additional 0.5% efficiency above the national efficiency levels implicit in the National Tariff. This scenario shows the baseline from which financial improvement is required.

    Transform – in this scenario the Trust addresses accessible improvements to the drivers of the deficit over a realistic period in addition to delivering a 0.5% efficiency above National Tariff assumptions. At the end of this programme the Trust will attain performance comparable to the best performing Trusts in its peer group.

    Do Maximum – this scenario represents an ambitious plan with stretching improvement programmes. At the end of this programme the Trust will attain performance comparable to the best performing Trusts nationally.

30. “Do Maximum” scenario is the only sustainable option identified. It is ambitious and requires recurrent levels of efficiency rarely seen within the NHS. Any underachievement will increase the challenge in the next year.

31. It is likely a 3 year recovery will not be accepted and we will be asked to go faster and further.

32. ’Do Maximum’ requires an ambitious change capability, establishing and implementing clinical and financial strategy with immediate effect in 2023-24.

33. 'Do Maximum', will require a minimum of a 3.5% recurrent reduction in expenditure in 2023-24, and will require a significant step change in the Trust's approach to transformation and achieving recurrent and sustainable efficiencies.

34. The Trust must deliver average recurrent efficiencies / productivity of c.10.74% over the next 3 years or £78.9m (excluding further growth and inflationary control) over the period to 2025-26.

35. Do Maximum represents a level of improvement rarely seen in the NHS, but the trust may still be asked to do more by the ICS.

36. These scenarios assume no additional pressures, that all future price rises are funded and all savings achieved are recurrent. It also ignores future efficiency requirements. As this position is uncertain we have focussed on addressing the exit run rate for 2023-24. Equally this position does not include the impact of convergence on system funding as the allocation method to providers has not been agreed.

	2024-25	2025-26	2026-27
Exit run rate underlying deficit	(78.9)	(53.2)	(27.5)
Recurrent WRP	25.7	25.7	27.5
Underlying deficit	(53.2)	(27.5)	(0.0)
Assumption % Recurrent efficiencies	3.5%	3.5%	3.7%

Capital

37. The capital strategy remains to maintain and to improve the Trust estate by way of investment, at the same time investing in the digital and diagnostic strategies and supporting medical equipment replacement.

38. In 2022-23 the Trust invested £32.5 million on new building works, improvements and equipment and information technology across all its sites with the accounting treatment of right of use leases being classified as capital expenditure from 1st April 2022 at a value of £9.9m. The Trust received £7.6 million of funding for the replacement of part of the roof on the Royal Blackburn site, after Reinforced Autoclaved Aerated Concrete (RAAC) was identified within its structure, which needed to be removed. Work continued with a further £6.4m being spent on the preparatory work to transfer our patient records to an electronic patient record. Other significant areas of spend included £3.6m on the conversion of two old theatres on the Burnley site to state-of-the-art Endoscopy rooms, £3.4m on PFI lifecycle costs and £3.1m on medical equipment.

39. A £27.1 million capital plan was submitted for 2023-24; of this £10.0million is reliant on external funding.

Figure 4: Trust 5-year capital plan

Capital programme	2023-24 £000's	2024-25 £000's	2025-26 £000's	2026-27 £000's	2027-28 £000's
Phase 9	0	40,000	0	0	0
Aseptic suite	0	10,000	0	0	0
Radiology	0	6,000	0	0	0
Other new externally funded schemes	2,480	3,210	0	0	0
Emergency Village					
- Coronary Care & Cardiology into D floor	2,188	0	0	0	0
- ED Paediatrics & Majors (frailty) into CCU	3,244	0	0	0	0
RAAC	4,132	0	0	0	0
Theatres electrical upgrade	491	1,060	0	0	0
Other estates schemes	3,127	4,123	2,500	1,500	1,500
EPR	1,863	470	0	0	0
Other IT schemes	430	1,500	1,500	1,500	1,500
Medical equipment	250	1,000	1,500	1,500	1,500
PFI lifecycle costs	2,967	2,123	3,604	3,604	3,604
Other internally funded schemes	1,000	1,128	2,044	3,218	2,178
IFRS 16					
Blood Sciences managed equipment service	1,853	0	0	0	0
Old Bank Lane	1,557	0	0	0	0
Hybrid theatre	0	1,113	0	0	0
Community Health Partnerships lease renewal	0	16,354	0	0	0
Other new leases	701	535	0	0	0
Property lease liability remeasurements	859	641	0	0	0
Gross capital expenditure	**27,142**	**89,257**	**11,148**	**11,322**	**10,282**
Funding and other items funded from capital resources:					
- Public Dividend Capital	9,924	59,210	0	0	0
- Depreciation	23,931	23,908	23,414	22,714	21,008
- Cash reserves	-90	87	0	0	0
- IFRS16	-2,892	10,269	-7,500	-7,500	-7,500
- Other sources of funding	500	500	500	500	500
- Other items funded from capital resources	-4,231	-4,717	-5,266	-4,392	-3,726
Funding available for capital expenditure	**27,142**	**89,257**	**11,148**	**11,322**	**10,282**

40. As with the revenue plan, at this point in the year there is risk attached to the capital plan, namely around staggering increased costs of materials and awaiting outcomes from bids and then limited ability to spend the money in the same financial year.

Recommendation

41. The Trust Board are asked to note the contents of this report.

Appendix A - ELHT Strategic Framework

ELHT Strategic Framework

Our collective organisational vision is to be widely recognised for **providing safe, personal and effective care.** Our Trust vision is underpinned by our core values. We have committed in all our activities and interactions to put patients first, respect the individual, act with integrity and to serve the community and promote positive change.

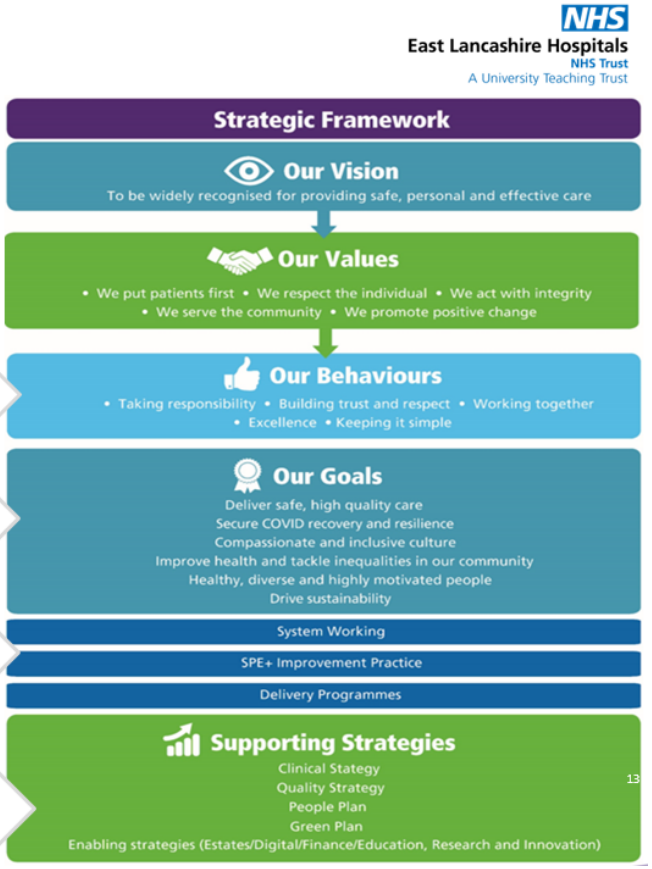
Our Strategic Framework (right) summarises how our vision and values are delivered throughout the organisation.

OUR BEHAVIOURS are an important foundation of providing safe, personal and effective care. These are fundamental to ensuring that our values can be achieved.

We have **SIX GOALS**. These are the *golden threads* that weave through all that we do; as individuals, teams and collectively as an organisation.

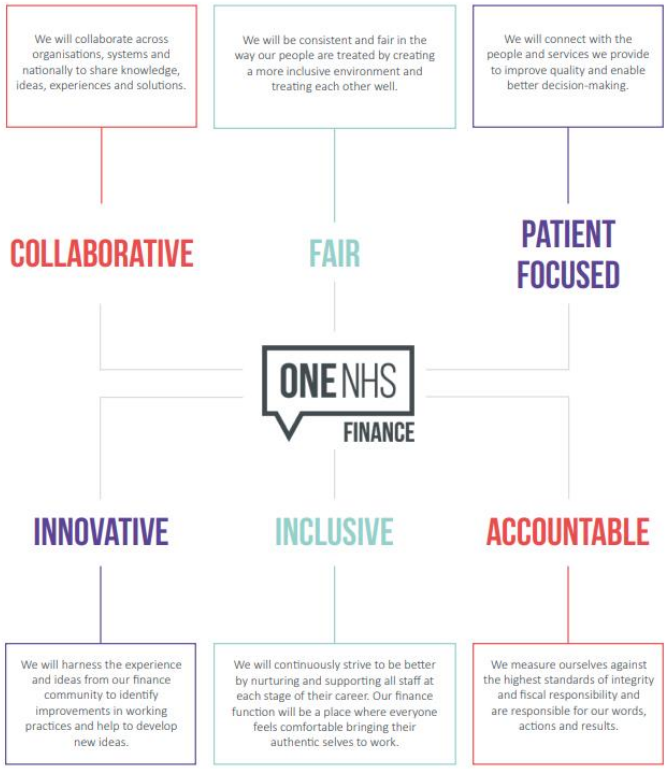
HOW we deliver our strategies, goals and vision is through our system working, our business structure and key delivery programmes. All our work is underpinned by our improvement practice. We have **11 delivery programmes**, **SPE+ improvement practice** and **business planning** to support delivery.

Our supporting strategies are the cornerstones of our Trust Strategic Framework, providing the plan and the **WHAT** – these strategies provide the details of how we will collectively support delivery of our vision and goals.



Appendix B – One NHS Finance Vision

One NHS Finance – Proud to support the delivery of world class healthcare
We are a diverse, highly skilled, and well-respected workforce with strong leadership working together to support the delivery of world class health and care. We are innovators and problem solvers, collaborating across systems to provide the best value for patients. We strive to improve our function and develop our people, making our NHS the employer of choice for a career in finance. Together we are One NHS Finance.
The six values that underpin the vision are: Fair, Patient-focused, Collaborative, Innovative, Inclusive and Accountable.



Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **14**

10 January 2024 **Purpose** Approval / Assurance / Information

Title	Maternity and Neonatal Services Update
Report Author	Miss T Thompson, Divisional Director of Midwifery and Nursing (Maternity Safety Champion)
Executive sponsor	Mr P Murphy, Executive Director of Nursing. (Board Level Maternity/Neonatal Safety Champion)

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

4. Continuous Quality and Service improvements, progress, and celebrations.

Recommendation: The Board of Directors are asked to.

- Receive and discuss the CNST-MIS update, all compliance reports and recommendations from year 5 in preparation for the board declaration submission on Thursday 1st February 2024.
- Have full oversight through direct reporting to ELHT trust board any barriers that may impact on the implementation and longer-term sustainability plans for delivery aligned with the maternity and neonatology safety ambition.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and 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 (None)
Related to recommendations from audit reports	Audit Report Title and Recommendation/s (None)
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to Maternity incentive Scheme (MIS) Year 5.
Related to ICB Strategic Objective	State which ICB Strategic Objective the paper relates to continue to deliver on the National Maternity and Neonatology Safety Ambition.

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 and neonatology services in response to the NHS England/Improvement (NHS E/I) – Full Ockenden review, Three Year Delivery Plan and neonatal critical care review.

   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 a 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 – PMRT dashboard included below shows compliance to all the required thresholds for all cases currently meeting timelines including the action plan. The Q3 report/action plan is submitted in (appendix 2).
2. Maternity Services Data Set (MSDS)		Compliant and Complete. July data submitted and as per previous publication of the scorecard in October – all areas passed.
3. Transitional Care (TC)		Compliant – Q2 TC audit is completed and submitted in (appendix 3). Q3 TC Audit Oct-Dec and Q3 ATAIN report to be complete in January and reported to Trust Board in March.
4. Clinical Workforce		Compliant – Annual Neonatal nursing staffing report with action plan submitted in (appendix 4), Neonatal medical and Anaesthetic workforce review assurances included within the report, evidence available in ELHT CNST portal. An update with regards to compensatory rest is included, and assurance with regards to consultant attendance audits.
5. Midwifery Workforce		Compliant – July-December 2024, second biannual, Midwifery staffing report review submitted in (appendix 5)

6. Saving Babies Lives v3 Care Bundle (SBLv3)		Compliant – Implementation is progressing well and on track for compliance required by February 2024. Elements 2-5 required an annual review of PMRT data, this is completed and submitted in (Appendix 6)
7. MNVP User Feedback		Compliant – East Lancashire Maternity Neonatal Voice Partnership (MNVP) meetings are taking place, MNVP chair has provided all the relevant evidence to demonstrate co-production and effective collaborations with ELHT Maternity and Neonatal services including a ratified workplan. The 2022 CQC survey results and action plan is continually reviewed and updated. Further discussions have taken place with the Maternity and Neonatal safety champions at the Floor to Board meetings to fulfil the CNST ask, plans to review the 2023 results are underway.
8. Training		Core competency framework version 2 local training plan was reviewed by LMNS at the QA visit, submitted to Trust Board. (Appendix 7) Anaesthetic compliance with PROMPT training has reached the required 80% attendance for the reporting period (1st Dec 22 – 1st Dec 23). An action plan is submitted in (Appendix 8) to detail how 90%+ attendance will be achieved by the end of February 2024.
9. Board Assurance		Compliant – PQSM Minimum Data Set is submitted within this report to update and inform Trust Board discussion with any exceptions. Evidence of Executive and Non-Executive engagement with the Safety Champions resources detailed within the report.
10. MNSI / NHS Resolution		Compliant – Maternity and Newborn Safety investigation Programme (MNSI) now hosted by the CQC as of the 1st of October 2023 along with the Early Notification (EN) Scheme. The scheme proactively investigates specific brain injuries at birth for the purposes of determining if negligence has caused the harm. This is monitored closely in all Trusts. ELHT Maternity and Neonatal Services hold a portal of all cases to be reported. An overview document of the submissions both for MNSI and EN is submitted in (Appendix 9).

2.2 Key updates and exceptions per Safety Action

2.2.1 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 20.12.2023]

* 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	Threshold	Jun-2[illegible]	Jul-2[illegible]	Aug-2[illegible]	Sep-2[illegible]	Oct-2[illegible]	Nov-2[illegible]	Dec-2[illegible]	Monthly Trend
SAFETY ACTION 1		Total Eligible Cases		5	4	3	2	1	5	1	
	PMRT02a	a) i Number of cases reported to MBRRACE within 7 days		5	4	3	2	1	5	1	
			100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	PMRT03a	a) ii Number of cases with surveillance data to MBRRACE within 28 days		5	4	3	2	1	5	1	
			100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	PMRT06a	c) i Number PMRT tool started 2 months		5	4	3	2	1	5	1	
			95%	*	*	*	*	*	*	*	
	PMRT04a	c) ii Number PMRT draft reports by 4 months		3	4	3	0	0	0	0	
			60%	60.0%	100.0%	100.0%	*	*	*	*	
	PMRT04c	Number PMRT draft reports not due		0	0	0	2	1	5	1	
	PMRT05a	c) ii Number PMRT published reports by 6 months		3	2	0	0	0	0	0	
			60%	60.0%	50.0%	*	*	*	*	*	
	PMRT05c	Number PMRT published reports not due		0	2	3	2	1	5	1	

As evidenced in the dashboard above, all required thresholds of compliance of those which have met their deadline date currently have been met for cases within the reporting period (30 May 2023 until 7 December 2023).

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.

ELHT Maternity & Neonatal services confirm that the PMRT review panel meetings have not been directly impacted by industrial action, and no meetings have required reschedule.

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

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 all requirements.

2.2.3 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 Neonatal Intensive Care Unit (NICU) of infants equal to or greater than 37 weeks.'

Quarterly reports are completed which inform the ATAIN improvement plan. Quarter 1 includes details from all reviews April to June and was reported to Trust Board in September 2023. Quarter 2 includes details from all reviews July to September and was reported to Trust Board in November 2023. Quarter 3 will include all reviews October to December and will therefore be reported to Trust Board in March 2024. The ongoing ATAIN improvement plan is consistently reviewed and follows the reporting pathway and timeframes as above.

'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.'

Q2 (July-September) data review and audit presentation is complete **[Appendix 3]**. This includes data relating to pre-term babies (34 - 36+6 weeks gestation) reflecting compliance

with BAPM Transitional Care Framework for Practice aligned for late pre-term and term babies.

2.2.4 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 and further in a dedicated meeting on the 24th November 2023. A preferred option has been agreed, and directorate managers are now completing an impact assessment exercise to review any impacts on Obstetric and Gynaecology activity. Following this a go-live date of the finalised process will be agreed.

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 with 100% compliance. A further audit in September, October, and November, up to the 7th of December 2023 as per CNST requirements finds 95% compliance (18/19 events attended by an obstetric consultant). This has been reviewed at unit level, the case was a pre-term breech birth which arrived to the unit at 8cm dilated with pathological CTG and was operated on by ST7 due to the timeframe pressures involved and level of urgency required.

Anaesthetics workforce

'A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients.'

A 2-month review of the anaesthetic rota has been completed and assurance gained that this demonstrates compliance with evidence to meet the Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1. This was complete and the position evidenced up to the 7th of December 2023 as per CNST requirements.

Neonatal medical workforce

'A review has been undertaken of any 6 month period between 30 May 2023 – 7 December 2023. The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce.'

Clinical Director for Neonatology, Dr Savi Sivashankar, has performed a review of the Neonatal Medical Workforce as described above. Findings give assurances that the Neonatal Medical Workforce is compliant with the relevant BAPM recommendations as listed within the technical guidance of the full CNST guidance (Appendix 1). The Trust board are asked to formally record this assurance within the meeting minutes.

Neonatal nursing workforce

An annual report has been submitted to Trust Board detailing an effective system of Neonatal nurse workforce planning and monitoring of safe staffing levels for the period of November 2022 - November 2023. An action plan is also submitted as a result of these findings. (Appendix 4).

In reference specifically to the requirements monitored by CNST Safety Action 4, the Neonatal Staffing Workforce Calculator against activity finds there is a deficit of **10.31 WTE Registered/ 2.81 WTE non Registered** required to meet the BAPM National Recommended Standards.

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

The Biannual midwifery staffing report which must be submitted to Trust Board every 6 months is included within this report (Appendix 5). This report contains all required information and assurance relating to the asks of Safety Action 5:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. - (birth rate plus)

b) Trust Board to evidence midwifery staffing budgets reflects establishment as calculated in above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

d) All women in active labour receive one-to-one midwifery care.

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

'The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. 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 22nd of November 2023, LMNS lead midwife for the implementation of Saving Babies Lives v3 conducted the 2nd quality assurance visit of this CNST reporting period to establish ELHT progress. 48 of the 70 interventions across the care bundle are currently implemented, and ELHT maternity and neonatal services are at 68.5% implementation. The requirement of CNST is to reach 70% overall implementation, ELHT maternity and neonatal services are assured that this will be achieved. Furthermore, a compliance target of 50% implementation for each individual element is required. ELHT have achieved this target to date.

An overview of the progress with the 6 elements of SBL following the LMNS QA visit in November are as follows:

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	5/10 interventions implemented and evidenced **(50%)**
Element 2 - Fetal Growth Restriction	14/20 interventions implemented and evidenced **(70%)**
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	21/27 interventions implemented and evidenced **(78%)**
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 (4 parts per million (ppm) 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 outside of BwD they are referred to Change Grow Live which is a new company that has taken over the contract formerly held with the Quit Squad.

However, plans to implement an in-house tobacco dependency treatment service are well underway since the appointment of a Prevention Lead Midwife in September 2023.

Four Tobacco Dependant Advisers have been appointed with start dates being the 8th of January 2024. Following a week of training and supported induction this new service will 'soft-launch' on the 15th January 2023 starting with visibility in all ELHT hospital Antenatal Clinics and the family hubs in East Lancashire and Blackburn. The service has experienced a slight

unavoidable delay from the initial proposal to soft-launch in December due to delays with the HR processes and the release of staff from their current posts.
The Smoking in Pregnancy guideline has been amended to reflect this change in service and has been ratified via the Quality & Safety Board on the 14th December 2023, this will support all required staff with navigating the changes to the service.

Elements 2 – 5 – The Perinatal Mortality Review Tool (PMRT) is a national tool which is used to investigate all stillbirths and neonatal deaths. The requirement is to use the PMRT to calculate the percentage of perinatal mortality cases annually:

- Where the identification and management of Fetal Growth Restriction (FGR) was a relevant issue [SBLCB Element 2].
- Where issues associated with reduced fetal movements (RFM) management have been identified [SBLCB Element 3].
- Where failures of intrapartum monitoring are identified as a contributory factor [SBLCB Element 4].
- Where prevention, predication, preparation or perinatal optimisation of pre-term birth was a relevant issue [SBLCB Element 5].

This exercise has been completed and is submitted to board within a concise report as submitted in (Appendix 6). To note safety with assurances of the above criteria, 0 cases were found in all cases. This is an amazing achievement and one to be shared and celebrated with all of the maternity team.

Element 5 – Fetal Monitoring – '*Identify a dedicated lead midwife (minimum of 0.4 WTE) and lead obstetrician (minimum 0.1WTE) with demonstrated fetal monitoring expertise to focus on and champion best practice in fetal monitoring.'*
ELHT have a 1.0 WTE dedicated lead midwife as demonstrated via the job description for the role. A lead obstetrician for fetal monitoring is also identified meeting the required WTE. The Trust Board are asked to confirm that these roles are in place.

2.2.7 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.*

Evidence provided to include MNVP ratified workplan and MNVP prioritising hearing the voices of Neonatal, Bereaved Families, BAME and high deprivation service users. This has been achieved by the Maternity & Neonatal services facilitating a schedule of engagement sessions, identifying the specific cohort of service users in attendance and supporting the MNVP chair with the resources required to collate rich information.

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

A key theme from the CQC maternity survey and MNVP feedback has been identified as delays in the postnatal discharge pathway, this has been discussed for feedback and co-production of further improvements at the October MNVP meeting.

The 2023 CQC maternity survey data has been received by the service, however this is currently embargoed for publication. The wider teams will receive a presentation to review the results in January 2024.

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, as per reports submitted to this forum on a bi-monthly basis.

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

A local training plan is in place for implementation of Version 2 of the Core Competency Framework, this is submitted to the Trust Board for agreement. (Appendix 7)

Attendance to required training sessions continued from Version 1 of the framework have been monitored and reviewed against the 80% attendance standard within the required reporting period (1st December 2022 – 1st December 2023). Escalation to the clinical director of Anaesthetics with regards to Anaesthetic training compliance for the PROMPT training sessions, during the stated reporting period has been sought this has now achieved the required 80% compliance. In addition this requires an explicit action plan to be submitted to the Trust Board for approval outlining the plan for all anaesthetists who are none compliant to attend the PROMPT training by the end of February 2024. This is submitted in **(Appendix 8).**

All other training attendance requirements have been met with 90%+ compliance and therefore require no action plan.

2.2.9 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

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

	Metric	Standard	Aug 23	Sept 23	Oct 23	Nov 23
Perinatal Data	1:1 care in labour	100%	100%	100%	100%	100%
	Stillbirth rate	<4.4/1000	4.01	2.05	3.83	2.03
	Term admissions to NICU	<7%	6.14%	6.26%	5.77%	6.52%
	Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	2.97%	3.12%	4.6%	3.29%
	3rd/4th degree perineal tear	<5%	3.79%	3.27%	3.73%	2.78%

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

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Perinatal Data:
All metrics within the perinatal data has been specifically reviewed against the Maternity Scorecard Data, ensuring all data is collated in the same way and enhancing data quality.

Term admission to NICU:
The division are aware of an increasing trend that was identified early in the year for in term admissions to NICU. This has since reduced to under the 7% threshold but continues to be closely monitored.
Respiratory issues are the main reason for term admissions. Further insight into contributing factors will be gained through various ongoing audit and service evaluation work including reviewing Induction of Labour and Elective C-Section pathways.
Following this, a joint maternity/neonatology group will use this insight to inform any quality improvement project. 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.

Obstetric Haemorrhage >1.5 litre
This % has remained static through the year predominantly. The slight October increase will be monitored, and themes or trends will be identified if rise is persistent.

Training Compliance:
The average for training compliance across all staff groups remains >90% attendance, however training compliance for Anaesthetist as an individual staff group for PROMPT training in November is 80%. An action plan is being submitted to Trust Board.

	Metric	Standard	Aug 23	Sept 23	Oct 23	Nov 23
Feedback	Service user feedback (MNVP)		-	3 sessions attended	2 sessions attended	0 sessions attended
	FFT satisfaction rated as good	>90%	100%	89.66%	100%	88.83%
	Number of level 4 complaints	-	1	3	4	4
	Executive safety walkaround	Bi-Monthly	ANC Cancelled	Burnley Birth Centre re-scheduled	N/A	NICU
	Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	N/A	Blackburn Birth Centre	N/A	Antenatal Clinic

	Metric	Aug 23	Sept 23	Oct 23	Nov 23
External Reporting	Maternity incidents graded moderate or above	4	1	3	0
	Cases referred to HSIB	4 (3 rejected)	0	1	2
	Cases referred to coroner	1	2	0	0
	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	Aug 23	Sep 23	Oct 23	Nov 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%

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MNVP Service User Feedback:
A schedule of engagement sessions has been implemented which highlights key sessions for the MNVP to attend and hear the voices of priority service user (BAME, high deprivation, neonatal families). MNVP lead has attended sessions and is providing feedback with support from the Maternity Transformation Team to collate and inform improvements.

0 Sessions attended in November due to other pressures on MNVP lead time, however further sessions identified for December.

FFT satisfaction rated as good:
The Quality & Safety facilitators are working through the feedback to review and adding insight into the area action plans for the ward manager/matrons to review and inform improvement.

Level 4 Complaints
There has been 4 level 4 complaints, no themes or trends have been identified

Coroner referral:
No coroner referral made

HSIB referral:
There has been 2 babies referred for cooling. There has been a cluster of cooled babies and so a cluster review is underway

CNST:
Submission is due 1st February 2023, with the final report to Trust Board in January. All safety actions currently on track for compliance.

'Evidence that both the executive and non-executive Maternity & Neonatal Board Safety Champions have registered to the dedicated Future NHS Workspace with confirmation of specific resources accessed and how they have been of benefit.'

Executive Maternity & Neonatal Board Safety Champion Peter Murphy has confirmed access to the NHS Futures Workspace and specifically found the Board Safety Champion Blogs to be helpful stating 'they resonated with me around the content of the areas we explore here at ELHT as the team provides assurance around the various elements of safety.' Non-executive maternity & Neonatal board safety champion Khalil Rehman confirmed registration in the summer and found the videos to be good on the future workspace platforms.

