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)

13 MARCH 2024, 12.30pm

BOARDROOM, FUSION HOUSE / MS TEAMS

AGENDA

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

OPENING MATTERS				
TB/2024/028	**Chairman's Welcome**	Chairman	v	
TB/2024/029	**Apologies** To note apologies.	Chairman	v	
TB/2024/030	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	d	
TB/2024/031	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 10 January 2024.	Chairman	d✓	Approval
TB/2024/032	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2024/033	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2024/034	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2024/035	**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/2024/036	**Patient/Staff Story** To receive and consider the learning from a patient/Staff story.	Chief Nurse	p	Information/ Assurance
TB/2024/037	**Corporate Risk Register and Risk Performance Report (including update for RIDDOR Risk)** 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/2024/038	**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.	Executive Medical Director	d✓	Assurance/ Approval

Agenda

TB/2024/039	**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/2024/040	**Maternity and Neonatal Services Update** *T Thompson to attend for this item.*	Chief Nurse / Divisional Director of Midwifery and Nursing	d✓	Information/ Assurance
TB/2024/041	**New Hospitals Programme Quarter 3 Board Report**	Chief Executive	d✓	Information
ACCOUNTABILITY AND PERFORMANCE				
TB/2024/042	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: a) Introduction (Chief Executive) b) Safe (Executive Medical Director and Chief Nurse) c) Caring (Chief Nurse) d) Effective (Executive Medical Director) e) Responsive (Chief Operating Officer) f) Well-Led (Executive Director of People and Culture and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB2024/043	**2023 National Staff Survey Summary Report**	Deputy Director of People and Culture	d✓	Information/ Assurance
GOVERNANCE				
TB2024/044	**Ratification of Remuneration Committee Terms of Reference**	Corporate Governance Manager	d✓	Approval
TB/2024/045	**Quarter Four 2023-24 – Communications Activity Report**	Executive Director of Communications and Engagement	d✓	Information
TB2024/046	**Trust Charitable Funds Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information

TB/2024/047	**Finance and Performance Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2024/048	**Quality Committee Summary Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2024/049	**People and Culture Committee Summary Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information
TB/2024/050	**Audit Committee Summary Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information
TB/2024/051	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
TB/2024/052	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2024/053	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2024/054	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2024/055	**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/2024/056	**Date and Time of Next Meeting** Wednesday 15 May 2024, 12.30pm, Boardroom, Venue To Be Confirmed	Chairman	v	

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **31**

13 March 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 10 January 2024 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:

(31) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 12.30PM, 10 JANUARY 2024

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	
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	

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement	
Mrs M Hatch	Associate Non-Executive Director	
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience	
Mrs K Quinn	Executive Director of People and Culture	

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary	
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs E Cooke	Joint Deputy Director of Communications	For Miss S Wright
Miss K Ingham	Corporate Governance Manager	
Mr M Maher	Clinical Director of Obstetrics	Item: TB/2024/014
Mr M Pugh	Corporate Governance Officer	
Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council	

Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2024/014
Mr J Walton-Pollard	Deputy Chief Nurse	For Mr P Murphy

APOLOGIES

Mr P Murphy	Chief Nurse
Mr R Smyth	Non-Executive Director
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)

TB/2024/001 CHAIRMAN'S WELCOME

Mr Sarwar welcomed Directors to the meeting.

TB/2024/002 APOLOGIES

Apologies were received as recorded above.

TB/2024/003 DECLARATIONS OF INTEREST

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

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

TB/2024/004 MINUTES OF THE PREVIOUS MEETING

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

RESOLVED: The minutes of the meeting held on 8 November 2023 were approved as a true and accurate record.

TB/2024/005 MATTERS ARISING

There were no matters arising.

TB/2024/005 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/2024/007 CHAIRMAN'S REPORT

Mr Sarwar provided a summary of his activities to Directors since the previous meeting. He highlighted that the 'One LSC' programme around the centralisation of corporate services across Lancashire and South Cumbria (LSC) was being moved forward but advised that there was still a substantial amount of work to do, as well as in relation to the clinical configuration work being led by Mr Hodgson. Mr Sarwar referred to the challenging financial environment that the Trust was currently operating in. He advised that there had been a particular focus at a Provider Collaboration Board level around what would need to be done to move the regional system back to a more balanced financial position over the coming years.

Mr Sarwar went on to provide a summary of highlights at Trust level. He informed Directors that he had recently attended an East Lancashire Child and Adolescent Service (ELCAS) accreditation event by the Royal College of Psychiatrists alongside Mr Hodgson, where the high quality of the service and its leadership had been recognised.

Mr Sarwar referred to the Trust's Annual General Meeting that had taken place in November 2023 and noted that this had been a good opportunity to reflect back on the year and recognise the exceptional work being done by colleagues.

He advised that he had also had the opportunity to meet with some of the Trust's volunteers over the Christmas period and extended his sincere thanks to them, adding that it had been clear from speaking with them how much of their time they dedicated to the organisation.

Mr Sarwar reported that Urgent and Emergency Care (UEC) pathways continued to experience significant pressures. He stated that the efforts of colleagues in managing this significant demand should be recognised. Mr Sarwar noted that the high levels of population sickness across East Lancashire (EL) were compounding these pressures and that the Trust would need to work alongside its partner organisations in order to ensure that patients received the treatments that they needed.

Mr Sarwar concluded his update by referring to the impact from the ongoing conflict in Gaza on the Trust's diverse workforce. He confirmed that the Trust would be making a formal statement on the conflict in the near future and that this would be shared with stakeholders, both directly and also via the Trust website. Mr Sarwar stressed that this statement would make it clear that any form of discrimination would not be tolerated within the organisation, whilst also offering support and help to any colleagues that may be in need of it.

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

TB/2024/008 **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 UK COVID-19 Inquiry and noted that it had now progressed into considering the care sector. He informed Directors that there had been a strong national focus on Urgent and Emergency Care (UEC) pressures and the impact from ongoing industrial action, including the longest period yet, which had run for six days from the 3 January 2024. Mr Hodgson stressed that the Trust would always recognise the right of colleagues to take industrial action but stated that it was undoubtedly affecting the organisation's ability to deliver patient care.

Mr Hodgson highlighted the advances made around COVID-19 vaccines referred to in his report, as well as the recently announced aim to eliminate cervical cancer by 2040. He also highlighted that a new Federated Data Platform was due to be rolled out across the NHS from the following spring which would help to bring together a suite of data relating to capacity, appointments and waiting lists and make it easier to coordinate patient care.

Mr Hodgson informed Directors that several developments had taken place at a LSC system level, with a particularly strong focus on key transformation programmes including the system-wide Clinical Strategy, Central Services Collaboration and People Strategy. He noted that these would play a pivotal role in addressing the financial challenges expected in 2024-25.

Mr Hodgson went on to provide a summary of the developments taking place at Trust level and highlighted that there had been a significant amount of activity over recent weeks. He referred back to the earlier points made by Mr Sarwar regarding the high levels of sickness in the Trust's local communities and confirmed that good progress was being made in health equity and how this would drive a fairer allocation of resources across East Lancashire going forward.

Mr Hodgson provided a summary of recent industrial action and reported that a total of 97 outpatient appointments and 38 inpatient appointments had been cancelled in December 2023. Directors noted that a further 342 outpatient appointments and 36 elective appointments had been stood down to date in January 2024. Mr Hodgson stressed that it was incumbent on

the Board and the Trust to continue to deliver safe, personal and effective care and deliver on its performance targets whilst also ensuring that it lived within its means financially. He added that further investments had been made by the Trust into staffing over winter, as well as a number of other initiatives that had come at a cost, including those that were part of its wider winter plan which had been approved by the Board in December 2023.

Mr Hodgson went on to inform Directors that there been a particular focus on ambulance handover times and confirmed that this was an area that the Trust continued to perform well in. He pointed out that this had clear ramifications on the pressures being seen in the Trust's Emergency Department (ED), as unloading patients to release ambulances to attend to others added to the congestion in the department.

Mr Hodgson stressed that, despite the many challenges facing the Trust, there was a substantial number of positive developments taking place. Directors noted that this included the Trust's ongoing and fruitful collaboration with the Prince's Trust, the Trust's chefs winning NHS Chef of the Year for the second time in three years, and five nurses being awarded the title of Queen's Nurse. Mr Hodgson highlighted that the Trust had recently featured in an episode of the Channel 5 'Cause of Death' documentary.

Mr Hodgson concluded his update by presenting Directors with the latest applications for Safe, Personal and Effective Care (SPEC) 'Silver' status. They were noted to be the Trust's Antenatal ward, Ward 16, Ward C6, Ward C18a, Ward C18b, the Elective Care Centre, the Gynaecology and Breast Centre and the Wilson Hey Theatre. Directors confirmed that they were content for 'Silver' status to be awarded to these areas.

Mrs Randall thanked Mr Hodgson for his update. She referred to the information provided around the five nurses who had received the Queen's Nurse title and enquired if these colleagues had been contacted to celebrate this significant achievement.

Mr Hodgson stated that he was unsure if this had been done but pledged to liaise with the Chief Nurse when he had returned from leave and action this if not.

Professor Baldwin observed that there were a number of references in the report to the Trust's Place-based partners across the North West and enquired if any consideration had been given to the potential impacts which may occur from the move towards further devolution of local authorities.

Mr Hodgson explained that this would hopefully serve as a mechanism to address some of the health inequality issues raised earlier in the meeting and allocate resources more effectively according to the needs of local communities.

Mr Sarwar commented that he felt that there was a clear need for a closer working relationship with local government. He noted that the Better Care Fund would play a key role and that further devolution would offer a number of opportunities over the coming years.

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

Directors approved the awarding of Silver SPEC status to the aforementioned wards/areas.

Mr Hodgson will liaise with Mr Murphy and write to congratulate the five nurses who have been recognised with the title of Queen's Nurse.

TB/2024/009 PATIENT STORY

Mr Walton-Pollard provided a brief introduction to the patient story and reiterated that they were fundamentally around bringing the experiences of patients, carers or relatives to the Board and to positively influence the decisions made by the Trust. He advised that the story which was being presented was a positive one but emphasised the need to maintain a balance between positive and negative experiences in the presentation of stories to the Board.

The patient story can be viewed here.

Mr Sarwar commented that the story presented had been a powerful one and had made clear the importance of the Trust's role in providing not only physical health care but also spiritual support to its patients and their families. He noted that the response taken by the patients loved ones in raising funds for the Trust showed the diversity in its local communities and the desire to give something back.

Mrs Randall stated that she had had the opportunity to witness the good work being undertaken by the team in the Trust's Chaplaincy first hand and emphasised the importance of recognising their contributions in the organisation.

Mr Hodgson agreed with the comments made around the importance of the Chaplaincy and its connections with local faith sectors. He noted that whilst this had always been an area of

strength at the Royal Blackburn Teaching Hospital (RBTH) site, this had not always been the case at Burnley General Teaching Hospital (BGTH) and highlighted that the new Spiritual Care Facilities had recently opened at the latter to address this imbalance.

Mrs Quinn stated that the story clearly highlighted the importance of the additional support given to patients and their families, as well as the value this brought to the Trust's staff.

Mr Sarwar observed that there had been references in the story to the Trust's End of Life Care and Bereavement Service and pointed out the importance of these colleagues' roles in ensuring that patients were able to pass away with dignity in a place of their choosing.

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

TB/2024/010 **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 20 risks on the CRR, two of which (risk ID 9545 - failure to provide surgery due to breakdown of equipment and risk ID 8216 - an electronic patient record system may compromise clinical management systems and processes, impact on patient safety, care and service provision) had been added since the previous meeting. Mr Husain added that one risk (risk ID 5791 - failure to recruit and retain to substantive nursing and midwifery posts) had been removed from the CRR and that proposals had been made to remove a further two due to the risk scores reducing to 12 (risk ID 8839 - failure to achieve performance targets and risk ID 8061 - tolerated risk - management of holding lists). He advised that it had since been decided at the most recent meeting of the Executive Risk Assurance Group (ERAG) to keep the score for risk ID 8061 at 15 due to a range of factors.

Mr Husain went on to highlight that the number of open risks had reduced by 57% from Q4 2021-22 to Q3 2023-24 and confirmed that the profiling and mapping of strategic and operational risks in line with organisational strategies, objectives and targets was now complete, as was the strengthening of the link between the CRR and the Board Assurance Framework (BAF).

Responding to a request for clarification from Mr Rehman as to why the issues relating to the transfer and storage of echo imaging were taking so long to resolve, Mr Husain explained that the matter was ultimately out of the Trust's control and was dependent on wider Integrated

Care Board (ICB) procurement processes. He confirmed that the matter was raised regularly with ICB colleagues in order for a solution to be developed and implemented.

Mr Hodgson stressed the importance for the Trust to ensure that it had strong risk management processes and that it was able to continue to provide assurance around this. He noted that healthcare would always carry an inherent degree of risk, much of which which was now even greater due to the current pressures being seen in UEC areas, and that this had been compounded by the recent implementation of the Electronic Patient Record (EPR) system at the Trust. Mr Hodgson explained that one of the main aims of the ERAG was to sense all of this based on the activity in the Trust and that it was important for the CRR to be reflective of the issues that the organisation was having to manage.

In response to a query from Mrs Bosnjak-Szekeres regarding the action for more information on Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) compliance to be provided at the next meeting in March 2024, Mr Husain confirmed that more discussion would take place around risk ID 7165 (failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)) at the February meeting of the ERAG.

RESOLVED: **Directors received the update and assurance about the work being undertaken in relation to the management of risks.**
Discussion will take place at the ERAG meeting in February with regard to risk ID 7165 (failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) in preparation to update the Board in March 2024.

TB/2024/011 BOARD ASSURANCE FRAMEWORK

Mrs Bosnjak-Szekeres referred Directors to the previously circulated document. She highlighted that all risks were currently red and noted that this was to be expected given the wider challenges currently facing the Trust and the healthcare sector. Mrs Bosnjak-Szekeres explained that as the Trust was now approaching the end of the current financial year, the annual process of reviewing risks and aligning them with strategic objectives would commence by the close of quarter 4.

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

TB/2024/012 **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 highlighted that all harm levels in the Trust remained below the national average but reported that there had been a rise in 'moderate' harm numbers over the past two months. Directors also noted that mortality numbers remained stable and that all duty of candour requests had been completed.

Mr Husain went on to advise that, of the five Never Events declared earlier in the year, two had had investigations completed and reports presented to the Patient Safety Incidents Requiring Investigation (PSIRI) Panel. He confirmed that the range of lessons learned from these incidents had been shared at various forums throughout the Trust.

Mr Husain informed Directors that three new priorities had been identified for the Patient Safety Incident Framework (PSIRF) and that these would form part of all Patient Safety Incident Investigations (PSIIs) when they were fully implemented.

In response to a query from Mrs Hatch as to the references in the report to a system related incidents increase, Mr Husain clarified that this referred to any incidents involving patients who may have been put at a disadvantage due to their experiences prior to them arriving at the Trust.

Mr Sarwar referred to the figures provided in the report around Patient Safety Syllabus Training and noted that the 63.8% total for Level 1b training was some way off the required target of 85%. He requested that this was looked at as a priority and timescales provided for when this was expected to improve. Mr Sarwar also suggested that the variation in Key Performance Indicators (KPIs) in relation to Safety Incident Responses provided in the report was scrutinised further at a future meeting of the Quality Committee.

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

Timelines for improvements to be made to Patient Safety Syllabus Training Level 1b and Level 2 will be provided at a later date.

Further scrutiny on the variation in KPIs for Safety Incident Responses will take place at a future meeting of the Quality Committee.

TB/2024/013 FINANCIAL STRATEGY 2023-27

Mrs Brown referred Directors to the previously circulated document and explained that it was being presented to the Board for ratification. She confirmed that it had been presented at various other forums, including at the Finance and Performance Committee, and was intended to provide a description of the challenges facing the Trust and a clear framework for how it could achieve financial balance/improvements.

Responding to a query from Mrs Bosnjak-Szekeres, Mrs Brown confirmed that the Strategy would likely require annual updates as further asks were placed upon the Trust over the coming years.

Professor Baldwin enquired whether there was a set of key performance indicators that could be provided alongside the Strategy to make it easier for Directors who were not members of the Finance and Performance Committee to monitor performance against it.

Mrs Brown confirmed that it was intended for elements of this Strategy to be built up through the Finance and Performance Committee but agreed that further consideration was needed around how this could be fed back to the wider Board.

Directors confirmed that they were content to approve the Financial Strategy for 2023-27.

RESOLVED: Directors received, noted and approved the Strategy. Consideration will be given to the development and provision of key indicators to Board members to enable easier monitoring of the implementation of the Trust's Financial Strategy for 2023-27.

TB/2024/014 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. She provided a summary of the Trust's current compliance status against the ten CNST safety standards.

Safety Action 1 - Perinatal Mortality Review Tool (PMRT): Miss Thompson confirmed that the Trust had successfully met all compliance requirements for this action and that the latest PMRT quarterly report had been included in the report (appendix two). Directors noted that all required thresholds had been achieved within the CNST reporting period. Miss Thompson

highlighted that the Trust's PMRT review panels had continued to meet and that none needed to be rescheduled as a result of ongoing industrial action.

Safety Action 2 - Maternity Services Data Set (MSDS): Miss Thompson confirmed that all areas relating to the MSDS had been passed.

Safety Action 3 - Transitional Care (TC): Miss Thompson advised that quarterly reports would continue to inform unexpected term admission and associated improvement plans. She also confirmed that work had taken place around pathways of care to ensure that infants were going to the right places at the right times and that all elements had been passed.

Safety Action 4 - Clinical Workforce: Mr Maher confirmed that the Trust was fully compliant with this action and advised that the associated options appraisal and action plan regarding compensatory rest (submitted to the Trust Board in September 2023) had been discussed among the relevant consultant body at a specialty Board meeting in October 2023. He confirmed that a preferred option had subsequently been agreed and that an impact assessment paper to review any potential impacts on Obstetric and Gynaecology activity would be completed and shared with colleagues prior to the go live date for the finalised process.

Mr Maher went on to inform Directors that consultant attendance audits as per Royal College of Obstetricians and Gynaecologists (RCOG) guidance had been completed and that an audit carried out from the 1 September to the 3 December 2023 had found 95% compliance, with 18 of 19 events attends by an obstetric consultant. He added that the outstanding event had been reviewed and had involved a pre-term breech birth, during which the patient had been operated on by a specialist training clinician due to the level of urgency involved.

Mr Maher advised that the latest Neonatal Medical Workforce Review had been submitted and had shown compliance with relevant British Association of Perinatal Medicine (BAPM) standards, as per CNST guidance.

Mr Maher referred Directors to the Neonatal Nursing Workforce Review (appendix 4) at the end of the report and explained that it provided an action plan relating to the findings including planning and safe staffing levels, for the period November 2022-23.

Safety Action 5 - Midwifery Workforce: Miss Thompson confirmed that the Trust was compliant with all requirements for this action. She informed Directors that the most recent bi-annual Midwifery Staffing Report had been included in the report (appendix five).

Safety Action 6 - Saving Babies Lives v3 Care Bundle (SBLv3): Mr Maher confirmed that the Trust was fully compliant against this action. He highlighted that that the 50% implementation target for each element of SBLv3 had already been successfully achieved and

that the 70% implementation target for the whole bundle would likely be achieved in time for an assurance visit from the Local Maternity and Neonatal System (LMNS) the following week. Mr Maher reported that the Trust had a 1.0 Whole Time Equivalent (WTE) dedicated lead midwife and had identified a lead obstetrician for fetal monitoring and the Board were asked to acknowledge this.

Safety Action 7 – Maternity Neonatal Voice Partnership (MNVP) User Feedback: Miss Thompson reported that the three key asks around listening to women, parents and families had been completed and that the Trust was fully compliant with this action.

Safety Action 8 – Training: Miss Thompson confirmed that the Trust was fully compliant against this action, bar one requirement around anaesthetist compliance with Practical Obstetric Multi-Professional Training (PROMPT) training. She advised that senior colleagues had already commenced work to ensure that the 90% target required by the end of February 2024 was met.

Safety Action 9 - Board Assurance: Miss Thompson referred Directors to the Perinatal Quality Surveillance Matrix (PQSM) Minimum Data Set provided on page 13 of her report. She highlighted that there had been a recent increase in term admissions to the Neonatal Intensive Care Unit (NICU) to 6.52% and confirmed that this was being closely monitored through perinatal audits. Miss Thompson also confirmed that both the Board's Executive and Non-Executive Neonatal Board Safety Champions, Mr Murphy and Mr Rehman, had successfully confirmed their registration to the dedicated Future NHS Workspace and referred to the comments that they had provided in the report.

Safety Action 10 - Maternity and Newborn Safety investigation Programme (MNSI) / NHS Resolution: Miss Thompson confirmed that the Trust was fully compliant against this action, with 100% of qualifying cases referred to the Maternity and Newborn Safety Investigations Special Health Authority (MNSI) and to NHS Resolution's (NHSR) Early Notification Scheme. She provided assurances to the Board that all families had received any required information and that there was full compliance with respect to duty of candour. Directors noted that the support evidence could be viewed at any time on the Family Care SharePoint system.

Mrs Randall observed that appendix five indicated that the Trust was around 20 midwives short of its requirements and enquired what plans were in place to address this.

Miss Thompson explained that a number of key posts had been recruited to over recent months and that she and her colleagues were working closely with the Trust's finance team to support the action plan that was in place to address other vacancies.

Responding to a request for clarification from Mrs Bosnjak-Szekeres regarding the declaration from the Trust Board that was due to be submitted by the 1 February 2024, Mr Sarwar confirmed that the Board were content to approve this submission and that it would be formally signed by Mr Hodgson.

In response to a query from Mrs Bosnjak-Szekeres regarding the discussions at the previous meeting regarding the Core Competency Framework Version 2 Local Training Plan, Miss Thompson confirmed that a Local Training Plan was now in place and was being submitted to the Board for agreement as per Safety Action 8 of the CNST.
Responding to a further query from Mrs Bosnjak-Szekeres regarding the business case for additional funding to satisfy Birth Rate+ nursing and midwifery staffing requirements, Miss Thompson clarified that an associated action plan was still being worked on and that meetings to progress this work would continue outside of the Board prior to an update being provided at a later date.

Mrs Sedgley referred to the information provided in the report around Safety Action 7 and listening to patient voices and enquired if there was any learning from this process that could be shared with other areas.
Miss Thompson confirmed that any areas of best practice were already being shared across other services and were being used to help to the shape the Trust's new Patient Experience Strategy.
Mr Walton-Pollard informed Directors that the new Patient Experience Strategy was due to be presented to the Quality Committee in March 2024 and then to the Board in May 2024.

RESOLVED: **Directors received the report and noted its contents.**
The Trust Board declaration will be signed by Mr Hodgson in advance of the submission deadline of 1 February 2023.
An update on the Birth Rate+ action plan and business case will be presented to the Board when available.
The new Patient Experience Strategy will be presented to the Quality Committee in March 2024 and then to the Board in May 2024

TB/2024/015 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 November 2023. He commented that the figures provided for the Trust's 4-Hour A&E Performance was good to see but acknowledged that there were still a significant number of patients who were waiting very long hours in the ED. Mr Hodgson paid credit to the work done by Mrs Gilligan and her colleagues in getting cancer and faster diagnosis performance back on track.

b) Safe

Mr Husain referred Directors to the Safe section of the report. He highlighted that there had been four confirmed cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) reported in the Trust over the year and confirmed that each case was being fully investigated. He also advised that the Trust was rapidly approaching its Clostridium difficile (C. diff) trajectory total of 53 cases for the year and that the Infection, Prevention and Control (IPC) team was working with colleagues in clinical areas to manage this.

Mr Husain reported that COVID-19 infection rates continued to vary from between 10-25 patients at any one time and explained that this was being affected in part by the lack of a national directive on COVID testing. He added that flu numbers had also risen to between 10 and 20. Mr Husain informed Directors that the uptake of COVID-19 and flu vaccines in the Trust had fallen from previous years and stressed that everything possible was being done to improve this.

Mr Walton-Pollard reported that fill rates for nurses were over 95% against establishment rates for day and night hours but advised that there were ongoing issues with support worker shortages due to significant vacancies in that sector. He confirmed that a piece of work was underway to address this and other governance issues that had been identified. Mr Walton-Pollard added it had been recognised that the reporting process around Professional Judgment Reviews was in need of refinement and that the findings from these would be presented to the Board on a six-monthly basis going forward.

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

The findings from Professional Judgement Reviews will be provided to the Quality Committee and Trust Board on a six-monthly basis.

c) Caring

Mr Walton-Pollard referred Directors to the Caring section of the report and highlighted that the results for Friends and Family Test (FFT) in the ED were currently showing 74% against a trajectory of 95% and indicated that this was likely a result of the significant pressures that the department was under. He stressed that this was a national phenomenon and that similar results had been seen at two other peer Trusts in the area when a benchmarking exercise had been carried out.

In response to a query from Professor Baldwin regarding the response rate for the FFT, Mr Walton-Pollard advised that this was currently hovering at around 25%, adding that this was once again in line with the results being seen elsewhere.

Responding to further queries from Mr Sarwar and Mr Hodgson, Mr Walton-Pollard confirmed that good progress had been made in reducing qualified Registered Nurse vacancies and subsequent temporary staffing spend. He acknowledged that more work was still needed around medical temporary staffing spend and that this formed part of the wider work being picked up by the Trust and the LSC system.

Mrs Quinn added that that it had been recognised that there were more opportunities across the system and that work had been launched in conjunction with Medical Directors from across the system to look at mirroring the successful work done around nursing bank and agency spend. She confirmed that a formal proposal on this work would be brought back to a future meeting once it had been developed further.

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

A further update on the work taking place to reduce medical bank and agency spend will be provided at a future meeting.

d) Effective

Mr Husain confirmed that the Trust's Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) performance remained within expected ranges at 1.12 and 110 respectively. He highlighted that crude mortality levels for the Trust remained

below national levels and that the number of deaths in the ED had also continued to fall from previous years.

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

e) Responsive

Mrs Gilligan reiterated that the ED had been extremely busy throughout November and December 2023. She reported that the Trust was ahead of its trajectories against the 4-hour A&E Performance standard but agreed with the earlier points made by Mr Hodgson that patients were still waiting for too long in the ED. Mrs Gilligan advised that work was ongoing in the Trust to see if anything else could be done to find additional space for patients and with system partners to reduce the numbers of patients coming into hospital and to quickly and safely discharge them where possible.

Mrs Gilligan went on highlight that the Trust was back on trajectory for resolution of its 62-day cancer backlog, following a dip over recent months. Directors noted that the Trust had exceed the 75% faster diagnosis standard in November 2023 and was likely to do the same in December. Mrs Gilligan reported that there were still no 78-week waiters and that every effort was being made to reduce the number of 65-week waiters to zero by the deadline of March 2024.

Mr Sarwar pointed out that the Trust was expected to continue to provide mutual aid to other organisations in LSC and that this inevitably had consequences on its performance.

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

f) Well-led

Mrs Quinn reported that sickness absence levels were currently tracking between 6% and 7%, with mental health and musculoskeletal issues remaining the top two reasons. She informed Directors that consideration was being given to introducing a new North West Absence Policy and that the practical consequences from this for the Trust would be fed back through the People and Culture Committee.

Mrs Quinn highlighted that bank and agency spend had continued to reduce and that the Trust was currently the only organisation in LSC that was meeting the agency cap. She reported that appraisal compliance in the Trust continued to fall short of where it needed to be and confirmed that work was ongoing in Divisions to address this. Mrs Quinn added that the Trust would also be reintroducing pay progression linked to this from the start of the next financial year onwards to promote further increases in compliance. Directors noted that mandatory training compliance levels were also not meeting the required levels in some areas and that this was being looked into further.

Mrs Brown informed Directors that the Trust's financial position remained at significant risk, with the forecast outturn of a deficit position of £39,100,000 likely to have been affected by ongoing industrial action and the implementation of the EPR system. She confirmed that work was ongoing with divisional colleagues and other teams to eradicate all unnecessary expenditure and that the Board would be kept apprised of the progress made in this area.

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

Any decision to introduce a new North West Absence Policy will be discussed at the People and Culture Committee, as well as any practical consequences of its implementation.

TB/2023/016 FREEDOM TO SPEAK UP REPORT

Mrs Quinn referred members to the previously circulated report and requested that it be taken as read. She reported that the service continued to be well utilised and that 21 new Freedom to Speak Up (FTSU) ambassadors had been recruited during October 2023. Mrs Quinn explained that specific training would be provided to them to enable colleagues to raise concerns with them. She went on to advise that all audit actions from the previous year had been completed, including those relating to mandatory FTSU training levels, and that further work would be done around the level three training that was intended for Boards.

Mr Sarwar commented that it was heartening to see the additional champions now in place across the Trust. He emphasised the need to maintain a culture that promoted FTSU on a day-to-day basis and not just as a response to external events.

Mr Rehman commended the quality of the report but suggested that more data around diversity of those using the FTSU service could be included in future iterations.
Mrs Quinn clarified that there was no national requirement to break data down in this manner but confirmed that the Trust's Staff Guardian, Jane Butcher, was in the process of collating this information.

Mrs Sedgley stated that, as someone who was still relatively new to the organisation, she would appreciate a further discussion around culture in the Trust's teams and whether colleagues felt that they had a voice and felt empowered to clinically challenge if they felt it was needed.
Mrs Quinn responded that although there was some information that could be taken from staff surveys around this query, it was not something that was actively measured. She stated that she would discuss the matter further with Mrs Anderson after the meeting to see how this could be triangulated further through the People and Culture Committee.

RESOLVED: **Directors received the report and noted its content.**
Future FTSU reports to include diversity information.
Discussions on how to better triangulate, via the People and Culture Committee, how empowered staff feel to clinically challenge colleagues will take place between Mrs Anderson and Mrs Quinn.

TB/2024/017 ELHT&ME ANNUAL REPORT AND ACCOUNTS 2022-23

The Board met as the Corporate Trustee for this item.

Mrs Brown informed Directors that the ELHT&Me Annual Report and Accounts were being presented to the Board for approval in advance of submission to the Charity Commission. She confirmed that both had been presented and recommended to the Board, acting as the Corporate Trustee, by the Trust Charitable Funds Committee at its most recent meeting. Mrs Brown highlighted that income for the year ending March 2023 had amounted to £839,000, some of which included income from the ELHT&Me Charity Hub and retail outlet.
Directors, acting as the Corporate Trustee for ELHT&Me approved the Annual Report and Accounts for ELHT&Me.

RESOLVED: **Directors, acting as the Corporate Trustee confirmed that they were content to approve the ELHT&Me Annual Report and Accounts for 2022-23 for submission to the Charity Commission.**

TB/2024/018 PROPOSAL FOR REVISIONS TO CHARITY DEED

The Board met as the Corporate Trustee for this item.

Mrs Bosnjak-Szekeres explained that authority was being requested from the Board to establish a new trading subsidiary for the ELHT&Me Charity Hub. She confirmed that revisions would possibly need to be made to the Charity Deed to ensure that a company could be legally established, and that additional Directors would need to be appointed to it. Mrs Bosnjak-Szekeres added that a recommendation was being made for the Trust's Deputy Director of Finance, Charlotte Henson, to be appointed as a company Director in addition to the appointments of Mr Smyth and Mrs Brown that the Board had agreed in December 2023.

Directors confirmed that they were content for the revisions set out in the report to be made to the Charity Deed and for them to be reviewed by Mr Smyth and Mrs Brown and agree them via Chairs action before submission to the Charity Commission. Directors also agreed for Ms Henson to be designated as a Director of the Trading Subsidiary.

RESOLVED: Directors received the report and noted its content.

Directors, acting as the Corporate Trustee, agreed for Mrs Bosnjak-Szekeres to arrange for the Charity Deed to be revised as required, per the recommendations set out above, and for Ms Henson to be designated as a Director of the new Trading Subsidiary.

TB/2024/019 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/2024/020 QUALITY COMMITTEE SUMMARY REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2024/021 PEOPLE AND CULTURE COMMITTEE SUMMARY REPORT

The report was presented to the Board for information.

TB/2024/022 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/2024/023 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2024/024 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2024/025 OPEN FORUM

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

TB/2024/026 BOARD PERFORMANCE AND REFLECTION

Mr Sarwar sought feedback from Directors as to whether they felt the Board had appropriately addressed and fulfilled its objectives in relation to its communities, staff, and stakeholders.

He stated that he felt that the Board had discussed staff, patients and stakeholders in equal measure and that there had been clear recognition of the stress and strains being placed upon staff.

Mr Hodgson stated that he had felt that the meeting had been strong in providing triangulated assurance around outcomes of service, particularly around the PSIRF and mortality and how these were benchmarked against national and regional figures.

RESOLVED: Directors noted the feedback provided.

TB/2024/027 DATE AND TIME OF NEXT MEETING

Mr Sarwar informed Directors that the next Trust Board meeting would be taking place on Wednesday, 13 March 2024 at 12:30.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **33**

13 March 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:

(33) Action Matrix

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
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.	Chief Nurse/ 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/2023/115: Response to NHSE Letter Regarding Internal Review of Processes in Relation to the Lucy Letby Case	An update on the Trust's implementation of Martyn's Law and how this compares with its peer organisations will be provided by the end of March 2024.	Executive Director of Integrated Care, Partnerships and Resilience	July 2024	Update: The Trusty is awaiting formal guidance from NHS England in relation to the application of Martyn's Law within the NHS. Once received a formal written update will be circulated to Board members.
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/ Executive Director of Integrated Care,	March 2024	Update: Additional information regarding RIDDOR performance is contained within the March CRR Report to the Board. A separate report has also been provided to Board members for information.

Item Number	Action	Assigned To	Deadline	Status
		Partnerships and Resilience		A further update will be provided to the Quality Committee in June 2024 prior to being presented to the Trust Board in July 2024.
TB/2024/008: Chief Executive's Report	Mr Hodgson will liaise with Mr Murphy and write to congratulate the five nurses who have been recognised with the title of Queen's Nurse.	Chief Executive / Chief Nurse	March 2024	**Complete:** the letters have been sent and meetings are planned to celebrate with the recipients of the award.
TB/2024/009: Patient Story	Consideration will be given to in person patient or staff stories at future meetings of the Trust Board.	Chief Nurse/ Executive Director of People and Culture	May 2024	Update: work is progressing on this, and it is anticipated that the first in-person patient/staff story at the Board in May 2024. It is envisaged that there will be a mixture of in-person and video patient and staff stories in the future.
TB/2024/012: Patient Safety Incident Response Assurance Report	Timelines for improvements to be made to Patient Safety Syllabus Training Level 1b and Level 2 will be provided at a later date.	Executive Medical Director	March 2024	Update: The Trust is continuing to increase completion rates with an aim of having 95% compliance by the end of March 2024.

Item Number	Action	Assigned To	Deadline	Status
				The requirement for staff to complete the mandatory patient safety training levels 1a, 1b and 2 was raised on this week's Senior Leaders Forum and on the Trust live team brief by the Executive Medical Director. It was requested that all staff check on the learning hub which levels they were required to complete and to complete by the end of March. It was also requested at the Senior Leaders Forum that managers pick this up as part of staff appraisals. It has been agreed with the communications team that a message is sent out weekly in the Trust Bulletin (through March) reminding staff to check and complete the training, and providing weekly figures to comms so these can be included within the bulletin.

Item Number	Action	Assigned To	Deadline	Status
	Further scrutiny on the variation in KPIs for Safety Incident Responses will take place at a future meeting of the Quality Committee.	Executive Medical Director	March 2024	This item will be discussed at the Quality Committee taking place in March 2024.
TB/2024/013: Financial Strategy 2023-27	Consideration will be given to the development and provision of key indicators to Board members to enable easier monitoring of the implementation of the Trust's Financial Strategy for 2023-27.	Executive Director of Finance	May 2024	Update: the work is ongoing and will; be presented to the Finance and Performance Committee in April 2024 and the Board in May 2024
TB/2024/015: Integrated Performance Report – Safe	The findings from Professional Judgement Reviews will be provided to the Quality Committee and Trust Board on a six-monthly basis.	Chief Nurse	Q1/2 2024-25	Update: this item will be first presented to the Quality Committee in Q1 of 2024-25 and then to the Board.
TB/2024/015: Integrated Performance Report – Caring	A further update on the work taking place to reduce medical bank and agency spend will be provided at a future meeting.	Executive Director of People and Culture/ Executive Director of Finance	March 2024	Update: this will form part of the update to the Board under the Integrated Performance Report.

Item Number	Action	Assigned To	Deadline	Status
TB/2024/016: Freedom to Speak Up Report	Discussions on how to better triangulate, via the People and Culture Committee, how empowered staff feel to clinically challenge colleagues will take place between Mrs Anderson and Mrs Quinn.	Executive Director of People and Culture	March 2024	Update: Mr Ireland has a meeting arranged with Mrs Anderson to discuss this and its presentation to the People and Culture Committee from May 2024 onwards.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT		**Item**	**35**
13 March 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

The Inquiry held the first preliminary hearing for its investigation into Procurement across the UK (Module 5) on Tuesday 6 February.

Evidence was not presented at this hearing, although submissions were made from the Counsel to the Inquiry and Core Participants to help prepare for the public hearings, where evidence will be heard.

This fifth investigation will consider and make recommendations on the procurement and distribution across the UK of key healthcare related equipment and supplies, including PPE, ventilators and oxygen. It will also consider the UK-wide procurement of lateral flow tests and PCR tests.

The Inquiry is also actively involving children and young people in its proceedings by collaborating with independent research specialists, Verian (previously Kantar Public), to conduct a targeted research project. This project aims to gather firsthand experiences from young individuals, especially those most affected by the pandemic.

The insights collected will contribute as legal evidence to the inquiry, influencing questioning and the Chair's recommendations. The Inquiry has taken precautions to ensure the well-being of participants, incorporating safeguarding measures and emotional support in its approach.

Inquiry Chair, Baroness Hallett, has made clear that the Inquiry will investigate the impacts of the pandemic on children and young people and this is set out in the Inquiry's terms of reference.

Further strike disruption amid ongoing winter demand

The NHS faced further strike disruption in February amid continued high demand for services. Strike action by junior doctors ran from 7am on Saturday (24 February) to midnight on Wednesday (28 February) with impact felt in most routine care as urgent and emergency services were prioritised.

At the end of this action, hospital doctors have taken 44 days or 1,056 hours of industrial action, equating to around 12% of the year.

NHS to roll out 'Martha's Rule'

The NHS will implement 'Martha's Rule' in hospitals across England from April, allowing patients and families to request an urgent review if their condition worsens. This patient safety initiative, named after 13-year-old Martha Mills who died from sepsis in 2021, will provide round-the-clock access to an independent critical care team for concerned individuals.

Available at least in 100 NHS sites, the 24/7 escalation process aims to address deteriorating conditions promptly. NHS Chief Amanda Pritchard believes it has the potential to save lives and has thanked Martha's family for their advocacy. The programme follows extensive campaigning by Martha's parents and builds on NHS England's Worry and Concern pilots launched in seven Trusts in last year, which developed and tested escalation methods for patients' and families' concerns.

ELHT will be adopting Martha's Rule through an initiative called Call for Concern. It will give patients, families, carers and colleagues round-the-clock access to an urgent review from an independent team if they are worried about a person's condition. Once embedded on hospital wards, it will be rolled out to include community patients.

Baby loss certificate launched to recognise parents' grief

Parents who have experienced the devastation of losing a baby before 24 weeks of pregnancy can now apply for a certificate to have their grief recognised.

The government launched a voluntary scheme in February to allow parents to record and receive a certificate to provide recognition of their loss. Initially, registration can be made for losses within the last 5.5 years, it is hoped this will increase to 90 years in the future.

Edenfield Centre Independent review

In November 2022, NHS England North West commissioned an Independent Review led by Professor Oliver Shanley OBE into the failings within Greater Manchester Mental Health NHS FT services, particularly at the Edenfield Centre.

The review aimed to understand the issues, make recommendations to prevent recurrence, and provide clarity and reassurance to patients, families, staff, and the public regarding ongoing service safety. The review focused on patient failings at the Edenfield Centre as reported by BBC Panorama and examined other secure services, addressing concerns such as ward-to-board escalation, oversight of patient safety, and staff culture.

The final independent review highlights areas of improvement and contains 11 recommendations for the Trust to consider, and concluded that a 'significant cultural shift' was required the scale of which 'should not be underestimated'.

Fifth anniversary of nursing associates

The Nursing and Midwifery Council (NMC) is commemorating the fifth anniversary of the initial cohort of nursing associates joining its register, with 5,500 nursing associates currently in the NHS.

Nursing associates, serving in various capacities, play a crucial role in patient care, acting as a bridge between healthcare assistants and registered nurses. This role allows registered nurses to focus on more complex assessments and care planning.

Additionally, the nursing associate position serves as a career pathway for healthcare support workers, offering a potential route into graduate-level nursing. Over the past five years, thousands of healthcare support workers from NHS Trusts have enrolled on training nursing associate programmes.

This move shows committed to ensuring bereaved parents feel supported through their grief and recognise their loss, acknowledging their pain and make sure they feel heard. The certificates will not be compulsory - it remains the choice of all parents to manage the difficult time of a loss, however they see fit.

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 10 January 2024. A recording of the meeting is available to watch online here: LSC ICB: 10 January Board Meeting.

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

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 2*.

One LSC update

The One LSC programme to bring central services together across the Lancashire and South Cumbria Integrated Care System continues to make progress.

This aim is to consolidate a number of common teams across the five provider Trusts in 2024-25 and the areas in scope for the first year are Digital, Estates, Finance, HR, and Procurement. One LSC will be hosted by ELHT.

The benefits expected include fostering shared learning and professional development, increasing service resilience, standardising processes and reducing variation for increased efficiency, and jointly managing vacancies to explore new working methods and minimise potential redundancies.

The Trust has been appointed as the host organisation for One LSC and a leadership team, led by a managing director accountable to all five Trusts, is being formed. Once established, this leadership team, supported by the programme team, will work with colleagues to consider how services can be further developed and improved, creating the ‘One LSC’ way of working across Lancashire and South Cumbria.

Colleagues joining One LSC will transfer under TUPE, on their current terms and conditions and within their current structures. Teams will continue to support Trusts as they do today; however, the relationship will change from that of ‘employer’ to ‘client’.

Acknowledging the challenges associated with change, a formal consultation period will be conducted with affected colleagues, involving collective and individual discussions. The transition's

timescales hinge on factors such as regulatory compliance, information governance, and detailed legal arrangements, with ongoing updates provided to Trust Boards and the PCB Joint Committee.

At the appropriate time a formal consultation period will be undertaken with colleagues affected by change, which will involve colleagues from ELHT, the other Trusts and staff side (trade unions). This will include both collective consultation and opportunities for 1:1 meetings to provide opportunity for open discussion, feedback and points of clarification to be addressed.

There is a commitment to establish One LSC in the next financial year (2024/25), pending key factors outlined in the 'Transition Checklist.' This includes regulatory compliance, information governance, infrastructure readiness, TUPE consultation, and legal/governance arrangements. Trust executive teams are finalising the services joining, and updates on progress are shared with Trust Boards and the PCB Joint Committee.

Law firm Browne Jacobson is working with Corporate Governance Leads/Company Secretaries in advising Trust Boards and on the necessary governance arrangements to establish One LSC. They are attending Board meetings to provide this advice.

Acknowledging the challenges to be faced, moving as quickly as possible will be crucial to delivering potential financial benefits. Despite a great deal of hard work to reduce costs, the Lancashire and South Cumbria health system has one of the largest collective financial deficits in the country, spending significantly more every day than the income received to provide services (for every £100 received, the system spends £110). Being in so much debt impacts on the health system’s ability to plan to provide truly great patient care in future years and all Trusts have been asked to make substantial reductions in spend next year.

Staff side (trade union) colleagues are engaged and continue to ensure correct processes are followed, fully supporting colleagues through the anticipated change.

In collaboration with staff side (trade union) colleagues a dedicated Engagement, Communications and Partnership Group has been created. This group will oversee the accuracy, consistency and timeliness of cascading information about decisions as they are taken as well as organising face-to-face roadshows.

The Provider Collaboration Board Joint Committee has reiterated its commitment to work in partnership with staff side (trade union) colleagues, to resolve a number of issues that have been raised as quickly as possible.

Provider Collaborative colleague briefing

A colleague briefing took place on 5 March 2024, 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 opened by Mike Thomas, Chair of University Hospitals of Morecambe Bay NHS Trust and included updates on collaboration, transforming clinical services, One LSC, and improving mental and physical health provided by Chief Executives from across the system.

New maternity and neonatal independent role

Louise Peacock has been appointed as the new maternity and neonatal independent senior advocate for Lancashire and South Cumbria. The role provides a new way to support women and families in case of adverse outcomes during their care. This includes incidents like baby loss, maternal death, or critical care unit admissions. As advocate, Louise will ensure their voices are heard, provide support at meetings, and assist through investigations and complaints processes.

Initially serving Blackpool Teaching Hospitals and University Hospitals of Morecambe Bay NHS Foundation Trust, the role is independent from NHS Trusts and reports to the Integrated Care Board, co-produced following the Ockenden review.

NHS Pharmacists to treat people for common conditions

Patients in Lancashire and South Cumbria will be able to receive treatment for seven common conditions at their high street pharmacy without needing to see a GP, as part of a major transformation in the way the NHS delivers care.

Over 350 pharmacies – 95 per cent of all pharmacies in the region – will be offering the ground-breaking initiative, with the health service making it easier and more convenient for people to access care.

Highly trained pharmacists will be able to assess and treat patients for sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women (under the age of 65) and if appropriate the pharmacist will be able to provide medication without the need for a GP appointment or prescription.

The major expansion of pharmacy services will give the public more choice in where and how they access care, aiming to free up 10 million GP appointments a year.

4. Local and Trust specific updates

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

Use of the Trust Seal

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

- On 8 February 2024 the seal was applied to the lease between the Trust, Calico Homes and Last Mile Electricity Ltd regarding an electricity substation on the north west side of Briercliffe Road, Burnley. The agreement was signed by Mr Martin Hodgson, Chief Executive and Mrs Michelle Brown, Executive Director of Finance.

Site pressures

Ongoing efforts are being made to provide safe, personal and effective care to patients amid prolonged and challenging pressures in the urgent and emergency care pathways.

Despite the substantial amounts of planning and preparation that took place in the early winter months, the Trust continued to face significant increases in the numbers of people attending the Emergency Department with high acuity.

The Trust has looked at further ways to improve its position and the experience being provided to patients and their loved ones. These have included relocating the ambulatory emergency care unit and urgent treatment centre and utilising the corridor entrance to the acute medical unit to relieve the pressure and create more space.

The Trust recently welcomed three of the four local MPs to the Emergency Department at Royal Blackburn Teaching Hospital, to see firsthand the scale of the continuing pressures on the urgent and emergency care pathways.

The MPs appreciated and understood the challenges and the operating context the Trust is facing and individually offered their support. A list is being compiled of areas which could benefit from additional help.

The focus remains on improving patient flow through the hospitals, and to utilise community services through the Intermediate Care Allocation Team. The team provides access to services aimed at helping individuals maintain their independence, preventing lengthy hospital stays, and avoiding unnecessary admissions to hospital.

In addition, The Emergency Department has reported a rise in attendances of individuals with urgent mental health challenges who unfortunately go on to experience long waits for mental health inpatient beds. While the department provides a place of safety, the environment can be distressing for those in crisis. The Trust is working with mental health providers and support services to ensure patients receive appropriate mental health treatment in the right environment as quickly as possible. In April, NHS111 will be introducing a mental health option on calling (press 2 if this is in relation to a mental health issue) providing immediate advice and guidance for those in need.

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 between 7am on Saturday 24 February until 11:59pm on Wednesday 28 February.

Working closely with colleagues and union representatives, patient safety was maintained at all times, and safe staffing levels were upheld, with some routine and non-urgent appointments and procedures rescheduled in order to do so. The vast majority of activity continued and those patients affected were contacted in advance.

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.

Financial plan 2023/24 and 2024/25

Martin Hodgson, the Trust's Chief Executive, recently participated in a system meeting led by Julian Kelly, Chief Financial Officer for NHS England. The meeting was attended by colleagues from the Integrated Care System, including Chief Executives from provider Trusts, focusing on the on the operational plans for the financial years 2023/24 and 2024/25.

The key metrics under scrutiny are the extent of the variance in income and expenditure and workforce whole-time equivalent reduction. Our 2024/25 plan incorporates necessary reductions aligned with the Trust's resilience needs, with notable progress in reducing reliance on agency spending and a dedicated effort to cut non-pay expenses. Weekly meetings with divisions and a non-pay control group have proven successful.

A subsequent meeting with Julian Kelly in March has been scheduled to finalise the 2023/24 plans and prepare for the upcoming financial year, 2024/25.

Becoming an anti-racist organisation

The Trust is committed to becoming an intentionally anti-racist organisation, making it a strategic priority for 2024/25. This commitment is outlined in the Trust's anti-racism statement and accompanying charter pledges for our patients, colleagues, visitors, and partner organisations.

The Aarushi Project, developed in collaboration with the Care Quality Academy, is an ongoing improvement plan within the Trust. It aims to help the organisation fulfil its anti-racism commitment by building upon existing workforce belonging and health equity initiatives. The project ensures accountability and assessment of the Trust's progress toward becoming an actively anti-racist organisation.

EPR update

Nine months on from the Electronic Patient Record (EPR) go-live, work continues to optimise the system and continue to improve the user experience through further training, support and improving processes.

Outpatients is a specific area of focus and colleagues are being supported to use the EPR system in the most effective way. Regular meetings are being held between clinicians and senior leaders to understand the challenges experienced with the system since going live. To address these, a new guidebook has been created to advise clinicians on best practice with a library of new Standard Operating Procedures (SOPs) to support them.

The Trust has also invested in a new and improved Outpatients solution which will make the process of recording procedures and outcomes much simpler. It is expected to be launched in April 2024.

One-to-one coaching sessions provided by Oracle Cerner have been progressing since October 2023 and feedback is extremely positive. It has been reported that clinical colleagues have shared their knowledge within their teams, encouraged others to sign up and have improved efficiency in clinics as a direct result.

Changes continue to be made to the system in response to colleague's feedback, ensuring it works in the most effective and efficient way possible and to increase confidence in using it. Weekly meetings involving clinical, operational and data and digital colleagues ensure thorough evaluation and safe implementation of changes. At present, there are over 150 change requests in progress, highlighting the commitment to continuous improvement and responsiveness to user feedback and evolving needs.

Measles update

The Trust continues to prepare as the number of measles cases in England continue to rise. The latest figures from the UKHSA show a further 60 laboratory-confirmed measles cases, bringing the total number since 1 October 2023 to 581. The majority of cases were in children under the age of 10.

In the 4 weeks since 22 January 2024, there have been 169 laboratory confirmed measles cases. The West Midlands accounted for the majority of these (47%, 79 of 169). The North West has seen a slight rise to 14% (23 of 169). There have been no laboratory-confirmed case in the Lancashire and South Cumbria area.

Parents, carers and young adults in England are being contacted by the NHS to book missed measles, mumps and rubella (MMR) vaccines as part of a major new campaign to protect those at risk from becoming seriously unwell.

Mandatory FFP3 mask fitting and use have been promoted for patient-facing colleagues. This is an essential part of the preparation for caring for patients with potentially contagious respiratory diseases.

NHS Staff Survey

Just under 4,400 people from a total workforce of almost 10,000 eligible people completed the survey last autumn, which is one of the largest of its kind in the world and provides a key performance indicator of staff experience and engagement in the NHS as a whole.

The data from the feedback provided annually helps Trusts across England compare with similar organisations and, where that is perceived to be better, learn from them, as well as tracking where things are improving or declining over years to enable improvement plans to be put in place.

The complete results of the survey for ELHT include an incredible amount of data from 118 questions. The full report will be available to review on the Trust's website.

As a general overview, compared to recent years ELHT scored significantly better in five questions, similar on about 80 questions and worse on 12 questions.

Within the results there are questions which relate directly to the NHS People Promise which features nine areas of commitment to colleagues and they are a compassionate and inclusive culture, reward and recognition, employee voice, being safe and healthy, learning, working flexibly, being a team, staff engagement and morale.

ELHT scored above average for seven out of these nine themes when compared with similar Trusts and below average on just two – being a team and staff engagement.

Star Awards

The highlight of the Trust's colleague recognition calendar is the STAR Awards, which will take place on 11 July 2024. Nominations for the eleven awards will open in March using a communications campaign building on the record nominations received the previous year. Judging will take place during May with finalists announced in June.

Last year a special face to face event where certificates and trophies were officially presented received positive feedback from attendees. This will be held again at a date to be confirmed in August.

Award for commitment to patient safety

Burnley General Teaching Hospital (BGTH) has been named as a Quality Data Provider after successfully completing a national programme of local data audits run by the National Joint Registry (NJR).

The NJR monitors the performance and effectiveness of different types of joint replacement surgery – such as hip, knee, ankle, elbow and shoulder operations – in a bid to improve clinical outcomes for patients and standards of care across hospital Trusts.

It launched the 'NJR Quality Data Provider' certificate scheme to encourage best practice and offer hospitals a blueprint for reaching high quality standards relating to patient safety. To achieve the award, colleagues at BGTH had to achieve six ambitious targets during the NJR's mandatory national audit period for 2022-23, including compliance with the NJR's mandatory national audit aimed at assessing data completeness and quality within the registry.

The audit ensures that the NJR is collecting and reporting upon the most complete, accurate data possible across all hospitals performing joint replacement operations.

Ribble Valley Business Awards nomination for ELHT&Me

ELHT&Me has been nominated for the second year running in the Not for Profit category of the Ribble Valley Business Awards, 2024. The winner of this award will be a not for profit business or social enterprise that has implemented and used innovative practices and approaches to meet community and public service objectives in the last year.

Our hospital charity was the winner of the category in 2023's awards and the fundraising team is grateful to be nominated again this year. It's a brilliant time to reflect on the incredible impact our charity has across the Trust, making a difference to colleagues, patients and families across East Lancashire.

Couple marry in hospital after cancer diagnosis

Sarah and Andrew Wilson, residents of Nelson, recently married at the Royal Blackburn Teaching Hospital due to Andrew's diagnosis of metastatic tonsillar cancer.

Despite the challenging circumstances, the team on ward C5, along with support from the Trust's charity ELHT&ME and local businesses, transformed the day room into a beautiful wedding setting. Grateful for the compassionate care received during their hospital journey, the newlyweds expressed thanks for the support provided by the ward.

End of life comfort boxes

Comfort boxes are being introduced as part of the Trust's ongoing commitment to make the care of those dying at the hospital as comfortable as possible. This thoughtful addition complements the existing end-of-life boxes offered by the Bereavement Team.

Sister/Charge Nurse Ridha Iqbal designed the comfort box for the ward she works on and is now fundraising to roll out the boxes across the Trust. The boxes contain a variety of items, including essential toiletries, notebooks, pens, Holy water for both Muslims and Christians, poems for families and a bag for loved one's belongings to be placed into.

Ridha is raising fund through the Trust's charity, ELHT&Me, which will go to the End of Life/ Bereavement Team and the Spiritual Team to further enhance the readily available boxes. The proposed additions include wooden crosses, rosemary beads, Quran cubes, handprint kits and a care kit for family members staying with their loved ones.

Prayer boxes launched

The Muslim Employee Network Group of ELHT has worked with the Trust's charity, ELHT&Me, to introduce prayer boxes. Salah, or prayer, holds profound significance in the Islamic faith, serving as a cornerstone of spiritual connection and Muslims observe this sacred ritual five times a day.