2.2.10 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. An overview document has been provided (appendix 9).

3. CONCLUSION

On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board will provide progress with assurances of the ten CNST maternity safety action submissions throughout the Year 5 reporting period. The progress and assurances with updates of all the objectives as outlined in the summary twill continue to be reported, these align with ELHT twelve-month schedule adapted from National policy, independent reports, and recommendations.

ELHT maternity and neonatology services are now able to confirm that all the evidence required for MIS Year 5 reporting period has been submitted and uploaded onto the ELHT SharePoint portal. Progress with compliance has been reflected with assurances throughout the MIS Year 5 reporting period and can be referred to in 2023 Trust Board papers.

Any other matters of safety or concerns if apparent will continue to be reported through the bimonthly maternity and neonatology safety champions floor to board agendas and reflected within trust board papers with discussions if required.

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
December 2023

Appendix 1 – CNST-MIS Y5 Guidance

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

Appendix 2 – PMRT Q3 Report (Including Action plan)

Q3 Quarterly PMRT report Oct-Dec 23.doc

Appendix 3 – Q2 Transitional Care Audit

Q2 TC audit July to Sept 2023 1.pptx

Appendix 4 – Neonatal Nursing Staffing Report (Including Action Plan)

Neonatal Nursing Staffing paper- Trust

Workforce Action Plan 23 - 24.xlsx

Appendix 5 – Midwifery (Bi – Annual) Staffing Report

A)B) & E) Maternity Bi annual staffing p

Appendix 6 – Annual PMRT review – as per SBLv3 requirement

PMRT appendix SBLv3 (1).odt

Appendix 7 – CCFv2 Training Needs Analysis

1) CCF V2 TNA.xlsx

Appendix 8 – Anaesthetic Doctor Attendance at PROMPT – Action Plan

Anaesthetic PROMPT compliance

Appendix 9 – MNSI / EN Reporting Overview

CNST SA 10 Year 5
Dec 23 update.docx

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **15**

10 January 2024 | **Purpose** | Information / Assurance

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

Summary: This paper presents the corporate performance data as of November 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: Finance & Performance Committee.

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- 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 74% improvement trajectory in November but just below the 76% threshold at 75.8%.
- 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%.
- The Trust vacancy rate is below threshold at 4.3%.

Areas of Challenge

- There were 2 Steis reportable incidents in November. 0 of these were never events.
- There were 7 healthcare associated clostridium difficile infections, 10 post 2 day E.coli bacteraemia and 5 Klebsiellas detected in month.
- There were 0 P.aeruginosa bacteraemia identified in November, bringing the year to date total to 9 vs the annual trajectory of 7.
- The Hospital Standardised Mortality Ratio (HSMR) remains 'above expected levels'.
- The Summary Hospital-level Mortality Indicator (SHMI) has remained as expected at 1.12, however it has been increasing for 12 month
- There was 1 maternal death and 1 stillbirth in November.
- There were 1133 breaches of the 12 hour trolley wait standard (27 mental health and 1106 physical health).
- There were a total of 2984 ambulance attends with 657 ambulance handovers > 30 minutes and 118 > 60 minutes. Following validation, 55 of the 118 were due to ED delays and 63 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.
- The Cancer 28 day faster diagnosis standard was not achieved in October at 73.4%.

- Performance against the cancer 62 day standard remains below threshold in October at 55.3%.
- There were 17.5 breaches of the 104 day cancer wait standard.
- ** Not updated** The 6wk diagnostic target was not met at 11.1% in October.
- ** Not updated** In October, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 70,539, which is above the trajectory.
- ** Not updated** The number of RTT pathways over 65 weeks has increased to 882, which is above the trajectory.
- ** Not updated** In October, there were 4,239 breaches of the RTT >52 weeks standard.
- In November, there were 9 breaches of on the day operations cancelled and not rebooked within 28 days.
- Sickness rates are above threshold at 6.2%
- 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 14%.
- The Trust is reporting a breakeven duty deficit of £29.5m for the 2023-24 financial year to date, £11.9m behind the £17.6m planned deficit, a movement of £0.7m in the month.

No Change

- 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.

Data Completeness

The table below shows the status of the metrics included in this report

Latest month available	
Latest update not available, reported up to last month	
Update not available	

Metric	Data Source	Lead/ Source	Dec-23	Date available
C diff, e coli, p.aeruginosa, klebsiella		Infection Control - Laura Moores		
Mixed sex breaches		Corporate information		
Average fill rates		Corporate information		
Staffing narrative		Heather Coleman		
Nurse Staffing - Fill rate table		Heather Coleman		
Steis		Incidents team		
VTE		Corporate information		Metric in development
Pressure ulcers		Jane Pemberton		
Friends & Family		Corporate information		
Number of complaints	Datix	Corporate information		
Complaints per 1000 contacts		Corporate information		
Patient experience		Quality - Sarah Ridehalgh/ Melissa Almond		
SHMI trend	National published SHMI	Performance team		
HSMR	Dr Foster	Performance team		
LeDeR		Julie Clift/ Alison Brown		No update provided
Structured judgement reviews (SJR)	Datix	Performance team		
Stillbirths	Maternity dashboard	Kathryn Sansby/ Carol Bell		
Maternal deaths	Maternity dashboard	Kathryn Sansby/ Carol Bell		
CQUIN	CQUIN Update	Andrew Costello		
A&E ELHT performance	Submitted performance	Corporate information		
A&E national performance	NHS Statistics	Performance team		14-Dec
12 hr trolley waits		Performance team		
Ambulance handovers	NWAS	Performance team		
Ambulance handovers ELHT breaches	NWAS	A&E - Adele Dibden/ Claire Ashcroft		Awaiting NWAS update
RTT ongoing, over 40, over 52 wks	Submitted performance	Corporate information		19-Dec
RTT ongoing graphs	Submitted performance	Corporate information		19-Dec
RTT admitted/non-admitted	Submitted performance	Corporate information		19-Dec
RTT average wait and ongoing %	Submitted performance	Corporate information		19-Dec
RTT national	NHS Statistics	Performance team		14-Dec
ELHT cancer - ELHT	Submitted performance	Cancer services - Victoria Cole		
ELHT cancer - national position	NHS Statistics	Cancer services - Victoria Cole		14-Dec
Delayed Discharges Chart		Andrea Isherwood/ Kathryn Heyworth		
Emergency readmissions		Corporate information		Metric in development
Diagnostics % waiting over 6 weeks		Corporate information		18-Dec
Diagnostic national performance	NHS Statistics	Performance team		14-Dec
Average LOS benchmarking	Dr Foster/ Model Health	Corporate information		
Average lengths of stay		Corporate information		Metric in development
Operations cancelled on the day		Corporate information		
Sickness, vacancy, turnover		HR - Mudassir Gire		
Overtime & Temporary costs		Finance - Ammaarah Yakub		
Appraisals		Learning hub team		
Appraisals AFC		Learning hub team		
Job plans		Salauddin Shikora		No update provided due to new s
Information governance		Learning hub team		
Core skills training		Learning hub team		
Finance/use of resource		Finance - Allen Graves		

Safe

	Indicator	Target	Actual	Variation	Assurance
M65	MRSA	0	0		
M64	Clostriduim difficile (C.diff) - 'Hospital onset healthcare associated (HOHA)'	n/a	6		
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	1		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	53	48		
M124	E-Coli (HOHA)	n/a	7		
M124.ii	E-Coli (COHA)	n/a	3		
M124.iv	E-Coli cumulative from April (HOHA & COHA)	129	92		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	0		
M155.ii	P. aeruginosa bacteraemia (COHA)	n/a	0		
M155.3	P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)	7	9		
M157	Klebsiella species bacteraemia (HOHA)	n/a	3		
M157.ii	Klebsiella species bacteraemia (COHA)	n/a	2		
M157.3	Klebsiella species bacteraemia cumulative from April (HOHA& COHA)	41	33		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	1		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	19.9		
M69	Serious Incidents (Steis)	No Threshold Set	2		
M70	Central Alerting System (CAS) Alerts - non compliance	0	0		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	#N/A		

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	97%		P
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	25%		
C40	Maternity Friends and Family - % who would recommend	90%	91%		P
C42	A&E Friends and Family - % who would recommend	90%	74%		F
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	14%		
C44	Community Friends and Family - % who would recommend	90%	94%		P
C38.5	Outpatient Friends and Family - % who would recommend	90%	96%		P
C15	Complaints – rate per 1000 contacts	0.40	0.13		P
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.12		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at May-23)	Above Expected Levels	110.1		
M74	Hospital Standardised Mortality Ratio - Weekday (as at May-23)	Above Expected Levels	110.9		
M75	Hospital Standardised Mortality Ratio - Weekend (as at May-23)	Within Expected Levels	108.0		
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

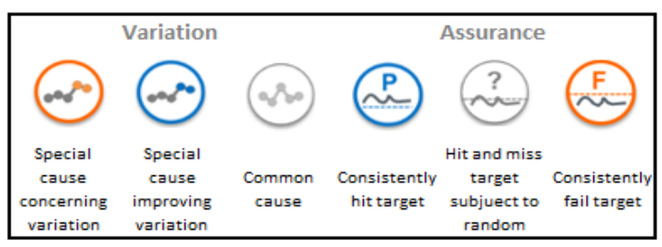
	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	76.0%	74.7%		P
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	76.0%	75.8%		P
M62	12 hour trolley waits in A&E	0	1133		F
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	657		F
M84	Handovers > 60 mins (Arrival to handover)	0	118		F
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set			
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set			
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	59,892			
C37.4	Referral to Treatment (RTT) 65 Weeks (Ongoing)	152			
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	1630			
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	5.0%			F
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	55.3%		?
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	88.5%		?
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	90.3%		?
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	98.0%		P
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	87.9%		?
C36	Cancer 62 Day Consultant Upgrade	85.0%	69.6%		?
C25.1	Cancer - Patients treated > day 104	0	17.5		?
C47	Cancer - % Waiting over 62 day (Urgent GP Referral)	N/A	7.60%		
C46	Cancer - 28 Day faster diagnosis standard	75.0%	73.4%		?
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	9		?
M138	No.Cancelled operations on day	No Threshold Set	70		
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%	6.2%		
M79	Total Trust vacancy rate	5.0%	4.3%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	73.0%		
M80.35	Appraisal (Consultant)	90.0%	98.0%		
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%	14.0%		
F9	Overtime as % of total paybill	0%	0%		
F1	Cumulative variance to planned financial performance (deficit) (£m)	£0.0	-£12.0		
F2	WRP achieved YTD - variance to plan (£m)	£0.0	-£14.1		
F3	Liquidity days	-25.8	-28.3		
F4	Capital spend v plan	85.0%	102%		
F18a	Capital service capacity	0.6	0.0		
F19a	Income & Expenditure margin	-3.5%	-6.3%		
F21d	Agency spend as a proportion of total pay bill (£m)	3.7%	3.9%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	92.3%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	97.4%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	95.1%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	98.1%		

NB: Finance Metrics are reported year to date.

KEY

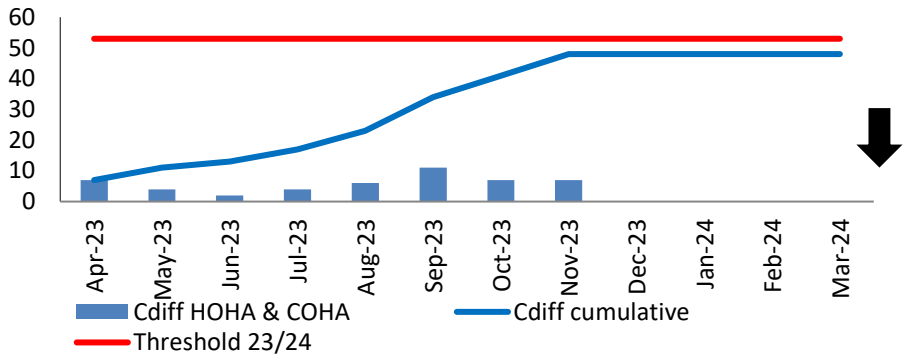


SPC Control Limits

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

SAFE

C Difficile (HOHA &



There were 0 post 2 day MRSA infection reported in November. So far this year there have been 4 cases attributed to the Trust.

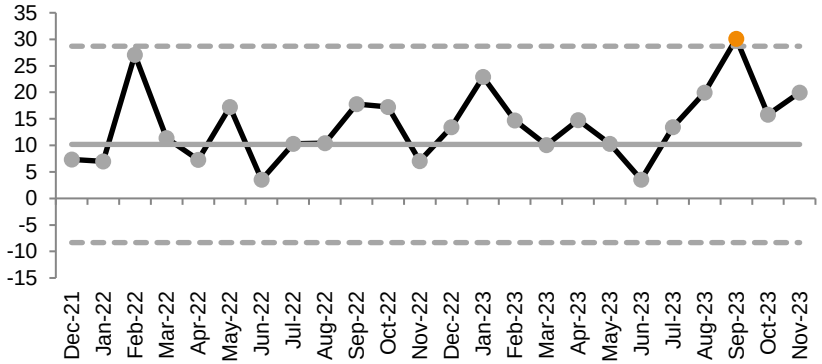
The Clostridium difficile objective for 2023/24 is to have no more than 53 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)'. The final figure for cases reported in 2022/23 was 65.

Since the implementation of Cerner in June, an issue has been identified with our reporting system. This has resulted in a number of cases reported as hospital acquired in error. The figures have since been corrected and amended in the National Reporting System.

There were 7 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in November; 6 cases were HOHA and 1 was COHA.

The year to date cumulative figure is 48 (HOHA & COHA). The detailed infection control report will be reviewed through the Quality Committee.

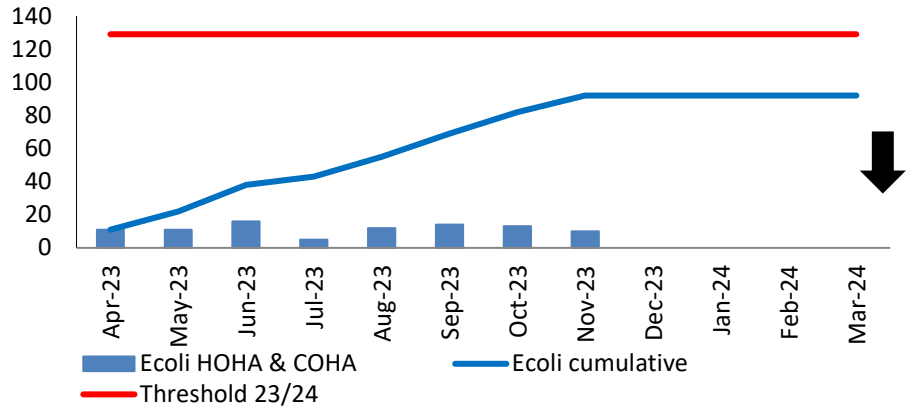
C Diff per 100,000 Occupied Bed Days (HOHA)



The rate of HOHA infection per 100,000 bed days is within normal variation in November.

SAFE

E. Coli (HOHA & COHA)

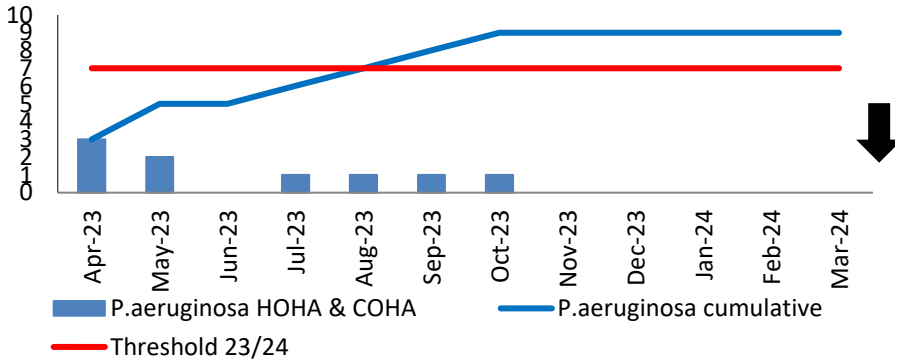


The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

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

There were 10 reportable cases of E.coli bacteraemia identified in November; 7 HOHA and 3 COHA. The year to date total is 92.

P.aeruginosa

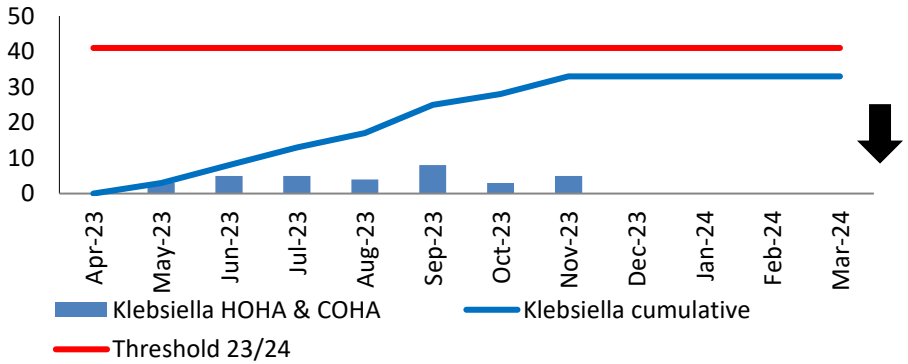


From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England.

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

There were 0 reportable cases of Pseudomonas identified in November, which brings the year total to 9 vs the annual trajectory of 7.

Klebsiella



There were 5 reportable cases of Klebsiella identified in November; 3 HOHA and 2 COHA.

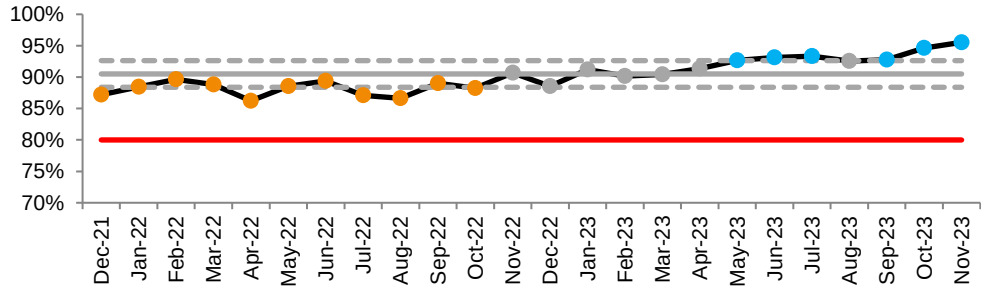
Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

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

SAFE

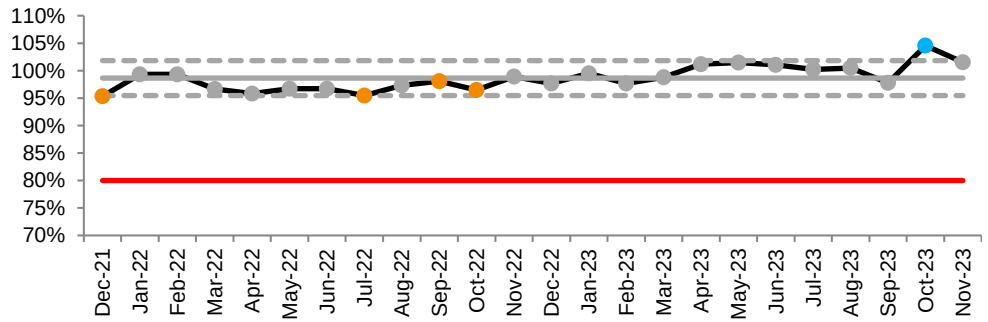
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



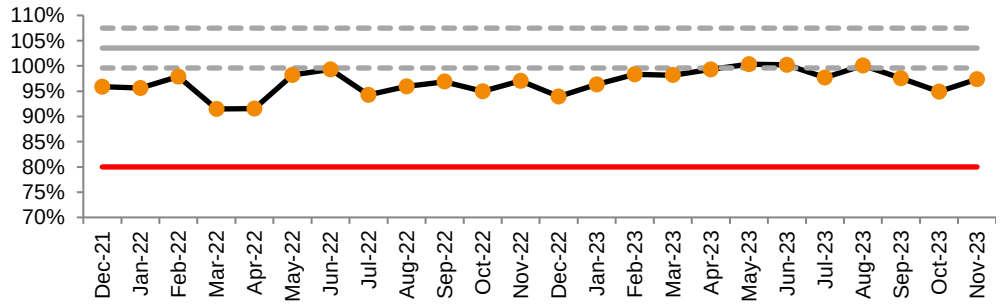
The average fill rate for registered nurses/ midwives during the day is showing improving variation when compared to the pre covid levels. Based on current variation it will consistently be above threshold.

Registered Nurses/ Midwives - Night



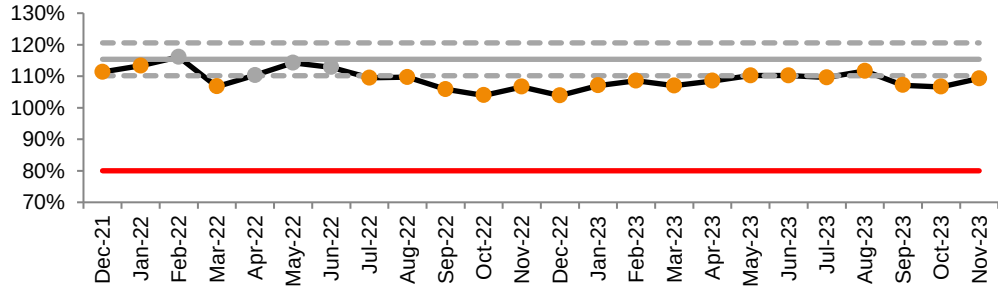
The average fill rate for registered nurses/ midwives at night is showing normal variation when compared to pre-covid levels. Based on current variation it will consistently be above threshold.

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.

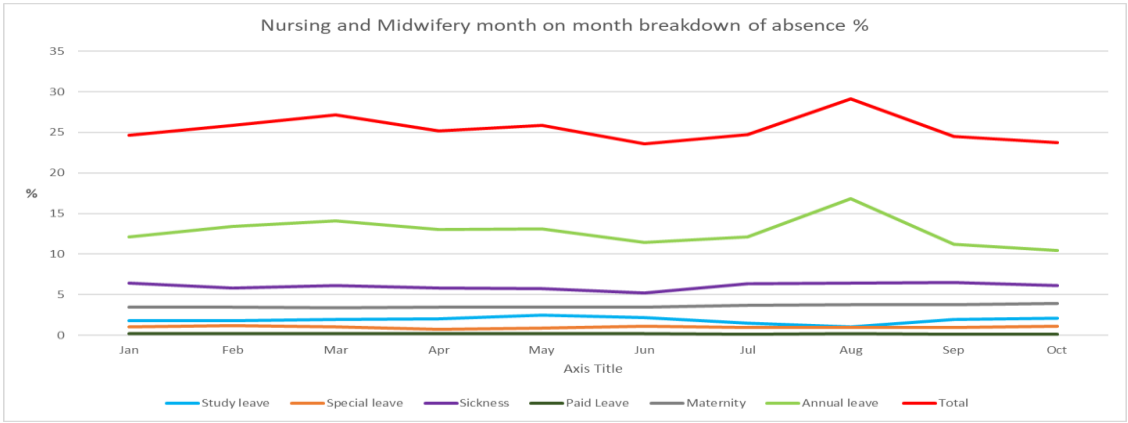
Care Staff - Night



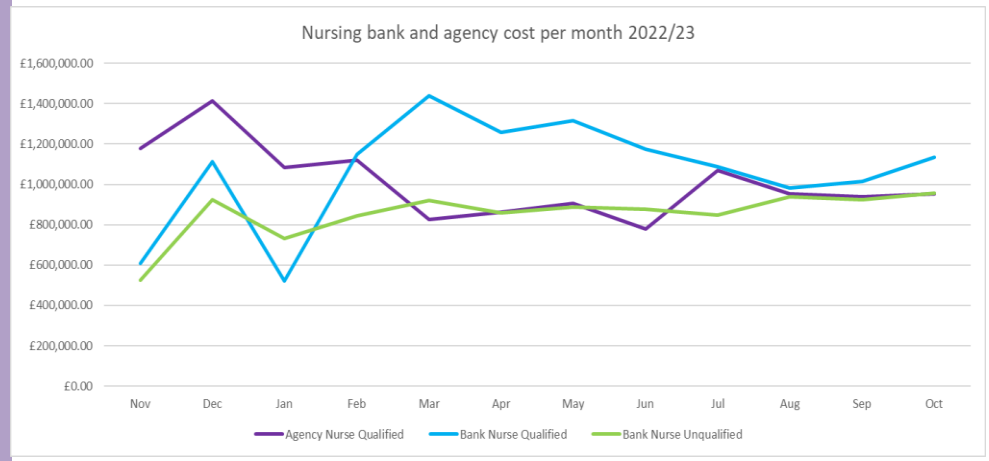
The average fill rate for care staff at night continues to be below the pre covid levels, however based on current variation will consistently be above the threshold.

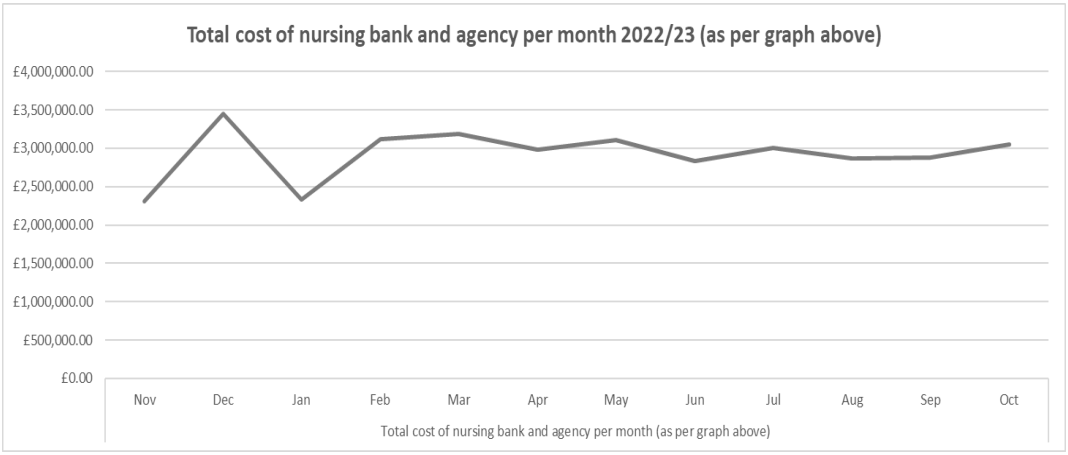
SAFE

Staffing in November 2023 remains challenging from a cross cover point of view between wards and HCA bank fill. There is still a high use of bank staffing however, agency use is showing a steady decline. Overall Nursing and Midwifery absence rates and bank and agency spend for November were unavailable at the time of the report. The data below shows the trends for 2023 taken from Power Bi



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





In November 2023, 0 areas fell below the 80% for Registered Nurses/Midwives for the day shifts, this is the same as last month.

It should be noted that actual and planned staffing does not denote acuity, dependency, the number of women in labour or bed occupancy. The divisions consistently risk assess and flex staffing resources to support staffing. Every option is explored throughout the day and night to support staffing.

SAFE

Latest Month - Average Fill Rate

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Nov-23	95.5%	97.4%	101.5%	109.3%	30,083	8.35	0	3	0	0

Monthly Trend

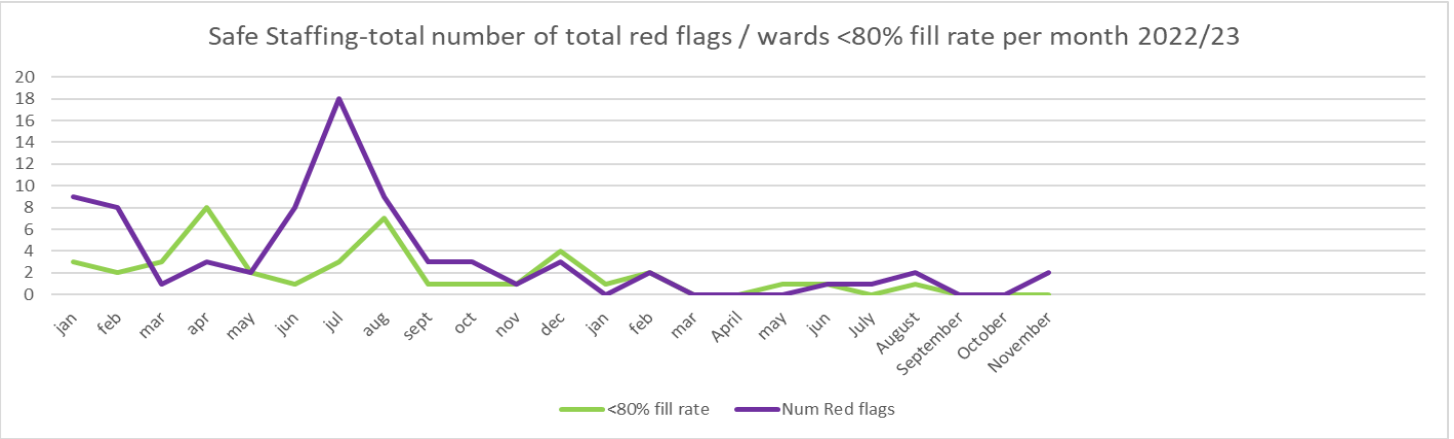
	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)
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
Oct-23	94.6%	94.9%	104.5%	106.6%	31,679	8.09	0	2	0	1
Nov-23	95.5%	97.4%	101.5%	109.3%	30,083	8.35	0	3	0	0

SAFE

National Nursing Red Flags

On reviewing November 2023 data there were 2 National Nursing Red Flags reported
SAS ward B22 – Higher than normal acuity and dependency. Delays in administration of pain relief. No harm came to any patients.
SAS ESU– Higher than normal acuity and dependency. Omission of regular checks on patients. No harm came to any patients.

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



Usage of a high proportion of agency staff, junior skill mix, and the constant moving of staff to support other areas can potentially affect morale. Staff are working extremely hard and are doing a remarkable job. Staffing the wards safely and supporting staff remains the highest of priority. Through the senior nursing teams, discussion has taken place particularly in relation to ensuring rest breaks are provided and supported with encouragement to the staff to report inability to take breaks to the matron and or clinical site manager.

Actions taken to mitigate risk.

* Safe staffing conference at 10:00 am followed up with meetings throughout the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours, utilising the acuity and dependency tool (Safe Care)
* Extra health care assistant shifts are used to support registered nurse gaps if available.
* Divisions have recruited to substantively to back fill maternity leave
* Nurse recruitment lead continues to work closely with divisions. The divisional meetings and support are being strengthened to ensure attendance and monitor outcomes.
* A 2023 ELHT strategy to recruit 244 international nurses over 12 months, this commenced in April 2023;
20 in April , 18 in May, 20 in June, 20 in July, 20 in August, 20 in September, 16 in October, 16 in November
* ELHT has agreed to recruited 8 international midwives. 6 have passed their OSCEs and working as qualified midwives.
* Nurse recruitment data task and finish group commenced, to agree data set and source to enable oversight of all nursing pipelines, vacancies and allocations. Data dashboard in progress and close to completion.

SAFE

Family Care Staffing Summary – November 2023

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

Maternity (Midwife to Birth Ratio)

Month	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Staffed to full Establishment	01:27	01:27	01:27	01:27	01:26	01:27	01:27	01:26	01:26	01:26	01:26
Excluding mat leave	01:27	01:27	01:28	01:27	01:26	01:27	01:27	01:26	01:26	01:26	1:26:69
Maternity leave	-	5.16	4.52	3.40	3.40	3.40	3.40	3.04	3.04	3.04	5.04
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	25.73	21.54	25.71	18.25	16.77	21.58	17.50	20.74	19.14	22.26	16.12
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) Backfill for mat leave included	24 wte (11) Backfill for mat leave included	14 wte (11) Backfill for mat leave included	12 wte (11) Backfill for mat leave included

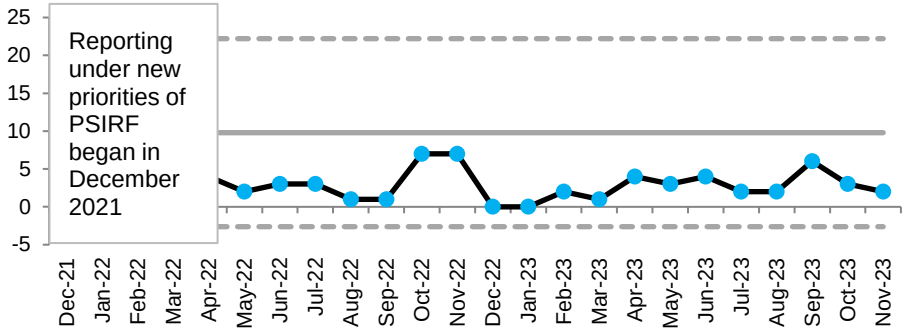
Maternity
Safe midwifery staffing levels also continue to be reviewed with the appropriate risk assessments 4 times a day at each safety huddles. Additional staffing/ leadership huddles will take place in periods of extreme staffing pressures to mitigate throughout maternity services; midwives are redeployed to other areas to support acuity and activity as and when required. Bank filled duties remain static as reflected above and monitored in monthly figures. Local midwifery red flags noted at each handover and reviewed by the local governance team on a weekly basis.

Neonatology –Acuity/ Dependency and activity peaks in November. 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. Closed to external transfers on some days due to acuity and activity.

Paediatrics – No staffing exceptions. Shortfalls reflect acuity and dependency as reflected in the planned Vs actuals.
Gynaecology – No staffing exceptions, temporary ward move to 16 at BGH due to the Trust regulation fireworks although this work has not yet commenced due to other Trust priorities.

SAFE

Serious Incidents



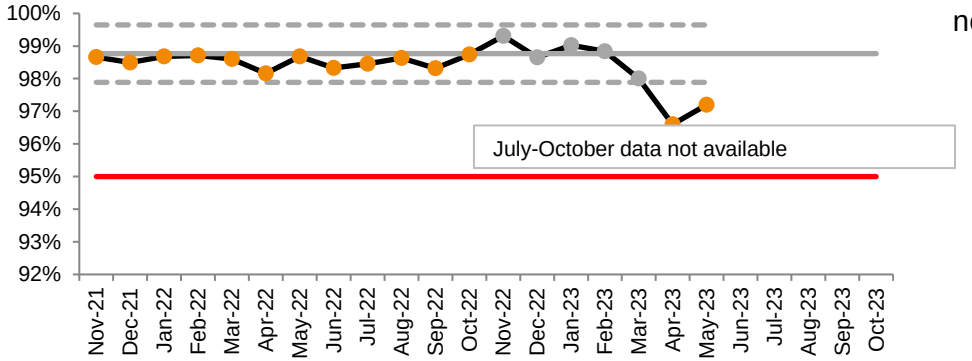
PSIRF Category	No. Incidents
National priority - Incident resulting in death	1
Diagnosis failure/problem	1

There were no never events reported in November.

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

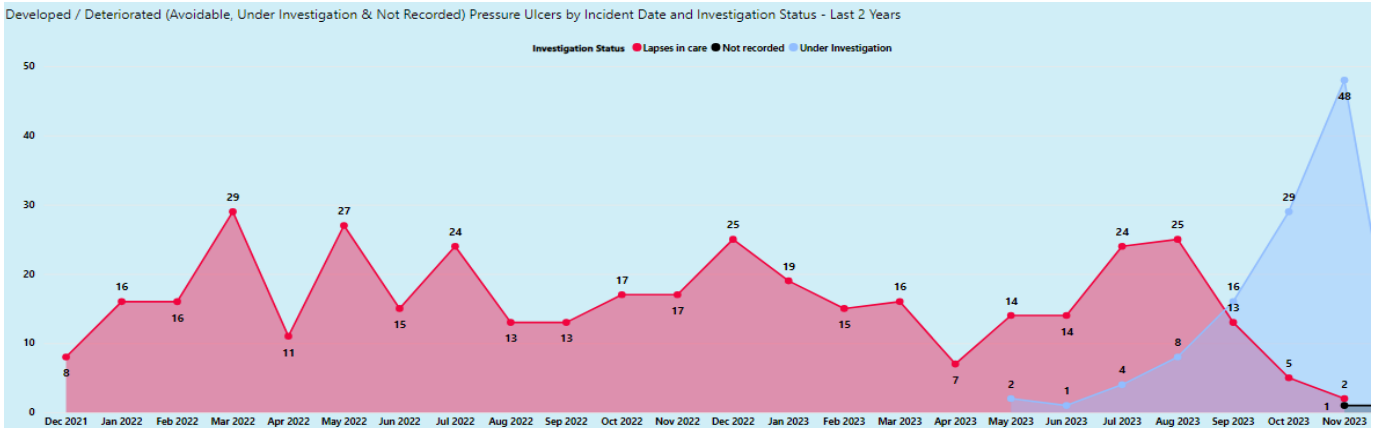


Venous Thromboembolism (VTE) assessment trend - data not available for July, August, September, and October.

SAFE

Pressure Ulcers

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



Category of Pressure Ulcer	Total Number of Lapses in Care		
	2021-2022	2022-2023	1.4.2023 – 30.11.2023
2	44	73	33
3	14	6	4
4	3	9	5
Unstageable	25	33	5
DTI	53	92	48
TOTAL	139	213	104

104 lapses in care have been confirmed from the 1 April 2023 however all listed patient safety reviews have not been through Pressure Ulcer Review and Learning Panels within Divisions.

A pilot is underway in conjunction with the Quality & Safety team using the Datix system for senior nurses investigating incidents in relation to pressure ulcers which aims to make the process slicker and timelier.

Mandatory training for all relevant staff goes lives from the 12 December 2023 which will start to give assurance that staff are equipped with the right knowledge and skills to prevent and manage both pressure damage and moisture associated damage.

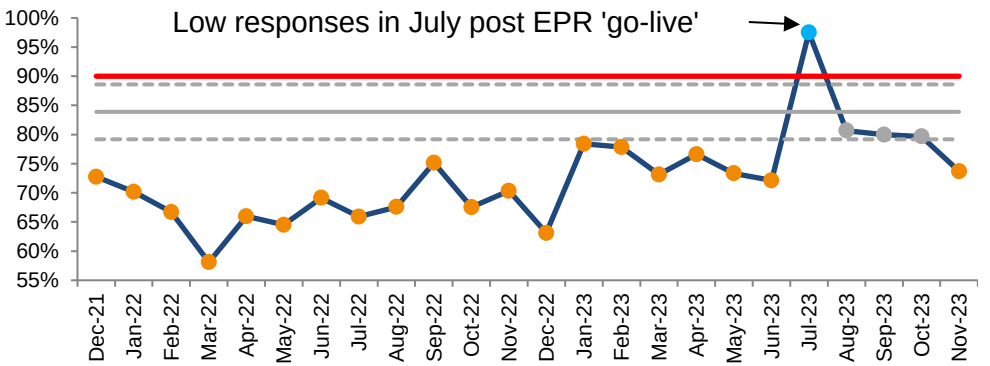
A benchmarking exercise is in progress with regards to the Trusts position against the National Wound Care Strategy Pressure Ulcer Recommendations and Clinical Pathways.

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.

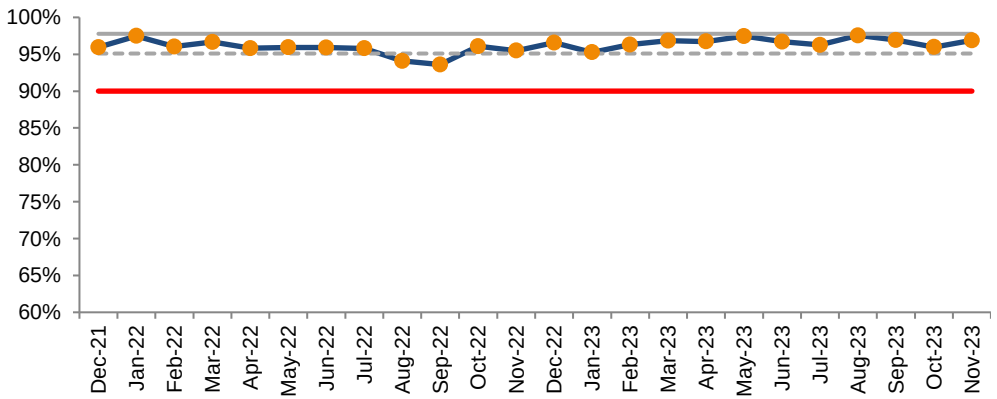
Baseline period for SPC comparison is Apr 18 - Mar 20

Friends & Family A&E



A&E scores are below threshold in November. The trend is showing significant deterioration 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.

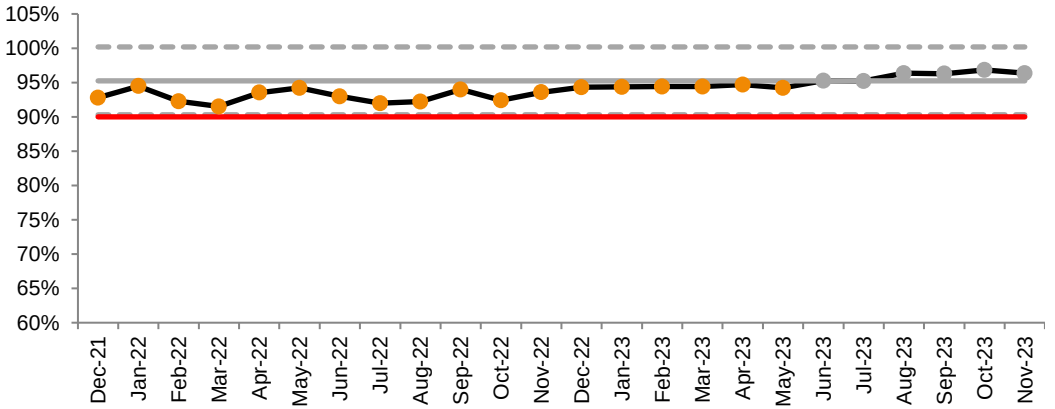
Friends & Family Inpatient



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

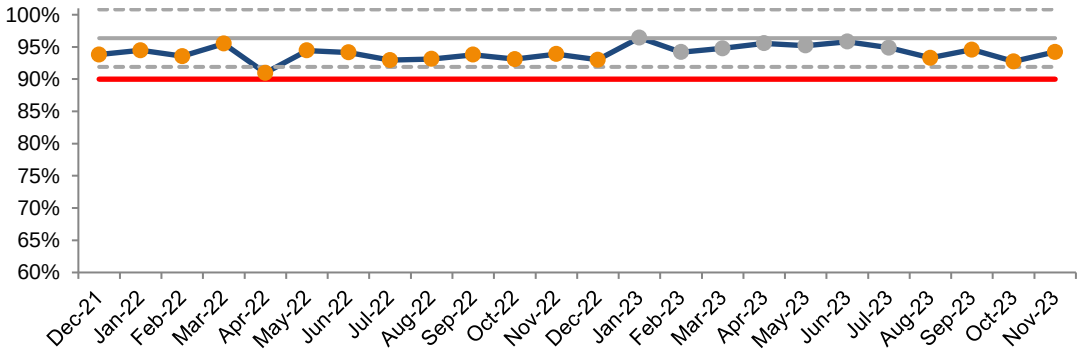
Friends & Family Outpatients



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.

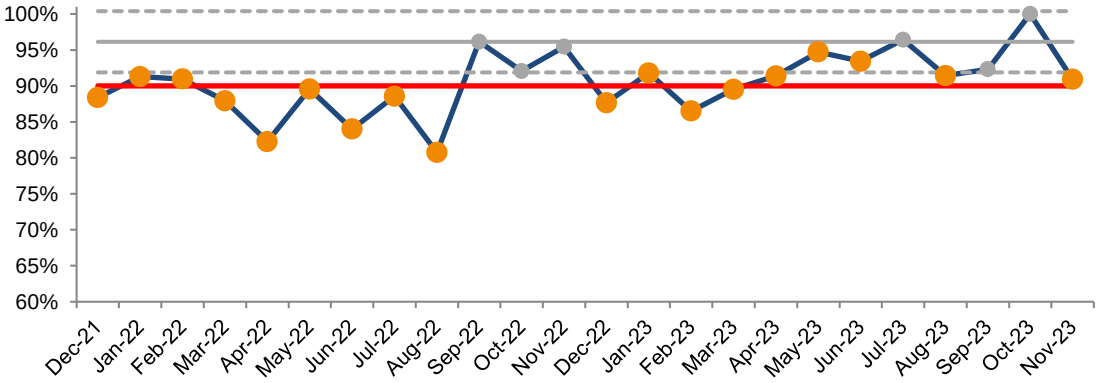
Friends & Family Community



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

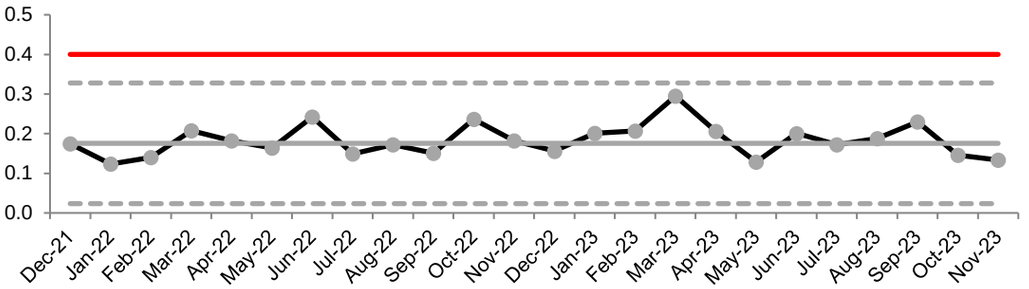


Maternity scores are above target this month but show significant deterioration when compared to the pre-covid levels.

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

CARING

Complaints per 1000 contacts



The Trust opened 17 new formal complaints in November.

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

For November the number of complaints received was 0.13 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	100.00	66.67	100.00	100.00	90.00
Community	Community and Intermediate Care Services	93.39	90.71	91.06	93.79	92.14
Community	Diagnostic and Clinical Support	100.00	100.00	100.00	100.00	100.00
Community	Family Care	100.00	-	-	93.75	95.00
Community	Surgery	100.00	99.09	-	-	99.35
Delivery	Family Care	100.00	100.00	100.00	100.00	100.00
ED_UC	Medicine and Emergency Care	77.78	69.57	55.56	60.42	63.91
Inpatients	Community and Intermediate Care Services	88.98	83.41	88.28	89.51	87.53
Inpatients	Diagnostic and Clinical Support	100.00	90.00	90.74	-	92.59
Inpatients	Family Care	92.98	86.25	89.19	90.44	89.88
Inpatients	Medicine and Emergency Care	91.67	78.13	77.45	79.53	80.44
Inpatients	Surgery	95.13	85.56	90.36	90.53	90.28
OPD	Diagnostic and Clinical Support	97.20	97.84	98.66	96.10	97.49
OPD	Family Care	97.02	97.37	96.49	95.28	96.34
OPD	Medicine and Emergency Care	99.52	97.37	96.97	97.42	97.70
OPD	Surgery	93.88	91.04	94.49	89.58	92.26
SDCU	Family Care	93.97	91.67	91.45	94.12	92.59
	Total	**94.96**	**91.86**	**90.00**	**92.45**	**92.15**

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

The Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) have not been updated due to data submission delay since Cerner implementation.

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 Jun 22 to May 23 has increased from last month, however remains within expected levels at 1.12, as published in Oct 23.

Dr Foster HSMR rolling 12 month

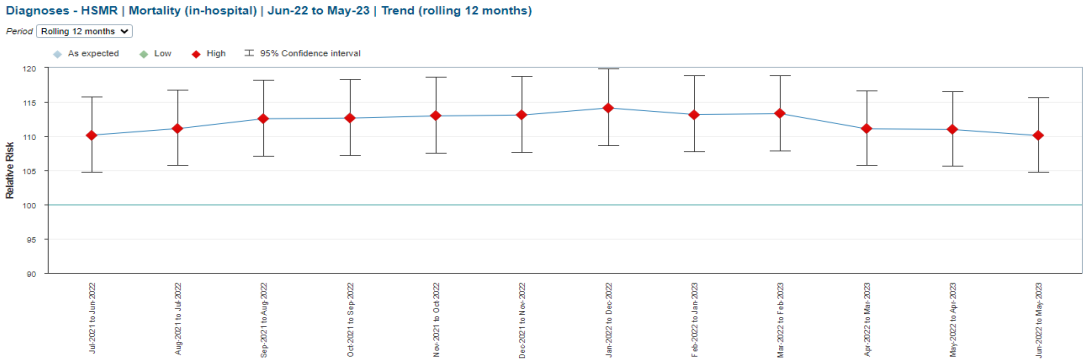
	HSMR Rebased on latest month Jun 22 – May 23
	ALL
TOTAL	110.1
Weekday	110.8
Weekend	108.1

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 110.1 against the monthly rebased risk model.

The benchmark model has been adjusted this month to account for data up to May 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.

Dr. Foster HSMR monthly trend



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	231	24	13	9	8	18	13	8	13					106
Allocated for review	46	212	250	262	214	163	230	24	8	8	8	7	5	1	3					64
SJR Complete	46	212	250	262	214	162	227	18	9	7	4	1	4	1	0					44
1 - Very Poor Care	1	1	0	0	1	1	1	1	0	0	0	0	0	0	0					1
2 - Poor Care	8	19	22	34	35	22	40	5	1	2	1	0	1	0	0					10
3 - Adequate Care	14	68	70	70	65	49	75	4	4	1	3	0	1	0	0					13
4 - Good Care	20	106	133	129	103	78	105	8	3	4	0	1	1	1	0					18
5 - Excellent Care	3	18	25	29	10	12	6	0	1	0	0	0	1	0	0					2
Stage 2																				
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	41	6	1	2	1	0	1	0	0					11
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	0	3	1	1	1	0	0	0	0					6
Allocated for review	6	18	21	30	35	22	41	3	0	1	0	0	1	0	0					5
SJR-2 Complete	6	18	21	30	35	22	36	1	0	1	0	0	0	0	0					2
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0	0	0	0	0	0					0
2 - Poor Care	3	6	7	13	13	10	19	1	0	0	0	0	0	0	0					1
3 - Adequate Care	2	10	13	13	21	10	13	0	0	1	0	0	0	0	0					1
4 - Good Care	0	1	0	2	1	1	3	0	0	0	0	0	0	0	0					0
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					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	1	0	5	1	0	11	8	7	10	0	0	0	0	42
stage 1 requiring completion	0	0	0	0	0	1	3	6	-1	1	4	6	1	0	3	0	0	0	0	20
Stage 1 Backlog	0	0	0	0	0	1	4	6	4	2	4	17	9	7	13	0	0	0	0	62
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	11	2	0	0	0	0	1	0	0	0	0	0	0	3
Stage 2 Backlog	0	0	0	0	0	0	11	2	0	0	0	0	1	0	0	0	0	0	0	3

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

No update provided

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.

O**f the 5 incentivised schemes:** all met the required upper performance targets for Q2 and are on track to achieve full compliance at present

Of the 4 specialist Service Schemes: all have met their upper performance targets for Q2 and are on track for full compliance

*CCG8 - A low submission rate have been flagged to the Vascular Team with regards to National Vascular Registry data from which the CQUIN is calculated

*CCG11 - figures for Palliative Chemo & Haemoglobinopathy services have been merged due to low numbers in the latter - the combined compliance figure is 90%.

Of the 6 non-incentivised schemes:

*1 reports at the end of Q3 (CCG1)

*2 have met the upper performance target and are on track to deliver

*3 have achieved below the lower performance targets - CCG12 & CCG14 have improvement plans which are being monitored via monthly action groups. CCG4 - an improvement plan has been requested from cancer services

The next submission deadline is the 31st January for CCG2 and the PSS schemes.