These thoughtfully crafted prayer boxes play a vital role in ensuring that crucial prayer times are never overlooked, offering a source of solace and convenience for our Muslim colleagues, patients and those in need.

All items in the prayer boxes, which are wipeable with no grooves, are in line with ELHT infection control policies and includes a single-use head scarf. The prayer boxes have been distributed to wards and departments to enable colleagues and patients to be able to offer their prayers in dedicated quiet rooms within the comfort of their wards, especially for those who cannot go to the Spiritual Care Centre, due to work pressures or ill health.

National Apprenticeship Week

To mark National Apprenticeship Week, the Trust launched its first ever Apprentice of the Year competition, providing a chance to recognise the exceptional apprentices and trainees who work at ELHT.

Apprentices work across the Trust in all roles and at all levels, with colleagues learning on the job in clinical areas, corporate colleagues completing professional qualifications such as the Chartered Institute of Personnel Development (CIPD) and senior leaders studying Masters-level management apprenticeships.

Webinars and roadshows took place during the awareness week covering topics such as customer service, CIPD and business administration.

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:

- LGBT+ history month
- Discover Islam month
- Cervical cancer prevention week

ENDS

Emma Cooke
Joint Deputy Director of Communications
26 January 2024

Appendix 2

Provider Collaboration Board – September 2023

The Provider Collaborative Board (PCB) met on 15 February 2024. 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 a number of key programmes of work as agreed with Trust Boards. Updates on the Central Services Portfolio, the Elective Recovery Programme Board, the Pathology Network Board, PCB Reset and Refresh and Communications and Engagement were discussed under Joint Committee working items.

System pressures – elective recovery and cancer

Although all Trusts remain exceptionally pressured, progress continues in reducing the number of patients waiting over 78 weeks for treatment. Based on performance to date, there is a risk that the revised trajectory submitted in November for 65-week waits would not be achieved.

The total waiting list size has stabilised however there has still been over a 12% growth in the waiting list since April 2023. The number of 52-week waits are now starting to reduce. All targets had been impacted by ongoing Industrial Action.

There had been significant MP interest in some Trusts, partly due to concerns raised by constituents, particularly in relation to urgent and emergency care. There is a desire to help, so there is an opportunity across Lancashire and South Cumbria (LSC) to enlist support on some agreed priorities.

System pressures – mental health and learning disabilities

Lancashire and South Cumbria NHS Foundation Trust (LSCFT) were congratulated for having been rated as ‘Good’ overall following their most recent Care Quality Commission (CQC) Inspection. LSCFT acknowledged there was more to do and that they would be acting upon all feedback received within their report. They agreed to share examples of good practice with professional leads. Going forward, CQC reports would be considered as part of the governance within the PCB.

Good progress was being made with neuro development as part of the Improvement and Assurance Group meetings (IAG). Autism continued to be the longest waits within the ICB. Good discussions had taken place with East Lancashire Hospitals NHS Trust (ELHT) on the transition of East Lancashire Child and Adolescent Services (ECLAS) to LCSFT and on the transition of physical health from LSCFT to ELHT.

Central Services Portfolio Group Update

Over the last 20 months, Trusts have agreed via the PCB Joint Committee to progress with plans to centralise a number of Central (Corporate) Services to create One LSC (One Lancashire and South Cumbria) under a single leadership structure. A partnership approach would be adopted in line with both the Government's shared service strategy (published in 2021) and the national NHS intention. LSC are one of the more advanced systems in developing this thinking. This work is an important aspect of system recovery and as such also comes under review by the Recovery and Transformation Board.

External legal advice and risk management advice has been shared with boards, which will support the development of a robust One LSC Board Assurance Framework (BAF). Trust boards had raised a number of important questions about the programme and a Board FAQ is being developed to ensure that these are properly addressed. Consideration is being given to ways of factoring in more involvement from Non-Executive Director colleagues as part of a reset of the PCB governance.

Next steps for the Central Services programme include; progressing the due diligence checklist and refinement of scope and budgets with Trust teams; finalisation of the financial transition and management plan including budgetary transfer and benefit sharing; detailed information to be sent to Boards around governance and next steps, supported by the external legal advisers, with the intention of providing Boards with appropriate assurance around the signature of the Strategic Collaboration Agreements (SCA) which will enable One LSC to be jointly governed for and on behalf of all Trusts.

Interviews for the One LSC Managing Director and the Directors of Procurement, Digital and Estates and Facilities are scheduled for 1 and 18 March. The recruitment process for the Directors of Human Resources (HR) and Finance will begin soon.

The PCB Joint Committee is committed to working in partnership with our Staff Side (Trade Union) colleagues and are working to resolve a number of concerns that they have raised collectively.

All colleagues are agreed on the importance of clear communications and the need for regular, targeted, two-way engagement opportunities and this was covered in detail as part of a specific agenda item.

Elective Recovery Programme Board Update

The priority transformation programmes within LSC Elective Recovery Programme are those that either require or benefit from a system and collaborative approach. This ensures both a co-ordinated and standardised approach to delivering priorities and that LSC is able to realise the benefits of working as one.

Agreement has now been secured from all Chief Information Officers (CIOs) and Chief Operating Officers (COOs) to have a single Patient Tracking List to better coordinate and manage waiting lists across all four acute Trusts. A preferred solution has been found and the teams and are working with the national Improving Elective Care Co-ordination for Patients team to take the project forward. This development is not only critical to the elective recovery programme – for example being able to use our Surgical Hubs for full system use – but to support other priority transformation programmes across LSC, specifically the fragile services and service reconfiguration programmes.

The shared strategic intentions for LSC are to use our Surgical Hubs as system assets, to optimise their utilisation by embedding GIRFT's principles of extended sessions and six-day working and use the opportunity expanding our surgical hubs presents to repatriate high value, low cost activity from the independent sector. The programme is on track to have the system-wide business case for extended sessions complete by the end of Q4.

Finance update

The PCB forecast outturn deficit for month ten is in line with the outturn deficit submission of 22 November 2023 with all Trusts on track to deliver figures within their agreed forecast deficits. PCB risks have been identified through the IAG meetings.

NHS England (NHSE) had expressed concerns about the level of the overall system exit run-rate projected at 31 March and discussions were on-going about this. It would be important to demonstrate to NHSE that the PCB has a clear three-year plan to address the deficit in a sustainable way. Individual Trusts would be seeking external validation of their plans to provide some additional assurance. Clinical transformation would be key to the delivery of the financial plan, and the commissioning of Urgent and Emergency Care would be particularly important given all the associated workforce costs within this workstream. Difficult decisions and trade-offs may be needed across the system to ensure that outcomes for patients improve despite the financial challenges.

There was an opportunity for Trusts to reduce the interest on their borrowing costs should they receive an appropriate share of additional deficit funding that may be available for those Trusts who had declared a planned deficit at the beginning of the year.

From an ICB perspective, it was important that Trusts maintained a consistent approach to new pressures and to recurrent savings. It was not completely clear how the deficit funding would be applied, and this would be picked up with NHSE.

Pathology Network Board Update

In April 2023, the four acute Trusts in Lancashire and South Cumbria agreed to delegate certain strategic matters in relation to Pathology Services to the PCBJC. A team from Changeology have been working closely with clinicians and senior staff within the Pathology Service to find a preferred way forward for the development of a centralised pathology hub. NHSE have stipulated that the STP wave 3 capital funding of £31.2m must be drawn down and spent by the end of March 2024 and that they require the submission of a combined full business case and outline business case. As the timetable for producing a credible and future proofed plan for the development of the pathology hub is so tight, Trusts are being asked to amend the terms of their delegations to the PCB to include final approval of the capital business case for Pathology.

Following an extensive engagement exercise, the Pathology Network Board approved progressing the tender process for replacing pathology equipment across LSC with a single primary supplier. The process will be led by the Lancashire Procurement Cluster using a competitive dialogue to go to market and maximise value for money and clinical benefits.

LIMS Update

The deployment of the Magentus LIMS solution is currently underway at Blackpool Teaching Hospital (BTH). The delivery timeline continues to be a challenge and a revised ‘go live’ date of the end of August 2024 has been agreed to address the outstanding issues identified during the pre and first phases of user acceptance testing.

The PCBJC noted the governance arrangements that had been put in place for both the LIMS accelerated project at BTH and the overall Network LIMS project.

PCB Reset and Refresh

Provider Chief Executives had had a number of discussions regarding future plans for the PCB and agreed that whilst there had been some good progress there were a number of opportunities to do things differently.

Successes to date included mutual aid and cross-provider working; improved provider performance and stable/improved SOF/CQC ratings; progress within Pathology, One LSC, Clinical Collaboration, Elective Recovery and Stroke; formally establishing the PCB Joint Committee; and good attendance and engagement at the PCB Colleague Briefings.

Their consensus is that there are four broad areas with the potential for further development: Governance; the Operating Model; our future vision, strategic ambition and long-term delivery plan; and our relationship and working arrangements with the ICS.

There are some clear themes emerging around direction of travel, governance, communications and resources which need focused attention and it was agreed that there would be a PCB session (or a series of sessions) with Chairs and Chief Executives, to help shape solutions to the four areas of improvement identified.

Communications and Engagement

Directors of Communications meet fortnightly (planning and strategy), and the Heads of Communications meet weekly (operational). Although not in scope to join One LSC in 2024/25, teams are doing some excellent work together, not least developing and managing the LSC-wide winter campaign, aligning policies and sharing best practice.

Trust Directors of Communication are working with the ICB Director of Communications to develop a system narrative which focuses on clinical transformation and describes our vision for the future. The ICB are leading on the engagement programme to support individual clinical programmes such as vascular and head and neck with input from Provider teams where appropriate.

The agreed Central Services communications plan has largely been delivered but needs to be continually updated in line with the overarching and evolving timeline for the programme. As part of this Communications, HR/OD and Staff Side (Trade Union) colleagues will develop plain English materials and organise engagement sessions to cascade information to wider audiences through the One LSC Engagement, Communications and Partnership Group. It is recognised that the development of a brand and identity for One LSC is important and this will continue to be discussed by the Directors of Communication as well as the One LSC Engagement, Communications and Partnership Group. Terms of Reference for this group have been agreed but work has been paused whilst Staff Side (Trade Union) concerns are considered.

During January 2024, Boards, Executives and Staff Side (Trade Union) colleagues have received briefings following CSESC and the PCB Joint Committee, ensuring timely and consistent dissemination of information. A monthly forum for senior Central Services leaders has been

established and a Central Services core brief and FAQs have been created with input from the programme team, HR Directors and Directors of Communication for leaders to use as a basis for engagement with their teams.

Materials are also available via the Engagement Hub. This is a single repository for core information, providing a 'one stop shop' for people wanting to know more about transformation across the whole system, not just Central Services and can be accessed by colleagues across the system.

All CEOs are committed to personally leading on engagement within their Trusts and contributing to the wider system engagement about the programme and Directors of Communications and the Programme Team are committed to providing the tools and support to help them do so.

The next Provider Collaborative Colleague Briefing will be a good opportunity to bring colleagues up to speed and answer questions on Central Services and other key transformation projects and this will take place on Tuesday 5 March from 12.30pm - 1.30pm via Microsoft Teams.

Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	10 January 2024
Title of paper	Chief executive's board report
Presented by	Kevin Lavery, chief executive officer, Integrated Care Board
Author	Kirsty Hollis, Associate Director and Business Support to the Chief Executive
Agenda item	5
Confidential	No

Executive summary

This report is a reflection of our achievements over the past twelve months, a position statement of where we are now and a look to the future and the opportunities that are available to drive system recovery and transformation.

The proactive approach to secure support for our system through recovery and transformation will help direct our short to longer term.

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	*Highlight any risks and where they are included in the report*
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	2 January 2024	Approved

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 officer

Integrated Care Board – 10 January 2024

Chief Executive's board report

1. Introduction

1.1 As I write this report, it is early December, and I am reflecting on something Oprah Winfrey said, "December is a time to reflect on the blessings of the past year and to embrace the opportunities of the coming one".

1.2 When we are in the midst of really challenging times, it is often difficult to look up and appreciate all the excellent work that is going on around us, that despite the pressure and complexity we live with on a daily basis, both in our work and personal lives, our colleagues from all sectors of our system continue to strive to give of their absolute best day in, day out.

1.3 And whilst the future might feel like a scary place and we might hesitate to peep around that corner, our system is on the precipice of massive opportunities to change the way we deliver services, to be innovative, to empower our workforce and most importantly, improve the health outcomes of or population.

1.4 This report is a reflection of our achievements over the past twelve months, a position statement of where we are now and a look to the future and the opportunities that are there for the taking.

2. Reflection - Staff Awards

2.1 This year, we launched our staff awards. Based on our PROUD values which are; People; Respectful; Open; Uniting; Delivering. We received over 175 nominations across the nine award categories. The awards were for individuals and teams and not only recognised the work that they do, but also the additional contribution that individuals make to our ICB community. We also celebrated partnership working and how working across organisational boundaries can deliver true quality services to our patients.

2.2 I, together with members of this Board including non-executive directors had the pleasure of attending the awards ceremony at which we announced our runners-up and winners. It was truly humbling to sit and listen to the citations for the winners and applaud their achievements. Words such as commitment, outstanding, pride, passion, creativity and innovation ran as themes throughout and it was incredibly uplifting to be able to celebrate with all the shortlisted nominees.

2.3 It is not appropriate to single out individuals, but I would like to formally put on record our congratulations and thanks to all those who were either nominated,

who took the time to make a nomination and to those who had the incredibly difficult job of judging. Thank you.

3. The here and now

3.1 The Board understands we face a major financial challenge for 2023/2024 and the Integrated Care Board (ICB) had initially agreed a system deficit plan of £80m. Subsequent to the plan, the ICS has faced significant unplanned pressures: individual packages of care volume and pricing, prescribing pricing and industrial action. Throughout the year, we have been in discussion with NHS England regarding the implications that this might have for the year-end financial position.

3.2 During November, the ICB was advised of additional non-recurrent funding allocated to it as part of the nationally identified £800m and that there had been a 2% relaxation of the elective activity target requirements. Whilst welcome, the impact of this additional funding had already been anticipated and factored into the assessment of our year end forecast position.

3.3 The financial challenge for both the current and future years remains significant, and officers will continue to liaise with NHS England.

4. Our Opportunities

4.1 Looking forward and the changing demographic of our population, the Health Foundation predicts that the nature of predominant illnesses / disease areas are likely to be diabetes, mental health conditions and management of long-term conditions. Our aging population with increased acuity in care needs could see the demand for our hospital bed base increase by some 60%. This is both impractical and unaffordable. To respond to this will require a seismic shift in the way we configure the health and care services we commission. There is no other alternative but to turn the dial and move to a more community centric system.

4.2 We have well defined and worked up plans for the building and infrastructure components of the New Hospitals Programme. Work is underway to develop new models of clinical care with a tertiary centre and a hub and spoke model for our hospitals. We need to do more to develop our community and primary care services. All three programmes are inextricably linked and need to be moving in tandem as without one, the other two might stumble. As a result, the ICB executive have launched a programme to transform care in the community.

4.3 In a bid to achieve our system financial position this year, we need to ensure that the short-term actions we take drive us towards the achievement of our longer-term plans and do not unwittingly set us off on a different path. Whatever actions we can bring forward and gain early benefit from, we should. The system needs to challenge itself to move further faster and to think innovatively about how we speed up delivery.

5. National Visits

5.1 We have continued to welcome colleagues from Department of Health and Social Care, NHS England and other Integrated Care Boards who are all keen to understand the challenges we face in Lancashire and South Cumbria and to learn from our experiences.

5.2 At the beginning of October, we welcomed Adam Doyle, Steve Russell and Matthew Style. Their visit started in Blackpool with a roundtable discussion involving staff working in services across health and care. Continuing healthcare, learning disabilities team, rapid response team, integration with mental health services and adult social care were all represented and contributed to the discussion. The three senior NHS England leaders then attended County Hall to have a facilitated discussion with system leaders about what help, and support is needed and what barriers could be removed in order to make improvements.

5.3 On the same day, NHS England's medical director, Professor Stephen Powis, visited Blackpool, accompanied by the ICB's associate medical director, Andy Curran. Professor Powis was taken to a local dentist and then on to a health centre to look at the innovative approaches being taken in Blackpool to tackle the challenges our population face, especially within the priority wards.

5.4 In November, NHS England's chair Richard Meddings and Sir David Behan visited Lancashire Teaching Hospitals NHS Foundation Trust and then spent time with us in County Hall to delve into a little bit more detail on our current position and how we are working with providers, primary care and local government to address the issues. They were then treated to a visit to the University of Central Lancashire to meet with the vice chancellor and other senior leaders to talk about how we inspire the health and social care workforce of the future including the use of cutting-edge teaching methods and technologies.

5.5 Later in November, Professor Bola Owolabi joined some of our voluntary, community, faith and social enterprise sector organisations in Blackburn with Darwen and East Lancashire, to see how the national Core20Plus5 strategy is being implemented in a bid to reduce health inequalities. Prof. Owolabi was invited to chair a meeting of a group of local parents to discuss their interest in influencing changes to local services. She was particularly interested to hear their reasons for joining the parent/carer panels and to understand what they hoped to achieve. She also witnessed the work of North Blackburn PCN who are striving to increase flu vaccination uptake for two- and three-year-olds in the area by delivering their service from the local family hub. Uptake in the area is currently reported as the lowest in Lancashire and it was pleasing to see a steady stream of adults and children receiving their vaccinations during the course of Prof. Owolabi's visit.

6. Staff Issues

6.1 In recent months, I have been delighted to have been contacted directly by members of ICB staff who have come forward with ideas on where we might look to make further efficiencies and improve the services we commission on behalf of our population. We want to encourage more of this and through our Programme Management team, we are developing a process for taking ideas that are generated through a “hopper” to allow those that show merit to be seen through to the conclusion of benefits realisation.

6.2 In early December, Dr Andy Knox gave a presentation to the whole staff briefing on the work tackling health inequity and prevention in Lancashire and South Cumbria. This was the first in a series of sessions which Dr Knox will deliver to our staff to help shift the thinking as we plan, commission and deliver services. It certainly created a buzz in County Hall and has inspired many to look at things through a different lens in the future.

6.3 I have recently welcomed Kirsty Hollis into the role of Associate Director and Business Partner to the Chief Executive. This is a portfolio change for Kirsty and she will now be working closely with me to support the day-to-day management of the ICB. Kirsty will focus on preparation for key meetings and supporting our executive team, leading on cross-cutting projects and supporting organisational development.

Kevin Lavery

27 December 2023

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

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

13 March 2024 **Purpose** Approval
Assurance
Information

Title	Corporate Risk Register Report (including update for RIDDOR Risk)
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) The corporate risk register has nineteen risks. One risk has been removed and two risks are to be integrated. A total of fifteen risks have no movement or change in risk scores and four risks have predicted risk scores of less than fifteen. No new risks have been approved onto the corporate risk register.
   b) The strategic and operational risks have been profiled and mapped in line with organisational strategy and objectives, with links strengthened to the board assurance framework.
   c) System enhancements to the risk management module of DATIX are being made to improve governance, risk management controls and assurances.

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. It is a health and safety legislative requirement and key line of enquiry of inspection used by regulatory bodies such as the Health and Safety Executive and Care Quality Commission when monitoring healthcare service provision
3. The benefits of good risk management are that it minimises loss, enhances decision making, improves organisational resilience, supports statute legislation and regulatory compliance, supports license to operate requirements, facilitates strategic and operational planning, improves organisational efficiency and drives innovation. This in turn reduces financial, legal and insurance costs, enhances stakeholder confidence and improves credibility, reputation and commercial viability.

Corporate Risk Register (CRR) Performance Activity

4. A summary of key points to note.
   a) The corporate risk register has nineteen risks. One risk has been removed and two risks are to be integrated. A total of fifteen risks have no movement or change in risk scores and four risks have predicted risk scores of less than fifteen. No new risks have been approved onto the corporate risk register.
   b) A breakdown of risks by risk type shows fourteen (74%) are clinical risks, two (11%) are financial risks, two (11%) are health and safety risks and one (6%) relates to a data and digital risk.

c) A more detailed summary and breakdown is included within the appendices.

Risk Management Performance Activity

5. 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 691 in Q4 2023-24 to date, a decrease of 60%.

b) Risks identified as being significant or moderate are down from 1,368 risks in Q4 2021-22 to 223 in Q4 2023-24 to date, a decrease of 84%.

c) Risks remaining open over 3 years old are down from 1,035 risks in Q4 2021-22 to 415 in Q4 2023-24 to date, a 60% decrease.

d) Overdue risks are down from 230 in Q4 2021-22 to 117 in Q4 2023-24 to date, a 49% decrease.

e) Less than 3% of tolerated risks have surpassed their review date.

f) Clinical risks (66%) remain the highest risk type category followed by health and safety risks (15%).

g) A breakdown of clinical risks shows the highest risk sub types relate to patient safety (31%) followed by medical devices (15%).

h) A breakdown of health and safety risks shows the highest risk sub types relate to manual handling (33%) followed by radiation risks (24%).

i) Highest numbers of divisional open risks on the risk register are held within diagnostic and clinical services (31%) followed by surgical and anaesthetic services (23%).

j) Highest numbers of directorate risks are held within radiology (14%), pathology (8%) and estates and facilities (8%).

Mitigations for risks and timelines

6. A summary of recent mitigations for risks and timelines to note.

a) Work to avoid duplication, improve standardisation and the quality and quantity of risks held on the risk register remains ongoing.

b) The risk management framework, process of escalation and use of the consequence scoring criteria to assess and score risks continues to be reaffirmed.

c) The strategic and operational risks have been profiled, mapped in line with organisational strategy and objectives, and links strengthened to organisational risk types and the board assurance framework.

d) An evaluation of risks held within PWE Healthcare and their integration onto the risk register has been completed.

e) A review of risk profiles to improve quality and quantity of risks has been completed with estates and facilities, manual handling and security management lead specialisms.

f) A targeted review and challenge of all live and tolerated risks, whereby the current risk score has met its target score and continues to be well managed, with the aim of reducing risks scores and or their closure has been completed.

g) As part of an organisation wide review of assurance structures, work has commenced regarding the use of standardised terms of reference for committees and groups to include the overview and management of risks within their areas of responsibility and control.

h) Supporting the data and digital service to improve the quality and quantity of information governance and e-PR risks remains ongoing.

i) Supporting services in addressing the three hundred and eighty seven foreseeable risks requiring review in the next three months remains ongoing.

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

7. Effective leaders and managers know the risks its organisation faces, prioritises them in order of importance and takes action to eliminate or reduce them to their lowest level practicable. A strong, effective governance and risk management framework that seeks to obtain quality assurance of the robustness of its internal management systems and controls, in particular, the identification and classification of strategic and operational risks, how they are managed, by whom, and where and their link to the board assurance framework, remains crucial to the success of any safety management system and will help prevent the risk register from being inappropriately used.

Resource implications and how they will be met

8. 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

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

Conclusion of Report

10. 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

11. 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

12. A summary of key focused activity.

    a) There has been a steady rise in risks held across divisions scoring fifteen or above not on the corporate risk register. A number of controls have been implemented to address concerns and drive improvements but this remains challenging. These include the continued reaffirmation of the risk management framework and process of escalation; improved scrutiny of risk scores, controls and assurances and their validity against catastrophic, severe/major and moderate consequence criteria; more detailed assurance within divisional reporting at the risk assurance meeting; the specific inclusion of key performance indicators and monitoring as part of the

quality strategy performance metrics; increased scrutiny by the executive risk assurance group and addressing challenges of risk handlers or leads being unable to present risks due to conflicting clinical priorities and urgent work activity. An evaluation of divisional quality and safety meetings and their effectiveness in reviewing and scrutinising risks scoring fifteen or above is to take place before the end of the financial year to further help mitigate those controls.

b) The development and roll out of a new proforma for risks held on the corporate risk register for use within reports that strengthen links to the board assurance framework and improve the quality and management of risks, in particular, the actions required to mitigate the risk has been completed, however, the introduction of e-PR, impact of industrial action, increasing organisational work pressures, movement of key staff and the withdrawal from RADAR, the total quality management system, has limited its full implementation. There is an expectation of their use at the beginning of the new financial year and of exploring system improvements to the DATIX risk management module that will help assist with progression.

c) DATIX is currently undergoing a number of system improvements to strengthen governance, risk management controls and assurances. These will include the assimilation of new risk approval statuses, new risk type and risk sub type categories, inclusion of committees and groups, linking of risks to the board assurance framework and better use of actions required to mitigate risks section, with further enhancements planned.

d) A number of measures have been put in place to improve risk management competencies of managers and staff, however, work to address risk management and assessment training, and its inclusion as part of the competency framework of managers, remains very challenging. The submission of a formal training evaluation report outlining the health and safety competency and training needs, including risk management and assessment, training plans, resources and roll out required for delivery and of monitoring attendance and compliance, is to take place within the financial year. The coaching of managers and staff with responsibility for managing risks along with the issue of guidance is helping provide a short term solution.

e) The transfer of risks to lead specialisms and subject matter experts remains on course to take place before the end of this financial year. All have been duly consulted.

f) 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.

g) A focused evaluation of risk profiles within radiology and pathology services and of risks associated with delayed transfers, missed diagnosis and sub-optimal care is to take place before the end of the financial year.

h) It is expected the review and implementation of recommendations following an audit of risk management controls by Mersey Internal Audit Agency (MIAA) will help attain substantial assurance or higher before the next evaluation.

i) Strengthening the risk management strategy and framework, including roles and responsibilities of individuals, committees and groups and its link to the health and safety strategy and framework remains on course for completion before the end of this financial year.

How the decision will be communicated internally and externally

13. 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

14. 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.