EFFECTIVE

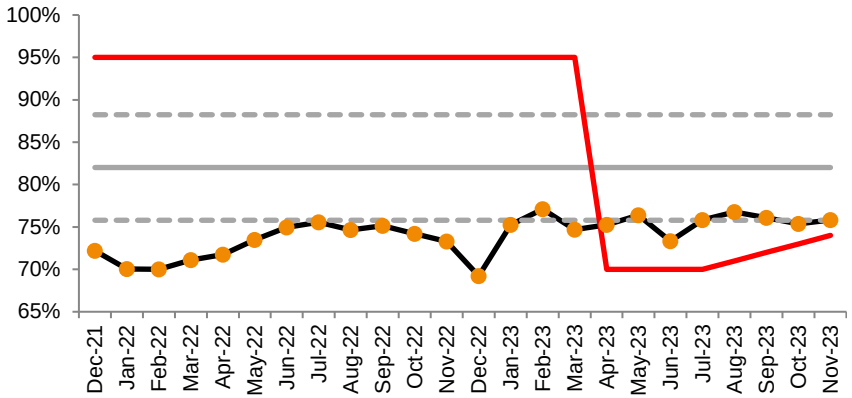
Ref:	Title of Scheme	Indicator	Lead/s	CQUIN Value	Period Calculation	Min (%)	Max (%)	Percentage Compliance (%)				Scheme performance (%)	Travel
								Q1	Q2	Q3	Q4		
CCG1	Staff Flu Vaccinations	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact	S Brewer	NA	All Quarters Quarterly 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	92			91.5	▲
*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	21	25		22	-
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	N/A	All Quarters Quarterly average %	35	55	8.9	11.9			10.4	▲
*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	68			62.5	▲
*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 H Robinson	1,100k	All Quarters Quarterly average %	0.5	1.5	15.3	9.5			12.4	▼
*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	95			90	▲
**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	100			93	▲

**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	96			96.5	▼
**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	83	93			88	▲
**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 (Palliative Chemo + Haemoglobinopathy)	65	75		90*			*Chemo & Haemo combined*	
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	37			35.5	▲
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	68			65	▲
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	N Robinson J Wilding	NA	All Quarters Quarterly average %	70	90	68	25			46.5	▼
*CCG15b	Routine outcome monitoring in CYP and community perinatal mental health services	Achieving 50% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measure recorded at least twice.	A Stuart J Fleming	1,100k	Whole period	20	50	66.2	68.6			67.4	▲

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

RESPONSIVE

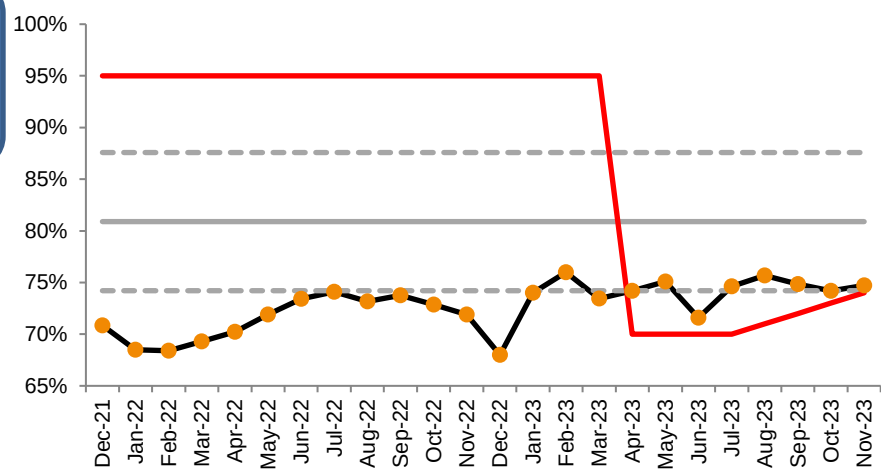
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 75.84% in November, which is below the 76% threshold and above the improvement trajectory (74%).

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

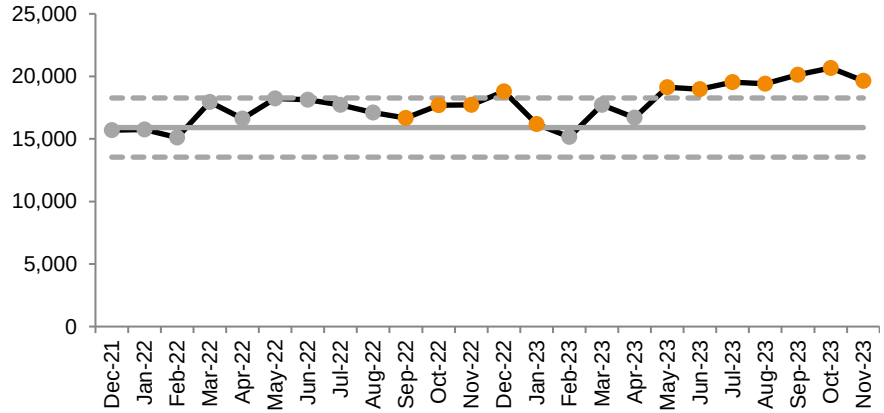
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 74.73% in November.

The national performance was 70.2% in October (All types).

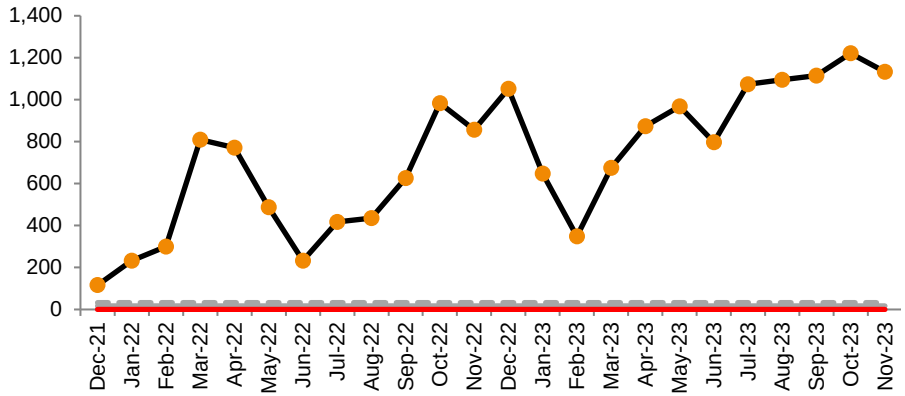
A&E Attendances - Trust



The number of attendances during October was 19,630, which is above the nornal range when compared to the pre-covid baseline.

RESPONSIVE

12 Hr Trolley Waits

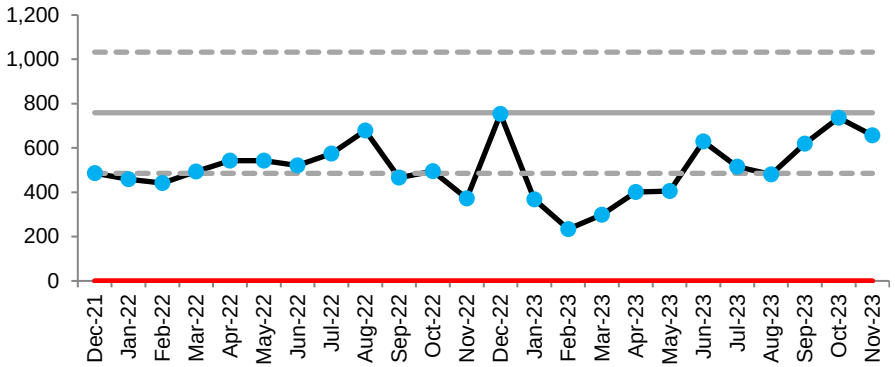


There were 1133 reported breaches of the 12 hour trolley wait standard from decision to admit during November, which is higher than the normal range. 27 were mental health and 1106 were physical health.

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

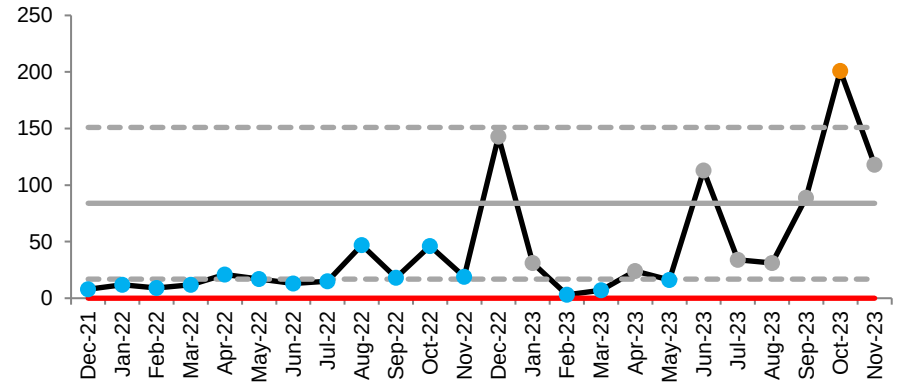
	Mental Health	Physical Health
No. 12 Hr Trolley Waits	27	1106
Average Wait from Decision to Admit	59hr 03 min	29hr 17 min
Longest Wait from Decision to Admit	166hr 06min	65hr 41 min

Ambulance Handovers - >30Minutes



There were 657 ambulance handovers > 30 minutes in November. 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 a total of 2984 ambulance attends with 657 ambulance handovers > 30 minutes and 118 > 60 minutes.

Following validation, 55 of the 118 were due to delays in ED and 63 were due to non-compliance with the handover screen.

The average handover time was 33 minutes in November

The longest handover in November was reported by NWAS as 6hr 42 minutes and was an NWAS delay.

RESPONSIVE

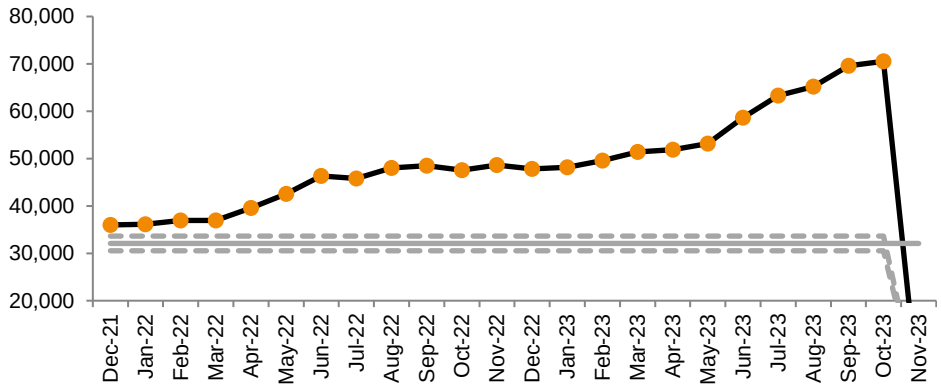
** Not updated** At the end of October, there were 70,539 ongoing pathways, which has increased on last month and is above pre-COVID levels.

There were 4239 patients waiting over 52 weeks at the end of October which has increased on last month and is above trajectory.
There were 882 patients waiting over 65 weeks at the end of October 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

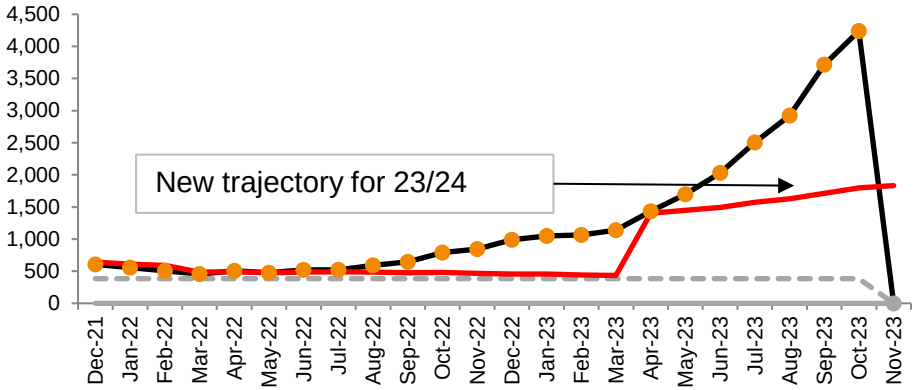
We are seeing a steady reduction in the March 24 65+ cohort and are tracking this weekly.

Trajectory
Actual

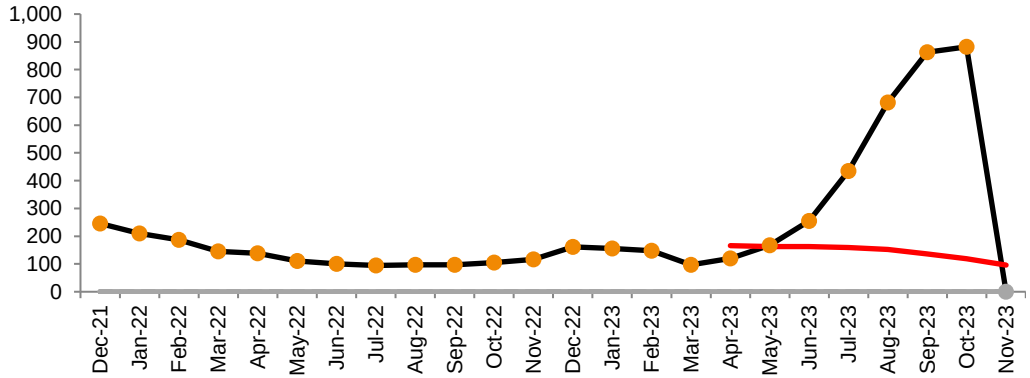
Referral to Treatment (RTT) Total Ongoing



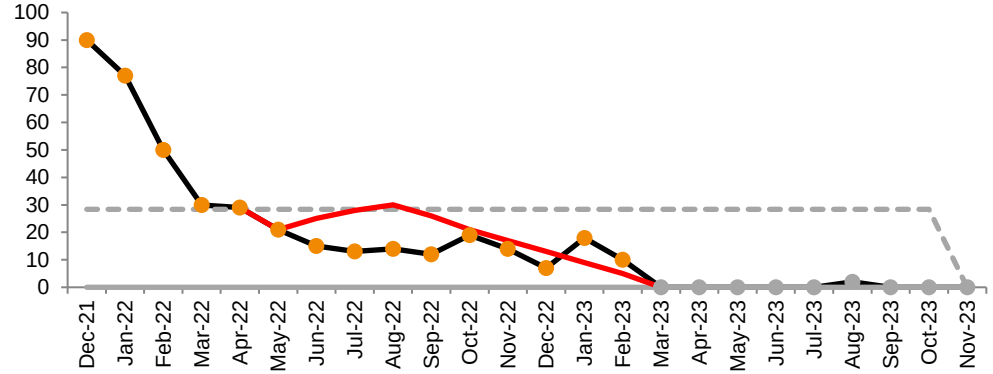
RTT Total Over 52 wks



RTT Total Over 65 wks



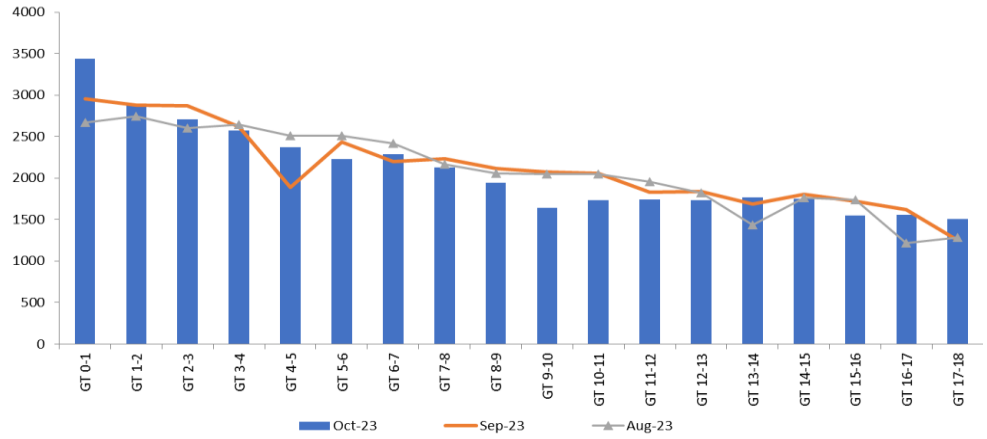
RTT Total Over 78 wks



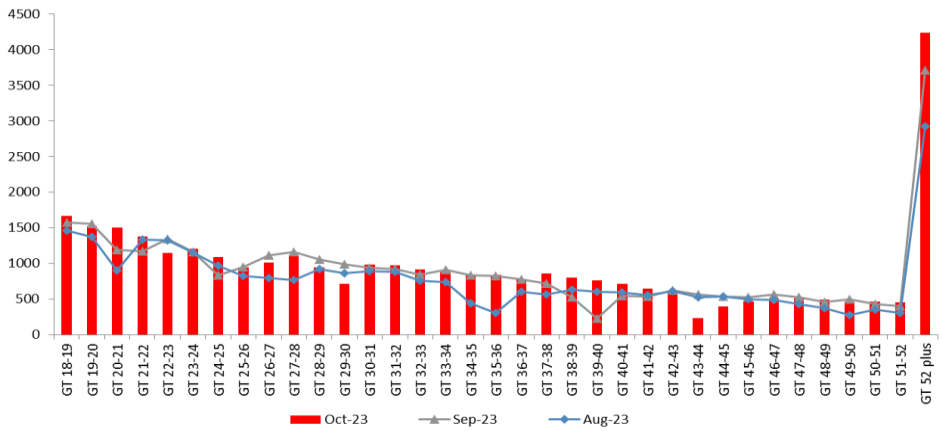
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

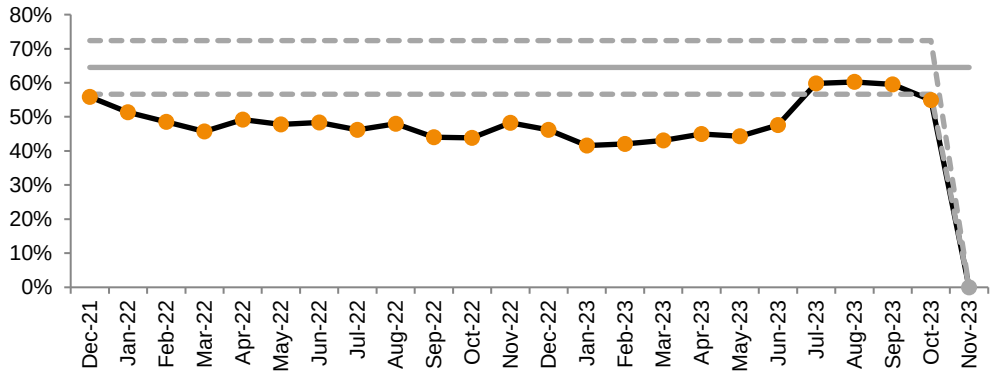


RTT Over 18 weeks

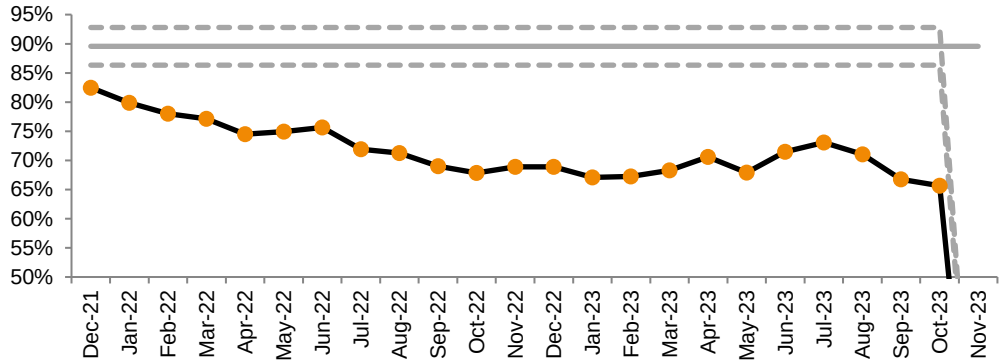


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted

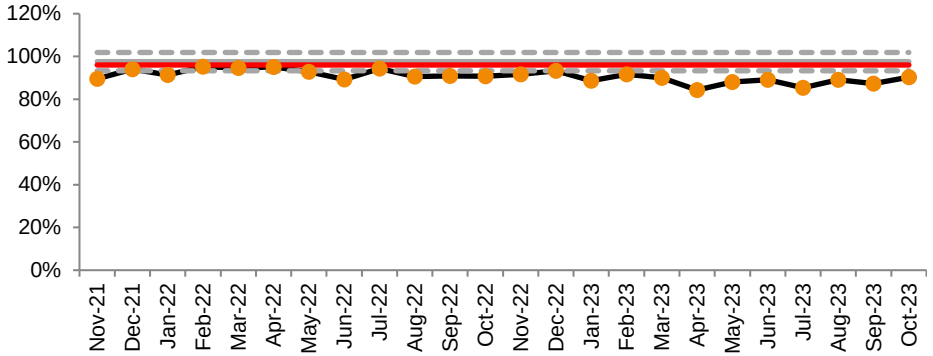


RTT Non-Admitted



RESPONSIVE

Cancer 31 day

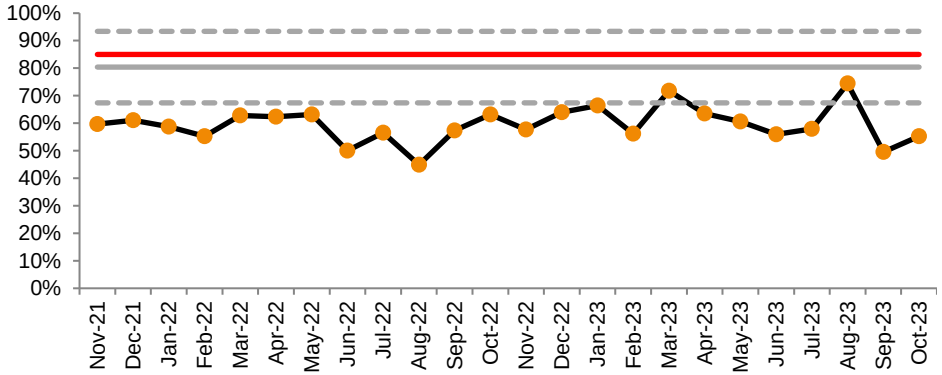


The 31 day standard was not achieved in October at 90.3%, below the 96% threshold.
National performance September - 89.7%

Q2 was not achieved at 87.2%
National performance Q2 - 90.8%

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

Cancer 62 Day

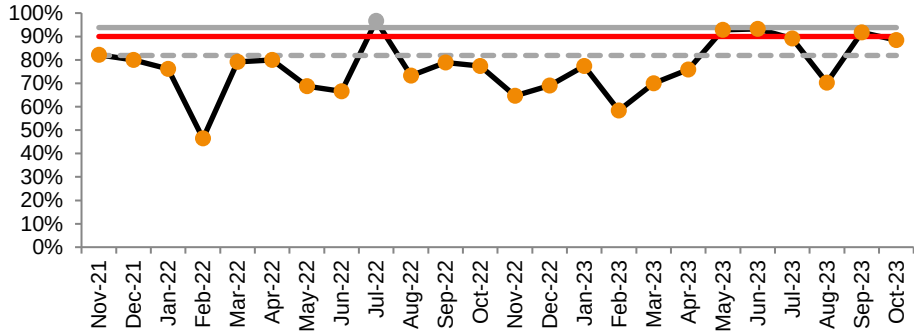


The 62 day cancer standard was not achieved in October at 55.3% below the 85% threshold.
National performance September - 59.2%

Q2 was not achieved at 63.2%
National performance Q2- 61.6%

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



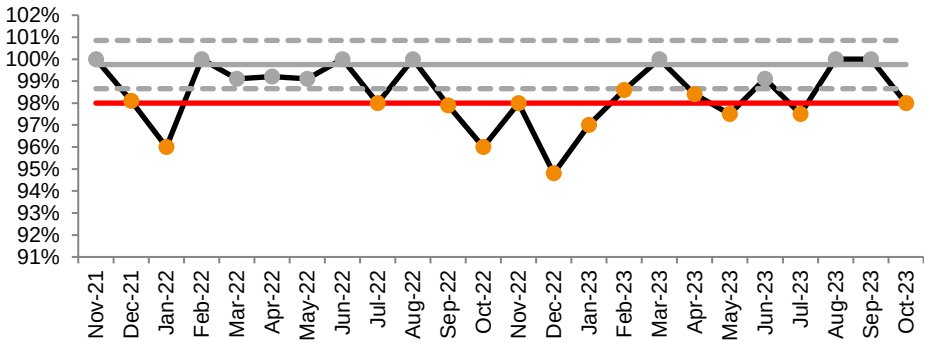
The 62 day screening standard was not achieved in October at 88.5%, below the 90% threshold.
National performance September - 64.6%

Q2 was not achieved at 85.8%
National performance Q2 - 64.4%

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)

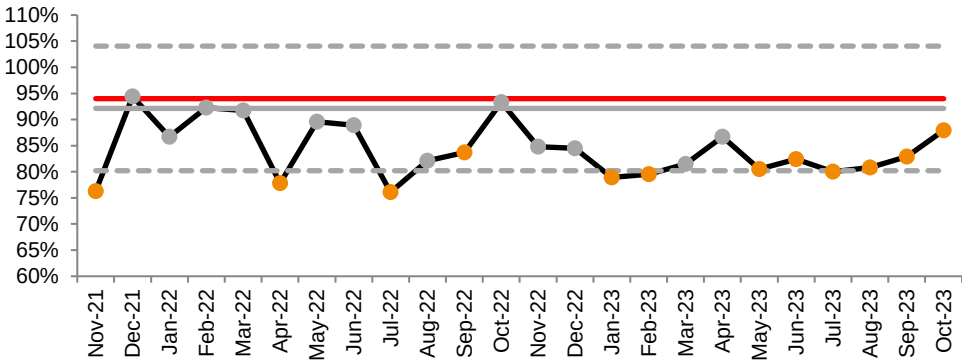


The subsequent treatment - drug standard was on target in October at 98%
National performance September - 97.6%

Q2 was achieved at 98.9%
National performance Q2 - 97.8%

The trend is showing deteriorating performance compared to the pre-covid baseline however, the indicator should consistently achieve the standard.

Cancer - Subsequent treatment within 31 days (Surgery)

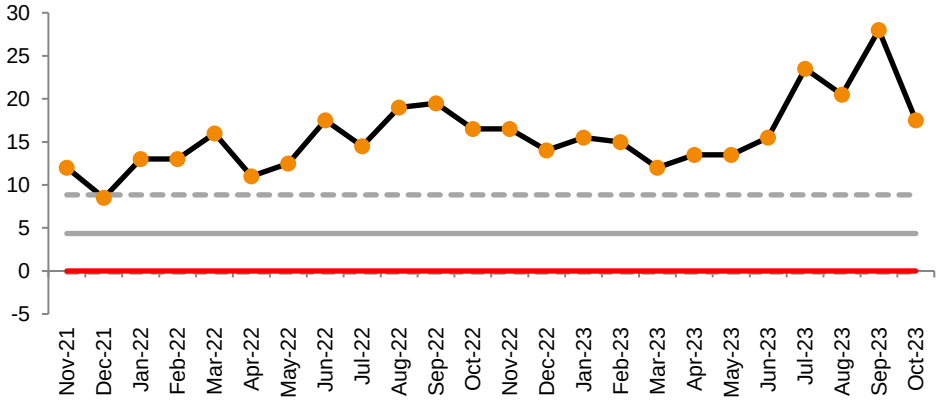


The subsequent treatment - surgery standard was not met in October at 87.9%, below the 94% standard.
National performance September - 77.6%

Q2 was not achieved at 81.3%
National performance Q2 - 78.1%

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

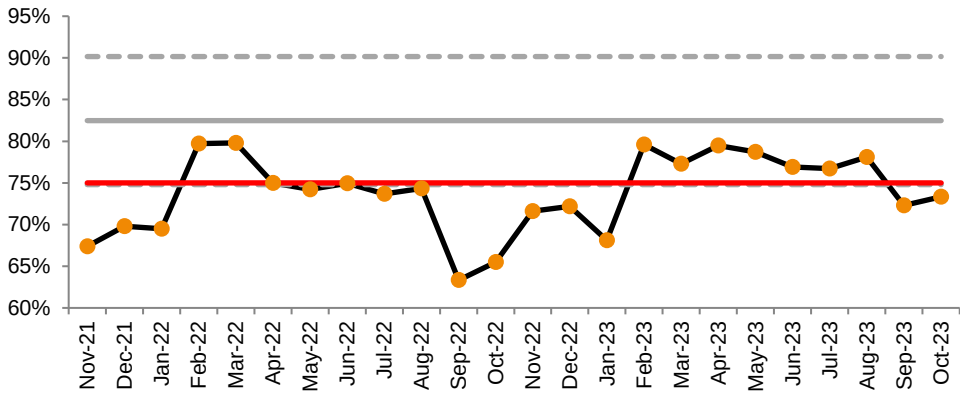


There were 17.5 breaches allocated to the Trust, treated after day 104 in October and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the consultants involved in the pathway as required.

The trend is showing a significant increase on the baseline.

RESPONSIVE

Cancer 28 Day faster diagnosis

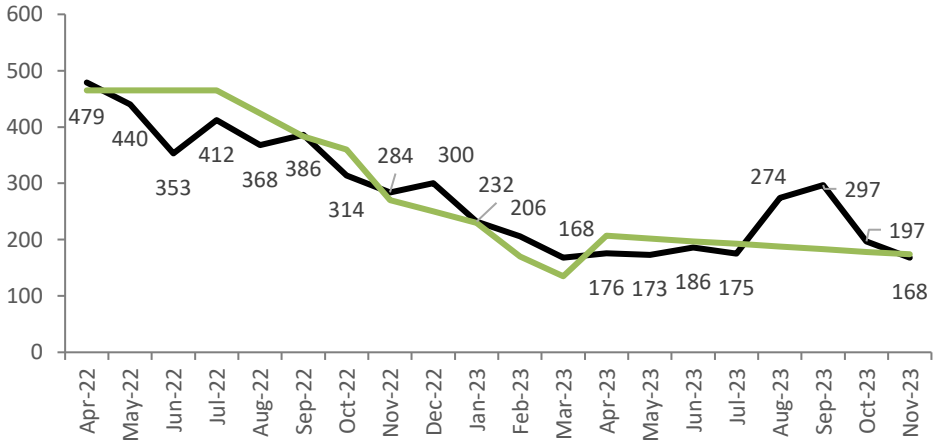


The 28 day faster diagnosis standard did not achieve the target in October at 73.4%.
National performance September - 69.7%

Q2 was achieved at 75.7%
National performance Q2 - 71.8%

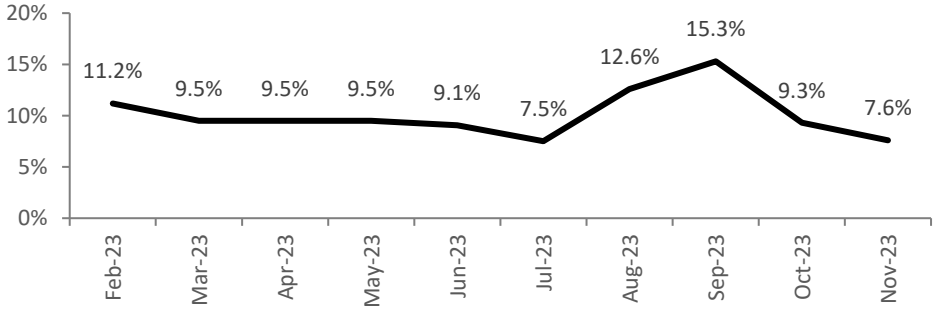
The trend is showing significant deterioration when compared to the pre-covid baseline.

Cancer >62 day vs trajectory



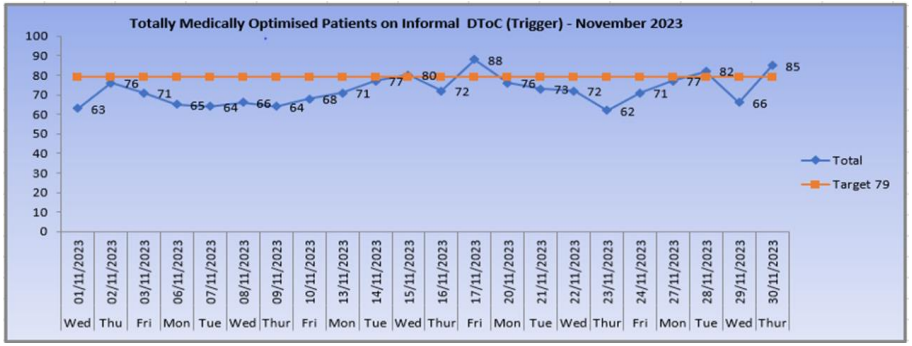
At the end of November the number of patients >62 days was 168 vs 174 trajectory. This was 7.6% of the total wait list.

Cancer % Waiting >62days (Urgent GP Referral)



RESPONSIVE

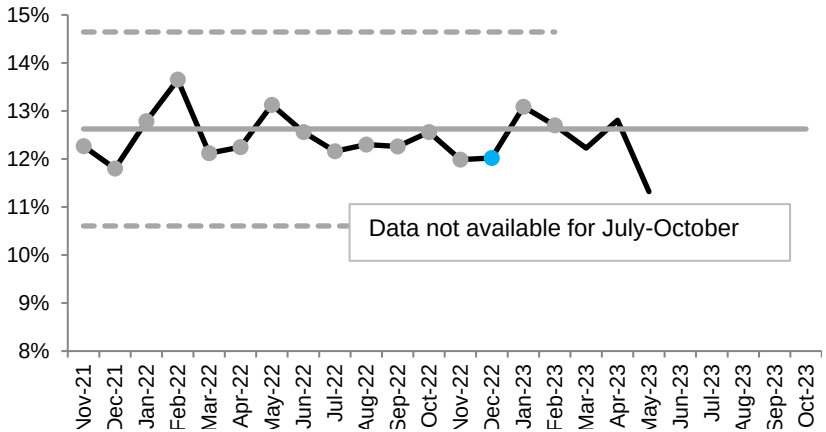
Delayed Discharges



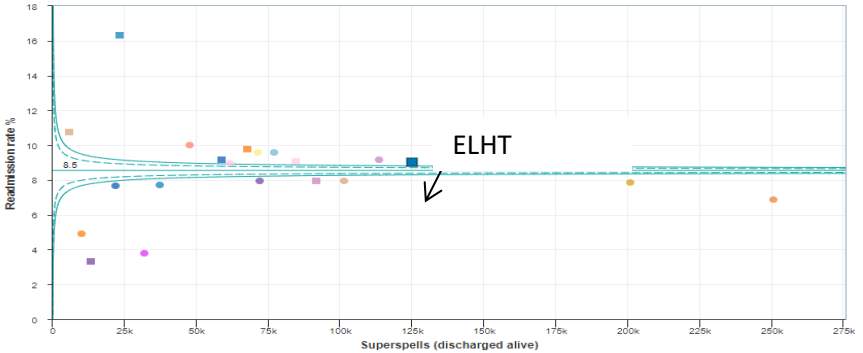
We continue to discharge patients using the rapid discharge principles set out in the Hospital discharge and community support: policy and operating model government guidance, utilising pathways 0-3. Pathways are being used to ensure patients have a discharge plan identified from admission, with pathway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

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

Emergency Readmissions

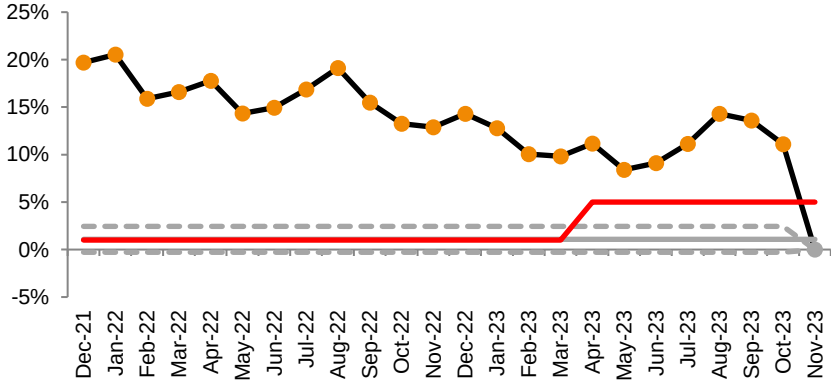


Readmissions within 30 days vs North West - Dr Foster
June 2022 - May 2023



Data not available for emergency readmission.

Diagnostic Waits



** Not updated ** In October, 11.1% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is above the 5% threshold. (95% of patients to receive a diagnostic test within 6 weeks by March 2025)

The trend remains significantly higher than baseline, however there are issues with data quality post EPR implementation, impacting on performance.

Nationally, the performance is failing the 5% target at 26.3% in September.

RESPONSIVE

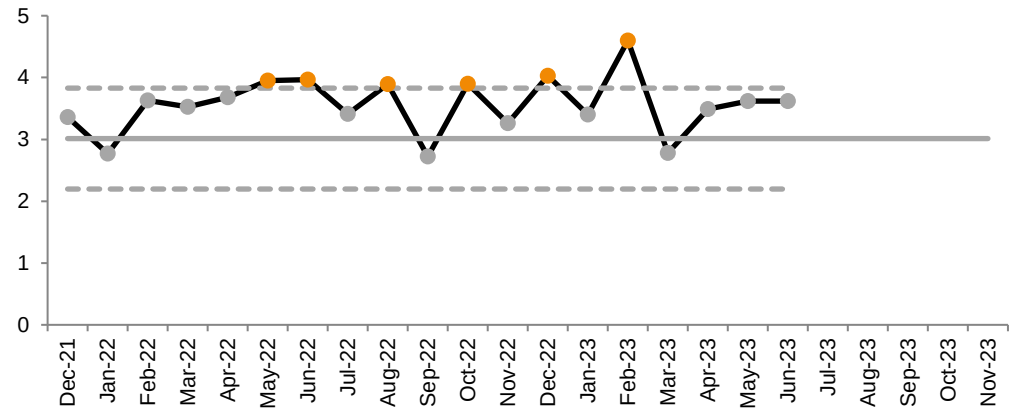
Average length of stay benchmarking

Dr Foster Benchmarking June 22 - May 23

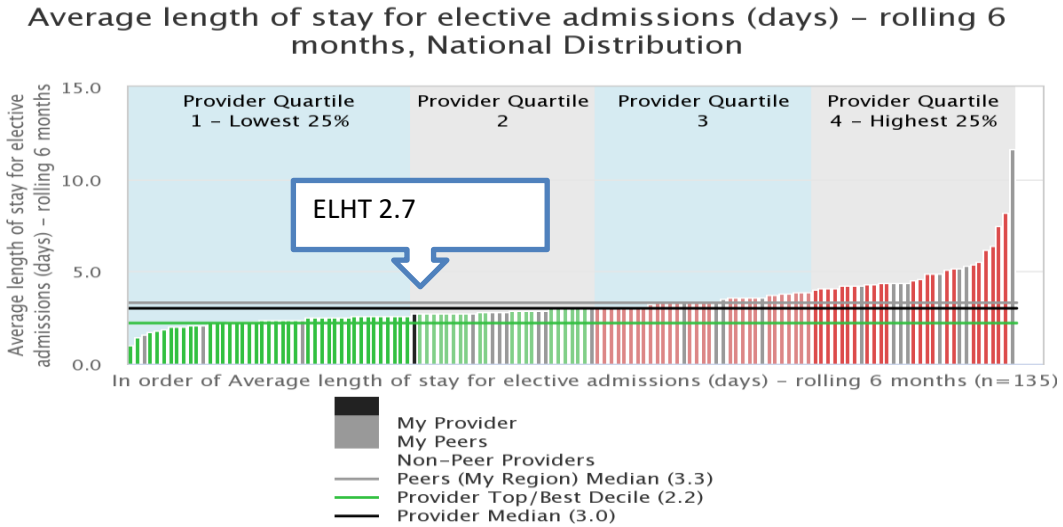
	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	62,610	10,442	52,168	3.2	2.7	-0.5
Emergency	61,620	61,620	0	4.1	4.6	0.5
Maternity/ Birth	12,500	12,500	0	2.4	2.3	-0.1
Transfer	226	226	0	7.9	24.0	16.1

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



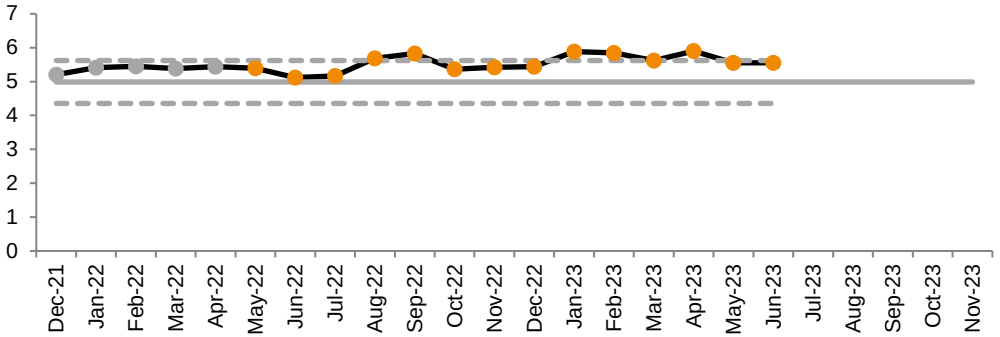
The Trust elective average length of stay is not avaiable between July-November.



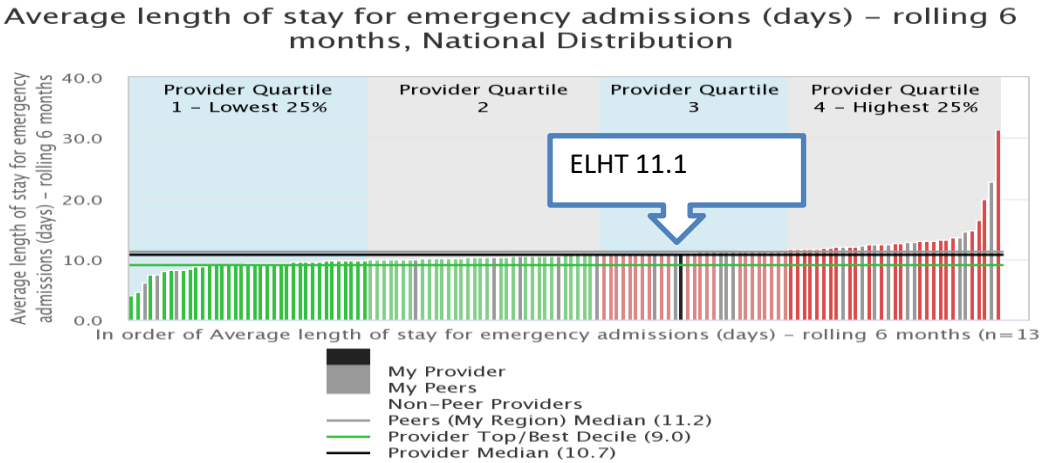
Data up to June 23 from the model health system shows ELHT in the second quartile for elective length of stay. Excludes day case.

RESPONSIVE

Average length of stay - non elective

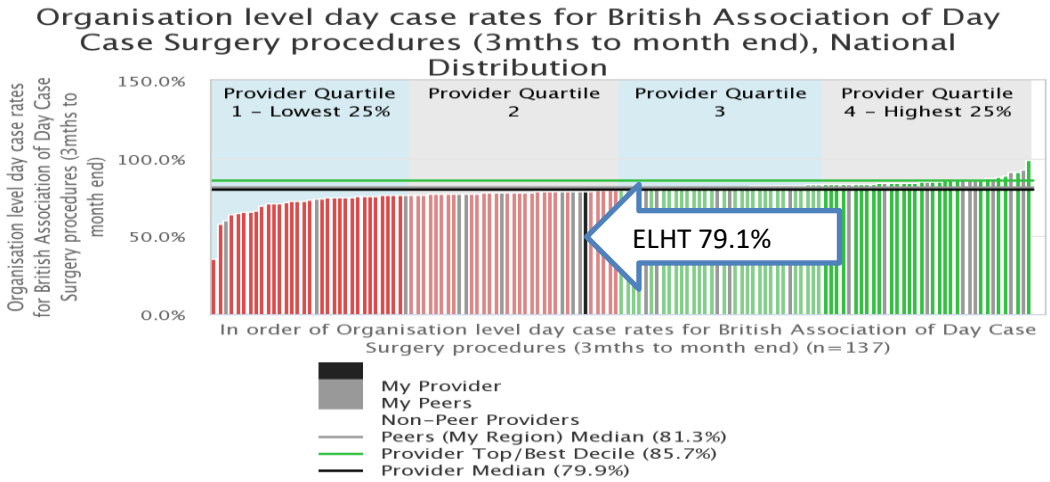


The Trust non-elective average length of stay is not available between July-November.



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.

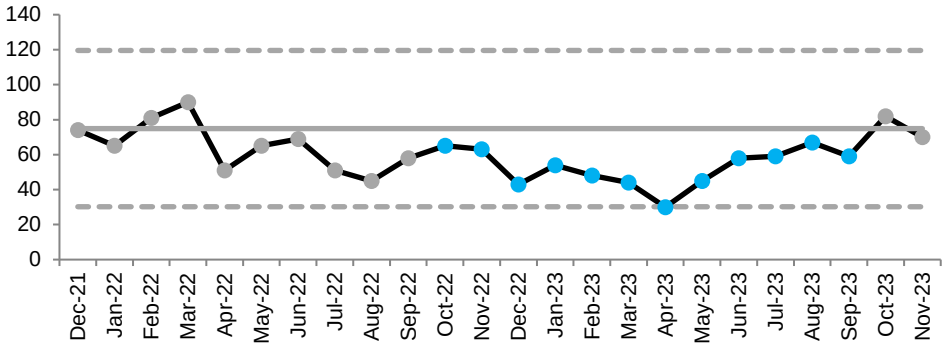
Daycase Rate



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

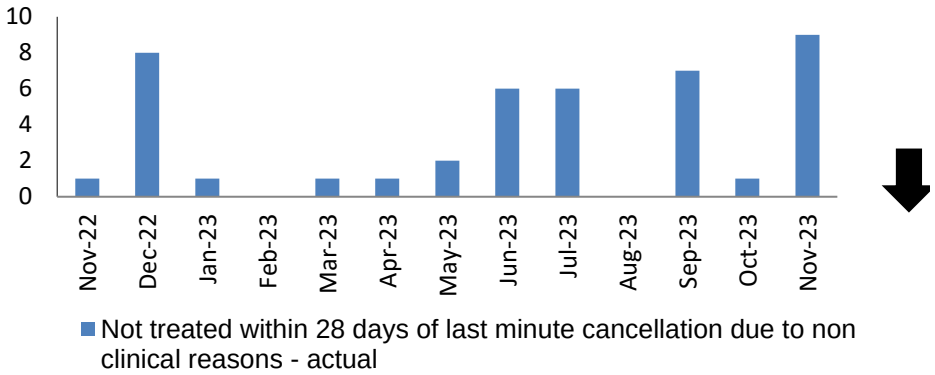
Operations cancelled on day



There were 70 operations cancelled on the day of operation - non clinical reasons, in November.

The trend is similar to pre-covid levels.

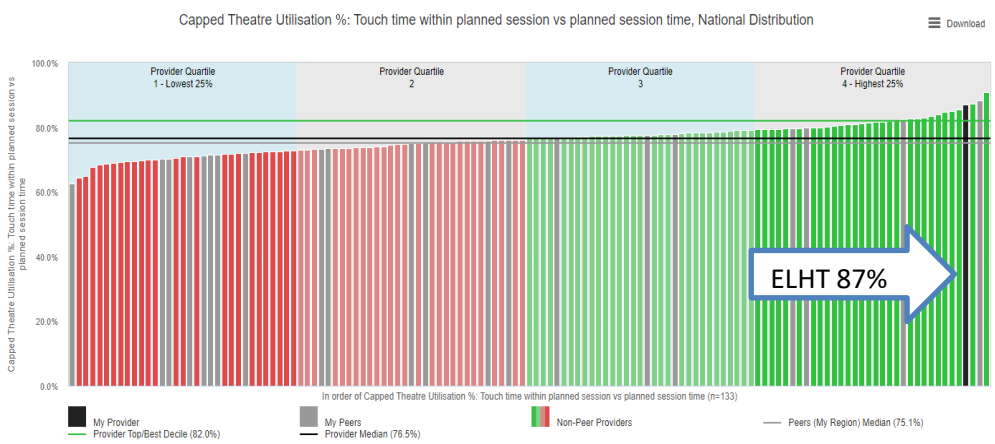
Operations cancelled on day - breaches of 28 day



There were 9 ‘on the day’ cancelled operation not rebooked within 28 days in November.

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

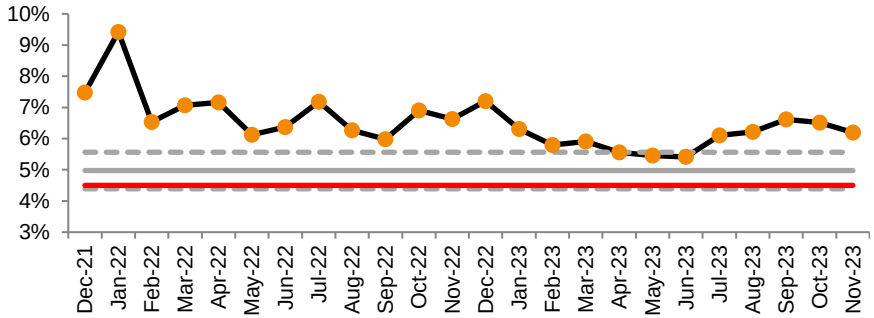


Data taken from 'The model hospital' shows capped theatre utilisation at 87% for the latest period to 18th June 23. This is in the fourth quartile nationally, with 4 being the highest and 1 the lowest.

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.

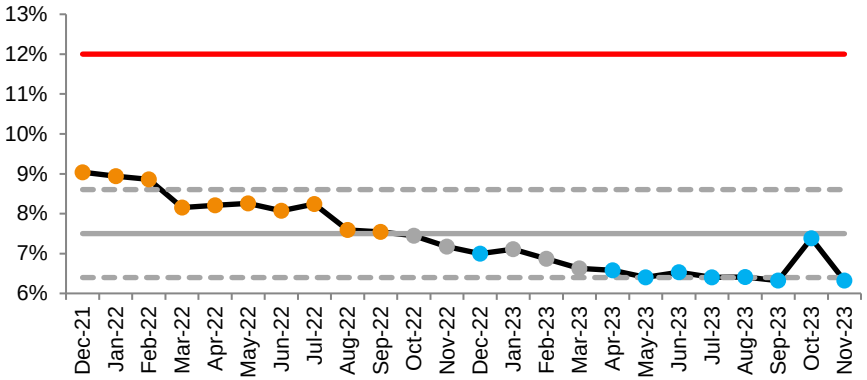
WELL LED

Sickness



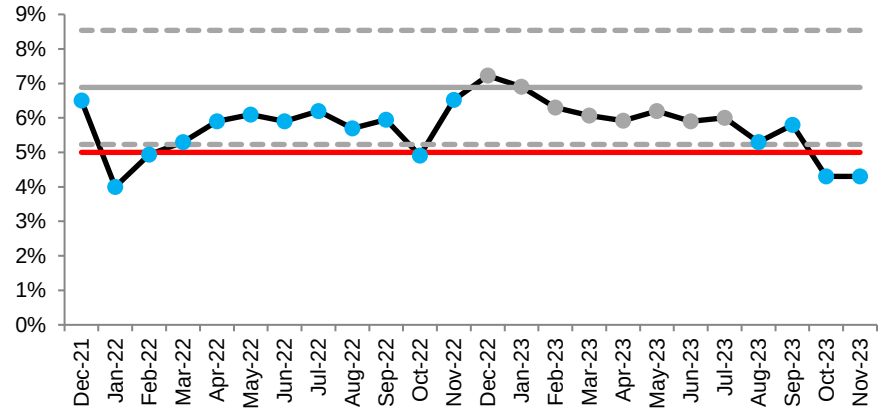
The sickness absence rate was 6.2% for November which is above the threshold of 4.5%. The trend is significantly higher than the pre covid baseline and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 6.3% in November 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



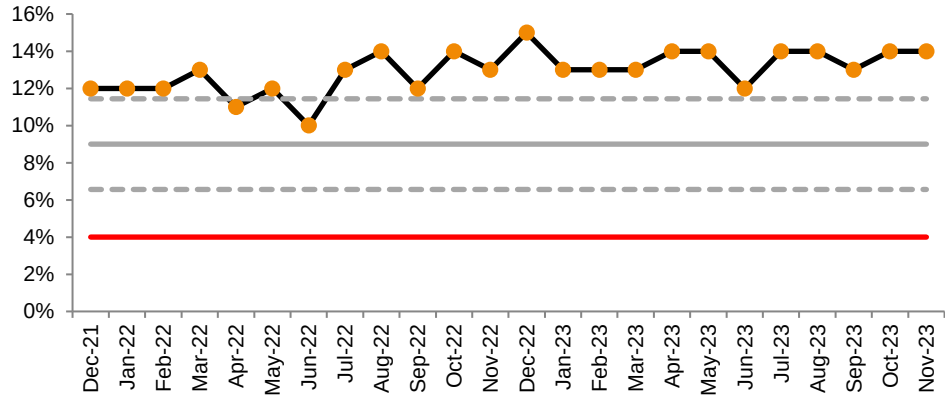
The vacancy rate is 4.3% for November which is below the 5% threshold.

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 November 2023, £4.6m was spent on temporary staff, consisting of £1.7m on agency staff and £2.9m on bank staff.

WTE staff worked (10,009 WTE) was 3 WTE more than is funded substantively (10,006 WTE).

Pay costs are £2.8m less than budgeted establishment in November.

At the end of November 23 there were 416 vacancies.

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

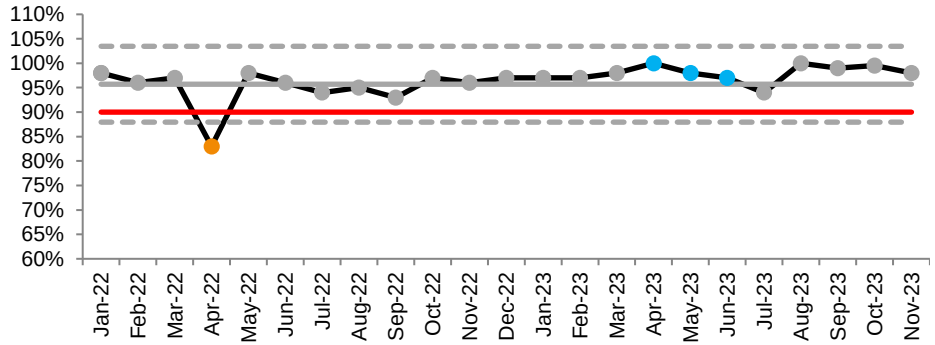
Job Plans

Stage	Clinicians
Active	211
In draft	145
Not started	47
In mediation or appeal	0
In sign off process	58

** Not updated** As at October 2023, there were 461 clinicians registered with a job plan on Allocate. The table shows the numbers in each stage of the job planning process.