15. 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

RIDDOR Performance Update

Detailed CRR

Mr J Houlihan, Assistant Director of Health, Safety and Risk, 23 February 2024

CORPORATE RISK REGISTER SUMMARY										
No	ID	Where the risk is managed	Title	Likelihood Score	Consequence Score	Risk Score (current)	Exec Risk Lead	Effectiveness of Controls (Datix)	Risk Movement	Progress
1	9771	Trust Wide	Failure to meet internal & external financial targets for 2023-24	5	5	25	M Brown	Adequate	⇔	No change or movement
2	9570	FC	No capacity for the storage of legacy ECHO images	5	4	20	P Murphy	Inadequate	⇔	Linked to DATIX ID 9367
3	9557	Trust Wide	Patient, staff and reputational harm as a result of the Trust not being registered for mental health provision	5	4	20	P Murphy	Limited	⇔	No change or movement
4	9545	SAS	Failure to provide surgery due to breakdown of equipment	5	4	20	M Brown	Limited	⇔	No change or movement
5	9336	MEC	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery	5	4	20	J Husain	Limited	⇔	No change or movement
6	8126	Corporate	Potential to compromise patient care due to sub optimisation of the electronic patient record system	5	4	20	J Husain	Adequate	⇔	No change or movement
7	9746	Corporate	Inadequate funding model for research, development and innovation	4	4	16	K Quinn	Limited	⇔	No change or movement
8	9705	SAS	Inability to provide a robust hepatobiliary (HPB) on call service	4	4	16	J Husain	Limited	⇔	No change or movement
9	9367	FC	ECHO Images Transfer	4	4	16	P Murphy	Inadequate	⇔	Linked to DATIX ID 9570
10	8941	DCS	Potential delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology	4	4	16	K Quinn	Limited	⇔	No change or movement
11	8033	Trust Wide	Complexity of patients impacting on ability to meet nutritional and hydration needs	4	4	16	P Murphy	Limited	⇔	No change or movement
12	7165	Corporate	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	4	4	16	T McDonald	Limited	⇔	No change or movement
13	6190	Trust Wide	Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales	4	4	16	S Gilligan	Limited	⇔	No change or movement
14	8808	Corporate	Breaches to fire stopping and compartmentalisation in walls and fire door surrounds - BGH	3	5	15	T McDonald	Adequate	⇔	No change or movement
15	8725	CIC	Lack of senior clinical decision making and inconsistent medical cover for CIC services	5	3	15	J Husain	Inadequate	⇔	No change or movement
16	7008	Trust Wide	Failure to comply with 62 day cancer waiting time target	5	3	15	S Gilligan	Limited	⇔	No change or movement
17	4932	Trust Wide	Tolerated Risk - Patients who lack capacity to consent to placements in hospital may be being unlawfully detained	5	3	15	P Murphy	Limited	⇔	No change or movement
18	8839	SAS	Failure to achieve performance targets	4	3	12	S Gilligan	Limited	⇩	Risk score challenged
19	8061	Trust Wide	Management of harm from the holding list	3	4	12	S Gilligan	Limited	⇩	Risk score challenged
	7764	Corporate	Breaches to fire stopping and compartmentalisation in walls and fire door surrounds - RBTH	2	5	10	T McDonald	Adequate	⇩	Risk removed from CRR. 95% of works completed

RIDDOR Performance Update

Strategy: Quality Strategy

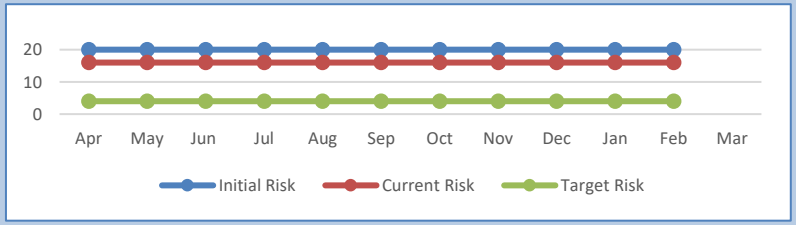
Executive Director Lead: Executive Director of Integrated Care, Partnerships and Resilience

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: 15 February 2024

Assurance Group: Quality Committee

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

Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Zero / Low / Med / High

Zero / Low

Links to BAF:

BAF ID	Title	Impact	Likelihood	Rating (current)	Effectiveness of Controls
2	The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter	5	4	20	Partially Effective

Controls: (What controls, systems and or processes do we already have in place to assist in managing and reducing the likelihood or impact of the risk)

1. Improved data capture and utilisation of incident management module of DATIX.
2. A centralised process is firmly established for the health and safety team to review and submit RIDDOR reportable incidents externally to the HSE.
3. Increased management and staff awareness and understanding of RIDDOR i.e. what is and what is not reportable, consequences and timescales involved, relevant work examples and the issue of guidance.
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

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. 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. Attendance of health and safety team at weekly complex case review meetings to help identify and determine potential RIDDOR reportable incidents to patients.

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.**	5. Work to increase compliance with RIDDOR reporting timescales has improved from 12% in 2021/22 to 47% in 2022/23 and remains constant at 47% in FYTD 2023/24 Specialist support, policy and procedure setting, oversight responsibility: 1. RIDDOR reporting requirements are contained within the scope of incident management policy and procedures. 2. Responsibilities of staff to report any health concerns embedded within scope of organisational health and safety at work policy. 3. Specialist advice, support or guidance readily available from the health and safety team. 4. Collaborative working partnerships established with clinical and non-clinical service specialisms and safety critical roles e.g. matrons, ward managers, patient safety lead investigators, incident and triage team, infection control, occupational health, estates and facilities, human resources, legal services, falls lead, manual handling lead, security management etc. should any significant trends be identified. 5. Days lost off work as a result of absence or injury captured as part of HR return to work process. Independent challenge on levels of assurance, risk and control: 1. RIDDOR performance increasingly attracting the interest of the Health and Safety Executive and Care Quality Commission.

Gaps in controls and assurance: Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level or to improve evidence that the controls are effective
Mitigating actions: Plans to improve controls/assurance
Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance

No.	Gap in controls and / or assurance	Action Required	Lead	Due Date	Progress Update/Impact	BRAG
1	No evidence of assurance certain types of medically diagnosed occupational related disease, infections or ill health are being identified or considered by occupational health as being RIDDOR reportable	Revisit & deliver RIDDOR awareness training to occupational health team Ensure occupational diseases are more explicitly included as part of RIDDOR performance reporting	Assistant Director of Health, Safety & Risk	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 & used to capture & inform	G
2	Limited assurance services are benchmarking or using RIDDOR performance as an important driver in reducing risk	Improve senior management overview, involvement & insight. Include RIDDOR performance as part of Quality & Safety KPI metrics. Improve communication & strengthen collaborative working partnerships. Better utilisation of Divisional Quality & Safety Leads to relay & enact upon important safety critical information.	Assistant Director of Health, Safety & Risk	Q2 2023	Increased senior management awareness of RIDDOR to help drive & reinforce importance of ensuring legislative compliance. RIDDOR performance now included & reviewed as part of Quality & Safety KPI metrics. Collaborative working partnerships strengthened with clinical & non-clinical service specialisms & safety critical roles, matrons, ward managers, patient safety lead investigators, incident & triage team, infection control, occupational health, estates & facilities, HR, legal services, falls lead, manual h&ling lead, security manager should any significant trends be identified.	G

3	Limited assurance managers & 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 & dangerous occurrences due to the increasing volume & complexity of accidents & incidents requiring review & 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 & quantity of accidents & incidents being reported in a timely manner. Review of incident investigation process to utilise lead specialisms & or subject matter experts more effectively when reviewing & investigating incidents within their areas of responsibility & control & of determining external reporting requirements of RIDDOR when undertaking investigations. Review of triage process to avoid multiple reviews of incidents & duplication. Pending review of incident reporting & investigation process the review & utilisation of health & safety team resources.	Assistant Director of Patient Safety & Effectiveness Assistant Director of Health, Safety & Risk	Q3-Q4 2023	Feedback regarding review of incident reporting, incident investigation & triage processes has been completed. Awaiting outcome. The total numbers of health & safety related incidents requiring review & investigation by the health & safety team to determine RIDDOR status continues to heavily dominate work pressures, accounting for c.25-30% of all incidents reported in DATIX which equates to c.550 incidents per month. A current breakdown in 2021/22 = 6,539 incidents, 2022/23 = 6,708 incidents, 2023/24 = 5,385 incidents to date (end Jan-24) The process of determining RIDDOR reportable incidents & ensuring legislative compliance is extremely time consuming & heavily dependent on the health & safety team which is impacting on effective service delivery. Review of health & safety team capacity & resources in progress..	A
4	Investigations to determine RIDDOR reportable incidents are highlighting gaps in quality management systems or processes & of existing policy, procedure & 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 & Safety Committee.	Assistant Director of Health, Safety & Risk	Q3 2023	Development & implementation a new health & safety strategy & framework will support delivery. Action completed. The creation, utilisation & benchmarking performance of workplace health & safety standards will support delivery of the workplan in seeking assurances quality management systems are in place to ensure legislative compliance. Standards to be introduced in Apr-24. Gaps in quality safety management systems have been identified & escalated to the Health & Safety Committee.	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 & their subsequent impact on external regulatory reporting requirements	Impact assessment being reviewed by PSIRF lead	Assistant Director of Patient Safety & Effectiveness	Q4 2024	RIDDOR awareness of patient safety lead investigators, lead specialisms & collaborative working partnerships along with attendance of the health & safety advisor at weekly complex case meetings to review patient safety incidents will help mitigation. Impact assessment of Learning from Patient Safety Events (LfPSE) requirements being monitored.	A
6	The replacement of DATIX with a new total quality management system (RADAR) may lead to loss of organisational memory & delay incident investigations & their subsequent impact on external regulatory reporting requirements	Impact assessment being reviewed by DATIX Manager / Systems Analyst	Assistant Director of Health, Safety & Risk	Q4 2024	The implementation of a new total quality management system (RADAR) has been withdrawn & an impact assessment review is no longer required.	G

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 & or duplication	Staff days lost off work as a result of injury included as part of human resources sickness management & return to work processes but is not captured or linked as part of DATIX incident management module	Assistant Director of Health, Safety & Risk	Q4 2024	The implementation of a new total quality management system (RADAR) has been withdrawn & an impact assessment review is no longer required. Exploring system improvements to the DATIX incident management module will help support delivery.	A
8	Achieve & maintain threshold target of 95% compliance with RIDDOR reporting timescales to reduce risk of legislative backlash..	Review governance arrangements for monitoring RIDDOR performance. Undertake a deep dive of health & safety accidents & incidents, thematic review & RIDDOR performance. Identify & explore challenging factors limiting progress. Despite huge effort, current compliance levels remains at 47% in FYTD 2023/24 & remain below the threshold level of achieving & maintaining 95% compliance.	Health, Safety & Risk Manager	Q4 2024	RIDDOR performance continuously monitored & reviewed as a standing agenda of the Health & Safety Committee, Quality & Safety KPI metrics. Current analysis highlighting an increase in health & safety related accidents & incidents & a 76% increase in RIDDOR reportable incidents when compared to previous FYTD figures, from 25 in Q1-Q3 2022-23 to 44 in Q1-Q3 2023-24 with numbers projected to exceed previous financial year figures. 72% of RIDDOR reportable incidents are staff related, 27% patient related & 1% third party. The top 5 RIDDOR reportable categories relate to falls (40%) followed by manual handling (20%), personal injury (18%), violence & aggression (12%) & sharps (8%). A falls strategy group, safer handling strategy group & staff safety strategy group (violence & aggression) are in place whose aims are to reduce numbers of incidents & levels of harm & of providing assurance of their effectiveness. 44% of RIDDOR reportable incidents have occurred within the MEC division followed by corporate services (17%). A further breakdown by services shows medicines for older people & stroke services have the highest numbers of RIDDOR reportable incidents, accounting for 18% followed by estates & facilities (16%), intermediate care (12%), emergency department (11%) & respiratory (6%) which may reflect current work pressures & activities. Further awareness, training & competence, staff behaviours & safety culture is to be explored. Additional challenging factors limited progress include increasing volumes of accidents & incidents i.e. falls, manual handling, medical devices & equipment, personal injury, sharps, violence & aggression; complexity of accident & incident investigations i.e. patient falls, ineffective use of lead specialisms when investigating incidents within their own areas of responsibility & control, ineffective use of local (handler) led investigations & resultant actions; delays in accident & incident reporting by managers & staff , how this is performance managed & enacted upon; difficulties of services providing information due to clinical priorities & workforce pressures & competing priorities & extremely limited resource within the health & safety team.	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.				
Controls and Assurances in place		Controls 1. Robust financial planning arrangements to ensure financial targets are achievable within the Trust. 2. Accurate financial forecasts. 3. Financial performance reports distributed across the Trust to allow service managers and senior managers to monitor financial performance. 4. Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made within delegated limits. Assurances 1. Frequent, accurate and robust financial reporting and challenge by the way of:- • Trust Board Report • Finance and Performance Committee Finance Report • Audit Committee Reports • Integrated Performance reporting • Divisional and Directorate Finance reports • Budget Statements • Staff in Posts Lists • Financial risks and • External Reporting and Challenge		**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. A high efficiency target than has ever been achieved in the past, to ensure the full Trust is engaged and playing their part in reducing efficiencies and the cost base. 2. The financial regime is managed at a system level rather than at a Trust level. 3. The financial gap is across the system gap not just the Trust. **Gaps / weaknesses in 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	
Update since the last report		**Update 13/02/2024** **Risk reviewed. No change in risk score** The Trust is reporting a deficit of £35.2m for the 2023-24 financial year to date, a movement of £2.9m in the month. The reason for the movement from plan is due to a combination of additional costs incurred from pressures in emergency medicine, industrial action, pay award, shortfall in funding, underachievement of the waste reduction programme and slippage on capital scheme to convert Trust HQ to ward space. .The overcommitment in the 2023-24 capital programme has been mitigated. The cash balance at end Jan-24 was £3m, a reduction of £2.1m compared to the previous month. The waste reduction programme achievement is £25.3m at month 9 which is £19.5m behind plan. It has been necessary to non-recurrently support this position by £9.2m. **Next Review Date 14/03/2024**		**Date last reviewed**	**13/02/2024**	
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
				25	**25**	**25**	**25**
			8-week score projection	**25**			
			Current issues	System wide external influences			

No	ID	Title				
2	9570	No capacity for the storage of legacy ECHO images				
Lead		Risk Lead: Dan Hallen / Victoria Hampson 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 available on ultrasound machines. Once storage reaches capacity ECHO machines will stop functioning and images will be lost. This is crucial in diagnosing lifesaving cardiac abnormalities and pulmonary pathologies.				
Controls and Assurances in place		<u>Controls</u> Existing service contract extended by adult services. Current ultrasound images are stored on scanning machines. <u>Assurances</u> Cerner e-PR has an imaging solution module, cloud storage and PAS patient list connected that can capture, store, access and share imaging data and multimedia across the system to provide a holistic patient view. Current capacity levels being monitored. The RBTH COAU capacity is 117.2 GB, remaining 247.9 MB (99.8% full). The BGH COPD capacity is approx.. 250 GB and BGH NICU approx. 800 GB with further capacity checks required. Meeting held between Chief Nurse, Executive Medical Director, Director of Finance and Divisional Director of Operations for Family Care to understand risk and mitigations required. The Technical Diagnostics Team at the ICB is exploring operating costs, with Bridgehead identified as a solution, along with cardio imagery. Planning parameters and vendor response in place for viability. Approach being considered for Siemens to partition VNA and to assist with the holding of data and or for Sectra to provide a fully functional solution until a permanent solution is found by the ICB.		Gaps and potential actions to further mitigate risk	**Gaps / weaknesses in controls** Additional cost implications for contract extension and software storage solution. Current ultrasound images stored on scanning machines have limited memory. Attempted input of paediatric echo images onto PACS is slowing the entire system down and are too big to be sent via the image exchange portal, with limited storage on Siemens VNA. Staff training in use of the system is required. Limited assurance compliance with the Royal College of Radiologists Standards for the provision of an ultrasound service is regularly reviewed and enacted upon. There is still no solution regards PACS/VNA procurement with the strategy for private and public cloud yet to be ratified. **Gaps / weaknesses in assurances** Cerner imaging module and current set up requires further exploration to determine effectiveness. Limited assurance current capacity level checks are being regularly monitored across BGH. Bridgehead solution dependent on CDC funding being released and approval from the ICB. Siemens solution may not help image sharing with Alder Hey
Update since the last report		**LINK TO DATIX ID 9367** **Update 15/02/2024** Risk reviewed. No change in risk score Both risks relating to ECHO images storage and transfer are to be integrated to form one risk and reflect progress in relation to both clinical management and digital solutions and the work of the ICB that will better support the management of these risks and potential reduction in risk scoring. **Next Review Date 15/03/2024**		Date last reviewed	15/02/2024	
				Risk by quarter 2023-24	Q1	Q2 / Q3 / Q4
						20 / 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 22/01/2024** 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 remains in progress. **Next Review Date 23/02/2024**	**Date last reviewed**	**22/01/2024**		
		Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
			20	**20**	**20**	**20**
		8-week score projection	**20**			
		Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

No	ID	Title				
4	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		**Update 26/01/2024** A task and finish group is in place with procurement and finance to progress replacement of medical devices and managed service option. **Next Review Date 26/02/2024**	**Date last reviewed**	**26/01/2024**		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
						20	**20**
			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.	**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.
Controls and Assurances in place	<u>Controls</u> 1. Robust ambulance handover and triage escalation processes to reduce delays. 2. Operational Pressure Escalation Levels (OPEL) triggers and actions completed for ED and Acute Medical Units (AMU). 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. <u>Assurances</u> 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.		

	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 30/01/2024.** Risk reviewed. No change in risk score. Continue to see increased overcrowding in ED with 30 patients on average on ED corridor, 14 patients in resus and 24 patients on the main hospital corridor. Along with opening the AMUB corridor (DATIX ID 9998) the service continues to see up to 110 to 120 patients for majors, which has capacity for a maximum of 76 patients on trolleys and 5 fit to sit along with a continuation of NWAS handover delays still being experienced. The UTC has now moved into AECU which should improve the pathway and service provision. Mini NAPF's continue to highlight red indicators, with a more formal assessment due anytime. The CQC attended an informal visit to gain an appreciation of the challenges and grip and control in place. The service has had two deaths in ED, one bedroom collapse and 1 on the corridor linked to poor care **Next Review Date 29/02/2024**	**Date last reviewed**	**30/01/2024**
		Risk by quarter 2023-24	**Q1** | **Q2** | **Q3** | **Q4** **20** | **20** | **20** | **20**
		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.

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

Gaps and potential actions to further mitigate risk

Gaps / weaknesses in controls

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. <u>Assurances</u> 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">Update 20/02/2024
The e-PR Programme Board is overviewing the management of this risk. A review of the gaps in controls and assurances and the process of escalation of Cerner related issues to be reviewed.

Next Review Date 15/03/2024</td><td>Date last reviewed</td><td colspan="4">20/02/2024</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>20</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 30/01/2024** Risk reviewed. No change in risk score. Impact of having study coordinators trained to undertake financial functions with them working closely with sponsors is improving the current position. The women's and children's team have been trained and are now working with sponsors to raise invoices. Pharmacy continue to experience limited capacity which impacts on CTiMP trials and the potential to generate income. An appointment to the post of finance officer within R&I has been successful and is awaiting completion of recruitment checks with an anticipated start date in Apr-24 **Next Review Date 29/02/2024**	**Date last reviewed**	**30/01/2024**

Risk by quarter 2023-24	Q1	Q2	Q3	Q4
		16	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 24/01/2024** Risk reviewed. No change in risk score. Locum now covering HPB on call following a period of induction. Substantive consultant on phase return and remains off the weekend/night on call for HPB. One consultant remains on the general surgery on call rota and partakes with HPB at the same time. **Next Review Date 28/02/2024**	**Date last reviewed**	24/01/2024		
		Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
				16	16	16
		8-week score projection	16			
		Current issues	System wide external influences			

No	ID	Title				
9	9367	ECHO images transfer				
Lead		Risk Lead: Dan Hallen / 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** Additional cost implications for contract extension and software storage solution. Current ultrasound images stored on scanning machines have limited memory. Staff training in use of the system is required. Development of VPN not fully embedded as a process. Limited assurance compliance with the Royal College of Radiologists Standards for the provision of an ultrasound service is regularly reviewed and enacted upon. Unwell cardiac children and neonates may not have appropriate investigation to aid diagnosis and management. **Gaps / weaknesses in assurances** Numbers of incidents regarding echo image transfer, delays in diagnosis, discharge without tertiary review of scan and clear management plan and of machine malfunction. Transfer images to desktop and screen sharing through MS Teams ineffective as there is a reliance on the availability and attendance of consultants from Alder Hey Children's Hospital. Solution provided by Siemens may not help image sharing.
Controls and Assurances in place		<u>Controls</u> 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. Development of Virtual Private Network (VPN) tunnel to Alder Hey Children's Hospital currently under trial. <u>Assurances</u> Work underway with software provider for storage of images that does not add to current storage capacity. Transfer of images to desktop and screen sharing through MS Teams meetings.				
Update since the last report		**LINK TO DATIX ID 9570** **Update 15/02/2024** Risk reviewed. No change in risk score Both risks relating to ECHO images storage and transfer are to be integrated to form one risk and reflect progress in relation to both clinical management and digital solutions and the work of the ICB that will better support the management of these risks and potential reduction in risk scoring. **Next Review Date 15/03/2024**	**Date last reviewed**	15/02/2024		
			Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					16	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: Neil Fletcher Exec Lead: Kate Quinn	**Current score**	**16**	**Score Movement**	⟺

Description	The cellular pathology department is not able to meet existing turnaround times (TAT's) required for cancer diagnosis and NHS screening services due to staffing levels and workload causing potential delays to patient diagnosis and treatment of serious illnesses such as cancers.	**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. Reminder issued for risk lead to review and update the risk in a timely manner and to revisit the risk score to reflect additional recruitment and clinical management controls. **Next Review Date 26/01/2024**	**Date last reviewed**	22/12/2023
		Risk by quarter 2023-24	Q1: 16 | Q2: 16 | Q3: 16 | Q4: 16
		8 week score projection	12
		Current issues	External influences regarding mitigation of risk beyond the control of the Trust. National shortage of histopathologists.

o	ID	Title
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 26/01/2024** Risk reviewed. No change in risk score. NST referral pending on Cerner. Nutrition consultant role recruited to and is due to commence employment in Mar-24. IHI nutrition project has commenced. A live MUST report in place to support wards to improve compliance. Cerner change request for MUST to be added to whiteboard and is due for implementation. **Next Review Date 26/02/2024**	**Date last reviewed**	**26/01/2024**

Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	16	16	16	16
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 managers and staff. **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, 6,708 in 2022/23 and 5,385 for this FYTD (Jan-24) with numbers projected to exceed previous year figures. 4. Current trend analysis highlighting a 76% increase in RIDDOR reportable incidents compared to previous financial year to date, from 25 in Q1-Q3 2022/23 to 44 in Q1-Q3 2023/24 5. Current compliance remains way below the threshold level of achieving and maintaining 95% compliance.
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. Attendance of health and safety team at weekly complex case review meetings to help identify and determine potential RIDDOR reportable incidents to patients. 8. RIDDOR performance included as part of Quality and Safety KPI performance metrics for senior management oversight and review. 9. Work to increase compliance with RIDDOR reporting timescales has improved from 12% in 2021/22 to 47% in 2022/23 and remains at 47% in 2023/24 to date.		

<table>
<tr><td rowspan="4">Update since the last report</td><td rowspan="4">Update 15/02/2024
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 15/03/2024</td><td>Date last reviewed</td><td colspan="4">15/02/2024</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>16</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		Current score	16	Score Movement	⟺
	Risk Lead: Robert Sutcliffe Exec Lead: Sharon Gilligan				

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 06/02/2024** 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 05/03/2024**	**Date last reviewed**	**06/02/2024**
		Risk by quarter 2023-24	Q1: **16** | Q2: **16** | Q3: **16** | Q4: **16**
		8 week score projection	**16**
		Current Issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title
14	8808	**BGTH - breaches to fire stopping and compartmentalisation in walls and fire door surrounds**

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

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

Update since the last report	**Update 22/01/2024** Risk reviewed. No change to risk scoring. Remedial work has not sufficiently progressed at this stage. A dedicated fire remediation project team is now overseeing the programme. Improvement works continue to be monitored and reviewed by the Fire Safety Committee **Next Review Date 22/02/2024**	**Date last reviewed**	**22/01/2024**			
		Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
			15	**15**	**15**	**15**
		8 week score projection	**15**			
		Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
15	8725	Lack of Senior Clinical Decision Making and Inconsistent Medical Cover for Community Intermediate Care Services

Lead	Risk Handler: Sharon Stidworthy 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 06/02/2024
Work remains ongoing between CIC and MEC divisions to look at a more sustainable medical model, A new divisional medical director is now in post. No major incidents continue to be reported to date.

Next Review Date 06/03/2024

Date last reviewed	06/02/2024			
Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
		15	15	15
8 week score projection	15			
Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
16	7008	Failure to comply with the 62 day cancer waiting time targets

Lead	Risk Lead: Sara Bates 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 29/01/2024** Risk reviewed. No change in risk scoring. 62 Day backlog trajectory in December 180 - submitted 181. Trajectories now set for remainder of the year and 2024/25 with plans to achieve all cancer standards by April 2025. Enhanced governance process for the management of cancer performance across the trust to be implemented with a phased approach starting Jan 2024, with the introduction of cancer action plan review meetings. Cancer performance meeting and backlog review meetings remain in place weekly. Full review of controls and assurances section as well as review of action plan undertaken. **Next review date 29/02/2024**	**Date last reviewed**	**29/01/2024**		
		Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
			15	**15**	**15**	**16**
		8 week score projection	**12**			
		Current issues	Recovery and restoration pressures, recruitment and retention			

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

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

Description	Patients referred to Lancashire County Council and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DoLS) authorisation are not being assessed by these agencies within the statutory timescales, or at all, which means the DoLS is in effect unauthorised.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Inability of supervisory body to process assessments within set statutory provision. 2. In the absence of assessments the inability of ELHT to extend urgent authorisations beyond required timescales set at 14 days. 3. In the absence of assessments patients will not have a DoLS authorised and will not have had relevant checks undertaken to ensure they are legally detained, leading to patients being detained without authorisation as not doing so would present an even greater risk. 4. Plans to change DoLS to Liberty Protection Safeguards (LPS) remains ongoing, with no date set for their implementation or subsequent publication of new National Approved Codes of Practice. **Gaps / weaknesses in assurances** 1. Continuous increase in numbers of DoLS applications
Controls and Assurances in place	Controls 1. Policy and procedures relating to the Mental Capacity Act (MCA) and DoLS updated to reflect the 2014 Supreme Court judgement ruling. 2. Mandatory training on the MCA and DoLS available to all clinical professionals. 3. Improvement plan introduced for the management of DoLS applications following internal audit to enable timely and accurate recording of applications made and to demonstrate application of MCA in absence of Local Authority (LA) review. 4. Applications being tracked by the Safeguarding Team 5. Changes in patient status relayed back to the Supervisory Body Assurances 1. Quarterly review of risk undertaken by the Internal Safeguarding Board. 2. Policy and procedural arrangements being adhered to by wards along with applications made in a timely manner. 3. Supervisory Body made aware of risk. 4. Legal advice and support readily available. 5. Additional support available for all ward based staff and provided by the MCA Lead and Safeguarding Team. 6. Despite challenges presented by the legal framework it is expected patients will not suffer any adverse consequences or delays in treatment etc. and that the principles of the MCA will still apply.		

Update since the last report	**Update 18/01/2024** 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. Awareness raised with ICB. **Next review date 16/02/2024**	**Date last reviewed**	**18/01/2024**			
		Risk by quarter 2023/24	**Q1**	**Q2**	**Q3**	**Q4**
			15	**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				
18	8839	Failure to achieve performance targets				
Lead		Risk Lead: Michelle Montague 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.				
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.		**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.	
Update since the last report		**Update 12/12/2023** Risk reviewed. Risk score reduced to 12 39,015 are on the active RTT pathway. 18,693 are >18 weeks, 1, 528 are >52 weeks and 356 are >65 weeks. 4 are >78 weeks and 2, 339 are at risk of breaching 65 weeks by end Mar 24. Current milestone of elective recovery is the eradication of patients waiting more than 65 weeks by end Mar 24. Micromanagement of all 65 and 78 week breaches continue to be 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, with recovery plans and trajectories continuously been reviewed. The recovery of activity has been lost due to continued industrial action and implementation of Cerner e-PR with further industrial action anticipated in Q4 2023-24. **Next Review Date 13/02/2024** **New risk lead assigned to review risk and risk score with expectation it will increase back to a score of 15 or above**		**Date last reviewed**	**12/12/2023**	
				Risk by quarter 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**12**	**12**
				8 week score projection	**12**			
				Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
19	8061	Management of Holding List

Lead	Risk Lead: Alison Marsh 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 12/02/2024
Risk reviewed. Risk score reduced to 12.
The holding list has 72,516 patients. 23, 082 are due in the next 3 months, 49,434 are between 0-3 months overdue. 25,401 of the overall total relate to SAS specialities. Those main specialities of concern are ophthalmology (13,635), urology (4,573), max fax (3,039), ENT (3,476), GS (1,880) and dermatology (1,790) and a review of how these can be addressed is in progress. A separate group has been instigated to review the holding list. Current pressures addressing RTT has impacted on volume of holding list patients. The national programme for waiting list validation for follow up patients has been put on hold since May-23, however, the development of the PEP+ validation system could be targeted for follow ups as well as the RTT. ELHT has a working group to assess PEP+ RAG ratings of follow ups required with LCAS and ECAD with dates expected to support identification of risk, however, this will require administrative and clinical input that could potentially incur additional pressures and financial impact.