WELL LED

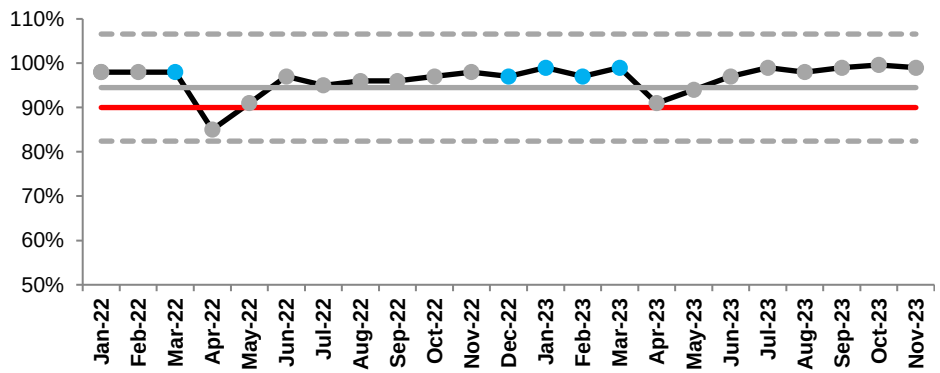
Appraisals, Consultant



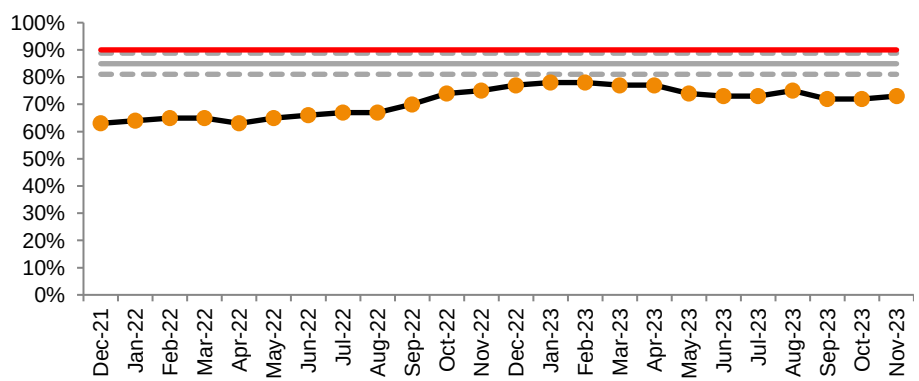
The appraisal rates for consultants and career grade doctors are reported for Apr - November 23 and reflect the number of reviews completed that were due in this period.

They both continue to be above target with 98% (consultant) and 99% (other medical) completed that were due in the period. 78% 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 November
Basic Life Support	2 years	90%	89
Conflict Resolution Training L1	3 years	90%	97
Equality, Diversity and Human Rights	3 years	90%	96
Fire Safety L1	2 years	95%	95
Health, Safety and Welfare L1	3 years	90%	97
Infection Prevention L1	3 years	90%	98
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%	90
Safeguarding Adults L1	3 years	90%	96
Safeguarding Adults L2	3 years	90%	95
Safeguarding Adults L3*	3 years	90%	75
Safeguarding Children L1	3 years	90%	96
Safeguarding Children L2	3 years	90%	96
Safeguarding Children L3	3 years	90%	84
Safeguarding Children L4	3 years	90%	100
Safer Handling Level 1	3 years	95%	96
Safer Handling Level 2 (Patient Handling)	3 years	95%	91

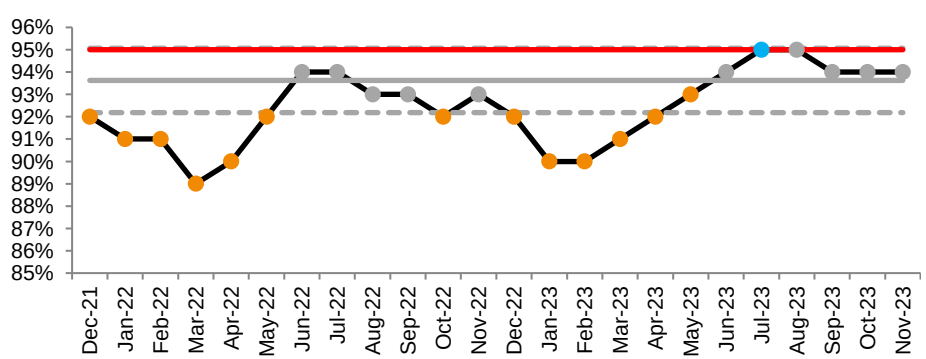
The core skills framework consists of eleven mandatory training subjects, with 19 modules in total. Training is via a suite of e-learning modules and knowledge assessments on the learning hub.

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

5 of the 19 modules are below threshold in November. 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

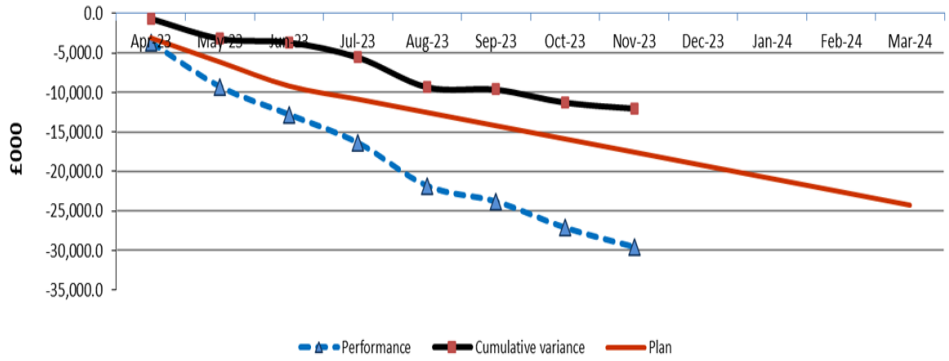


Information governance toolkit compliance is 94% in November which is below the 95% threshold. The trend is now above pre-covid baseline, however remains at risk of not meeting the target.

WELL LED

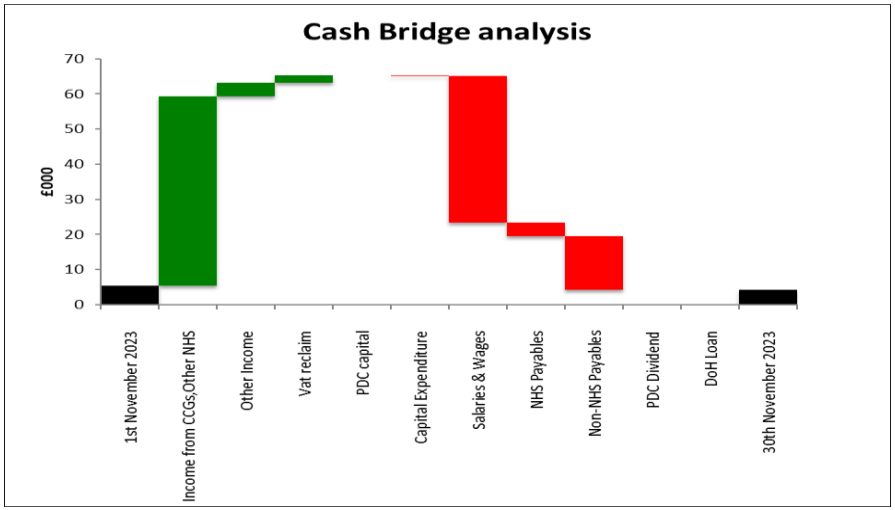
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



The Trust is reporting a breakeven duty deficit of £29.5m for the 2023-24 financial year to date, £11.9m behind plan.

Cash



The Trust's cash balance is £4.4 million as at 30th November 2023.

The Trust is reporting a breakeven duty deficit of £29.5m for the 2023-24 financial year to date, £11.9m behind the £17.6m planned deficit, a movement of £0.7m 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 2023-24 capital programme remains overcommitted, and conversations are talking please to increase the CDEL in year across the system.

The cash balance on 30th November was £4.4m, a reduction of £1.0m compared to the previous month. An additional £9.0m of Public Dividend Capital (PDC) revenue support was received earlier this month, taking the total received to date to £22.0m with a further £17.1m requested for quarter four.

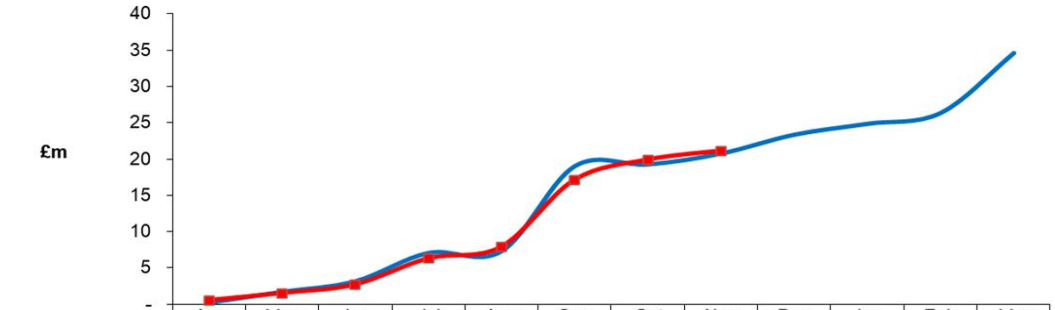
The Trust has met the Better Payment Practice Code (BPPC) target to pay 95% of invoices on time by value for the financial year to date. However, the impact of the Trust's financial performance in 2023-24 on its cash position has had an impact on BPPC performance which remains below target for non-NHS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

The Waste Reduction Programme achievement is £20.9m at month 8, £14.1m behind plan. It has been necessary to non-recurrently support this position by £9.2m.

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	19.03	19.28	20.77	23.37	24.86	26.36	34.59
Actual	0.54	1.54	2.72	6.31	7.90	17.12	19.91	21.13				

The Trust is £0.4m ahead of planned capital spend as at 30th November 2023.

Waste reduction programme

WRP schemes analysis

Identified schemes in tracker

Division	Green £000s	Amber £000s	Red £000s	Non Recurrent £000s	Recurrent £000s	Identified Schemes £000s	Annual Target £000s
Trust Wide Schemes	16,500	2	6,608	16,332	6,778	23,110	48,530
Medicine & Emergency Care	1,211	1,135	0	1,206	1,140	2,345	1,294
Community & Intermediate Care	2,126	25	0	109	2,041	2,150	410
Surgical & Anaes Services	1,064	10	0	300	774	1,074	1,338
Family Care	480	20	0	0	500	500	809
Primary Care	10	10	0	0	20	20	30
Diagnostic & Clinical Support	529	820	113	0	1,461	1,461	1,058
Estates & Facilities	3,380	1,184	989	1,828	3,725	5,553	622
Corporate Services	1,901	174	1,358	739	2,694	3,433	387
Education, Research & Innov'N	150	15	10	0	174	174	140
Total	27,350	3,393	9,077	20,513	19,307	39,821	54,618

Schemes to the value of £20.9 million have been transacted in the year to date. Additional identified schemes will be assessed for delivery

TRUST BOARD REPORT **Item** **16**

10 January 2024 **Purpose** Assurance
Information

Title	Freedom To Speak Up Report
Report Author	Mrs J Butcher, Head of Freedom to Speak Up
Executive sponsor	Mrs K Quinn, Executive Director of People and Culture

Summary: This report has been prepared to advise the Committee of progress made since the last annual report in May 2023. The report will now be submitted twice yearly following recommendations within the recent audit undertaken. It includes number of staff who have raised concerns in Quarter 1 and Quarter 2, emerging themes, actions taken, Freedom to Speak Up Guardian service updates and the latest news from the National Guardian Office. This report is being shared with Trust Board in January 2024.

Recommendation: To approve to note and approve the content of the report. Once approved the report will be made available to managers and staff. To commit to completion of the Level 3 Freedom to Speak Up Follow Up training for all Band 9 and above including Board Members.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Healthy, diverse and highly motivated people
Related to key risks identified on Board Assurance Framework	1 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. 2 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	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Freedom to Speak Up Review Assignment Report 2022-23

Legal	No	Financial	No
Equality	Yes	Confidentiality	Yes

Background

The importance of listening to staff cannot be overemphasised. When staff raise concerns, they want to know that they are encouraged and supported to do so and can do it safely in a protected environment. Following on from the Sir Robert Francis Review, it is a requirement of the NHS Standard Contract that Trusts appoint a Freedom To Speak up (FTSU) Guardian with the organisation who is "someone to whom staff can go to, who is recognised as independent and impartial, has authority to speak to anyone within or outside the Trust, is expert in all aspects of raising and handling concerns, has the tenacity to ensure safety issues are addressed and has dedicated time to perform this role".

Introduction

This report has been prepared to advise the Committee of progress made since the last annual report in May 2023. The report will now be submitted twice yearly following recommendations within the recent audit undertaken. It includes number of staff who have raised concerns in Quarter 1 and Quarter 2, emerging themes, actions taken, FTSU Guardian service updates and the latest news from the National Guardian Office (NGO).

Progress

a) Over 1400 concerns have been raised through the service since April 2016 – September 2023
b) FTSU training Level 1 and 2 has been mandated for all staff since 18 October 2023
c) 21 new FTSU Ambassadors have been recruited across multiple sites and are due to officially launch in January 2024
d) FTSU information and details now included on coaching and leadership information and SharePoint pages from the TODI team
e) FTSU promotion month ran in October 2023. There was numerous promotions about the importance of speaking up and breaking barriers from Trust comms and we received good engagement from staff. Walkarounds were completed at over 12 different hospital sites
f) A 'Breaking barriers' survey was completed as part of FTSU month to find out what staff felt the barriers were to speaking up. The survey had 437 responses and the top 2 responses was the worry about potential detriment / repercussions and if the issue was about a colleague / line manager / friend.

g) FTSU presentations have been delivered to new student nurses (Dec 23), FY1 doctors (Aug & Sept 23), FY2 doctors (Aug 23) and Consultant leadership course (Oct 23)

h) Audit actions now completed

i) FTSU information has been reported at divisional level at DMB meetings and will continue to be expanded across all divisions during the coming year.

Freedom to Speak Up – Number of cases, themes and actions taken to address

The figures submitted to the National Guardian's Office for Quarter 1 & 2 2023 are 55 and 62 respectively.

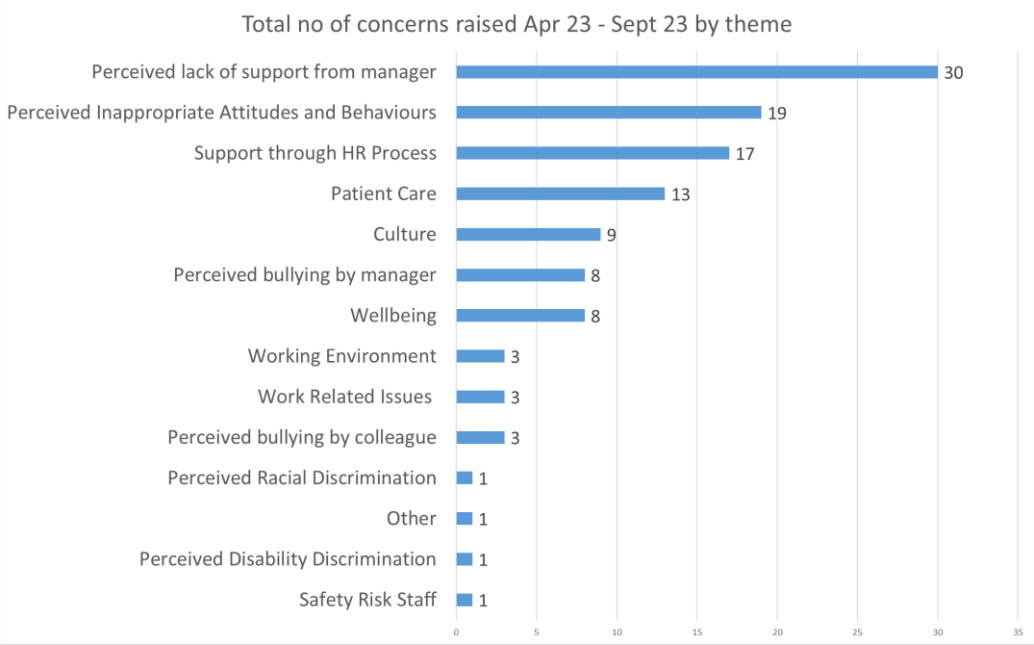
		Q1	Q2
Total no		**55**	**62**
Raised anonymously		0	1
Element of patient safety		5	14
Element of B&H		12	13
Element of worker safety or well-being		27	23
Element of inappropriate behaviours and attitudes		31	21
Staff member suffered detriment as a result of raising a concern		0	0
Concern raised by:	**AHP**	5	4
	Medical and Dental	6	4
	Ambulance	0	0
	Nurses & Midwives	16	9
	Administrative and Clerical	14	32
	Additional Professional Scientific	2	1
	Additional clinical services	6	6
	Estates and Ancillary	5	5
	Healthcare Scientists	0	0
	Students	0	0
	Not Known	1	0
	Other	0	1
No. of staff providing feedback about the service		0	8
Given their experience would they speak up again?	**yes**	0	8
	no	0	0
	maybe	0	0

	I don't know	0	0

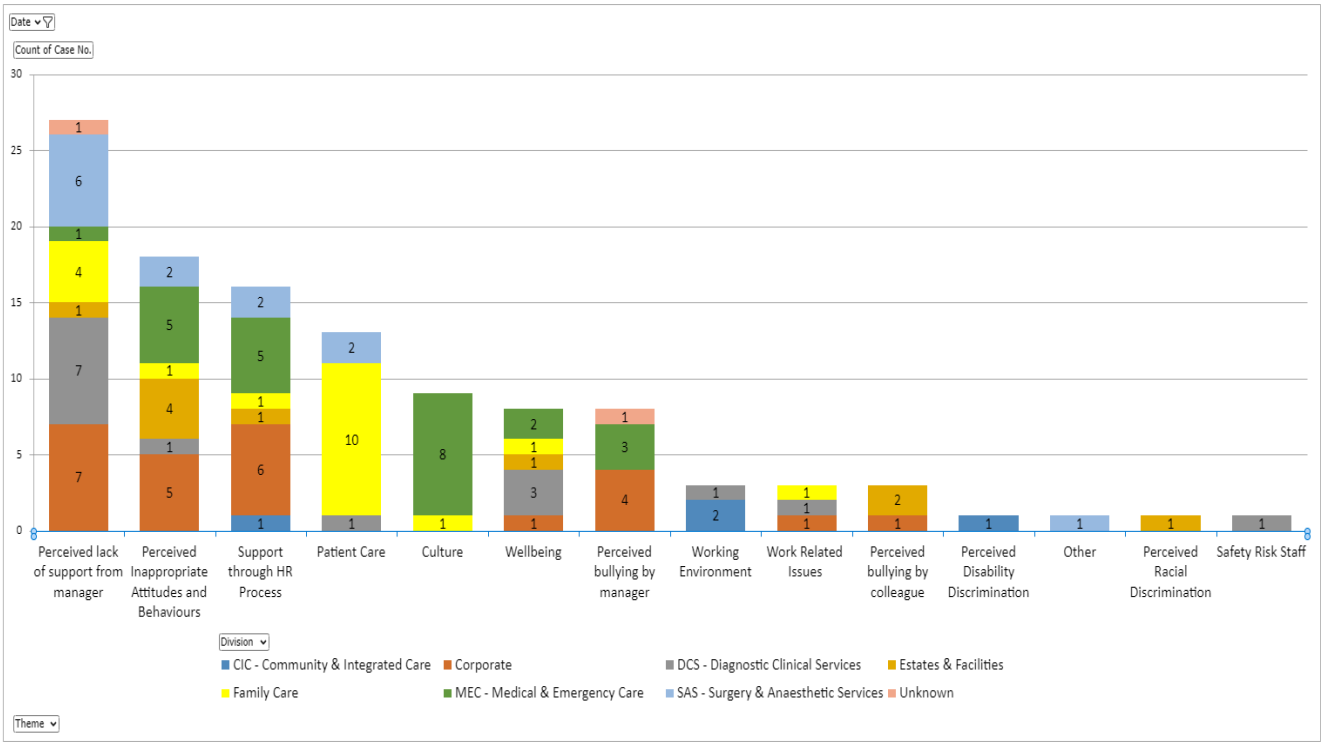
This is an increase of 14 concerns in Q1 and 3 concerns in Q2 compared to last years reported figures.

Only one of these concerns was anonymous and out of the 8 staff who provided feedback, all 8 of them said given their experience they would speak up again. Admin & Clerical staff feel the most able to speak up being the group of staff who have raised the most concerns since April 2023. We have had no concerns raised by students or healthcare scientists during this period however we have proactively presented the FTSU service to nursing students recently and intend to undertake similar work with our healthcare scientists.

Emerging Themes April 2023 – Sept 2023 (Q1 and Q2)



Themes by Division April 23 – Sept 23 (Q1 and Q2)



The highest level of concerns raised have been in relation to perceived lack of support from manager - 29 cases. Followed by 18 concerns raised in relation to inappropriate behaviours, then the third being 17 staff requiring support through HR processes. With the concerns raised under perceived lack of support, the majority were dealt with and resolved by opening communication channels with the manager and the staff member with our intervention. And the remainder were dealt with by the staff member alone following in depth conversations with the FTSU Guardians, thus empowering them with confidence to speak out.

We continue to see a trend of increasing concerns following the implementation of the standards of behaviour framework as staff now have a more understanding of how they should expect colleagues to behave, what is appropriate and what isn't appropriate. Some of these cases are referred to resolution and result in mediation and some we offer support and empowerment to colleagues to address them directly.

In relation to support through HR processes, this can be where a colleague has no union representation and wants support, or the concern can be that the individual is unclear of a process and needs support and understanding. Also, we are involved due to a resolution form

being submitted and the colleague indicating their wish for the FTSU Guardian to offer support working alongside the Unions.

The high proportion of patient care concerns for Family Care and culture concerns for MEC, stem from two FTSU Guardian cultural reviews we carried out in May and July of this year. There is a full report and action plan currently being worked through with the divisional director of ops and senior team within Family Care including feedback meetings with all staff. In relation to the review in MEC the review was referred to HR.

Now that we are producing division specific reports, we are working more closely with each individual division to address the concerns within their areas.

Breaking Barriers Survey

During FTSU month in October we created a survey to understand if our staff felt able to speak up, and if not, what our staff felt the barriers were. We offered an online survey for staff to fill out which was widely promoted through Trusts Comms and did many walk arounds at different sites so staff could fill it in on paper. We received 437 responses.

Just under half (49.4%) of all respondents said they had spoken up in the past. And of those who hadn't, it is positive that 91.2% of respondents said they would know how to speak up, should they need to in the future.

The top two responses were the fear of detriment or repercussions as a result of speaking up (24.7%) and if the issue is about a colleague / line manager / friend (21.9%).

Not having feedback (17.7%), a lack of communication (12.8%) and a worry about confidentiality (16.6%) were the next top responses which shows by managers not closing the feedback loop, this creates anxiety and a barrier to staff in wanting to speak up again.

The plan is to work alongside the organisation and our Union partners to educate our staff and share successful cases that have been dealt with through the FTSU Guardian office to

demonstrate ways to combat these barriers. i.e. mandatory training Level 1 and 2 will assist to address the feedback issue.

There is speculation that staff who have a protected characteristic are less likely to speak up and be more worried of the consequences should they do so, due to intersectionality. We were interested to see if this would be reflective of staff's experience and although 4.04% of staff surveyed felt it was a barrier, we are reassured that this is significantly less than the other concerns. We are also reassured that the barriers felt by those who identified as having a protected characteristic was also reflective of all respondents concerns.

The full report with data analysis breakdown will be available and shared in January 2024.

Freedom to Speak Up Mandatory training

FTSU training Levels 1 and 2 became mandatory on 18 October 2023. There are 3 levels of FTSU training:

Level 1	Speak Up	All staff
Level 2	Listen Up	All staff
Level 3	Follow Up	Band 9 and above

In 9 weeks this has increased compliance from 0.8% to 63.9% (Level 1) and from 0.7% to 57.3% (Level 2). Staff have a grace period to complete and we are aiming for 90% compliance by next year. Level 3 is due to be mandated in the New Year. We ask that the all staff above Band 9 complete the 'Follow Up' training.

Freedom to Speak Up Ambassadors

During October we relaunched and recruited to the existing the FTSU Champions role and renamed them FTSU Ambassadors. We are pleased to announce we have now trained/retrained 23 Ambassadors who will be officially launched in January 2024 who have been selected from a variety of roles, departments and sites within the organisation.

A comprehensive campaign will be launched to introduce the FTSU Ambassadors explaining their roles and how staff can engage with them. Clear pathways and guidance will be established for FTSU Ambassadors to ensure confidentiality and protection for those who speak up.

National Guardian Office Update

The National Guardian Office (NGO) has mandated refresher training for FTSU Guardians to be completed yearly. This was completed by both FTSU Guardian's in November 2023.

The NGO have released the results of the national FTSU Guardian survey 2023:

- There has been a sharp decline in FTSU Guardians perception of the improvements in the speak up culture of the healthcare sector. Only 45% said there had been an improvement. In previous years most respondents had said there was an improvement (73%, 2021, 80%, 2020)
- It is positive to note that 84% of respondents said their organisation was taking action to tackle barriers to speaking up, a 9% increase compared to last years results, and three-quarters of respondents said retaliation as a result of speaking up was not tolerated.
- Almost two-thirds of respondents (66%) identified that nothing will be done, was a barrier to workers in their organisation speaking up.

In November 2023, the NGO has also laid their Annual Report before parliament highlighting the work of FTSU Guardians and the NGO. The report shares learning which indicates that more work is needed for speaking up to be described as business as usual in the healthcare sector in England.

As a result of the Lucy Letby case, the Trust has received a letter from NHS England, underlining the importance of Freedom to Speak Up and leaders' importance in cultivating an open and honest culture.

Dr Jayne Chidgey-Clark. National Guardian for the NHS also responded to the Lucy Letby case saying "…These terrible events, though rare, underline why it is so vital that everybody feels safe to speak up about anything which gets in the way of delivering great care." The Secretary of State has announced an independent inquiry, the results of which will be vital to be understood and learned from.

Next Steps

A business case has been drafted and is due to be presented shortly. This business case outlines the additional resources required within the team to improve the current service offered and the availability / accessibility of the FTSU Guardians. Also to introduce a more proactive model where education and learning are an integral part of the service.

Continue to work closely with each individual division regarding specific areas of concern.

We currently have several areas within the Trust requiring our support in the form of a cultural review. The intention is to plan these in early next year. Business case dependent, the intention is to proactively offer our availability to undertake cultural reviews.

Meeting with CQC in relation to the Emergency Department well led domain visit is planned for January 2024.

Recommendation

To approve to note and approve the content of the report. Once approved the report will be made available to managers and staff.

To commit to completion of the Level 3 FTSU Follow Up training for staff members Band 9 and above.