Next Review Date 12/04/2024
New risk lead assigned to review risk and risk score with expectation it will increase back to a score of 15 or above

Date last reviewed	12/02/2024			
Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	20	20	12	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** **38**

13 March 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 February 2024. In addition, the Finance and Performance Committee, Quality Committee and People and Culture Committee have received the risks relevant to the Committee at their most recent meetings in February and March 2024 and agreed to recommend the BAF risks within their remit to the Board for ratification.

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.

The Trust has recently received the Assurance Framework Briefing Report from Mersey Internal Audit Agency (MIAA), which will be presented to the Audit Committee on 8 April 2024. It contains three recommendations, which relate to the depth of BAF related discussions held at Committee and Board level, risk appetite and risk scoring. These recommendations will be included as part of the annual review of the BAF, which is commencing this month with the Executive Directors reviewing their individual risks and the risk appetites. Following this, the ERAG will undertake a review which will feed into the Board review session which will be held in quarter 1 of 2024-25. This review will also include 1:1 review session with the Committee Chairs.

As part pf the annual review of the BAF the Board will review the alignment of the BAF with the Trust and System strategic objectives.

Recommendation: The Board is asked to discuss and approve the BAF and note the annual review process for the BAF.

Report linkages

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

		Drive sustainability
Related to key risks identified on Board Assurance Framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
	2	The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
	3	A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
	4	The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register (CRR)	Please refer to the BAF report for relevant CRR risks	
Related to recommendations from audit reports	Assurance Framework Key Financial Controls Risk Management Core Controls	
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement People Plan Priorities Waste Reduction Programme	
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.	

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by:

Executive Directors, February 2024

ERAG, 15 February 2024

Finance and Performance Committee, 26 February 2024

Quality Committee, 28 February 2024

People and Culture Committee, 4 March 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 January 2024 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 no updates to the controls or assurances section of the risk.
3. With regard to the actions section of this risk, there have been a number of updates, including changes to the due dates for two of the actions (1 and 9), the details of which are included in the detailed BAF sheet.

Risk 2: (Risk Score 20 (C5 x L4) The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.

4. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
5. There has been one new addition to the controls section of the risk, which are detailed in the BAF sheet.
6. With regard to the actions section of the risk, there have been minor updates added to the progress section for actions 3, 4, and 5. In addition, a new action (9) has been added relating to the Trust's Electronic Patient Record and associated issues with data submission on activity, mortality and coding to national teams.

Risk 3: (Risk Score 20 (C4 x L5) A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.

7. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
8. There have also been updates to all of the actions with the exception of number 8. In addition there have been a number of revisions to the due dates (for actions 4, 5, 6, 9 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.

9. Several amendments have been made to the controls section of the risk, the details of which are set out in the detailed BAF sheet.
10. A number of revisions and additions have also been made to the assurances section of the risk, the details of which are again set out in the detailed BAF sheet.
11. There have been updates to all of the actions, substantially so for actions 5 and 6. A new action (7) has also been added which relates to the risk of impact to colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients due to racism.

Risk 5: (Risk Score 25 (C5 x L5) The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

12. There have been a small number of updates to the controls section of the BAF risk which can be seen in the detailed BAF sheet.
13. There have been updates to actions 1 and 2 and action 3 has been marked as complete. These changes are highlighted in the BAF sheet.

Recommendation

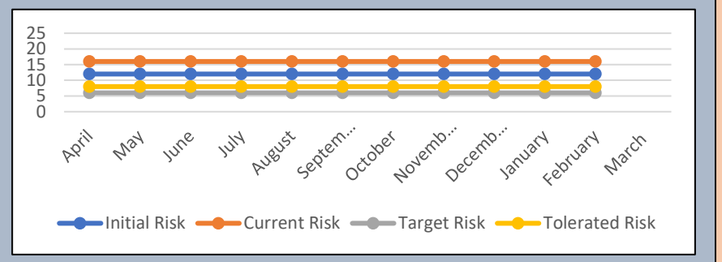
14. The Board is asked to review, discuss and approve the revised BAF.

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: February 2024 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)

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

- The ICB operating model and key system-level strategies and priorities are developing but not yet mature.
- 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.

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

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

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

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

<u>ELHT:</u>

- ELHT Strategic framework has been developed to ensure clear alignment of organisational aims to wider system aims.
- Key organisational strategies have been developed/in development to clearly outline ELHT priorities for development as a partner in the wider system.
- Strategy deployment framework/process will support development and delivery of organisational plans aligned to wider system, supported by Accountability Framework to monitor delivery.
- 11 Key Delivery and Improvement Programmes, 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.)

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

- ICS/PCB/PBP Updates are a standing agenda item at Executive meeting and Senior Leadership Group.
- 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.

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

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

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

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

BAF Risk 1 – Integrated Care / Partnerships / System Working

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	System strategies and delivery plans not yet sufficiently developed to give confidence in delivery of tangible outcomes and progress not always consistently clear.	Work with partners to finalise system strategies, priority programmes and delivery structures for 2023-24	Director of Service Development and Improvement with SRO leads	End July 2023 Revised date of April 2024~~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 draft set of commissioning intentions/commissioning plan/framework is being sent to providers on Monday 12th February 2024 for review. There is now system agreement to develop a joint clinical strategy and details /dates are currently being progressed to develop this strategy.	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 Programme ~~workstreams priority and deliverables for 2023-24 and beyond need signing off and benefits realised~~requires successful mobilisation of One LSC with ELHT as Host	Work with PCB via Central Services Programme Board to clarify ~~priorities/benefits, delivery methodology, consultation and sign off mechanisms.~~transition requirements and fully establish host governance arrangements to support successful mobilisation of One LSC	~~Senior Responsible Officers~~Director of Finance / Director of People and Culture / Director of Service Development and Improvement / Director of Corporate Governance	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.~~Work underway to finalise governance and transition requirements including due diligence for hosting of service by 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	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. Further alignment work will be completed for ELHT against PLACE priorities once commissioning intentions are issued on 12th February 2024.	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 within quarter 1 of 24/25. ~~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 with completion end of February 24. Mobilisation plans are in development.~~.~~	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	April 2024	Improvement Hub has clear priority programmes of improvement work that it is supporting and reporting to relevant Trust sub-committees. Priorities for 24/25 have now been agreed. The programmes of work link clearly through to supporting the organisation goals. A Trust Board development session was held on the~~arranged for~~ 30 January 2024 to review and update SPE+ Improvement Practice development plan in line with national NHS Impact requirements for 2024-25. In addition, work is ongoing to continually build improvement capacity within the organisation through education, training and coaching.~~Priorities have now been agreed for 24/25.~~	A

BAF Risk 1 – Integrated Care / Partnerships / System Working

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
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	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	~~February~~ March 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. The Accountability Framework will be presented to the Finance and Performance Committee meeting in March 2024. The Committee will be asked to endorse the document on behalf of the Board. It has not been possible to complete this work within the initial timeframe due to a number of timing issues.	A

BAF Risk 2 – Quality and Safety

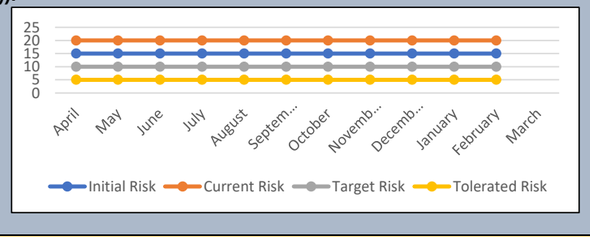
Risk Description: The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.		**Executive Director Lead:** Executive Medical Director and Chief Nurse	
Strategy: Quality Strategy	**Links to Key Delivery Programmes:** Quality and Safety Improvement Priorities	**Date of last review:** Executive Director: February 2024 ERAG: February 2024	**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	Potential to compromise patient care due to sub optimisation of the electronic patient record system~~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 EPR Programme Board will run until the end of February 2024 and will be replaced by a new Digital and Data Board.

- 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.

Specialist support, policy and procedure setting, oversight responsibility:

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

Independent challenge on levels of assurance, risk and control:

- 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	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

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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	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 the end of 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

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BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
9	EPR	Data submission to national teams on activity, mortality, coding, audit to ensure that accurate and validated assumptions on income, HSMR/SHMI and activity.	Executive Director of Finance / Executive Medical Director / Chief Nurse / Chief Operating Officer	August 2024	Ongoing work with our East Lancs team, coders and the Mortality Steering Group (with deep dives into outliers). Working with divisions on ensuring that that we capture activity levels. Working with national teams.	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: February 2024
ERAG: February 2024

Lead Committee: Finance and Performance Committee

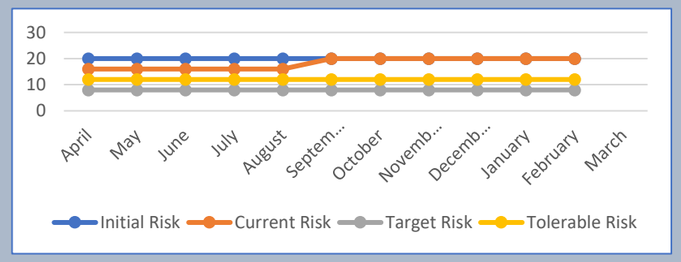
Links to Corporate Risk Register

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**
8398	Failure to achieve performance targets	**12***
8061	Management of harm from the holding list	**12***

- **Suggested for removal from the CRR, but review of scoring requested at the recent ERAG meeting.**

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

Current Risk Rating: **C4 x L5 = 20**
Initial Risk Rating: C4 x L5 = 20
Tolerable Risk Rating: C4 x L3 = 12
Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Moderate

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

Overall planning and delivery processes:

- Robust annual planning processes and review processes in place to continually assess clinical and operational demand and capacity across all specialities, modalities and points of delivery.
- Trust clinical strategy developed covering a 5-year period to support ongoing delivery and development of elective and emergency care services.
- Development of systems and processes to support reduction in risk to Health Equity supported by a plan to address health inequalities at place level.
- Development of system and processes to assess and reduce risk of clinical harm potential for patients on both the elective waiting lists and emergency care pathways ensuring safe, personal and effective care.
- Collaborative working across Lancashire and South Cumbria on the delivery and development of both elective and emergency care services with programmes of work identified.
- Additional elective capacity provided through insourcing, Independent Sector contracts and Mutual Aid arrangements within Lancashire and South Cumbria ICB.
- Annual business planning and review of progress against delivery in place. This includes performance trajectories for Urgent and Emergency Care including out of hospital (virtual ward, 2-hour Urgent Community Response), front door services (ambulance handover times, 76% 4-hour standard by March 24) same day emergency care (SDEC) and in-patient capacity planning supported by the bed model.
- A joint place delivery and improvement plan (via the Urgent and Emergency Care Delivery Board (UECDB)) for urgent and emergency care (UEC) in place. Further work around primary care access needs to be confirmed from place leads/ICB, work is being carried out around priority wards and integrated neighbourhood care.
- Robust planning arrangements in place for planned strike, winter and bank holidays to ensure appropriate capacity planning in response to the demand forecast.
- Visible performance dashboard for assurance (Emergency and Elective care) in place ensuring strengthened grip and control.

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

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

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

Specialist support, policy and procedure setting, oversight responsibility:

- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital.
- Cancer Alliance support on focussed areas requiring improvement.
- Integrated Performance Report and remedial and improvement plans reviewed at Senior Leadership Group, Quality Committee, Finance and Performance Committee and Trust Board.
- Lancashire and South Cumbria oversight and co-ordination via Elective Activity Co-ordination Team, Elective Care Recovery Group, Lancashire and South Cumbria Chief Operating Officers meetings.
- In relation to the requirement for 6-week diagnostic performance to be at 95% by March 2025, trajectories in place at modality level.
- The clinical strategy is in place and now aligned with the LSC plans and the annual planning process.
- System level plan monitoring at Pennine Lancashire via UECDB and Integrated Care Board (ICB) level via relevant system forums
- National UEC recovery plan requirements aligned to place based plans.
- Enhanced escalation policy which is activated when patients have been in the emergency department for an excessive amount of time (12 hours from arrival) in place 24/7supported by surge escalation capacity on the inpatient wards during times of pressure.

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.

Independent challenge on levels of assurance, risk and control:

- 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.	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
	Target revised to 107% by the regulator to recognise the impact of the first industrial action				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~~.~~ Whilst this is a 2023–24 performance indicator we are in the early planning stages for 2024–25 and this will be updated in the next review of the BAF.	
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~~was 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 Performance was 6.89% at January 2024~~(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. Cancer action plan refreshed and updated and monitored through the Cancer Steering Board	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	~~February~~ March2024	As of ~~December 2023~~December 2023, outpatient utilisation report~~ing~~ has been developed, ~~further testing will take place throughout December to ensure its accuracy~~. There are still some issues with cancelled slots and the BI and Outpatient team are working to rectify. 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. However the new report and additional improvement	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
					resource and daily monitoring as part of 65 weeks performance should support of delivery of this by end of March.	
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	~~February 2024~~April 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.~~ ~~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.~~ As of week of 28th January the theatre utilisation report has now been built and we are able to obtain and monitor our performance for both capped and uncapped theatre utilisation. The BI and operational teams continue to monitor for data quality issue and areas requiring improvement The Division has a number of actions they are undertaking to improve performance. ~~. As it has only been recently built, it is currently being tested.~~ Performance for Capped Theatre Utilisation was at 84.6% for week ending 25th February. Due to information only recently been made available and the Divisional able to identify actions to improve and sustain performance the due date has been extended to April 2024	~~A~~
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~~September 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 and these have been achieved in November and December further industrial action in December and January was not achieved as a result of industrial action and sickness, February was below the revised trajectory - There are daily meetings with divisional reps on managing all patients at risk of breaching 78 and 65 weeks The new planning guidance has altered the target for managing <65 week maximum wait from March 2024 to September 2024 The Trust has achieved the revised trajectories set for February 2024 676 against 823.	~~AR~~

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
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~~Extending the footprint within ED by relocating Ambulatory Care and delivering the Urgent Treatment Centre in the Ambulatory Care department. Introduction of a new Acuity Triage model should improve the time to triage and support streaming patients in to alternative pathways Working with NWAS colleagues to book patients into UTC appointments slots where clinically appropriate.	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 implementation and learning from Cerner and refocusing on Everyday Matters to support safe and timely patient flow/discharge.	The discharge bundle has been introduced across all wards. Initial internal audit (draft) suggests low compliance. Plans in place to re-establish the discharge matron focus on pathway 0 discharges by 17th April 23. Safe Discharge Multi-disciplinary team (MDT) steering group established in May 23 to drive through clinical changes at ward level. NHSE visit in May 23 following the Trust rated as one of the top 11 organisations for high discharge pathway 0. Positive feedback received from NHSE on observed best practice during the visit. Bed Manager now commenced in post and is supporting community bed management.	A
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. Use of escalation beds and trolleys when required in extreme pressures	Executive Director of Integrated Care Partnerships and Resilience/ Chief Operating Officer	~~End January~~May 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~~ CCU and B18 will relocate to new Heart Care Unit May 2024, This will create additional bed capacity but workforce resource will be required~~.~~ Winter plan confirms the mobilisation of a winter escalation ward (B6) at the RBTH site from December 2023. ~~In addition, subject to~~	**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
					Board approval a further 15 community beds will be mobilised with the transfer of the Albion Mill site from LSCFT to ELHT. This will be pilot scheme and aiming for go live date in April 2024 BGH Essential fire works continue with Ward 16 operating from Ward 22, loss of 27 beds.	
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 of 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. Working collaboratively with NWAS colleagues on handover times and processes including the improvement of the HAS compliance data	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/Chief Nurse	~~January~~ End of March 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. The BI team continue to work on on-going data quality issues and monitoring through data quality reports. Issues are managed as identified. 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: Deputy Director:February 2024
ERAG: February 2024

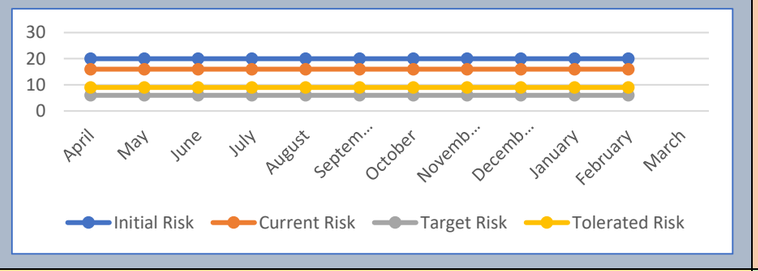
Lead Committee: People and Culture Committee

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~~ Ambass~~a~~dors ~~–~~ in line with the national FTSU agenda. They report to the Staff Safety Group, People & Culture Committee, 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 IC~~S~~B 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~~People & Culture Committee (~~FPC~~PCC) as part of the ~~quarterly~~ Trust workforce report. This also forms part of the workforce section of the Integrated Performance Report (IPR).
- There is an agreed IC~~P~~B Workforce Strategy that will be managed and delivered through the IC~~P~~B 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~~PCC. 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~~ PCC~~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 Non-Executive Champion 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~~ Ambassoadors embedded across the organisation to support the FTSU Guardian in enabling staff to raise concerns. The Trust ~~is currently recruiting~~continues to recruit new ~~champions~~ Ambassoadors to increase access and fill gaps caused by turnover, including discussions with our local BMA representative about increasing the number of FTSU Ambassadors within the medical workforce.
- Recent MIAA (internal) audit of the FTSU service gave substantial assurance.
- Included FTSU within the Trust's mandatory training programme.
- ~~Implementation~~ Continued expansion 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~~continues to be embedded across the organisation and is now 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~~including a focus on wellbeing for leaders and managers. The Core Management Pathway will launch in Q1 2024/25.

- 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. Significant progress on data quality, looking at vacancy rates, alongside colleague absence and bank/agency usage
- 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, through the sharing of practical tools and peer support models~~.~~
- Culture dashboard being developed for inclusion in divisional performance review meetings and for presentation at P&C Committee.
- The Trust is part of Cohort 2 of the People Promise Exemplar Project with NHS England, linking with the regional NHSE Team and Systems Retention Lead and will take forward a 30, 60, 90 day programme of improvement linked to the People Promise to improve retention and morale.
- A review of mental health support for colleagues across the Trust is being commissioned

Specialist support, policy and procedure setting, oversight responsibility:

- 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.
- Aarushi Project on ELHT becoming intentionally anti-racist is part of the Clinical Quality Academy programmes of improvement and has agreed scope with executive sponsorship from CEO.

Independent challenge on levels of assurance, risk and control:

- WRES and Workforce Disability Equality Standard (WDES) standards are monitored nationally and reported to the Trust Board on an annual basis.
- 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.

BAF Risk 4 – Culture Workforce Planning & Redesign

	• 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.

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~~now utilised as part of our values and beahviour-based recruitment. 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~~was 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.~~ Significant work on embedding this piece of work across the Trust, support continues, but as business as usual~~.~~ (consideration to be given whether to move this item into sources of assurance).	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~~continue to provide updates through the Workforce Report 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~~	G

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					~~this will be achieved by the July 2024 deadline.~~ International recruitment has been a success, delivering on plans and a decision has been taken to reduce the next intake and review future plans, so as not to impact on opportunities for newly qualified nurses, where we have a very strong pipeline.	
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 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, with a successful candidate being appointed and a commencement date agreed of 1 May 2024. This will provide an additional focus and access to a network of national, regional and system level colleagues to enable spread of learning	G
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 IC~~P~~B 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~~	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					~~recruited and commencing in post, from April 2023 to date there have been 100 nurses commenced at the Trust from overseas~~Due to the success of the programme to recruit international nurses (170 recruited in 2023/24), a decision has been taken to reduce the planned numbers in early 2024/25 to enable a review, alongside other pipelines (eg, newly qualified). 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. Teams across People & Culture and DERI continue to work with Divisions to explore opportunities for workforce transformation and developing career pathways within each profession, as part of our annual planning cycle.	
5	Risk of staff leaving the NHS due to burnout.	On-going delivery of the ELHT People strategy underpinned by a compassionate and inclusive culture ~~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~~People & Culture Directorate ~~are continuing~~ continue to explore how staff can be further supported during this ongoing period of unprecedented demand. Given the on-going need identified regarding supporting staff with their mental health an external review has been commissioned to review the existing staff mental health pathways and interventions. This will be complete with full recommendations by April 2024 Colleague Care month took place Jan/Feb 2024 and, during this time, health and wellbeing sessions were well attended. Staff were particularly engaged with sessions on self-care and managing your mood. Project M – a peer support group for line manager wellbeing was launched in January 2024 by the CEO with 300+ managers engaged with the sessions. The LSC occupational health and wellbeing collaborative programme has been identified as one of the early functions to move across to the Central Services platform once the host Trust has been agreed on 19 September 2023. PCB OH and Wellbeing services are currently scoping a future service specification in readiness for the future model. ~~Following a review of in and out of scope services to move to One LSC. OH and wellbeing may now be part of the later phase (D3). Work continues to develop a future model.~~ ~~OH and wellbeing team have robust plans to support staff wellbeing through its Winter Well campaign, flu and COVID vaccination campaign. This will continue through until March 2024.~~	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Regarding the future model for Occupational Health and Wellbeing, the timescale is now likely to be ~~March~~ April/June 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 ~~January~~ March 2024.	The potential impact of ~~ongoing~~ any industrial action is monitored through the Industrial Action cell which ~~meets weekly~~now meets as/when action is called. ~~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 remaining issues relate to our Medical colleagues, supported by the BMA, HCSA and Unite The BMA ~~have agreed to put an offer to consultant and SAS members and the outcome is awaited~~put an offer to members, which was rejected by a narrow margin (51:49). ~~However j~~Junior doctors continue to be in dispute and are re-balloting members for a fresh strike mandate.	G
7	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients due to racism.	Trust becoming anti-racist. Progress being made through using improvement science, adoption of NW BAME Assembly framework. Programme of transformational culture change to be developed.	Executive Director of People and Culture	End of March 2025	Project team established as part of the CQA with support from the improvement team taking forward four themes and targeting work to within FCD in first instance. Data gathering underway. Scope to be expanded due to concerns raised re the experience of medical staff and trainees within Obs and Gynae. ICS system project and NHS NW regional project on anti-racism. Diagnostic work underway to support the design of a board development session. BAME network engagement underway on antiracist statement, framework and draft strategy led by Aarushi leads, Campaign support being provided by communications team. Health equity training piloted with ops teams to be rolled out by HE L~~l~~ead and Inclusion Team with support/ eLearning to be developed by Marmot foundation. Too Hot to Handle report – review needed by HR, EDI, FTSU and Staff Side in respect of cases at ELHT to ensure we reflect on practices and ensure we learn from these findings.	A

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: February 2024
ERAG: February 2024

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.
- Planning guidance awaited for 2024-25. Draft plans submitted to Finance and Performance Committee.

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. Trust and ICB 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	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 No further changes will be applied in the current financial year, the focus is to ensure any queries are resolved for 2024-25 Following the implementation of the ePR the activity data issues are being worked through. The Trust has been informed it is not likely to be monitored against the ERF target in year due to the data issues and will be reviewed in May 2024, giving the Trust more time to work through the issues	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	£40m is identified and is being worked up. (74% of the cumulative 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	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. A full contract review will take place as part of the 2024-25 review process.	BR

BAF Risk 5 – Financial Sustainability

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
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 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

13 March 2024

Item	**39**
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 new Patient Safety Incident Response Plan (PSIRP) and the outcome of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel decision-making process on high level investigation reports.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do. Invest in and develop our workforce. Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	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

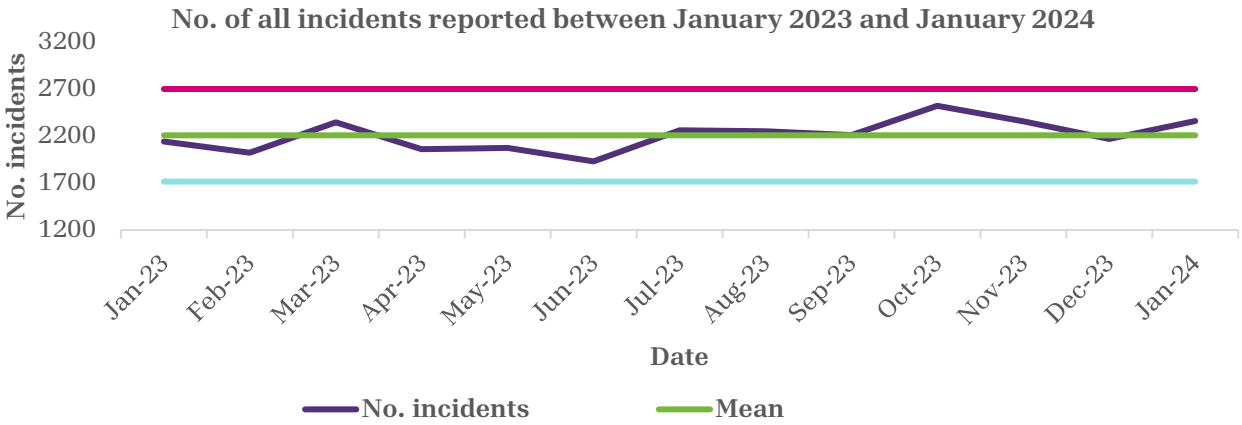
Impact

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, there continues to be expected variation in the number of incidents reported per month. However, reporting levels remain with control limits, this is common cause variation which we would expect with the nature of incident occurrence and reporting.



Graph 1: Incidents reported over last 12 months.

1.2 All harm levels remain below national levels. Moderate harms have been consistently increased for last 3 months and above Trust mean for 2022 since May 2023 but still well below national and being monitored. Incidents resulting in death whilst low actual numbers (3 x was the highest in Aug 2023), these have been consistently above the Trusts 2022 average since May 2022, 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.

1.3 From April 2024 the Trust will move to reporting all incidents to the new Learning from Patient Safety Events (LFPSE) national database, and as such we will no longer be able to record incidents as no harm impact not prevented. Therefore, this could result in an increase in the recording of greater levels of harms. We will however be able to record the level to which a patient safety incident contributed to the impact.

2. Duty of Candour

2.1 There have been **0** breaches, of Duty of Candour, as set out in CQC Regulation 20. A recent Patient Safety Incident Investigation highlighted that a family had raised concerns with regards to not receiving a duty of candour letter and apology provided at the time of incident. To gain assurance of the Trust duty of candour

process an audit is being completed across all divisions, if any areas of concern are identified from the audit these will be discussed and actioned at Patient Safety Group.

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 In May 2023, the overall percentage of incidents being reviewed within 30 days across the Trust was 65.7% this has increased to 78.3% in December 2023.

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 Divisions have developed new governance and support processes to improve compliance with the timely completion of incident investigations including PSRs. These processes are embedding in the Division and begging to identify areas for improvement.

4.3 Learning from PSRs are shared at the Divisional Patient Safety Incidents Requiring Investigation (DPSIRI) Panels and though Divisional and Directorate Patient Safety Groups. Any Divisional safety issues identified are either incorporated into divisional quality improvements, identified on the risk register for management or developed as safety improvement actions. Each division provides a bi-monthly report to the Lessons Learnt Group (this will be Trust Wide Quality Governance from March 2024) 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 December 2023 and January 2024, the Complex Case meeting reviewed 51 incidents of which 5 met the PSIRF 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 January 2024, the Trust had 19 open PSII incidents of which 5 were being investigated by HSIB.

5.3 At the end of January 2024 there was 1 PSII which has been open longer than 6 months and 4 HSIB reports.

5.3.1 4 x MNSI (was HSIB) reports are overdue which are outside of the control of trust, 1 x was received at the end of November 2023 but is awaiting Family Care Division to develop a safety improvement plan and present at PSIRI for approval.

5.3.2 There is only 1 x PSII overdue, the investigation and report has been completed and presented at PSIRI within timescale, but amendments were required, the report was due to be presented at PSIRI on 21st Feb 2024.

5.4 In December 2023 and January 2024, 13 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 reported 4 Never Events for this financial year (April 2023 to March 24). After investigation 1 reported Never Event was agreed for de-escalation by NHSE England as it did not meet the Never Event Criteria.

- *Transfusion of ABO incompatible blood component – Investigation report completed with safety improvements.*
- *Wrong Implant (Knee) – Investigation report completed with safety improvements.*
- *Misplaced NG Tube – Investigation report completed with safety improvements.*
- *Wrong site surgery (injection) – Investigation report completed; incident de-escalated as not meeting Never Event criteria by NHS England.*

6.2 A special addition of the Patient Safety Bulletin for Never Events is currently being drafted and will be published and made available to all staff in March 2024, to highlight learning from the investigations.

7. PSIRI Panel Approval and Learning from Reports

7.1 During October 2023 and November 2023, 6 new PSII reports were presented at the Trusts PSIRI panel. 1 report were approved by the panel with some minor amendments required, and revision of the improvement plan was required. 4 reports were not approved and required resubmission to the panel following amendments. 1 report was approved with no amendments required.

7.1.1 Incident resulting in death (eIR1256899) – The report was not approved and required a safety recommendation and some additional narrative to be added, the report was returned to the next meeting and approved with some minor amendments. The areas identified for improvement were:

- Ensure compliance with the completion of the Silver Trauma and Primary Survey screening within the Emergency Department.
- Consider whether Cerner needs to have an alert for completion of Sliver Trauma/Primary Survey
- Staff to be reminded about the importance of documenting their discharge decisions.

7.1.2 Vulnerable adults – nil by mouth (eIR1243514) – The report was not approved with additional narrative to be added and a review of two safety recommendations required. The areas identified for improvements were:

- Review of Senior Dietetic cover and supervision for dietitians at Community Hospitals.
- Reassurance to be sought on completion of MUST assessments and the quality of data inputted.
- Nutrition and Hydration steering group to considers whether all patients need food and fluid charts completing or just those at risk.
- Task and finish group to consider how collaborative working at Community Hospitals can be improved.
- Reminder to all Trust staff about the correct protocol to follow in respect of nasogastric tube insertion attempts.
- Advisory text to added to automatic email replies from the Specialist Nutrition Nurses Team to inform staff to bleep for assistance.

7.1.3 Incident resulting in death (eIR1259136) – The report was not approved and required a review of two of the actions. The areas identified for improvement were:

- Review of guidance and policies around the management of patients on Anticoagulation medication requiring invasive procedures, to ensure it is accessible and standardised across services.
- Ensure the processes related to the management of patients on Anticoagulation medication requiting invasive procedures are adhered too.
- Consideration for the development of patient information for patients on Anticoagulation medication requiting invasive procedures.
- Review of organisation of endoscopy lists and standardisation of practice related to the review of lists by clinicians.

7.1.4 Never Event (eIR1256238) – The report was not approved additional recommendations and actions to be included. The areas identified for improvements were:

- Improvements for the checking off implants prior to implantation, silent focus and exploration of the 'Scan for Safety' were already underway in the Service.
- Review of how implants are stored.
- Review of the process for obtaining implants during an operation.
- Review of the implant checking process in NatSSIPs 2.

7.1.5 Incident resulting in death (eIR1256180) – The report was approved with no changes required. The areas identified for improvements were:

- No further safety recommendations were made following this investigation as the previous PSII investigation have identified similar safety issues and there are ongoing safety recommendations and systemic improvement plans developed to address these issues.

7.1.6 Incident resulting in death (eIR1255479/eIR1257479) – The report was approved with some minor amendments required. The areas identified for improvements were:

- The Emergency Department and the Ambulatory Emergency Care Unit to review their current pathway, systems and processes, and guidance in place for the management of patients presenting with a headache to ensure the pathway supports clinicians in differentiating between primary and secondary headache and the actions required when a Computerised Tomography Scan is normal.

8. Mandatory National Patient Safety Syllabus Training Modules

8.1 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 level 1a training (figures shown in table 3) with just over 90% of all staff successfully completing the core module.

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

8.3 To encourage staff to complete the training and increase compliance a reminder is being sent out in the Trusts weekly communication bulletin asking all staff to check compliance and complete any levels outstanding.

Table 3: Patient Safety Syllabus Training (as of 26th Feb 2024)

Patient Safety Training Modules	KPI Target by March 24	% of staff completed training
Patient Safety Level 1a – all staff	95%	90.9%
Patient Safety Level 1b – Boards and senior leadership	95%	75.5%
Patient Safety Level 2 – Essential to role	95%	84.9%

9. Lancashire and South Cumbria PSIRF Community of Practice

9.1 To help embed and further improve incident management and investigations under the national PSIRF across Lancashire and South Cumbria a community of practice group has been set to identify ways of improving patient safety.

9.2 The two main areas of focus are:

9.2.1 Development of joint investigation guidance for investigation involving 2 or more trusts to ensure key stakeholder engagement, timely completing and shared learning.

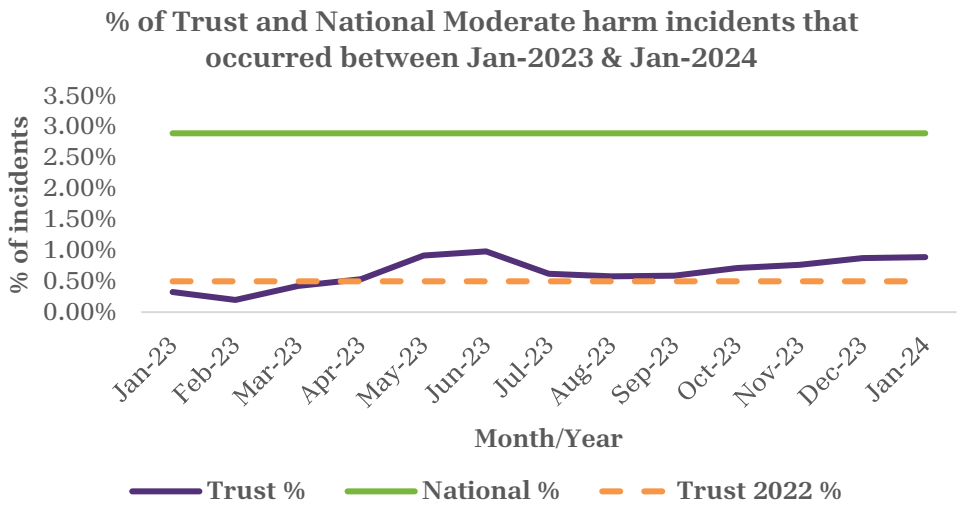
9.2.2 Development of patient safety training package and shared resources to deliver training across the area. The training package is hoping to include Human factors, family/patient engagement when things go wrong, duty of candour, patient safety response skills.

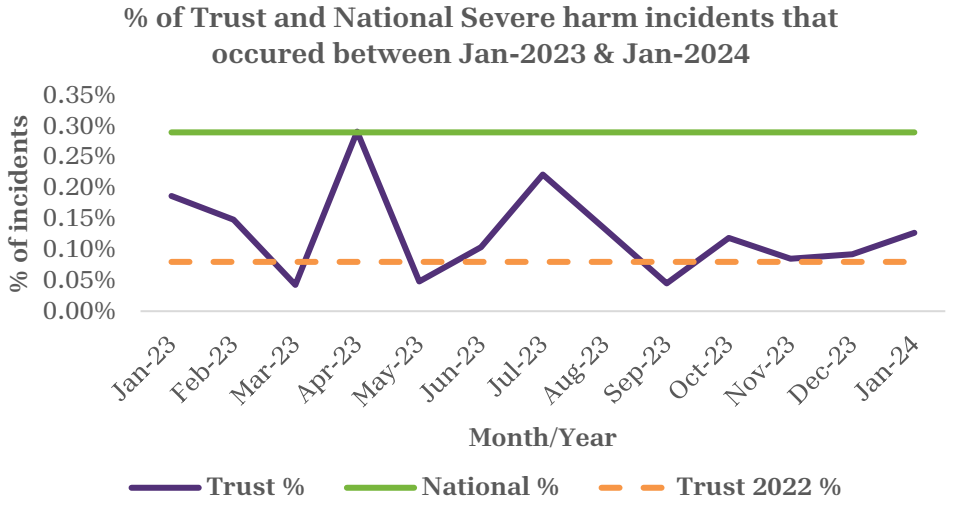
10. Maternity specific serious incident reporting in line with Ockenden recommendations

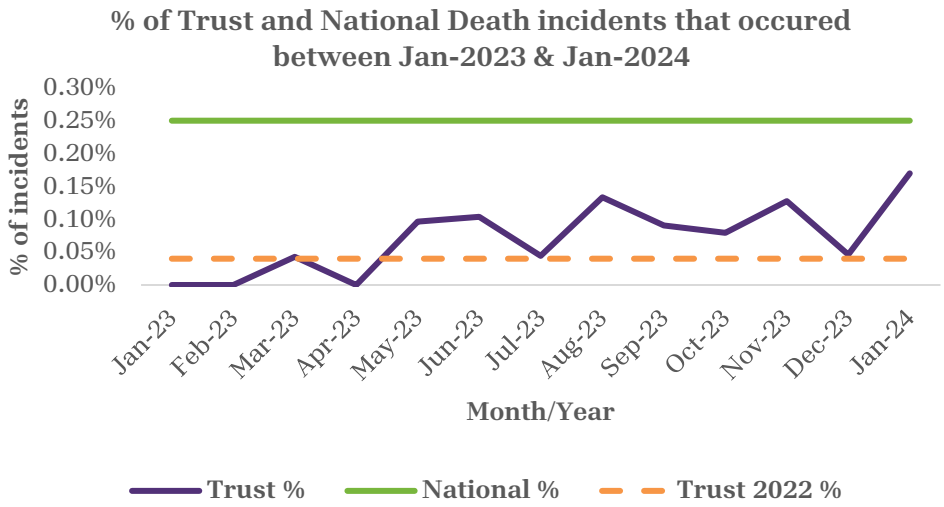
10.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 58 maternity related incidents have been reported on StEIS of which:

- 32 have been closed by the ICB with learning.
- 15 have been agreed for de-escalation from StEIS.
- 6 are currently being investigated by HSIB.
- 5 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 90%	May	June	July	Aug	Sep	Oct	Nov	Dec	Trend
CIC	Total IR2 reported	328	336	368	391	331	306	362	314	
	(total number investigated) % complete within 30 calendar days	(267) 81.40%	(284) 84.52%	(303) 82.34%	(348) 89.00%	(300) 90.63%	(283) 92.48%	(313) 86.46%	(247) 78.66%	↓
DCS	Total IR2 reported	143	122	141	128	139	174	143	148	
	(total number investigated) % complete within 30 calendar days	(81) 56.64%	(77) 63.11%	(91) 64.54%	(76) 59.38%	(75) 53.96%	(99) 56.90%	(90) 62.94%	(104) 70.27%	↑
FC	Total IR2 reported	199	238	330	253	252	348	307	245	
	(total number investigated) % complete within 30 calendar days	(131) 65.83%	(154) 64.71%	(225) 68.18%	(201) 79.45%	(171) 67.86%	(259) 74.43%	(173) 56.35%	(193) 78.78%	↑
MEC	Total IR2 reported	959	796	883	885	877	926	880	947	
	(total number investigated) % complete within 30 calendar days	(642) 66.94%	(578) 72.61%	(629) 71.23%	(624) 70.51%	(601) 68.53%	(732) 79.05%	(772) 87.73%	(793) 83.74%	↓
SAS	Total IR2 reported	374	386	457	385	391	542	425	346	
	(total number investigated) % complete within 30 calendar days	(213) 56.95%	(252) 65.28%	(332) 72.65%	(248) 64.42%	(264) 67.52%	(366) 67.53%	(332) 78.12%	(270) 78.03%	→
Corp	Total IR2 reported	68	40	70	53	78	79	78	69	
	(total number investigated) % complete within 30 calendar days	(28) 41.18%	(16) 40.00%	(34) 48.57%	(20) 37.74%	(55) 44.87%	(44) 55.70%	(39) 50.00%	(14) 20.29%	↓
Trust Total	Total IR2 reported	2071	1918	2249	2095	2068	2375	2195	2069	
	(total number investigated) % complete within 30 calendar days	(1362) 65.7%	(1361) 70.9%	(1614) 71.7%	(1517) 72.4%	(1466) 70.8%	(1783) 75.0%	(1719) 78.3%	(1621) 78.3%	→

Total number of IR2s open on DATIX over 30 calendar days old

Division	CIC	DCS	FC	MEC	SAS	Corp
No. open	54	66	101	127	273	272

Appendix B: KPI Dashboards for PSRs

Division	Number of PSRs open	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 24	Trend >90
CIC	No. open	41	41	43	26	47	51	73	47	↑
	No. open more than 90 calendar days	15	5	7	6	7	2	2	7	
DCS	No. open	6	8	11	11	17	19	19	19	↑
	No. open more than 90 calendar days	1	1	4	6	9	4	2	3	
FC	No. open	28	35	33	27	36	43	43	40	→
	No. open more than 90 calendar days	13	13	14	15	11	13	12	12	
MEC	No. open	83	118	135	157	168	141	105	107	↑
	No. open more than 90 calendar days	25	25	36	39	45	28	12	19	
SAS	No. open	44	49	41	49	55	57	71	76	↓
	No. open more than 90 calendar days	1	9	12	11	13	11	21	19	

**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	Jan	Total / Trend
No. incidents at Complex case	32	21	22	20	21	22	31	25	20	31	245
No. incidents agreed as PSII including (MNSI was HSIB)	5 (1)	4 (0)	5 (2)	2 (0)	1 (0)	6 (0)	3(2)	0	1(0)	4(1)	31 (6)
No. over 6 months	N/A	N/A	3	6 (2)	10 (2)	10 (2)	8(2)	6(2)	7(4)	5(4)	↓
Total No. of PSIIs Open including (MNSI was HSIB)	N/A	N/A	30 (6)	29 (4)	29 (4)	32 (5)	28(6)	26(6)	24(6)	19(5)	↓
No. approved/closed by PSIRI including (MNSI was HSIB)	0	4 (1)	3 (1)	3 (1)	0	3 (0)	5(0)	2	4	9 (2)	33 (5)

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

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

13 March 2024 **Purpose** Approval / Assurance / Information

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

Summary: The purpose of this report is to provide:
1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Maternity Safety Ambition, specifically relating to the ten CNST (Clinical Negligence Scheme for Trusts) 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) because 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 (Integrated Care Board) 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 are submitted to sub-group Quality Committee to inform Trust Board.

   This bi-monthly assurance report will be submitted to the ELHT Board of Directors for appropriate assurance, oversight, monitoring and escalation within the maternity and neonatology services.

2. CNST - MATERNITY INCENTIVE SCHEME

2.1 Summary overview

Safety Action	Progress/ Status	Progress update to present & Comments
1. Perinatal Mortality Review Tool (PMRT)		**Compliant** – All thresholds met within CNST Y5 periods. **Ongoing Surveillance** – PMRT tracker and dashboard continues to be monitored as per process – screenshot and status below. Q4 report (Jan-Mar) to be presented to May Trust Board.
2. Maternity Services Data Set (MSDS)		**Compliant** - July data submitted and as per previous publication of the scorecard in October – all areas passed. **Ongoing Surveillance** – Continued review of the published scorecard monthly.
3. Transitional Care (TC)		**Compliant** –Q3 TC Audit Oct-Dec and Q3 ATAIN report complete and included in appendices of this report. **Ongoing Surveillance** – Continued monthly TC audits with quarterly review of results and actions. Q4 (Jan-Mar) Audit and Report to be presented to May Trust Board.

4. Clinical Workforce		**Compliant** – Locum SOPs (STANDARD OPERATING PROCEDURES) in place, consultant attendance audits complete, workforce reviews for Anaesthetics, Neonatal Medical and Neonatal Nursing complete. **Ongoing Surveillance** – Compensatory rest action plan in place and a business case to be completed to meet the requirements of the compensatory rest asks. Neonatal Nursing Workforce action plan aligned with BAPM requirements for a level 3 unit and transitional care service, mitigations in place as unfunded. Business case to be completed to demonstrate the unfunded asks. There has been dialogue through the neonatal critical care transformation review that funding will become available for all Trusts with deficits of BAPM compliance.
5. Midwifery Workforce		**Compliant** – Bi-annual staffing reports submitted to Trust Board included detail and assurance of all CNST SA5 asks. **Ongoing Surveillance** - Birthrate+ business case is completed and presented 5th March 2024 at Trust Panel. Birthrate+ acuity app continues to monitor 1:1 care and supernumerary and midwifery red flags each month.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		**Compliant** – 70% overall implementation and 50% of each individual element was reached for CNST Y5. ELHT are currently at 81% overall implementation. **Ongoing Surveillance** - Leads of each element continue to work on outstanding actions. Overview of implementation continues to be updated at Perinatal Governance Board monthly.
7. MNVP User Feedback		**Compliant** – MNVP meetings and workplan in place. Engagement schedule for MNVP lead to attend sessions and gather feedback. Co-production of improvements in place. Patient experience group for Maternity and Neonatology implemented to review and action CQC (Care Quality Commission) maternity survey results and FFT (Friends and Family Test) results. **Ongoing Surveillance** – East Lancashire Maternity Neonatal Voice Partnership (MNVP) meetings continue to take place. Next meeting is the 5th of March 2024. (NED invited) Regional MNVP workshop took place 22nd February 2024 to move forward with the workplans across the services. Capacity remains an issue in relation to Engagement schedule of session for MNVP chair and representatives to attend remains in place. Senior Support and Share walk round now implemented to further inform triangulation of patient experience feedback. When opportunity permits, these to be noted
8. Training		**Compliant** – Core competency framework version 2 local training plan was reviewed by LMNS (Local Maternity and Neonatal System) at the QA visit, submitted to January Trust Board. Anaesthetic compliance with PROMPT reached 100% attendance by the end of February 2024. **Ongoing Surveillance** – Central MDT attendance training dashboard held and monitored by the Maternity Training Team. 100% compliance for anaesthetists.
9. Board Assurance		**Compliant –** PQSM in place with minimum data set monthly, safety champions in place with safety reporting structure available

		to staff. Triangulation of incidents, complaints and claims meetings took place. **Ongoing Surveillance** – PQSM Minimum Data Set is reviewed monthly with safety champions and at Perinatal Governance Board. Safety champion and executive walk rounds continue. Bespoke data triangulation meeting implemented to further analyse themes of incidents, complaints, and claims. SCORE (Safety Culture, Operational Risk, Reliability) culture survey update – please reference 28th February 2024 Quality Committee Papers.
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		**Compliant –** All required reporting completed for CNST Y5. **Ongoing Surveillance** – ELHT Maternity and Neonatal Services hold a portal of all cases to be reported as monitored by the Maternity Governance Lead.

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*	Jul-2*	Aug-2*	Sep-2*	Oct-2*	Nov-2*	Dec-2*	Jan-2*	Feb-2*	Monthly Trend
SAFETY ACTION 1	PI	weeks											
		Total Eligible Cases		5	4	3	2	1	5	2	1	2	
	PMRT02a	a) i Number of cases reported to MBRRACE within 7 days		5	4	3	2	1	5	2	1	2	
			100%	100.0%	100.0%	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	2	1	1	
			100%	100.0%	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	2	0	0	
			95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	*	*	
	PMRT04a	c) ii Number PMRT draft reports by 4 months		3	4	3	1	0	3	0	0	0	
			60%	60.0%	100.0%	100.0%	50.0%	0.0%	60.0%	*	*	*	
	PMRT04c	Number PMRT draft reports not due		0	0	0	0	0	2	2	1	2	
	PMRT05a	c) ii Number PMRT published reports by 6 months		3	4	3	2	1	3	0	0	0	
			60%	60.0%	100.0%	100.0%	100.0%	100.0%	60.0%	*	*	*	
	PMRT05c	Number PMRT published reports not due		0	0	0	0	0	2	2	1	2	

As evidenced in the January Trust Board report, all required thresholds of compliance for deadlines within the reporting period for CNST Year 5 (30 May 2023 until 7 December 2023) were met.

The above dashboard shows all deadlines until the 27th of February 2024, and depicts 2 draft reports which were not completed within the 4-month timeframe – 1 for a death reported in September and 1 for a death reported in October. Due to the maternity and neonatal away day planned for the 12th of January 2024 and lack of quoracy to triangulate timings for PMRT 4-month cases in advance of this, the planned PMRT meeting in January 2024 was unable to take place. This impacted on the ability to meet the 4-month draft report deadline of these two cases however this does not impact CNST Year 5 as these deadlines are outside of the reporting period.

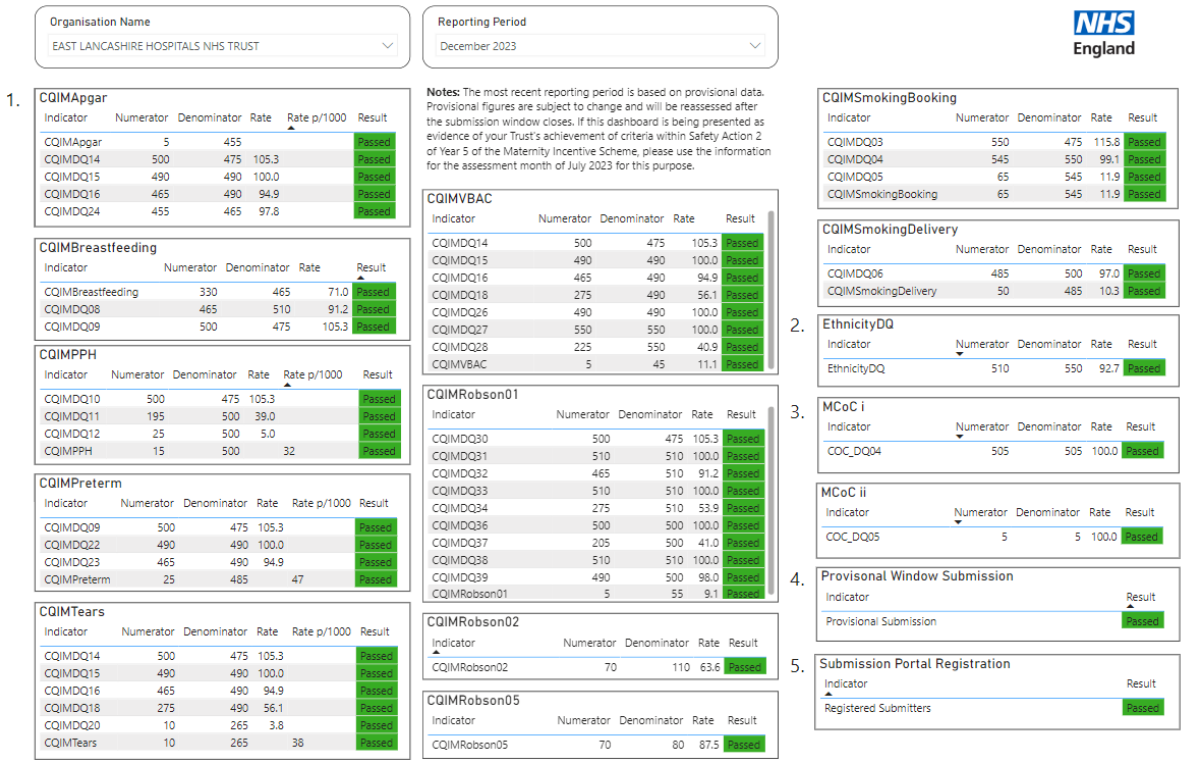
The standard for this period is 60% of draft reports to be completed within 4 months, and these 2 cases would not have reduced the average compliance to below 60%.

This has been escalated to the clinical director and divisional director of midwifery. Both cases were discussed at the meeting in February 2024 and the final reports have been completed within the 6-month period.

Further detail of all PMRT cases and monitoring will be included within the quarterly report submitted to the Trust Board; 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. The next report due will cover January-March 2024 and will be submitted to May 2024 Trust Board.

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

As reported to January Trust Board, the requirements of CNST Year 5 were all met for this safety action. The 'Clinical Negligence Scheme for Trusts: Scorecard' in the Maternity Services Monthly Statistics Publication Series continue to publish monthly compliance with all elements of Safety Action 2. As below, ELHT maternity services continue to show compliance with all elements.



Organisation Name: EAST LANCASHIRE HOSPITALS NHS TRUST

Reporting Period: December 2023

NHS England

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes. If this dashboard is being presented as evidence of your Trust's achievement of criteria within Safety Action 2 of Year 5 of the Maternity Incentive Scheme, please use the information for the assessment month of July 2023 for this purpose.

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	455			Passed
CQIMDQ14	500	475	105.3		Passed
CQIMDQ15	490	490	100.0		Passed
CQIMDQ16	465	490	94.9		Passed
CQIMDQ24	455	465	97.8		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	330	465	71.0	Passed
CQIMDQ08	465	510	91.2	Passed
CQIMDQ09	500	475	105.3	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	500	475	105.3		Passed
CQIMDQ11	195	500	39.0		Passed
CQIMDQ12	25	500	5.0		Passed
CQIMPPH	15	500		32	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	500	475	105.3		Passed
CQIMDQ22	490	490	100.0		Passed
CQIMDQ23	465	490	94.9		Passed
CQIMPreterm	25	485		47	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	500	475	105.3		Passed
CQIMDQ15	490	490	100.0		Passed
CQIMDQ16	465	490	94.9		Passed
CQIMDQ18	275	490	56.1		Passed
CQIMDQ20	10	265	3.8		Passed
CQIMTears	10	265		38	Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	500	475	105.3	Passed
CQIMDQ15	490	490	100.0	Passed
CQIMDQ16	465	490	94.9	Passed
CQIMDQ18	275	490	56.1	Passed
CQIMDQ26	490	490	100.0	Passed
CQIMDQ27	550	550	100.0	Passed
CQIMDQ28	225	550	40.9	Passed
CQIMVBAC	5	45	11.1	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	500	475	105.3	Passed
CQIMDQ31	510	510	100.0	Passed
CQIMDQ32	465	510	91.2	Passed
CQIMDQ33	510	510	100.0	Passed
CQIMDQ34	275	510	53.9	Passed
CQIMDQ36	500	500	100.0	Passed
CQIMDQ37	205	500	41.0	Passed
CQIMDQ38	510	510	100.0	Passed
CQIMDQ39	490	500	98.0	Passed
CQIMRobson01	5	55	9.1	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	70	110	63.6	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	70	80	87.5	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	550	475	115.8	Passed
CQIMDQ04	545	550	99.1	Passed
CQIMDQ05	65	545	11.9	Passed
CQIMSmokingBooking	65	545	11.9	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	485	500	97.0	Passed
CQIMSmokingDelivery	50	485	10.3	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	510	550	92.7	Passed

3.

MCoC i

Indicator	Numerator	Denominator	Rate	Result
COC_DQ04	505	505	100.0	Passed

MCoC ii

Indicator	Numerator	Denominator	Rate	Result
COC_DQ05	5	5	100.0	Passed

4.

Provisonal Window Submission

Indicator	Result
Provisional Submission	Passed

5.

Submission Portal Registration

Indicator	Result
Registered Submitters	Passed

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 3 includes all reviews October to December as per appendix 2. The ongoing ATAIN improvement plan is reviewed bi-monthly at the divisional ATAIN meeting as per appendix 3.

'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 was submitted to January Trust Board. Q3 (October – December) is submitted as per appendix 4 and finds significant assurance against compliance.

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

The elements for ongoing surveillance outside of the CNST reporting year for this safety action include the following:
Consultant Attendance audit – this will next review January-March data in an analysis due to take place in April and will therefore assurance and/or mitigations will be submitted to Trust Board in May.
Neonatal Nursing Workforce action plan – as submitted to January Trust Board. This is in place and a full update as lead by the Neonatal matron will be included in the May Trust Board report.

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 was submitted to January 2024 Trust Board. This covers the ask for Birth rate plus requirements as reflected in the September 2022 recommendations. The Business case for the deficit in funding is completed.

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.'

The requirements of CNST Year 5 as above were successfully met.