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Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **17**

10 January 2024 **Purpose** Approval

Title	ELHT&Me Annual Report and Accounts 2022-23
Report Author	Mr A Graves, Head of Financial Control
Executive sponsor	Mrs M Brown, Executive Director of Finance

Summary: The 2022-23 Annual Report and Accounts for ELHT&Me are presented for review and approval by the Trust Board, as Corporate Trustee, prior to submission to the Charity Commission.

Recommendation: The Charitable Funds Committee recommends the Trust Board to approve the 2022-23 Annual Report and Accounts for ELHT&Me for submission to the Charity Commission

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

(17) ELHT&Me Annual Report and Accounts 2022-23

Annual Accounts – Audited

FOR THE YEAR ENDED

31st March 2023

Charity Registration Number 1050478

ELHT&Me

ELHT&Me Accounts 2022-23

STATUTORY BACKGROUND

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

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

MAIN PURPOSE OF THE CHARITY

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

Statement of Trustee responsibilities

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

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

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

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

These financial statements were approved by order of the Corporate Trustee on 23 November 2023 and were signed on its behalf by:

…….. ……..

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

Michelle Brown
Executive Director of Finance
East Lancashire Hospitals NHS Trust

ELHT&Me Accounts 2022-23

Statement of Financial Activities

	Note	2022-23 Unrestricted funds £'000	2022-23 Restricted funds £'000	2022-23 Total £'000	2021-22 Total £'000
Income from:	3				
Donation and legacies		**506**	**72**	**578**	792
Other trading activities		**221**	**1**	**222**	168
Investments		**33**	**6**	**39**	36
Total		**760**	**79**	**839**	996
Expenditure on:	4				
Raising funds		**(9)**	**0**	**(9)**	(9)
Charitable activities		**(760)**	**(35)**	**(795)**	(802)
Total		**(769)**	**(35)**	**(804)**	(811)
Net gains / (losses) on investments		**(105)**	**(16)**	**(121)**	107
Net income / (expenditure)		**(114)**	**28**	**(86)**	292
Transfers between funds		**(34)**	**34**	**0**	0
Net movement in funds		**(148)**	**62**	**(86)**	292
Reconcilation of funds:					
Total funds brought forward		**1,715**	**242**	**1,957**	1,665
Total funds carried forward		**1,567**	**304**	**1,871**	1,957

ELHT&Me Accounts 2022-23

Balance Sheet

	Note	31 March 2023 £'000	31 March 2022 £'000
Fixed assets			
Investments	9	**1,652**	1,785
Current assets			
Stocks		**7**	0
Debtors	7	**115**	128
Cash at bank and in hand		**191**	224
Total current assets		**313**	352
Liabilities			
Creditors: amounts falling due within one year	8	**(94)**	(180)
Net current assets		**219**	172
Total assets less current liabilities		**1,871**	1,957
Total net assets		**1,871**	1,957
The funds of the Charity:			
Restricted income funds		**304**	242
Unrestricted funds		**1,567**	1,715
Total Charity funds		**1,871**	1,957

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

Approved by order of the Corporate Trustee on 10 January 2024 and signed on its behalf by:

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

Michelle Brown
Executive Director of Finance
…….. East Lancashire Hospitals NHS Trust

ELHT&Me Accounts 2022-23

Statement of Cashflows

	Note	2022-23 £'000	2021-22 £'000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities		**(159)**	37
Cash flows from investing activities			
Dividends and interests from investments	3	**39**	36
Purchase of investments		**(723)**	(196)
Proceeds from the sale of investments		**810**	173
Net cash inflow from investing activities		**126**	13
Net cash (outflow)/ inflow before financing		**(33)**	50
Cash flows from financing activities		**0**	0
Net cash outflow from financing activities		**0**	0
Change in cash and cash equivalents in the reporting period		**(33)**	50
Cash and cash equivalents at beginning of the year		**224**	174
Cash and cash equivalents at end of the year		**191**	224

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

Net income/(expenditure) for the reporting period (as per the statement of financial activities)		**(86)**	292
Adjustments for:			
(Gains)/losses on investments		**46**	(73)
Dividends and interest from investments	3	**(39)**	(36)
(Increase)/decrease in stocks		**(7)**	0
Decrease /(Increase) in debtors	7	**13**	(103)
(Decrease) in creditors	8	**(86)**	(43)
Net cash provided by (used in) operating activities		**(159)**	37

ELHT&Me Accounts 2022-23

Notes to the Accounts

1 Basis of preparation

1.1 Basis of accounting

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

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

1.2 Going Concern

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

2 Accounting policies

2.1 Recognition of income

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

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

2.2 Income with related expenditure

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

2.3 Grants and donations

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

2.4 Tax reclaims on donations and gifts

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

2.5 Contractual income and performance related grants

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

2.6 Gifts in kind

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

2.7 Legacies

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

2.8 Donated services and facilities

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

2.9 Volunteer help

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

2.10 Investment income

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

Notes to the Accounts

Accounting policies cont.

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

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

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

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

2.15 Support costs
Support costs include central functions and have been allocated to funds on a basis of closing fund balances as at the 31 March 2023.

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

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

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

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

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

2.21 Trustee indemnity insurance
There is no Trustee indemnity insurance.

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

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

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

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

Notes to the Accounts

3 Analysis of Income

	2022-23 Unrestricted Funds £'000	2022-23 Restricted Funds £'000	2022-23 Total £'000	2021-22 Total £'000
Income from donation and legacies				
* Donations	**311**	**72**	**383**	581
Legacies	**118**	**0**	**118**	0
Grants	**77**	**0**	**77**	211
	506	**72**	**578**	792
Income from other trading activities				
Income from training activities	**91**	**1**	**92**	103
Income from trading	**43**	**0**	**43**	0
Other income	**87**	**0**	**87**	65
	221	**1**	**222**	168
Income from investments				
Investments listed on the London Stock Exchange	**30**	**5**	**35**	36
Interest on cash/bank	**3**	**1**	**4**	0
	33	**6**	**39**	36

* Donations for 2022-23 include £90,000 of notional income for gifts in kind received (2021-22: £13,000). The corresponding notional expenditure entry is shown in note 4 to these accounts.

** The £43,000 trading income relates to sales generated in the charity hub shop which was opened during the year on the 19 November 2022.

4 Analysis of Expenditure

	2022-23 Activities Undertaken Directly £'000	2022-23 Support Costs £'000	2022-23 Total £'000	2021-22 Total £'000
Expenditure on raising funds				
Investment management and admin fees	**9**	**0**	**9**	9
	9	**0**	**9**	9
Expenditure on charitable activities				
Fund raising expenses	**13**	**5**	**18**	45
Gifts in kind	**90**	**37**	**127**	17
Staff welfare / training / amenities	**140**	**54**	**194**	90
Retirement gifts and long service awards	**25**	**10**	**35**	68
Trading expenses	**24**	**9**	**33**	0
Furniture and equipment	**39**	**16**	**55**	17
Training	**31**	**13**	**44**	58
Medical and surgical equipment	**83**	**34**	**117**	390
Other expenditure	**123**	**49**	**172**	117
	568	**227**	**795**	802

Notes to the Accounts

5 Details of certain items of expenditure

5.1 Support Costs

	2022-23 £'000	2021-22 £'000
Finance and administration costs	**223**	174
Banking charges	**1**	1
Fees for examination or audit of the accounts	**3**	3
	227	178

Support costs have been apportioned to individual funds in accordance with Note 2.15, as well as the investment income shown in note 3 and the gains / (losses) on investments shown in the Statement of Financial Activities.

5.2 Trustee expenses and remuneration

None of the members of the Trust Board were paid expenses or received remuneration during the year ended 31 March 2023 (2021-22: £nil) when acting on behalf of the Trust Board as a Corporate Trustee of the Charity.

5.3 Staff costs

The Charity did not employ any staff or incur any staff costs during the year ended 31 March 2023 (2021-22: £nil). The costs asscociated with the administration of the charitable funds have been disclosed under support costs in accordance with the stated accounting policy of the Charity.

6 Operating leases

	2022-23 £'000	2021-22 £'000
Operating lease expense		
- Minimum lease payments	2	178
Future minimum lease payments due:		
- not later than one year	14	0
- later than one year and not later than five years	27	0
- later than five years	0	0
	41	**0**

The Charity had one operating lease as at 31 March 2023. This relates to a three year lease for the Charity shop hub which commenced on the 1 February 2023. In 2021-22, £178,000 was spent on the lease of two surgical robots which were funded by the Charity until 30 November 2021.

7 Debtors - falling due within one year

	31st March 2023 £'000	31st March 2022 £'000
Trade debtors	**42**	107
Prepayments and accrued income	**73**	21
	115	128

Notes to the Accounts

8 Creditors - falling due within one year

	31st March 2023 £'000	31st March 2022 £'000
Trade creditors	**(4)**	(3)
Amounts due to East Lancashire Hospitals NHS Trust	**(16)**	(108)
Accruals	**(74)**	(69)
	(94)	(180)

9 Investment assets

9.1 Fixed assets investments

	2022-23 £'000	2021-22 £'000
Market value at 1 April	**1,785**	1,689
Add: additions to investments at cost	**723**	196
Less: disposals at carrying value	**(810)**	(173)
Add: net gain/(loss) on revaluation	**(57)**	60
Investment cash	**11**	13
Market value at 31 March	**1,652**	1,785

9.2 Analysis of investments

	2022-23 £'000	2021-22 £'000
Investments listed on a recognised stock exchange or held in common	**1,549**	1,692
Other investments	**103**	93
Market value at 31 March	**1,652**	1,785

9.3 Material investment holdings

Material investment holdings are holdings with a market value of more that 4% of the total market value of investments as at 31 March 2023, which is approximately £66,000 (31 March 2022: £71,000).

	2022-23		2021-22	
Investment	**Holding**	**Market Value £'000**	Holding	Market Value £'000
Twentyfour AM Corporate Bond	**835**	**69**	917	88
Robeco	**802**	**73**	852	86
Ishares Physical	**3,317**	**103**	3,657	105
Fidelity	**91,441**	**73**	10,697	74
Schroder	**106,430**	**85**	93,361	97
Muzinich Funds GBL Tactical Credt HGD	**706**	**66**	707	70

Notes to the Accounts

10 Related party transactions

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

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

11 Endowment, restricted income funds & major fund movements

11.1 Restricted Funds held

Fund Name	* Site	Fund Purpose
Clinical Education Fund	ELH	For use by the Directorate of Education, Research and Innovation (DERI).
R Jackson Fellowship Fund	ELH	For the education of non-medical professionals and their students in ELHT and other health care employers in East Lancashire.
Thomas Egan Physiotherapy Fund	RBTH	Legacy for the general use of physiotherapy at RBH.
Harold Wardley Pathology Fund	RBTH	For the benefit of Pathology Service BRI.
Chemo Unit - Rosemere Fund	RBTH	For the Chemotherapy unit.
H Eastwood Childrens Resp Fund	ELH	Specifically for children with breathing difficulties.

** RBTH Royal Blackburn Hospital*
ELHT East Lancashire Hospitals NHS Trust

11.2 Transfer between funds

A transfer between funds of £34,000 was actioned in 2022-23 to move a restricted donation that had been incorrectly allocated to an unrestricted fund.

Notes to the Accounts

11.2 Movements of major funds

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

Fund	1 April 2022 £'000	Income £'000	Expenditure £'000	Transfers £'000	Gains & Losses £'000	31 March 2023 £'000
Pharmaceutical Directorate	54	4	(6)	0	(3)	**49**
Pharmacy Endowment	33	6	(3)	0	(2)	**34**
Staff Gym	32	21	(18)	0	(2)	**33**
Trust General	294	401	(299)	6	(33)	**369**
Nhs Charities Together	330	34	(110)	0	(13)	**241**
Alan Shorrock Legacy	139	2	(13)	0	(7)	**121**
Diabetes	36	1	(10)	0	(1)	**26**
Dcs General Purpose	35	1	(5)	1	(2)	**30**
Educational Fund	22	17	(7)	0	(2)	**30**
Clinical Education	137	76	(23)	34	(12)	**212**
Ef - R Jackson Fellowship	75	1	(7)	0	(4)	**65**
ELHT Cardiac Training	31	2	(14)	0	(1)	**18**
Life Support Training Rbh	89	54	(48)	(34)	(3)	**58**
Dr Newsomes Leukemia	56	1	(5)	0	(3)	**49**
Rbh Larascopic	55	3	(16)	0	(3)	**39**
Trust Ophthalmology General P	10	53	(6)	0	(3)	**54**
Community Neurodevelopmental	39	1	(4)	0	(2)	**34**
General NICU	57	44	(43)	0	(3)	**55**
Fetal Medicine	30	6	(30)	0	0	**6**
ELHT Lottery Distribution	93	69	(43)	0	(6)	**113**
Victoria Nurses Assistance	36	0	(4)	0	(2)	**30**
Other funds	274	42	(90)	(7)	(14)	**205**
Total	**1,957**	**839**	**(804)**	**0**	**(121)**	**1,871**

ELHT&Me Annual Report

Annual Report 2022-23

Contents

photos = Paige / Morecambe Bay / Red Rose Awards / Tough Mudder / Race night / Tractor run / cheque presentations / 10k / ELHT&Me FC / collection tins and penny boxes / Alfie / Fashion Show / Young Farmers event

Chairman’s Report

Welcome to ELHT&Me's Annual Report for 2022-23.

I hope you will agree that this vibrant and colourful overview of everything that has been delivered in the past 12 months provides an incredible insight into the vast range of activity which is being carried out for colleagues, patients and families at East Lancashire Hospital NHS Trust.

Whilst I always have a keen interest in the work of the official hospital charity and follow its progress, I must admit I was blown away when I read through everything that had been achieved.

It’s a brilliant testimony to the energy, enthusiasm and expertise of our amazing charity team, Denise Gee, Demi Houghton and Rebecca Bartle who are out in our hospital sites and in the community throughout the year, championing the cause and encouraging people to get involved.

They are well known and easily recognised around the Trust and in our communities in their teal uniforms, and always with a smile, and I want to thank them for everything they have achieved. It’s way over and above anything that could ever be captured in something so binary as a ‘job description’. They live and breathe the charity and I am grateful to them for that.

Thanks is due also to everyone who supports ELHT&Me, including our Trustees, volunteers, staff and patients, who have helped the charity to become the beating heart of the Trust. Thank you also to everyone who has helped with donations, fund raising in any shape or form, leaving legacies in memory of loved ones or by buying tickets for our lotteries and prize draws.

It all matters and makes a huge difference. Without the charity the Trust simply wouldn’t be able to support the wide range of projects designed to make life easier for those who need it.

On each page of this report, you’ll find stories demonstrating what has been achieved and the impact it has had. It is also clear that 2022-23 was a year where ELHT&Me made significant progress in delivering against the priorities of our strategy.

This was most notably with the opening of a central hub close to the entrance of Royal Blackburn Teaching Hospital. The hub includes offices for the team and space for people to stop by and talk about fund raising or how they can contribute, but most noticeably it has become a hive of activity due to its eye-catching retail space which has outperformed our year one aspirations considerably.

The Trust is very proud indeed of this development and was delighted when the charity team was invited to London as part of the Creating Better Futures Awards, which recognise excellence in four sustainability priorities: Climate, Environment, Communities and People. ELHT&Me were awarded the Gold Standard Communities and People award for the creation and delivery of the hub which was very well deserved!

That the hub was created without any financial investment thanks to our landlords and a team of admirable contractors who gave their time and expertise for free, is beyond amazing. This meant no charity funds were used to create the hub and all our money continues to be provided for projects which benefit staff and patients.

That ELHT&Me makes a real difference to the lives of patients and colleagues was also a determining factor for the judges at the Ribble Valley Business Awards who named the charity the winner in the 'Not for Profit' category. More than 400 businesses and charities were nominated for awards across 18 categories, so it was another real achievement for the team.

If you live in the Ribble Valley I really must commend the charity's weekly health and wellbeing show on Ribble Valley FM to you give it a listen and hear all the latest updates about how ELHT&Me is helping people.

Our vision continues to be to support the Trust to provide money which simply isn't available in the general NHS budget, working on projects that make a difference to the whole community and beyond.

There continues to be huge support for this and within the annual report you can read about some remarkable fundraising activity that have captured the hearts of local people.

From our local premier league football clubs gifting the spirit of Christmas to patients, families taking on some enormous challenges in memory of their loved ones and the ongoing generosity of our regular corporate donors the support never ceases to make me feel humble. We are grateful to everyone equally.

I hope that you will enjoy reading this report and that you are as proud as I am to be associated with ELHT&Me. If you want to get involved in any way please come forward, you'd be very welcome indeed as we press forward into 2023-24.

Shazad Sarwar
Chair, East Lancashire Hospitals NHS Trust

Objectives and Activities

ELHT&Me is a registered charity (Registered number 1050478) in accordance with the Charities Act 2011.

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

We invest in projects which promote better physical and mental health and wellbeing for the people of East Lancashire.

We work in strategic partnership with East Lancashire Hospitals NHS Trust, using charitable funding to enhance NHs provision, but not substitute it.

The objective of the charity is ‘for any charitable purpose or purposes relating to the general or any specific purposes of the East Lancashire Hospitals NHS Trust or the purposes of the National Health Service’.

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

- Improvements to the services provided to patients, primarily through the purchase of equipment that would be outside the NHS funding, as well as improvements to the patient environment and experience.
- Training for Trust staff and to help to develop and improve staff amenities. The trustees have considered the Charity Commission’s guidance on public benefit when reviewing the charity’s aims and objectives and in planning future activities and setting the grant making policy for the year. To achieve our aims and objectives ELHT&Me will actively seek and apply for grants, become front facing through the charity hub creation at Royal Blackburn Teaching Hospital and increase corporate relations. The charity will also design and deliver large scale events whilst establishing legacies to generate income.

Image

Our Purpose

ELHT&Me's purpose is to support East Lancashire Hospitals NHS Trust to enhance the experience of patients, families, colleagues and the wider community served through our five hospitals and community services, beyond that achieved by routine NHS funding. ELHT&Me supports the strategic priorities of East Lancashire Hospitals NHS Trust in providing the best possible healthcare for its combined population of approximately 566,000. From the smaller things, like providing music on wards, to larger projects, such as funding state-of-the-art medical equipment, ELHT&Me is here to make a positive difference.

Achievements and Performance

ELHT&Me is immensely proud to have been able to play a pivotal role in supporting NHS, patients, and wider communities throughout the year 2022-2023; this could not have been achieved without the support from all the donors, fundraisers and partners and supporters of our charity. This has enabled us to support a wide range of important projects throughout the year.

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

Patient and family support

Supporting early patient mobilisation for patient on rehabilitation pathways, assisting the journey with specialist seating.

This new seating is enhancing capabilities of the critical care team's offerings through enabling a patient to return to their usual level of mobility quicker than ever. Supporting their mobility empowers them to reach goals throughout recovery and in turn, allows more patients to be cared for.

The team has significantly benefited from the multitude of features of the Sydney Go Flat Chair, helping in both the physical and emotional rehabilitation of critical care patients.

Environment

Areas of Royal Blackburn Teaching Hospital's childrens ward have been transformed into themed designs including hot air balloons, calming neutral scenes and world map being centrepiece of a 6 bed bay.

The striking new additions brighten the hospital's walls, helping children to recover in an environment tailored to them.

Insert photo

The renovations of two family rooms in the Lancashire Womens and Newborn Centre's Neonatal Intensive Care Unit give a modern, calm, comfortable environment during what can be a difficult time.

These two rooms include a full kitchen and en-suite. With flat screen television and freshly painted walls brightening up the rooms, as well as full kitchen and en-suite, families now have a homely feel where they can spend precious time closer to their babies.

The Unit cares for the sickest and smallest of babies, providing a whole range of neonatal care, catering for the delivery rate of more than 6,200 babies born every year.

Claire Norney, NICU Ward Manager, said "With the nature of the work that we do, it's so important for families to be close to their babies during what can be a very anxious time. We desperately need these areas because our patients can be in our care for some time and some travel a long distance to receive our care as a centre of excellence."

The renovated rooms are also to be extended even further with the addition of a gym.

Insert photo

Equipment

We have expanded the opportunity for patients to choose to receive the treatment of the scalp cooling cap technology. Having two on the ward met demand until this year when more patients were hopeful to use the equipment and we took action to launch an appeal with the goal of achieving an additional system.

The appeal received phenomenal levels of support from individuals and groups throughout our community which led to us raising a considerably higher amount. This meant that we were able to procure a dual system, and this now gives the chemotherapy unit the ability to treat four patients at the same time.

Scalp cooling works by narrowing the blood vessels beneath the skin of the scalp, which reduces the amount of chemotherapy medicine that reaches the hair follicles. With less chemotherapy medicines in the follicles, the hair can be less likely to fall out. The cold temperature also reduces the hair follicles' metabolic activity, which makes the cells divide more slowly and protects them from the medicine.

Wellbeing

Alfie joined the Trust in 2022 and has had an immeasurable impact, providing comfort to individual colleagues and teams in need of a friendly face he even met their Royal Highnesses, William and Catherine at Clitheroe Community Hospital!

He has blossomed into a remarkable therapy dog, bringing smiles and happiness to countless individuals throughout the Trust and in the local community.

The Charity is immensely proud of Alfie's accomplishments, and we are looking forward to the continued positive influence he will bring to our colleagues, patients and community.

Insert photo with Zak Kerr

Plans for Future Periods

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

Financial Review

Annual review of income and expenditure

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

Income for 2022-23 includes a £76,000 legacy from the late Trevor Unsworth for general charitable purposes.

The Charity shop hub opened on 19 November 2022 generating trading income of £43,000 and incurring costs of £18,000 included in other expenditure.

Analysis of income	2022-23 £'000	2021-22 £'000
Income from donation and legacies		
Donations	383	581
Legacies	118	0
Grants	77	211
	578	792
Income from other trading activities		
Income from training activities	92	103
Income from trading	43	0
Other income	87	65
	222	168
Income from investments		
Investments listed on the London Stock Exchange	35	36
Interest on cash/bank	4	0
	39	36
Total	**839**	**996**

Total expenditure for 2022-23 of £804,000 compares to £811,000 in the previous financial year. At £194,000, expenditure on staff welfare, training and amenities represented the largest use of charitable funds.

Analysis of expenditure	2022-23 £'000	2021-22 £'000
Expenditure on raising funds		
Investment management and admin fees	9	9
	9	9
Expenditure on charitable activities		
Fund raising expenses	18	45
Gifts in kind	127	17
Staff welfare / training / amenities	194	90
Retirement gifts and long service awards	35	68
Trading expenses	33	0
Furniture and equipment	55	17
Training	44	58
Medical and surgical equipment	117	390
Other expenditure	172	117
	795	802
Total	**804**	**811**

When net losses on investments of £121,000 are taken into account, fund balances have decreased by £86,000 in 2022-23 to £1,871,000, of which £1,567,000 is unrestricted with £304,000 held in restricted funds.

The market value of the Charity's investment portfolio as at 31 March 2023 was £1,652,000 (31 March 2022: £1,785,000), £1,549,000 of which is managed by the

Charity's investment managers. The total return, income generated plus capital appreciation, over the period was -4.3%. This is against the FTSE 100 and British Government Securities (BGS) benchmark of -3.5%. The £40,000 of income generated equates to an income yield of 2.1%.

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

Investment Strategy and Policy

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

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

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

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

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

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

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

Risk Management

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

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

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

Reserves Policy

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

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

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

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

Structure, Governance and Management

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

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

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

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

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

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

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

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

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

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

Fund managers have delegated authority to incur expenditure below £3,000.

Expenditure above £10,000 requires the following signatories, Fundholder, Deputy/Executive Director of Finance, plus one of the following:

- The Charitable Fund Committee approval; or

- Three members of the Trust Board, of which one must be either the Charitable Trust Committee Chair or Executive Director of Finance.

In addition to fund manager approval, expenditure between £3,000 and £10,000 also requires approval from either the Deputy Director of Finance or Executive Director of Finance.

Director Recruitment, Appointment, Induction and Training

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

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

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

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

Committee Membership

- Stephen Barnes (Chairman of the Committee)
- Richard Smyth
- Michelle Brown
- Christine Douglas (until 31 July 2022)
- Julie Molyneaux (from 1 August 2022 until 19 March 2023)
- Pete Murphy (from 20 March 2023)
- Shelley Wright

The Members of the Corporate Trustee (Board) for 2022-23 were:

- Professor Eileen Fairhurst, Trust Chairman (to 31 October 2022)
- Mr Shazad Sarwar, Trust Chairman (from 6 December 2022)
- Mr Martin Hodgson, Chief Executive
- Mrs Trish Anderson, Non-Executive Director (Interim Chairman from 1 November 2022 to 5 December 2022)
- Mr Stephen Barnes, Non-Executive Director
- Mr Richard Smyth, Non-Executive Director
- Miss Naseem Malik, Non-Executive Director
- Mr Khalil Rehman, Non-Executive Director
- Professor Graham Baldwin, Non-Executive Director
- Mrs Feroza Patel, Associate Non-Executive Director
- Mr Mike Wedgeworth, Associate Non-Executive Director
- Dr Fazal Dad, Associate Non-Executive Director
- Mr Jawad Husain, Executive Medical Director
- Mrs Sharon Gilligan, Chief Operating Officer

- Mrs Michelle Brown, Executive Director of Finance
- Mr Tony McDonald, Executive Director of Integrated Care, Partnerships and Resilience
- Ms Christine Douglas, Chief Nurse (until 31 July 2022)
- Mrs Julie Molyneaux, Interim Chief Nurse (from 1 August 2022 to 19 March 2023)
- Mr Pete Murphy, Chief Nurse (from 20 March 2023)
- Mrs Kate Atkinson, Executive Director of Service Development and Improvement
- Mr Kevin Moynes, Executive Director of HR and OD until 31 December 2023)
- Mrs Kate Quinn, Executive Director of People and Culture (from 1 January 2023)
- Ms Shelley Wright, Joint Executive Director of Communications and Engagement

Declaration

The Corporate Trustee declares that it has approved the Annual Report of ELHT&Me for 2022-23.

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

Michelle Brown
Executive Director of Finance
East Lancashire Hospitals NHS Trust

Reference and Administrative Details

Registered charity name: ELHT&Me

Charities Charity Registration Number: 1050478

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

Trustee: East Lancashire Hospitals NHS Trust

Key Management Personnel: Trust Charitable Funds Committee

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

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

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

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

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

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

Independent Examiner's Report to the Trustees of ELHT&Me

I report on the financial statements of ELHT&Me for the year ended 31 March 2023, which are set out on pages 1 to 10.

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the financial statements. The charity's trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the financial statements under section 145 of the 2011 Act;
- follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- state whether particular matters have come to my attention.