An overview of the current progress with the 6 elements of SBL (Saving Babies Lives) is as follows, this reflects 57/70 interventions implemented overall – 81% which was agreed with the LMNS at the assurance visit in January 2024:

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	6/10 interventions implemented and evidenced **(60%)**
Element 2 - Fetal Growth Restriction	17/20 interventions implemented and evidenced **(85%)**
Element 3 - Reduced Fetal Movement	2/2 interventions implemented and evidenced **(100%)** [1 intervention contains 4 asks)
Element 4 - Effective fetal monitoring during labour	4/5 interventions implemented and evidenced **(80%)**
Element 5 - Reducing preterm births and optimising perinatal care	24/27 interventions implemented and evidenced **(89%)**
Element 6 - Management of Diabetes in Pregnancy	4/6 interventions implemented and evidenced **(67%)**

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.*

MNVP lead for ELHT, and colleague representatives attended a MNVP 2024/25 workplan planning meeting on Thursday 22nd February 2024 hosted by Healthwatch. It was agreed that a workplan for this year will be standardised for all MNVP leads across the LMNS working towards the requirements of key strategies such as the 3-year delivery plan.

The engagement schedule across our services continues and the MNVP lead has attended sessions as below:

14th December 2023 - Neonatal Community Clinic
16th December 2023 - Livesey Family Hub Feeding Support
23rd January 2024 - Prevention Lead Session
4th February 2024 - Tessa Clemson Yoga Session (Great Harwood)
16th February 2024 - Darwen Family Hub Feeding Support

A feedback tracker has been devised allowing joint access by both the MNVP lead and the service to aid in collation of feedback to analyse and identify themes for improvement. The agreed process is for the MNVP

lead to input feedback into this tracker following each engagement session, the tracker is automated to count the themes arising and these should inform discussions at the quarterly MNVP meetings where co-produced improvements can be agreed and monitored.
We currently feel that improvements need to be made to ensure this process is being followed as agreed, and this will be a key focus throughout March 2024 via liaison between the divisional director of midwifery and MNVP lead.

ii) *Ensuring an action plan is co-produced with the MNVP following annual CQC maternity survey data publication.*
The 2022 action plan update and 2023 CQC maternity survey data has been submitted as per the detailed update provided within the Floor to Board Report presented to the February 2024 Quality Committee meeting. This will be shared with the MNVP via the quarterly MNVP meeting taking place on the 5th of March 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.
A directorate level Maternity Patient Experience Group is now in place to review service user feedback from various routes including the survey above and friends and family tests. 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?

As reported to the January Trust Board, all required MDT training attendance as per Version 1 of the Core Competency Framework was compliant to 80%+ as required. Specifically, attendance to the PROMPT (emergency training) sessions for Anaesthetic colleagues required an action plan to meet 90%+ attendance by the end of February 2024.

All other training attendance requirements were met with 90%+ compliance and therefore required no action plan.

The Maternity Training Team, who hold the central MDT training database, have given assurance that the Anaesthetic PROMPT training compliance has now reached 100% at the end of February 2024.

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 February 2024:

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	Oct 23	Nov 23	Dec 23	Jan 24
Perinatal Data	1:1 care in labour	100%	100%	100%	100%	100%
	Stillbirth rate	<4.4/1000	3.83	2.03	3.87	1.9
	Term admissions to NICU	<7%	5.77%	6.52%	4.86%	4.85%
	Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	4.6%	3.29%	3.36%	3.42%
	3rd/4th degree perineal tear	<5%	3.73%	2.78%	3.58%	4.6%

	Metric	Standard	Oct 23	Nov 23	Dec23	Jan 24
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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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 December we was at 72% compliance. Those non-compliant are all booked in over Jan and Feb 2024 and if all attend when they have promised, we will then be at 100%.

	Metric	Standard	Oct 23	Nov 23	Dec 23	Jan 24
Feedback	Service user feedback (MNVP)		2 sessions attended	0 sessions attended	1 sessions attended	1 session attended
	FFT satisfaction rated as good	>90%	100%	88.83%	89%	89%
	Number of level 4 complaints	-	4	4	0	3
	Executive safety walkaround	Bi-Monthly	N/A	NICU	N/A	N/A
	Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	N/A	Antenatal Clinic	N/A	N/A

	Metric	Sept 23	Oct 23	Nov 23	Jan 24
External Reporting	Maternity incidents graded moderate or above	1	3	0	6
	Cases referred to MNSI	0	1	2	1
	Cases referred to coroner	2	0	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	Oct 23	Nov 23	Dec 23	Jan 24
CNST	Progress with CNST 10 safety action compliance				

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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. These meetings are bi-monthly.

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 3 level 4 complaints in January, these have all been reviewed and are in progress.

Coroner referral:
0 cases have been referred to the Coroner in January.

MNSI referral:
There has been1 case referred to MNSI in January – this was a cooled baby; The MRI scan showed no evidence of Hypoxic Ischeamic Encephalopathy (HIE) therefore the referral was rejected.

CNST:
The trust submitted 100% compliance with all safety actions.

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%

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.

3. CONCLUSION

On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board will continue to inform progress with assurances of the ten CNST maternity safety actions throughout the reporting period.

As this report falls between CNST Year 5 and Year 6, updates have been included to evidence ongoing surveillance and adherence to the requirements.

As confirmed in the January Trust Board Report, ELHT maternity and neonatology services confirmed that all the evidence required for MIS Year 5 reporting period was submitted and uploaded onto the ELHT SharePoint portal. Progress with compliance was 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 for further discussions as and when 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

February 2024

Appendix 1 – CNST-MIS Y5 Guidance

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

Appendix 2 – ATAIN Q3 Report

B) ATAIN Q3 report October-December 2:

Appendix 3 – ATAIN improvement plan

ATAIN Improvement Plan - Feb 2024 updat

Appendix 4 – Transitional Care Q3 Audit

Q3 TC audit October to December 2023.pp

Appendix 5 – Floor to Board Report – Quality Committee

Floor to Board
Quality Committee Fe

NHS Resolution

Maternity Incentive Scheme – year five

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

V1.1 July 2023

Contents

Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year five: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by **12 noon** on **1 February 2024** and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Trust Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
    - There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **1 February 2024**.
- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions'

evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution

- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of
  MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions, then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution
  Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by **1 February 2024** at **12 noon** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.

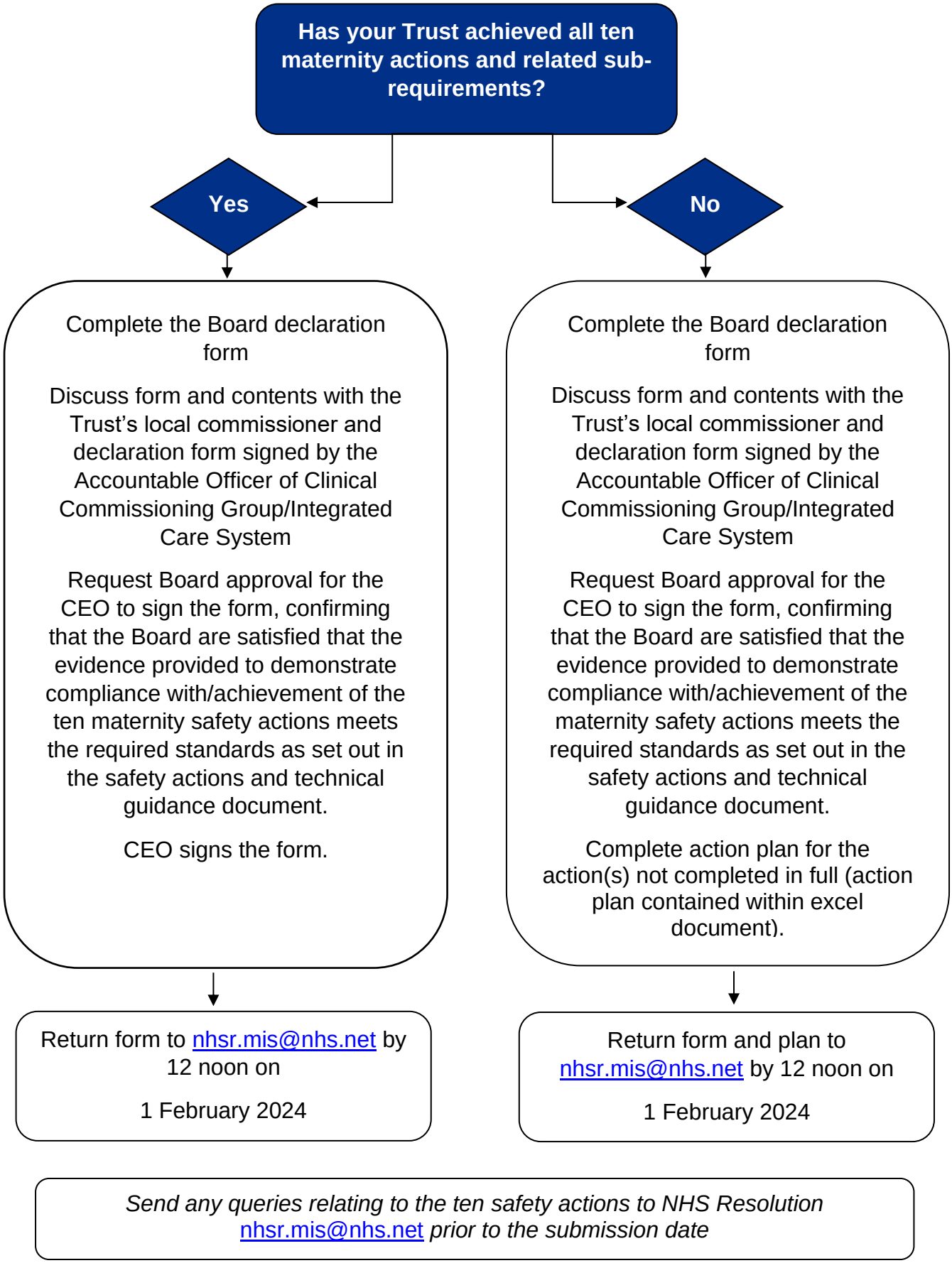
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The Board declaration form will be available on the MIS webpage at a later date.
- Trusts are reminded to retain all evidence used to support their position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described above) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution nhsr.mis@nhs.net prior to the submission date.
- The Board declaration form must be sent to NHS Resolution nhsr.mis@nhs.net between **25 January 2024** and **1 February 2024** at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from submission date.
- Submissions and any comments/corrections received after **12 noon** on **1 February 2024** will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
    - alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation
    - technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- NHS Resolution clinical advisors will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Further detail on the results publication, appeals window dates and payments process will be communicated at a later date.

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 1 February 2024 to NHS Resolution nhsr.mis@nhs.net. The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.


Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
Return form to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Return form and plan to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Send any queries relating to the ten safety actions to NHS Resolution nhsr.mis@nhs.net prior to the submission date

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

Required standard	a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from **30 May 2023,** MBRRACE-UK surveillance information should be completed within one calendar month of the death. b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30 May 2023** onwards. c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**
Minimum evidential requirement for Trust Board	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter from **30 May 2023** that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**12 noon** on **1 February 2024**

Technical guidance for safety action 1

Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the MBRRACE-UK/PMRT system to track your notifications and reviews: www.npeu.ox.ac.uk/pmrt/faqsmis; these FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk.

Technical Guidance **Guidance for SA 1(a) – notification and completion of surveillance information**	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that a single notification portal (SNP) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through the SNP and this information will be passed to MBRRACE-UK. It will then be necessary for reporters to log into the MBRRACE-UK surveillance system to provide the surveillance information and use the PMRT.
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from **30 May 2023** onwards must be notified to MBRRACE-UK within seven working days.
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission

	to CDOP. This will also be the required route for providing additional information about the death required by both CDOPs and the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months
Are there any exclusions from completing the surveillance information?	If the surveillance form needs to be assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.
Guidance for SA1(b) – parent engagement	
We have informed parents that a local review will take place and they have been asked if they have any reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' perspectives and questions can be considered during the review this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.

Parents have not responded to our messages and therefore we are unable to discuss the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will also be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
Guidance for SA1(c) – conducting reviews	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: • All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.
What happens when an HSIB investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the MIS standards for these babies may therefore be impacted by time frames beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place, and this will be accounted for in the external validation process.

What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: 
What is meant by "reviews should be completed to the draft report stage"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details of assistance in using the PMRT to complete a review.
What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the unit who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
What should we do if our post-mortem service has a turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.

What is review assignment?	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided.
How does 'assigning a review' impact on safety action 1, especially on starting a review?	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the external validation process.
What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between **30 May 2023** and **7 December 2023** you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
What deaths should we review outside the relevant time period for the safety action validation process?	Trusts should review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 5 MIS requirements.
Guidance for SA1(d) – Quarterly reports to Trust Boards	
Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period, within the PMRT for user-defined time periods. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.
Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'.

	Please note that these reports will only show summaries, issues and action plans for reviews **that have been published** therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – Technical issues and updates	
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on the PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action 1, will be communicated via NHS Resolution email and will also be included in the PMRT 'message of the day'.

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

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023. 2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: **Midwifery Continuity of carer (MCoC)** **Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be published in October 2023.

	If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information). 4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. 5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.
Minimum evidential requirement for Trust Board	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at 12 noon

Technical guidance for safety action 2

Technical guidance	
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? • **Proportion of babies born at term with an Apgar score <7 at 5 minutes** • **Women who had a postpartum haemorrhage of 1,500ml or more** • **Women who were current smokers at delivery** • **Women delivering vaginally who had a 3rd or 4th degree tear** • **Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** • **Caesarean section delivery rate in Robson group 1 women** • **Caesarean section delivery rate in Robson group 2 women** • **Caesarean section delivery rate in Robson group 5 women**	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2023 data for these CQIMs. Due to this, Trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If maternity services have suspended Midwifery Continuity of Carer (MCoC) pathways, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 3i. If your Trust has suspended all MCoC pathways, criteria 3ii is not applicable and does not need to be completed. If your Trust is continuing with some provision of MCoC pathways, then criteria 3ii does still apply.

Will my Trust fail this action if women choose not to receive continuity of carer?	No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output. If women choose not to be placed onto a MCoC pathway, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102.
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS England specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool
For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 3?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement, and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for the scheme. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics in criteria 3.

The monthly publications and Maternity Services DashBoard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics The scores for each data quality criteria can be found in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series
The monthly publications and national Maternity Services DashBoard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

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

Required standard	a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies **equal to or greater than 37 weeks**. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.
Minimum evidential requirement for Trust Board	**Evidence for standard a) to include:** Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.
	Evidence for standard b) to include: • Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. • Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.

	• Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan.
	Evidence for standard c) to include: Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring **OR** An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**30 May 2023** to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process from years three and four of the maternity incentive scheme was to inform future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review. This should be in place and maintained in order to inform ongoing capacity planning of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the Operational Delivery Network (ODN), LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in ATAIN reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
We have undertaken some reviews for term admissions to NICU, do we need to undertake more and do all babies admitted to the NNU need to be included?	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the Avoiding Term Admissions into Neonatal Units (ATAIN) work to date. The expectation is that reviews have been continued from year 4 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 4 of the 2022/23 financial year (beginning January 2023). This may mean that some of the audit is completed retrospectively. We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies **equal to or greater than 37 weeks** to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all admissions should be included, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were admitted with jaundice and 35% of babies were admitted with hypothermia then focus on these two cohorts of babies.

	In addition to this, the number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues and the number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
What do you mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year and should cover the period of the MIS **30 May 2023 – 7 December 2023**.
What should the Transitional Care audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template; however, the audit needs to include aspects of the local pathway. ATAIN-CASE-NOTE-REVIEW-PROFORMA-Revised-2022-converted.pdf We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
How long have the neonatal safety champions been in place for?	Trust Board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/

	https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk)

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

Required standard	a) **Obstetric medical workforce** 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document:

	‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’ into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. **b) Anaesthetic medical 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. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) **c) Neonatal medical workforce** The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements **have not been met** in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). **d) Neonatal nursing workforce** The neonatal unit meets the BAPM neonatal nursing standards. If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed

	and include new relevant actions to address deficiencies. If the requirements **had been met** previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS. 3) Trusts/organisations should provide evidence of standard operating procedures and their implementation 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. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations. **NB**. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG 4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS. **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Obstetric medical workforce** 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 **Anaesthetic medical workforce** Trusts to evidence position by 7 December 2023 at 12 noon **Neonatal medical workforce** A review has been undertaken of any 6 month period between **30 May 2023 – 7 December 2023** **a) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 5 reporting period **30 May 2023 – 7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2023. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to short term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to long term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2023 and prior to submission to the Trust Board and have a plan to address any shortfalls in compliance.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long term locums are employed who are not fully supported/supervised?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to long term locums?	Safe staffing | RCOG

	All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors acting down?	Trusts should provide documentary evidence of standard operating procedures and their implementation Evidence of implementation/compliance could be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should produce a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Trusts cannot self-certify if they have no evidence of any standard operating procedures by **October 2023**. They can self-certify if they have been unable to achieve appropriate compensatory rest in individual circumstances such as excessive staffing pressure have prevented the doctor accessing this. They should, however, demonstrate that they have an action plan to ensure future compliance and provide assurance to the Board that this is place.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to consultant attendance out of hours?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this element of safety action 4 if	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans

consultants have not attended clinical situations on the mandated list?	implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net and RCOG	

Anaesthetic medical workforce

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	**A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.**

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication whether the standards not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps. This action plan should be submitted to the LMNS and ODN.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	

NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1** Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3. NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice. **Tier 2** A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP. NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone. NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.

LNU **Local Neonatal Unit**	**Tier 1** At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7. In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework. **Tier 2** An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week. LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7. **Tier 3** Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit. LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually. No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training**.**

SCU **Special Care Unit**	**Tier 1** A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. **Tier 2** A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit. **Tier 3** In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology).
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 5 reporting period.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021). A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance	
Neonatal nursing workforce standards and action	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

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

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) 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. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

	• Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.
	
	  ○ The midwife to birth ratio
	
	  ○ The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
	
	• Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	30 May 2023 – 7 December 2023
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at **12 noon**

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637 https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to

	midwives at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 5 of MIS.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

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?

Required standard	1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. 2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.
Minimum evidential requirement for Trust Board	1) The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. A new implementation tool is now available to help maternity services to track and evidence improvement and compliance with the requirements set out in version three. The tool is based on the interventions, key process and outcome measures identified within each element, and is available at https://future.nhs.uk/SavingBabiesLives Providers should use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, **providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.** These percentages will be calculated within the national implementation tool. 2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust, using the implementation tool and includes the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.

	• Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/ The implementation tool is available at https://future.nhs.uk/SavingBabiesLives and includes a technical glossary for all data items referred to in MSDS Additional resources are in production and will be advertised on this page. Any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net Some data items are or will become available on the National Maternity Dashboard or from NNAP Online For any other queries, please email nhsr.mis@nhs.net
What is the rationale for the change in evidential requirements to SA6 in Year 5?	The broad principles that will apply to the implementation of the standards detailed in the Saving Babies' Lives Care Bundle (version 3) are: The use of the implementation tool will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle (for some elements this may only require evidence of a protocol, process, or appointed post). These data will form the basis of compliance with safety action 6 of this version of the maternity incentive scheme. This approach acknowledges the increased number and/or size of elements in this new version of the care bundle. The indicators for each of the six elements are set out below. Data relating to each of these indicators will need to be provided via the national implementation tool. ***Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and/or Neonatal System e.g Badgernet and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding.***

What are the indicators for Element 1	*Process Indicators* 1a. Percentage of women where there is a record of: 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment 1b. Percentage of smokers* that have an opt-out referral at booking to an in-house/in-reach tobacco dependence treatment service. 1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date. *Outcome Indicators* 1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. 1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks. *a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). **Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.
What are the indicators for Element 2	*Process Indicators* 2a. Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking. (This should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.) 2b. Percentage of pregnancies where a Small for Gestational Age (SGA) fetus (between 3rd to <10th centiles) is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital. 2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT). *Outcome Indicators*

	2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). 2e. Percentage of live births and stillbirths >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected.
What are the indicators for Element 3	*Process Indicators* 3a. Percentage of women who attend with Reduced Fetal Movements (RFM) who have a computerised Cardiotocograph (CTG). 3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan by the next working day to assess fetal growth. *Outcome Indicators* 3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. 3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation.
What are the indicators for Element 4	*Process Indicators* 4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors, and situational awareness. 4b. Percentage of staff who have successfully completed mandatory annual competency assessment. 4c. Fetal monitoring lead roles appointed. *Outcome Indicators* 4d. The percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 2018[48].

What are the indicators for Element 5	*Process Indicators* 5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU). 5b. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 5c. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. 5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. 5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. 5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. 5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. 5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (5a – 5g above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation). *To minimise the need for local data collection to support these improvements the formal collection of process measure data can be restricted to the seven interventions listed in this section, the use of volume targeted ventilation and caffeine is recommended but these data are not currently recorded or presented with national datasets. In addition, the gestational limits for some of the indicators and/or the groups studies have been adjusted to align with current nationally collected data (e.g., data on babies born only below 34 weeks or data on the number of babies*

	receiving antenatal corticosteroids rather than the number of mothers) *Outcome Indicators* **5i. Mortality to discharge in very preterm babies** (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner). **5j. Preterm Brain Injury** (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: ✓ Germinal matrix/ intraventricular haemorrhage ✓ Post haemorrhagic ventricular dilatation ✓ Cystic periventricular leukomalacia 5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was a relevant issue. 5l. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: ✓ In the late second trimester (from 16+0 to 23+6 weeks). ✓ Pre-term (from 24+0 to 36+6 weeks).
What are the indicators for Element 6	*Process Indicators* 6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). 6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.

	6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. 6d. Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. 6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities, and availability of expertise. *Outcome Indicators* 6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashboard (aiming for >95% of women). 6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women). Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.
What considerations need to be made to ensure timely submission of data to evidence implementation and compliance with locally agreed progress measures?	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. MSDS does not capture all process and outcome indicators given in the care bundle. A summary of this appears in the technical appendix for version 2 of the care bundle, available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/tools-and-guidance

	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.
Would a Trust be non-compliant if <60% of smokers set a quit date?	As stated in SA6, 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. The implementation tool will set out the evidence requirement for demonstrating compliance with each intervention. Where element process and outcome measures are listed in the evidence requirement, a performance threshold is recommended, but this is for agreement between a provider and their ICB in view of local circumstances.
The SBLCBv3 that was published on the 31st May 2023 included a typo in Appendix D Figure 6 with BMI as >18.5kg/m and it is not clear what "other features" mean	This has now been amended and states **<18.5kg/m** with further clarity provided regarding "other features".
How do we provide evidence for the interventions that have been implemented?	The evidence requirements for each intervention are set out within the implementation tool. You will need to verify that you have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBLCB eLearning for Health modules is currently being updated in line with the latest iteration, Version 3 of the Care Bundle and will include a new section to support implementation of element 6. We have asked for the ultrasound element to be reviewed for its relevance, this was developed separately, and we will make sure the completion of the e learning is focussed on elements 1-6.
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at **12 noon**

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

Required standard	1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. 2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. 3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.
Minimum evidential requirement for Trust Board	**Evidence should include:** • Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. • The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.
Validation process	Self-certification to NHS Resolution using the Board declaration form.

What is the relevant time period?	Trusts should be evidencing the position as **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at 12 noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people, and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality, and experience of maternity and neonatal care.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What advice is there for Maternity and Neonatal Voices Partnership (MNVP) leads when engaging and prioritising hearing the voices of neonatal and bereaved service users, and what support or training is in place to support MNVP's?	MNVPs should work in partnership with local specialist voluntary, community, and social enterprise (VCSEs) with lived experience to gather feedback. Engagement needs to be accessible and appropriate, particularly for neonatal and bereaved families. It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided. MNVPs can also work in collaboration with their trust bereavement leads to ensure adequate support is in place for themselves and the families they may engage with. Attendance at the trust training could be beneficial.
When will the MNVP guidance be published?	We are working with our stakeholders to publish the MNVP guidance as soon as possible. As it is not yet published, it is acknowledged that there may not be enough time ahead of the reporting period for full implementation of all the requirements of the MNVP guidance. Where an element of the guidance is not yet fully implemented, evidence must be presented that demonstrates progress towards full implementation within 12 months.

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

Required standard and minimum evidential requirement	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review. It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1

Technical guidance for safety action 8

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A **training plan** should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. NHS England » Core competency framework version two Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.
How will the 90% attendance compliance be calculated?	The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups by the end of the 12 month period

Where can I find the Core Competencies Framework and other additional resources?	• https://www.england.nhs.uk/publication/core-competency-framework-version-two/
	• Includes links to the documents:
	  ○ Core competency framework version two: Minimum standards and stretch targets
	  ○ 'How to' guide - a resource pack to support implementing the Core Competency Framework version two
	  ○ Core competency framework: training needs analysis
	• NHS England V1 of the Core Competency Framework https://www.england.nhs.uk/publication/core-competency-framework/
	• https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth

What training should be included to meet the requirements of the Core Competency Framework Version 2?	All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles: 1. Service user involvement in developing and delivering training. 2. Training is based on learning from local findings from incidents, audit, service user feedback,

	and investigation reports. This should include reinforcing learning from what went well. 3. Promote learning as a multidisciplinary team. Promote shared learning across a Local Maternity and Neonatal System.
Which maternity staff should be included for Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor) • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees
Which maternity staff should be included for Module 3: Maternity emergencies and multiprofessional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants. • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota. • Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) **who contribute to the obstetric rota.**

	• Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 5 compliance assessment • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 5 compliance • At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff
Does the multidisciplinary emergency scenarios described in module 3 have to be conducted in the clinical area?	At least one emergency scenario needs to be conducted in the clinical area or at point of care. You need to ensure that 90% of your staff attend a minimum of one emergency scenario that is held in the clinical area, but not all of the scenarios have to be based in a clinical area.
Which staff should be included for Module 6: Neonatal basic life support?	Staff in attendance at births should be included for Module 6: Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. The staff groups below are not required to attend neonatal basic life support training: • All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). • Local policy should determine whether maternity support workers are included in neonatal basic life support training.

I am a NLS instructor, do I still need to attend neonatal basic life support training?	No, if you have taught on a course within MIS year 5 you do **not** need to attend neonatal basic life support training
I have attended my NLS training, do I still need to attend neonatal basic life support training?	No, if you have attended a course within MIS year 5 you do **not** need to attend neonatal basic life support training as well.
Which members of the team can teach basic neonatal life support training and NLS training?	Registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates. A detailed response to this can be found on the CCF NHS Futures page CCF NHS Futures page - FAQ
What do we do if we do not have enough instructors who are trained as an NLS instructor and hold the GIC qualification?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your Local Maternity and Neonatal System (LMNS) to explore sharing of resources. There may be difficulty in resourcing qualified trainers. Units experiencing this must provide evidence to their trust board that they are seeking mitigation across their LMNS and an action plan to work towards NLS and GIC qualified status by 31st March 2024. As a minimum, training should be delivered by someone who is up to date with their NLS training.
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined.
How do we involve services users in developing and <u>delivering</u> training?	Please refer to the "How To" guide for ideas on how to involve service users in the developing and delivering of training. This is **Principle 1** of the CCFv2 that recommends MNVP leads could be a member of the multidisciplinary educational teams (MET) to support the planning and selection of themes/local learning requirements to reflect in the training. Ways in which service users and service user representatives can support the delivery of training include with video case studies, inviting service users to tell their story or inviting charitable/support organisations for example local Downs Syndrome groups; LGBTQIA+ Communities; or advocates for refugees.