This report, including my statement, has been prepared for and only for the charity's trustees as a body. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body for my examination work, for this report, or for the statements I have made.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the financial statements presented with those records. It also includes consideration of any unusual items or disclosures in the financial statements, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the financial statements present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, which is complete, no matters have come to my attention which give me reasonable cause to believe that in any material respect:

- accounting records were not kept in respect of ELHT&Me in accordance with section 130 of the 2011 Act; or
- the financial statements do not accord with those records; or

- the financial statements do not comply with the applicable requirements concerning the form and content of financial statements set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the financial statements give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which, in my opinion, attention should be drawn in order to enable a proper understanding of the financial statements to be reached.

Nicola Wakefield
Mazars LLP
One St Peters Square
Manchester
M2 3DE

Date:

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Enquiries to Allen Graves
Email allen.graves@elht.nhs.uk

Royal Blackburn Teaching Hospital
Haslingden Road
Blackburn
BB2 3HH

10 January 2024

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

Dear Sir/Madam,

ELHT&Me – independent examination of the financial statements for the year ended 31st March 2023

This representation letter is provided in connection with your Independent Examination of the financial statements of the Fund for the year ended 31st March 2023.

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

Our responsibility for the financial statements and accounting information

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

Our responsibility to provide and disclose relevant information

We have provided you with:

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

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

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

Accounting records

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

Accounting policies

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

Accounting estimates, including those measured at fair value

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

Contingencies

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

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

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

There are no contingent gains which should be disclosed.

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

Laws and regulations

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

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

Fraud and error

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

We have disclosed to you:

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

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

Legacies and other income

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

Related party transactions

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

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

Impairment review

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

Charges on assets

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

Future commitments

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

Subsequent events

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

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

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

Yours faithfully

Name	Stephen Barnes
Position	Chair
Date	10 January 2024

Signed on behalf of the Corporate Trustees for ELHT&Me

TRUST BOARD REPORT **Item** **18**

10 January 2024 **Purpose** Approval / Assurance / Information

Title	Proposal for Revisions to Charity Deed
Report Author	Mrs A Bosnjak-Szekeres, Director of Corporate Governance Miss K Ingham, Corporate Governance Manager

Summary: The Board, acting as the Corporate Trustee for ELHT&Me, received and approved a proposal to establish a trading subsidiary for the ELHT&Me Charity Hub on 13 December 2023. Following a review of the requirements by the Director of Corporate Governance/Chartered Governance Professional for the formation of the trading subsidiary the Trustee are required to address changes to the Charity Deed and the appointment of Directors for the new entity.

Recommendation:

The following recommendations are made for the consideration of the Board, acting as the Corporate Trustee:

- The Charity Deed be revised to address the points above. These changes will need to be approved by the Charity Commission. It is proposed that the Charitable Funds Committee Chair and the Director of Finance review the changes and are agreed via Chairs action before submission to the Charity Commission. The revised deed will be presented to the next Board, meeting at the Corporate Trustee for ratification.
- A senior manager within the Trust, who is not a Board member and therefore not part of the Corporate Trustee of ELHT&Me be designated as a Director of the trading subsidiary. It is suggested that such a senior Director should be a member of a chartered profession.

Report linkages

Related Trust Goal	Deliver safe, high quality care Improve health and tackle inequalities in our community
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	N/A	
Related to recommendations from audit reports	N/A	
Related to Key Delivery Programmes	N/A	
Related to ICB Strategic Objective	N/A	

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Introduction

1. On 13 December 2023 the Trust Board received and approved a proposal to establish a trading subsidiary for the ELHT&Me Charity Hub.
2. The Hub was opened in November 2022 and provides a retail area for patients, visitors and colleagues and currently has a forecast turnover for 2023-24 of £86,590, which is above the maximum turnover threshold of £80,000 permitted for a small charity trading. As such there is a requirement to establish the hub as a trading subsidiary of ELHT&Me.

Requirements

3. In preparation for the formation of the trading subsidiary, the Director of Corporate Governance has undertaken a review of the requirements and identified two matters which must be addressed before the registration can take place, they are as follows:
    a. Section D1 of the current Charity Deed states: in furtherance of the Objects, but not otherwise the Trustee may exercise any of the following powers: to raise funds and invite and receive contributions: **provided that in raising funds the trustee shall not undertake any substantial permanent trading activity** and shall conform to any relevant statutory regulators.
    b. Ensure that the Directors of the trading subsidiary are not all trustees of the charity. Currently Mrs Michelle Brown and Mr Richard Smyth have been proposed as Directors of the subsidiary.

Recommendation

4. The following recommendations are made for the consideration of the Board, acting as the Corporate Trustee:
    a. The Charity Deed be revised to address the points above. These changes will need to be approved by the Charity Commission. It is proposed that the Charitable Funds Committee Chair and the Director of Finance review the changes and are agreed via Chairs action before submission to the Charity Commission. The revised deed will be presented to the next Board, meeting at the Corporate Trustee for ratification.
    b. A senior manager within the Trust, who is not a Board member and therefore not part of the Corporate Trustee of ELHT&Me be designated as a Director of

the trading subsidiary. It is suggested that such a senior Director should be a member of a chartered profession.

TRUST BOARD REPORT **Item** **19**

10 January 2024 **Purpose** Information

Title	Finance and Performance Committee Summary Report
Report Author	Mr M Pugh, Corporate Governance Officer
Executive sponsor	Mrs L Sedgley, 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 30 October, and 27 November 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: **30 October 2023**
Committee Chair: **Stephen Barnes, Non-Executive Director**

ITEMS APPROVED

- Members approved the minutes from the meetings held on 13 and 25 September 2023 as a true and accurate record.

ASSURANCE RECEIVED

1. Finance Reporting

Members were informed that at the end of Month 6, the Trust was showing a deficit of £23.8 million against a year plan of £24.3 million. Members were advised that although the Trust was below plan, it was still £9.6 million away from where it should be. Members were informed that £14.8 million had been identified in Waste Reduction Programmes (WRP) against a plan of £25.3 million. Furthermore, the Trust had a low cash balance of £2.1 million.

Members were updated on risks associated with the capital plan due to a reduction in available funding, noting that assumed income of £2.4 million was no longer available. Members were advised that along with increased costs against the Electronic Patient Record (EPR) implementation, and the works taking place on D Floor for the Emergency Flow Scheme, there was a £2.5 million forecast overcommitment at present. It was confirmed that plans to mitigate this pressure were currently in development.

Members were updated on the forecast financial outturn, noting that the “best-case” outcome would be achieving the £24 million deficit. It was noted that the risk adjusted position would be around £46.5 million, with this including any unidentified WRP, potential pay award, Winter pressures and industrial action. Members were informed that the “worst-case” would be a deficit of £58 million and would be as a result of the red WRP schemes not being achieved.

Members were updated on risks that could prevent the Trust from achieving the financial position, including the pressures within the Emergency Department (ED), ongoing costs of industrial action, increasing sickness absence due to Covid-19, potential future pay awards,

and not meeting the 107% elective recovery target. They noted that work to mitigate the risks would continue in the background.

Members were updated on the Trust's agency spend, be advised that work continued to reduce the level of spend however due to recent industrial action, there had been increased usage of agency staff. An update was provided on the Better Payment Practice Code (BPPC) with members noting that the Trust was meeting 3 out of 4 targets.

Members were updated on the medium-term financial strategy, being advised that the strategy covered the current baseline position, drivers of deficit, grip and control, WRP, and collaboration and transformation. Members were informed that with regards grip and control, the Trust utilised a small number of waivers and each one needed to be approved by the Director of Finance.

Members were updated on the Healthcare Financial Management Association (HFMA) checklists, commenting that there were two self-assessments that the Trust had been asked to complete. It was explained that the Trust had been asked to rate itself on a scale of 1 to 5 against 72 measures, with anything rated between 1 and 3 requiring an action plan for improvement. Members were informed that following an update to the exercise undertaken in November 2022, only one area remained with a score of 3.

2. Improvement Update

Members were informed that the Trust was busier than ever before, with the ED being the busiest in the North West and therefore, patients were spending an unacceptable amount of time in ED. Furthermore, patients in ED had higher acuity and were more complex. Members were informed that a number of patients were being directed to alternate treatment settings including GPs where appropriate.

Members were informed that the Trust was performing the best across the system for the 21 day length of stay target. Members noted that the Trust had 19 patients with Covid-19, and this, along with the ongoing impact from the implementation of the Electronic Patient Record (EPR) system, was resulting in an exhausted workforce with low morale. It was explained that a considerable amount of work was being done to address this, with members of the Executive team working with the department to support them.

Members were advised of the intention to mobilise a winter ward, and that the Trust was now experiencing in excess of 700 patients per day, with the highest number being 850 per day. It was noted that pressures in the department and risks associated with quality, safety and finances were of concern.

3. Integrated Performance Report (IPR)

Mrs Gilligan referred members to the previously distributed document and provided an overview of the grip and control measures that had been implemented to regain Cancer performance and reduce the backlog of patients.

Members were informed that the backlog had reached 321 patients in September 2023 due to losing grip and control and the impact of a number of senior personnel changes within the service. It was explained that to regain control, the area was being micromanaged, including the production of daily reports. Members noted that the most recent data showed 196 patients waiting on the 62-day Cancer waiting list, which was now only slightly away from trajectory.

Members were updated on the Referral to Treatment (RTT) performance, noting that the Centre were aware of issues relating to the EPR implementation which were being worked through. In addition, the ongoing impact of industrial action, and the theatre lifecycle works had affected the RTT figures. As per the national target, the Trust was aiming to have 0 patients who would have waited longer than 65 weeks by the end of March 2024, and would be doing all that it could to achieve this.

Members were informed that, despite the implementation of the Cerner EPR system and having a number of reduced clinics as a result of industrial action, the Trust was still achieving its plan for new Outpatient appointments.

4. Community Services Transfer

Members were updated on the direction of travel for community services, noting that as part of this work, the Trust would likely be transferring services between providers and also taking on the service provision for Albion Mill, including some of its staffing. It was noted that with regards Albion Mill, along with the Trust's Chair, they had met with the Chief Executive of Blackburn with Darwen Borough Council (BWDBC) to discuss the future use of the building and maximising capacity.

Members were informed that discussions with the Integrated Care Board (ICB) had taken place to discuss the risk that would be placed on the Trust. Members were informed that there was a willingness for the transaction to take place and that this would need to happen in 2024/25, however it would be phased over a number of different stages, commencing around April 2024, with Child and Adolescent Mental Health Services (CAMHS) transferring later in the year.

Members were informed that in the first phase, 15 beds would be brought online which would help with discharges and free up capacity within Emergency Care. Members were updated on the work involved with the transfer of physical adult health services from BWDBC and Lancashire and South Cumbria NHS Foundation Trust (LSCFT) to ELHT, with CAMHS then transferring to LSCFT. Members noted that a paper had been provided to the ICB regarding the commissioning intentions for CAMHS across Lancashire and South Cumbria (LSC), proposing a single service provider.

Members were advised that as part of the due diligence process, the Trust was beginning to understand the challenges in the transfer, and once that had been established, would understand the gap and consequences to the Trust.

5. Albion Mill

Members were updated about the proposal to mobilise 15 intermediate care beds at Albion Mill as a proof of concept. Members were advised that the ICB had fully funded the concept for 12 months. Furthermore, the Trust would take responsibility for the clinical and operational running of the site, however the running of the estate would remain with the local council. It was noted that the current proposal didn't involve the TUPE of staff, with minor exceptions associated with the Community Services transfer. Members noted that no contracts held by the Trust would be novated as part of the proposal and that the work would align to the National Intermediate Care framework that had been published over the summer.

Members noted the aim to reduce hospital admission and readmission and improve flow and discharge to support pressures across the UEC pathways. Furthermore, should the proposal be successful, there would be the potential to mobilise the remaining beds, subject to a full business case and Board approval, and create a 35-bed unit.

6. Board Assurance Framework

Due to time constraints within the meeting, this item was not discussed, and members agreed that it would be reviewed via other sub-committees of the Trust Board and would be reviewed again at a future Finance and Performance meeting.

7. Corporate Risk Register

Due to time constraints within the meeting, this item was not discussed, and members agreed that it would be reviewed via other sub-committees of the Trust Board and would be reviewed again at a future Finance and Performance meeting.

8. Corporate Services Benchmarking Report

Due to time constraints within the meeting, this item was deferred to the November Finance and Performance Committee meeting.

9. Lancashire Procurement Cluster – Strategy Update Momentum & Pace

Members were provided with an update on the work being undertaken by the Lancashire Procurement Cluster (LPC). Members were reminded that the LPC were part of the Trust and provided services to the Trust and others across LSC.

Members were advised that the LPC supported the Provider Collaboration Board's intentions for collaborative work and central services. Members were informed that a common digital platform for procurement was being established, with Blackpool Teaching Hospitals NHS Foundation Trust now in possession of a business case so that they could move on to the same platform as ELHT and Lancashire Teaching Hospitals NHS Foundation Trust.

Members were informed about the commitment for Trusts to endorse the expectation to collaborate for all procurement activities. Members were reminded about the new control issues that had been set by the ICB for vacancy and procurement, with any procurement exercise over £200,000 needing to follow the process for collaborative procurement.

Members were updated on the savings achieved by the LPC for ELHT, as well as the work to reduce the rate cards for Band 5 nursing staff.

10. Private Finance Initiative (PFI) Update

Members were informed that the Trust continued to liaise with the PFI partners for remedies at the Royal Blackburn Teaching Hospital and Burnley General Teaching Hospital sites.

11. Committee Self-Assessment

Due to time constraints within the meeting, this item was taken as read and members agreed for the self-assessment to be shared with members of the meeting for completion.

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

No items were raised for escalation the Trust Board or Audit Committee, 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: **27 November 2023**
Committee Chair: **Liz Sedgley, Non-Executive Director**

ITEMS APPROVED

- Members approved the minutes from the meeting held on the 30 October 2023 as a true and accurate record.

ASSURANCE RECEIVED

1. Pathology Network Business Case Proposal

Members were provided with an update on the Pathology Network Business case development, covering a number of points, including the programme plan, site selection, clinical model, scope and scale of the work and the funding/finance options. Members noted that there was a plan in place to develop a combined Outline Business Case and Full Business Case by the end of April 2024, with a funding draw down to be completed by March 2025.

With regards site selection, it was reported that the criteria for the site have been agreed and that a paper was being prepared for the next Pathology Board meeting to make recommendation about the site. Members noted that it was anticipated that a site would be selected by the end of the calendar year. Members discussed the funding options for the development of the site when selected.

2. Finance Reporting

Members were updated on the month 7 position, financial outturn position for the ICB, an overview of the 2% run rate reduction for each Division, the forecast year-end financial outturn position required, actions being taken to achieve the requirements risks to their achievement, and an overview of the current cash position and need for further Public Dividend Capital (PDC) borrowing.

It was reported that following the Board meeting held on Wednesday 8 November 2023, where the Board had approved the submission of a PDC revenue support application for the amount of £7,000,000 for the remainder of the 2023-24 financial year, the Trust's planned financial deficit position had been reviewed and increased to £39,100,000. As such there was a need to submit a further PDC revenue support application for £17,000,000. Members discussed

the proposal and agreed to make a recommendation to the Trust Board, that the application should be submitted, within the required timeframe.

An update was provided on the Trust's capital position, noting that there was currently a £2,535,000 gap in available and required funds. As a result, discussions were ongoing to determine whether the work to the old Trust Headquarters could be phased differently to mitigate this risk.

Members received an update on the national cost collection submission and noted that the deadline for submissions had been delayed until 11 December 2023. Members noted that the submission would be shared with the Committee when available.

Members discussed the data quality and reporting issues that had been seen as a result of the implementation of the Trust's Cerner EPR system.

3. Improvement Update

Members received an update summarising the activity taking place around non-elective pathways and the early improvements that were starting to come through. It was noted that an improvement week event had been held at the start of November 2023 to look at opportunities to reduce the volume of conveyances to acute hospital sites, with confirmation provided that this had been a successful exercise overall.

An update was provided on the separate programmes of work taking place around longer length of stay and reported that there had been a reduction of 18.2% in over 21-day length of stay since the previous meeting. Members were informed that 'digital champions' had been identified in the Trust's clinical flow team to take advantage of the new patient management opportunities provided by the EPR system.

Members were informed that an external 'report out' event had recently taken place around the work being done on frailty across LSC. It was clarified that this was a longer-term programme of work that was intended to promote the prevention of frailty and any associated syndromes. Members noted that a new 'Engineering Better Care' toolkit was being trialled as part of this work, which was intended to facilitate better visualisation of complex systems for managing care across wider scales.

4. Integrated Performance Report (IPR)

Members were informed that the Trust was now back on track for its cancer performance after a deterioration the previous month, noting that work was ongoing to manage 65-week patients, including the recent submission of a revised trajectory. Furthermore, the Trust remained on track to achieving the 76% target for the 4-hour Accident and Emergency target. A summary was provided of the Trust's restoration performance against the 2019-20 baseline, highlighting that performance in the second half of the year was projected to be better on aggregate that it had in the first.

5. Community Services Transfer

Members were advised that the due diligence around the Adult Mental Health Service and ELCAS was now progressing at a pace and that both were due for completion in December 2023. Members were informed about a full day workshop event that had recently taken place, alongside detailed reviews of each workstream, with relevant leads and key corporate colleagues and it was confirmed that Executive colleagues were being kept apprised regarding the progress made and any areas of risk.

Members noted that the due diligence process had flagged up a number of issues with cost and data and that these were being actively worked through. Furthermore, discussions were ongoing around vulnerable services and how they could be supported and kept safe over the coming months and years.

6. Albion Mill

Members were informed that weekly joint Operational and Mobilisation meetings with the Trust's partners were now in place and were being used to drive the Albion Mill proposal forward. It was noted that some key estates related issues had been identified, however assurances were provided that these were on track to be resolved prior to any mobilisation.

7. Corporate Services Benchmarking Report

Members were informed that similar benchmarking exercises were carried out nationally on an annual basis. It was highlighted that the findings showed that the Trust was already very efficient in many areas and was under the national financial spend benchmarking for all of its

corporate services. Members were informed that £1,000,000 of opportunities had been identified across Payroll and Procurement and confirmed that a meeting would be arranged with relevant colleagues to discuss the next steps.

8. Private Finance Initiative (PFI) Update

Members were updated on the progress that had been made regarding the fire safety work taking place at the Burnley General Teaching Hospital site. It was explained that a draft programme had been received from Albany and Equans colleagues regarding commencing the fire programme on the Phase 5 development and indicated that this work would start in January 2024 if it was accepted.

It was confirmed that the inpatient fire programme for the Royal Blackburn Teaching Hospital site for 2023-24 had now been completed, although work in non-inpatient areas would continue through winter.

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

No items were raised for escalation to either the Audit Committee or 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

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TRUST BOARD REPORT **Item** **20**

10 January 2024 **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 1 November.

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: **1 November 2023**
Committee Chair: **Catherine Randall, Non-Executive Director**

ITEMS APPROVED

The minutes of the previous meeting held on 27 September 2023 were approved as a true record of the meeting.

ASSURANCE RECEIVED

1. Patient / Staff Safety

Members received a detailed update on the pressures currently being seen in the Trust's Urgent and Emergency Care Pathways. It was noted that considerable strain was being place on already overstretched teams and that a number of serious incidents had recently occurred in the Emergency Department. The Committee was provided with an overview of the measures and actions taken in response, including the implementation of 'surge beds' across wards and departments, the extension of the Trust's Older People's Rapid Assessment functions into its discharge lounge, reconfiguration of community services and an ongoing test for change with the North West Ambulance Service around earlier interventions for category three and category four patients to try and reduce the number of ambulance conveyances coming into the organisation.

The Committee:

Agreed for a report detailing Key Performance Indicators, risks and actions for urgent and emergency care pathways to be provided by the senior leadership team from the Medicine and Emergency Care division for the next meeting.

2. Cervical Screening Provider Lead Annual Reports

The Committee received a number of reports summarising activity in the Trust's colposcopy service over recent years. It was noted that the service had been impacted significantly by the COVID-19 pandemic, as many of its staff had either had to shield themselves or had taken leave for other reasons and that a significant amount of restorative work had taken place since.

3. Patient Safety Incident Response Plan (New Priorities)

A report was presented to members that provided a detailed overview of the Trust's three new Patient Safety Incident Response Plan priorities. It was confirmed that these would be 'going live' from the 1 December 2023 onwards.

4. Learning from Never Events

Members were informed that, of the five Never Events reported by the Trust since January 2023, three had had investigations completed, with the remaining two still in progress. The Committee noted that a series of actions had already been taken in response and that work was underway to develop a patient safety bulletin to summarise the key learning from all investigations once they were completed.

5. Floor to Board Report for Maternity and Neonatology Services

The Committee received the latest iteration of the Floor to Board for Maternity Services. It was highlighted that a three-year delivery plan had been developed and published by NHS England (NHSE) in March 2023 which was intended to align the findings and recommendations from the Ockenden, Reading the Signals and Kirkup Reports. Members were informed that this plan was focused on four key themes (listening to and working with women and families with compassion, growing, retaining, and supporting our workforce, developing and sustaining a culture of safety, learning, and support and standards and structures that underpin safer, more personalised, and more equitable care) and that these would be used as the basis for the structure of future Floor to Board reports. An update was also provided on the Trust's progress against the ten safety standards for the Clinical Negligence Scheme for Trusts – Maternity Incentive Scheme (CNST-MIS) and it was confirmed that it was on track for all asks associated with this.

6. National Patient Experience Surveys Update

The outcomes of the national 2022 Inpatient Survey, the 2022 Urgent & Emergency Care Survey and the 2023 National Maternity Survey were presented to members. It was confirmed that the Trust had performed relatively well overall, with improvements reported in top 20

scores but advised several challenges had been identified around doctors answering questions more clearly and the challenges being seen in the Emergency Department.

The Committee:

Agreed for an update on the development of the Trust's Patient Experience Strategy to be provided at a future meeting.

7. Corporate Risk Register (CRR)

The latest iteration of the Corporate Risk Register was presented to members. It was confirmed that reviews of risks were taking place on a regular basis and that consistent work was being done to review and close any that were outstanding.

8. Board Assurance Framework (BAF)

The revised BAF was presented to members for approval. It was noted that Executive Directors had reviewed and revised their respective risks, with a recommendation made to increase the score for BAF Risk 3 - Elective Recovery and Emergency Care Pathway from 16 to 20 to reflect the pressures discussed earlier in the meeting.

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

None.

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TRUST BOARD REPORT **Item** **21**

10 January 2024 **Purpose** Information

Title	People and Culture Committee Summary Report
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mrs T Anderson, Committee Chair

Summary: The report sets out the summary of the papers considered, and discussions held at the People and Culture Committee meeting held on the 6 November 2023.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal		Compassionate and inclusive culture Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	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		ID 9746: Inadequate funding model for research, development and innovation
Related to recommendations from audit reports		-
Related to Key Delivery Programmes		People Plan Priorities
Related to ICB Strategic Objective		-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

(21) People and Culture Committee Summary Report

Meeting: **People and Culture Committee**
Date of Meeting: **6 November 2023**
Committee Chair: **Trish Anderson, Non-Executive Director**

ITEMS APPROVED

The minutes of the previous meeting held on 4 September 2023 were approved as a true record of the meeting.

ASSURANCE RECEIVED

1. Staff Story

The Committee received a report from Nancy Berry, a clerical officer working in the Trust, summarising her experiences in the Trust following a diagnosis of dyslexia and dyscalculia in 2012. Mrs Berry advised that the responses she had received from her managers in the Trust had been less than positive and that she still struggled for appropriate adjustments to be made, even after moving between a number of new roles. Members recognised that there was still a substantial amount of work to do in the Trust around reasonable adjustments and that imminent changes to the Access to Work programme, would only make this more challenging. An invitation was extended to Mrs Berry to attend a future meeting to discuss her situation further and whether it had improved.

2. Focus Spot: Health and Wellbeing Update

Members received a presentation that summarised the work taking place in the Trust around staff health and wellbeing. It was explained that the Trust's approach to health and wellbeing was integrated into its People Promise and People Plan and was focused on treating individuals based on their unique differences. Members noted that this approach had resulted in significant improvements in recent staff survey results, particularly in the 'we are safe and healthy' and 'we work flexibly' indicators, but that further support would be needed due to the challenging environment that the Trust was currently operating in. It was highlighted that there were now over 288 Wellbeing and Engagement Champions in place across the Trust and that they would continue to play a key role over the coming years.

3. Leadership Strategy Update

An update on the implementation of the Trust's Leadership Strategy was provided to the Committee. Members noted that good progress had been made against the Leadership

Strategy workplan, following the initial launch the Core Leadership Pathway in March 2023, and that the feedback received from those taking part indicated that colleagues valued the additional Executive input now in place and the focus on leadership styles. The Committee was also informed that a new Core Management Pathway would be launching in the next quarter, which was intended to be a flexible offering to support the 'onboarding' process for new management colleagues.

4. Workforce Update

A Workforce Update was provided to the Committee. Members were informed that recruitment remained a significant focus for the Trust and noted that good progress had been made in reducing the number of outstanding vacancies. It was highlighted that good work was also taking place around staff retention and flexible working, with a new team based rostering system due to be rolled out across wards over the coming months.

5. Corporate Risk Register Report

The Committee received the latest iteration of the Corporate Risk Register. Members noted that a number of new risks had been put forward at the most recent meeting of the Executive Risk Assurance Group for inclusion on the register but that these had not yet been accepted.

6. Board Assurance Framework (BAF)

The revised BAF was presented to members for approval.

7. Medical Appraisal and Revalidation Annual Submission 2022-23

The Medical Appraisal and Revalidation Annual Submission for 2022-23 was presented to the Committee. It was highlighted that the overall appraisal rate for medics had consistently reached the 95% mark over recent years. Members confirmed that they were content to recommend the statement of assurance in the report to the Trust Board for ratification later in the week.

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

Members agreed that concerns raised in the meeting regarding the ongoing consultant job planning process were escalated to the Audit Committee.

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TRUST BOARD REPORT **Item** **22**

10 January 2024 **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 8 November 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: **8 November 2023**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 13 September 2023 were approved as a true record of the meeting.

ITEMS DISCUSSED

At the meeting of the Trust Board on 8 November 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: BwD Community Services Transaction
d) Round Table Discussion: Albion Mill
e) Round Table: Urgent and Emergency Care Pressures Update
f) Financial Strategy 2023-27
g) Never Events Update
h) Fire Remediation Programme Update: Burnley General Teaching Hospital
i) Fire Remediation Programme Update: Royal Blackburn Teaching Hospital
j) Electronic Patient Record Progress Overview
k) Nosocomial Infections Update
l) Responsible Officer's Report to Trust Board Regarding Doctors with Restrictions
m) Industrial Action Update

ITEMS RECEIVED FOR INFORMATION

None.

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TRUST BOARD REPORT		**Item**	**23**
10 January 2024		**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 8 November 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

(23) Remuneration Committee Summary Report

Meeting: **Remuneration Committee**
Date of Meeting: **8 November 2023**
Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 15 September 2023 were approved as a true record of the meeting.

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 8 November 2023, the following matters were discussed in private:

a) Cost of Living Increase for a Very Senior Managers