	NHS England will be sharing examples of practice over the year and on their NHS Futures page.
The TNA suggests periods of time required for each element of training, for example 9 hours for fetal monitoring training. Is this a mandated amount of time?	The TNA has been inputted with **example** times to demonstrate how the calculations are made for the backfill of staff that is required to put a training plan in place. The hours for each element of training can be flexed by the individual trust in response to their own local learning needs.
Do all the modules within the CCF require a multidisciplinary attendance?	Multidisciplinary team working has an evidence-base and has been highlighted in The Kirkup Report (2022). Key Action 3 (Flawed Team working) was a significant finding with the recommendation to improve teamworking with reference to establishing common purpose, objectives, and training from the outset. It is therefore a requirement that there is a strong emphasis on multidisciplinary training throughout the modules in response to local incidents. The staff groups within the multidisciplinary teams being trained may also vary, depending on the incident/emergency being covered.

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?

Required standard	a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings. c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.
Minimum evidential requirement for Trust Board	**Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:** • Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. • Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). • To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need. **Evidence for point b)** • Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions

	must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting. **Evidence for point c):** Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Time period for points a and b)** • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st December 2023. • The expectation is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023. • The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff engagement sessions are visible to both maternity

	and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than the 17th July 2023. • Evidence that a review of the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. This should continue to be undertaken quarterly as detailed in MIS year 4. **Time period for points c)** • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have **registered** to the dedicated FutureNHS workspace to access the resources available no later than 1 August 2023. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of quarterly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 2 meetings held by 1 February 2024
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) Measuring culture in maternity services: Safety Culture Programme for Maternal and neonatal services: https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board safety champions to access the culture and leadership

	programme, view wider resources and engage with a community of practice to support them in their roles. The Perinatal Culture and Leadership Programme - Maternity Local Transformation Hub - Maternity (future.nhs.uk) is a dedicated space for NHS England's Perinatal Culture and Leadership Programmes, with resources for senior leaders and their teams to support local safety culture work.

Technical guidance for safety action 9

Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: • Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board. • Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician.
What do we need to include in the dashBoard presented to Board each month?	The dashboard can be locally produced, based on a minimum data set as set out in the Board level measures. It must include the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three and four requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 1 July 2023.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.

What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here 2021 Scorecards launch - NHS Resolution https://resolution.nhs.uk/2020/10/27/claims-scorecards-for-2020/
What are the expectations of the Board safety champions in relation to quality improvement work undertaken by the maternity and neonatal quality improvement programme?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will be involved in the Perinatal Culture and Leadership Programme. As part of this programme every service will be undertaking work to meaningfully understand the culture of their services. This diagnostic will either be a SCORE culture survey or an alternative as agreed with the national NHSE team. It is expected that diagnostic findings are shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings.
What if our maternity and neonatal services are not undertaking the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture is a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work.
What are the expectations of the NED and Exec Board safety champion in relation to	As detailed in previous years MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provide an opportunity to share

their support for the Perinatal Culture and Leadership Programme (PCLP), culture surveys and ongoing support for the Perinatal 'Quad' Leadership teams? / What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal 'Quad' Leadership teams?	safety intelligence, examples of best practice and identified areas of challenge. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive. As a minimum the content should cover: - Learning from the Perinatal Culture and Leadership Development Programme so far - Plans to better understand their local culture. This will be use of the SCORE culture survey, or suitable alternative as agreed by the national NHS England team. - Updates on the SCORE survey, or alternative when undertaken. - Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, a formal report following this work should be presented at Board by the Perinatal leadership team. Progress with interventions relating to culture improvement work, and any further support required from the Board
Clarification as to evidence required to meet the standard: *Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.*	The NED and Exec Board Safety Champion will be able to evidence they have registered on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace through minutes of a trust board meeting providing confirmation of specific resources accessed and how this has been of benefit. This will be reported as part of the board submission to NHS Resolution.
How often should the Board Safety Champions be meeting and engaging with the perinatal 'Quad' team?	Meetings between the Board Safety Champion(s) and Quad member(s) should be occurring a minimum of quarterly. We would expect a minimum of two meetings during this reporting period.
Who is expected to have undertaken the Perinatal Culture and Leadership Quad programme?	The expectation is that the senior perinatal leadership team (the Quad) have undertaken the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the

	DoM/HoM, clinical lead / CD for obstetrics, clinical lead for neonates and the operational manager.
Is there an expectation that the board safety champions have undertaken the programme?	The Board Safety Champions should be supporting the Quad and their work as part of the PCLP, but there is no expectation for them to attend the programme.
Evidence that a monthly review – Most Trust meet bi-monthly (every other month) & are unable to meet this requirement	A review must be undertaken at every board meeting. If this is bi-monthly that will be sufficient, but this is the minimum requirement.
Examples have been requested for how to review the data from scorecards	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historic claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historic themes re-emerged. An example is now available from the MIS team at NHS Resolution, and staff are happy to talk through this process if it is helpful.
The perinatal quality surveillance model requires review in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife to provide evidence of trust-level intelligence being shared and actions reported on areas of concern. This needs to happen before 1st July and therefore does not give trusts enough time to carry out this review	The expectation is that this process should already be in place as it was a requirement in previous years, with the year 4 requirement for this to be in place by 16th June 2022. However, in recognition of the challenges of embedding a new quality surveillance model the timeframe of the 1st July has been amended to 1st December 2023 to allow additional time for trusts.
Clarification as to what constitutes a trust board, can sub committees be categorised as a board?	This refers solely to the Board of the trust, and it is a requirement that the board oversees the quality of their perinatal services at every meeting.

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?

Required standard	A) Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to **7 December 2023.** B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until **7 December 2023**. C) For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB/MNSI and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB/MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's

	involvement, completion of this will also be monitored, and externally validated.
What is the relevant time period?	Reporting to HSIB – from 6 December 2022 to **7 December 2023** Reporting period to HSIB **and** to NHS Resolution – from 6 December 2022 to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon

Technical guidance for Safety action 10

Technical guidance	
Where can I find information on HSIB?	Information about HSIB/ MNSI and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/ From October 2023 this website will no longer be available and the HSIB maternity programme will be hosted by the CQC. Further details will be circulated once available.
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website: • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB/MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or] • Was therapeutically cooled (active cooling only) [or] • Had decreased central tone AND was comatose AND had seizures of any kind. Once HSIB/MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
What is the definition of labour used by HSIB and EN?	The definition of labour used by HSIB includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Changes in the EN reporting requirements for Trust from	With effect from 1 April 2022, Trusts have been required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed

1 April 2022 going forward	they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB//MNSI report with the EN team within 30 days of receipt of the final report by uploading the HSIB/MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB/MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB/MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution. There is more information here: ENS Reporting Guide - July 2023 (for Member Trusts) - NHS Resolution
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases that HSIB/MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to HSIB/MNSI or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB/MNSI because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB/MNSI reference number (document the HSIB reference in the “any other comments box”). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB/MNSI maternity team (maternity@hsib.org.uk).
How should we report cases to NHS Resolution?	Trusts’ will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB/ MNSI as under investigation. They must also complete the ***EN Report*** form and attach this to the Claims Reporting Wizard: https://resolution.nhs.uk/wp-content/uploads/2023/05/EN-Report-Form.pdf
What happens once we have	Following the HSIB/MNSI investigation, and on receipt of the HSIB/MNSI report and MRI report, following triage, NHS Resolution will overlay an

reported a case to NHS Resolution?	investigation into legal liability. Where families have declined an HSIB/MNSI investigation, no EN investigation will take place, unless the family requests this.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB/MNSI as soon as they occur and to NHS Resolution as soon as HSIB/MNSI have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIBMNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and HSIB/MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

FAQs for year five of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided.** It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the Accountable officer (AO) for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution The declaration form must be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission.
Our current commissioning systems are changing, what does this mean in terms of sign off?	There have been structural changes for NHS Commissioning as a result of 2022 Health and Care Act. Where this has caused significant reconfiguration and adjustment of commissioning systems, sign off by the accountable lead for commissioning maternity services can be considered
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10,

	standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc. For more details, please refer to the conditions of the scheme.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and Accountable Office (IBC). Where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to NHS Resolution.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2023. **It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 1 February 2024, NHS Resolution will treat that as a nil response.**
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 1 February 2024**. If not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.

Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated link contacts via link on the NHS Resolution website. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme/
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results. The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal: • alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation • technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated at a later date.

Merging Trusts	Trusts that will be merging during the year four reporting period (30 May 2023 – 7 December 2023) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2022/23 and the reporting of claims and management of claims going forward.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the maternity incentive scheme?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Q2) Why have these safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Obstetric Anaesthetists Association, Royal College of Anaesthetists, HSIB, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England & Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health
- Care Quality Commission
- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff
- HSIB/CQC

Q4) How will Trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at nhsr.mis@nhs.net **by 12 noon on 1 February 2024**

Please note:

- Board declaration forms will be reviewed by NHS Resolution and discussed with the scheme's Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.
- If a completed Board declaration form is not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.

East Lancashire Hospitals NHS Trust

Avoiding Term Admissions Into Neonatal Units (NICU) (ATAIN)
Q3 2023 (October- December 2023 data)
Links with 2023 ACTION PLAN

Item

Purpose Information√

Action√

Monitoring√

Title	Avoiding Term Admissions Into Neonatal Units (ATAIN)
Author	Kathryn Sansby, Quality and Safety Lead for Maternity and Neonatology

Summary: This report aims to demonstrate oversight of the number of term babies admitted to NICU. It will provide a summary of the data gathered from completed reviews of all unanticipated term admissions to NICU to determine whether there were modifiable factors which could be addressed as part of an action plan.

Recommendation: To be shared with the Head of Midwifery and named neonatal safety champion with shared oversight for progress in meeting the action plan, and with the board level safety champion.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform and deliver best practice.
CNST Safety Standard 3 f)	An action plan to address local findings from Avoiding Term Admissions into Neonatal units (ATAIN) reviews has been agreed with the neonatal safety champion and Board level champion. Progress with the agreed ATAIN action plan has been shared with the neonatal safety champion and Board level champion.

Quarterly ATAIN report (Q3 October – December 2023)

MIS (CNST) requires 100% of unexpected term admissions to NICU to have a thorough MDT review of antenatal, intrapartum and postnatal care with a view to identifying modifiable factors to inform the ATAIN action plan and reduce the unnecessary separation of mothers and babies. All outstanding reviews have been escalated and a plan is in place for their completion. The table will be updated each quarter.

	Total Term Live Births	Total Term Admissions to NICU	Unexpected Term Admissions to NICU	No. MDT Reviews Completed	No. of reviews partially completed	No. of reviews not commenced	Potentially avoidable admissions to NICU
Q4							
Jan 2023	**432**	**24 (5.5%)**	**21 (4.8%)**	**21**	**0**	**0**	**0**
Feb 2023	**422**	**25 (5.9%)**	**22 (5.2%)**	**22**	**0**	**0**	**1**
March 2023	**484**	**38 (7.8%)**	**32 (6.6%)**	32	0	**0**	**4**
Total Q4	**1338**	**87 (6.5%)**	**75 (5.6%)**	**75 (100%)**	**0**	**0**	**5 (7%)**
Q1							
April 2023	**383**	**31 (8.1%)**	**27 (7.0%)**	**27**	**0**	**0**	**2**
May 2023	**439**	**40 (9.1%)**	**37 (8.4%)**	**37**	**0**	**0**	**3**
June 2023	**437**	**36 (8.2%)**	**32 (7.3%)**	**32**	**0**	**0**	**2**
Total Q1	**1259**	**107 (8.5%)**	**96 (7.6%)**	**96 (100%)**	**0**	**0**	**7 (7%)**
Q2							
July 23	**449**	**29 (6.45%)**	**26 (5.79%)**	**26**	**0**	**0**	**0**
August 23	**469**	**30 (6.39%)**	**28 (5.97%)**	**28**	**0**	**0**	**0**
Sept 23	**445**	**28 (5.9%)**	**26 (5.84%)**	**26**	**0**	**0**	**0**
Total Q2	**1363**	**86 (5.83%)**	**80 (5.42%)**	**80 (100%)**	**0**	**0**	**0**
Q3							
Oct 23	**485**	**27 (5.56%)**	**24 (4.94%)**	**20**	**2**	**0**	**1**
Nov 23	**460**	**31 (6.73%)**	**29 (6.30%)**	**25**	**4**	**0**	**2**
Dec 23	**466**	**28 (6.00%)**	**22 (4.72%)**	**9**	**6**	**7**	**0**
Total Q3	**1411**	**86 (6.09%)**	**75 (5.31%)**	**54**	**12**	**7**	**3**
Total year	**5371**	**366 (6.81%)**	**326 (6.06%)**				

MIS (CNST) Specific data Q3 October-December 2023

Number of admissions to NICU that would have met TC admission criteria but were admitted to NICU due to staffing or capacity	Number of babies that were admitted to NICU because of their need for nasogastric tube feeding but would have been cared for on TC if NGT feeding was supported there	Number of babies that remained on NICU because of their need for nasogastric tube feeding but would have been cared for on TC if NGT feeding was supported there
0	**0**	**0**

Term admissions to NICU Q3 October-December 2023

- 86 Term babies were admitted to NICU in this quarter.
- 11 of these were planned admission or had known anomalies therefore the admission was expected. The reasons for these admissions included social admissions (4) or known congenital anomalies (7).
- 75 were unexpected term admissions to NICU.
- 5 of these were admitted for therapeutic cooling and have been referred to MNSI for further investigation; 3 have been accepted for investigation, 2 are being triaged.
- The admission rate for ELHT remains above the local target of 5% but is below the national target of 7%

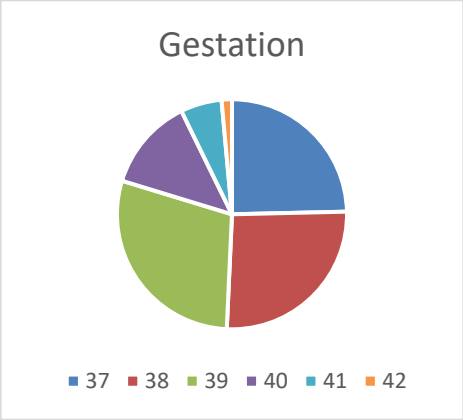
Summary of quarterly ATAIN reviews

69 unexpected term admissions have been reviewed using the ATAIN tool in this quarter.

5 Term Admissions were cooled babies therefore have been reviewed as a Patient Safety Review and referred to MNSI.

- 100% of admissions were appropriate
- There was no unnecessary separation of mums and babies
- 95.6% of admissions were unavoidable (66)
- 4.4% of admissions had issues identified that may have led to the admission to NICU and had care been different the admission may have been avoided (3)
- The 3 admissions that may have been avoidable are being reviewed as PSRs and individual actions will be agreed
- 86.9% of unexpected admissions had good care, no learning identified (60)
- 13.1% of unexpected admissions had incidental learning identified (9)

Gestation at admission;



Gestation	No. admissions
37	**17**
38	**18**
39	**20**
40	**9**
41	**5**
42	**1**
Total	**69**

- 50.72% of unexpected admissions were babies born before 39 weeks gestation (35)
- Only 1 of these babies received antenatal steroids

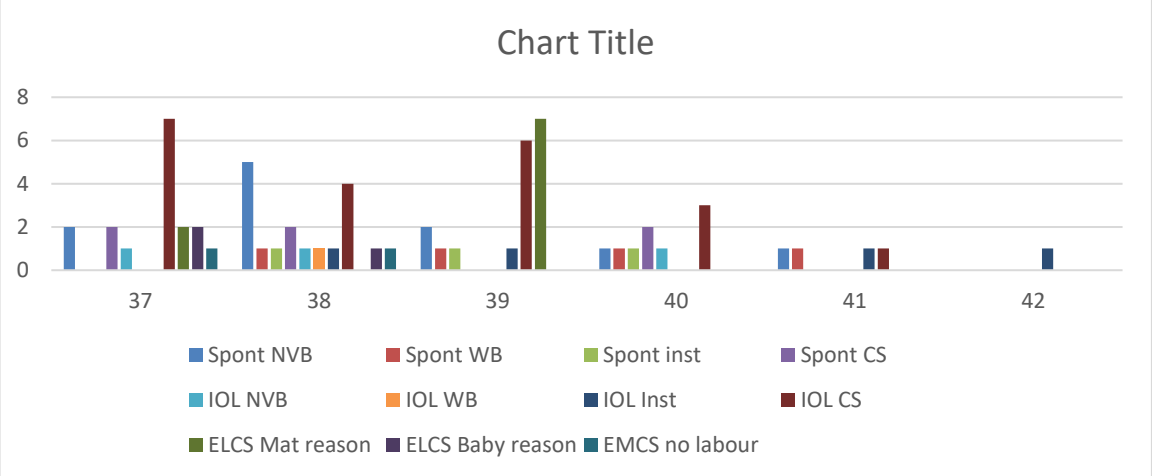
Gestation and mode of birth;

- 44.9% of unexpected admissions were babies who had had labour induced (31)
- 74.1% of unexpected admissions were babies born by caesarean section following induction of labour (23/31)
- 48.3% of unexpected admissions were inductions of labour before 39 weeks gestation (15/31)
- 62.3% of unexpected admissions were babies born by caesarean section in total (43)

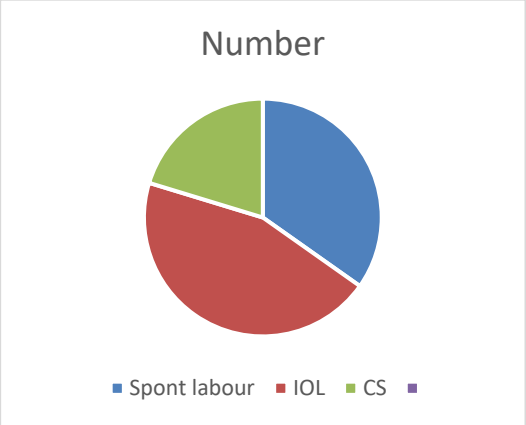
Mode of birth;

Spont. NVB	Spont. WB	Spont. Inst.	Spont. CS	IOL NVB	IOL WB	IOL Inst	IOL CS	ELCS Mat reason	ELCS Fetal reason	EMCS no labour
11	4	3	6	3	1	4	23	9	3	2

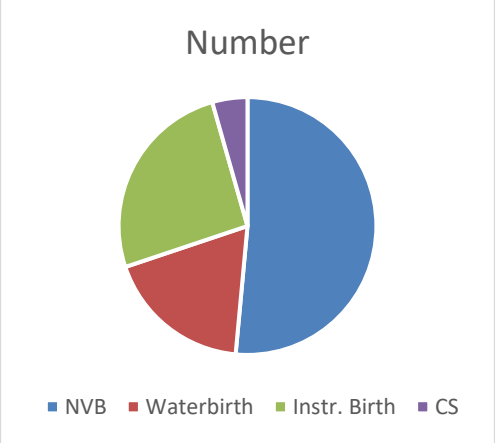
Mode of birth and gestation



Admission by onset of labour;
Total admissions for births following spontaneous labour = 24
Total admissions for births following Induction of labour = 31
Total admissions for births by Caesarean section without labour = 14



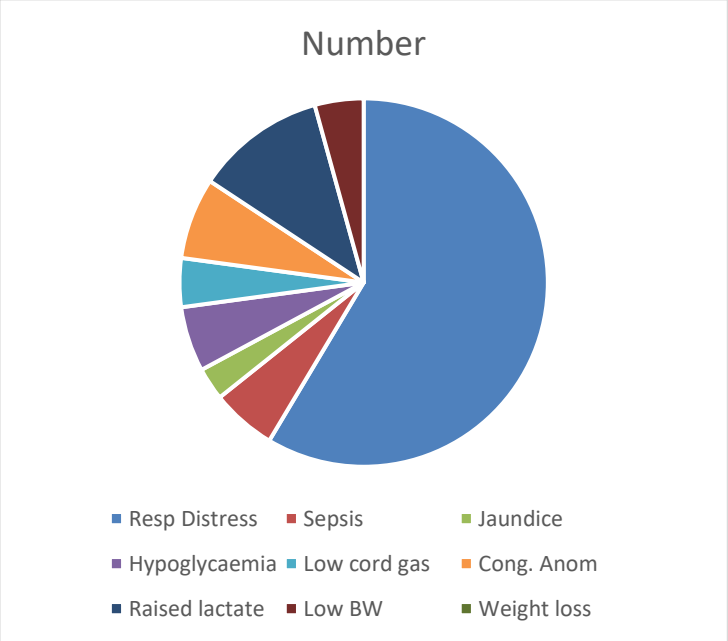
Admissions by mode of birth;
Total admissions for normal vaginal births = 14
Total admissions for waterbirths = 5
Total admissions following instrumental birth = 7
Total admissions for births by Caesarean section = 43



Reason for admission

- Respiratory Distress remains the main reason for admissions – 59.64% (41/69)
- 50% of babies admitted with respiratory distress were born before 39 weeks gestation.
- 11.5% of the unexpected admissions had diabetic mums (8)

Resp. distress	Sepsis	Jaundice	Hypoglycaemia	Low cord gas	Congenital anomaly (not identified antenatally)	Raised lactate	Low birth weight	Weight loss > 15%
41	4	2	4	3	5	8	3	1



Additional factors

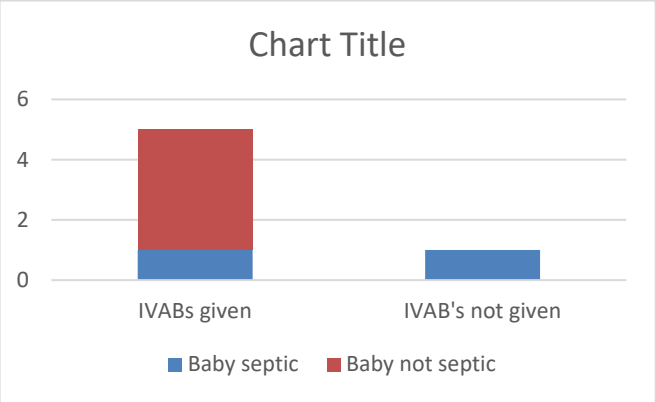
Warm bundle

Completed	Partially completed	Not completed	N/A (eg BBA)
21	30	17	1

Although the warm bundle has not been completed in every case, hypothermia was not a reason for admission in any baby

Maternal GBS – 6 mums were GBS+ve

- 2 of these babies developed sepsis
- 5 of the mum's received antibiotics in labour



Maternal sepsis identified

- 3 mothers had sepsis identified in the intrapartum period.
- All these women had the septoc bundle commenced and were given IV antiobiotics prior to birth
- 2 of the babies born to these mums developed sepsis

Source of admission

CBS	Theatre	Postnatal ward	Birth centres	Home
20	16	27	4	2

40 babies were admitted to NICU from their place of birth – Central birth suite and theatres being the main source of admission.

Incidental learning Quarter 3

- Documentation at all stages of maternity care requires improvement, including;
  - Medical review
  - Documentation of feeds
  - Documentation of resuscitation
  - Documentation of reason for intervention such as decision for C section

- Fresh eyes review and hourly review of CTG must be performed and documented. Medical staff must document their reviews and not perform remote reviews.
- No consultant appointment at 16 weeks
- Use of interpreters at all appointments
- Induction of labour before 38 weeks for maternal request
- Elective Caesarean section at 38 weeks for LGA
- Meows should be performed as per guidance and documented in the appropriate place on Badgernet
- Babies being transferred to Postnatal ward quickly after birth- a period of observation on CBS was indicated
- Neonatal observations not performed in line with guidance
- Warm bundle must be completed following birth and baby's temperature checked prior to transfer and documented on Badgernet

ATAIN Safety Improvement Plan

Progress	40%
Tasks Not yet started	0
Tasks on hold	0
Ongoing Tasks awaiting response	1
Ongoing Tasks which need support	2
Ongoing Tasks with no issues	6
Overdue Tasks	1
Tasks Complete	6
Total no of tasks	15

WORKSTREAMS/ THEMES & TASKS	LEAD	PROGRESS	DEADLINE	STATUS	UPDATE DATE	UPDATE COMMENTS (To add extra detail into a cell on another line hold 'Alt' and 'Enter' Keep the most recent update to the top of the cell)
Respiratory						
Meeting to review TC nurse operational pathway to support outreach care for elective caesarean sections to provide support with initial care plans. Task & finish group to consider.	R Dawson/ TC Team	Ongoing - need support	31/05/2024	Not due		
Continous education updates and raising awareness on uninterrupted skin to skin lead by the infant feeding team and wider leadership teams within maternity and neonatology.	Donna Butler/ Mischa Russell/ Jennie Birtwistle/Sue Henry	Ongoing - no issues	31/03/2024	Not due	30/08/2023	Simulations and flowchart commenced for uniterrupted skin to skin for babies born in theatre. (Audits to support this)
Perform further audit of causes of respiratory admission - Consider Link to ongoing IOL Service Evaluation and Intergro	S Loveridge / S Sivashanker	Ongoing - Awaiting response	31/05/2024	Not due		Awaiting decision regarding this action
Hypoglycaemia						
ANNP's to audit hypoglycaemic cases to provide rich data for improvement	C Harrison / R Patel	Ongoing - no issues	31/05/2024	Not due		
Observations & Monitoring						
Refresher training re recording of MEOWs on Badger	Digital Leads	Complete	27/02/2024	Complete		Mandatory training package for all staff to complete
Categorisation of CTGs - escalation by CTRG workshops and inclusion on fetal monitoring day	Fetal Monitoring Leads	Complete	27/02/2024	Complete		Mandatory Fetal Monitoring study day CTG monthly workshops
Escalation - share escalation process for staff escalating concerns to doctors and Midwife co-ordinator with all staff		Ongoing - no issues	31/03/2024	Not due		
Failure to attend appointments not being followed up in line with guidance - guideline to be recirculated with staff prompts to be shared with all staff	K Sansby	Ongoing - no issues	31/03/2024	Not due		
Induction of Labour						

Review information given to women re IoL and choice - **Link to ongoing service evaluation for IoL**	R Sessions	Ongoing - no issues	31/05/2024	Not due	Service user questionnaire underway Feb24-Mar24 to establish current experience with information and choice around IoL. This was delayed slightly due to awaiting survey to be translated into key languages
C-Section					
Review information given to women re steroids before 39 weeks - **link to ongoing audit r.e. C-section rates**	S Loveridge	Ongoing - need support	29/02/2024	Overdue	Overdue action due to pressures with staffing and Doctors' strikes
Communication					
Use of interpreters at all appointments/contacts - not to use family members	Matermity Transformation team	Ongoing - no issues	31/05/2024	Not due	Maternity Transformation Team members and Consultant Midwife have attended the Trust training on use of translation services February 2024. Requested data from Trust translation manager re use of DA languages specific to Maternity
Insert new rows ABOVE this one					

Healthier Pennine Lancashire

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Transitional care (TC) Audit October-December 2023

ELHT Maternity/ Neonatology

CNST year 5 (Safety Action 3/Quarter 3)

Savi Sivashankar/Rebecca Fennell/Helen Oates

Safe | Personal | Effective

October 2023
Number of term and late preterm admissions(numbers)

Term admissions 31

Preterm admissions 10

Term admissions causes (numbers)

- **Resp disease – 9**
- HIE suspected/confirmed - 3
- Jaundice - 1
- Hypoglycaemia - 1
- Monitoring – 4
- Cong anomaly - 1
- Sepsis suspected - 4
- Readmission for transfer – 4 (4 repatriations from other hospitals)
- Social - 1
- Other- (specify) – 3 (poor condition at birth, other cardio/respiratory issue, other neurological disease)

Term - SCBU days that could have been delivered on TC

- SCBU days on NICU-total 59 days
- Could have been on TC - total 7 days
- Reason- mum discharged from PNW - Awaiting foster carer

Late preterm babies - causes of admission (numbers)

- Resp disease – 6
- Hypoglycaemia - 2
- Jaundice – 1
- Absent end diastolic flow - 0
- Prematurity – 1
- Other (specify) - 0

Preterm (34-37 weeks) - SCBU days that could have been delivered on TC

Preterm days of SCBU on NICU – total 22 days
Total days could have been on TC – 2 days
- Reason: full NG feeds

Number of days TC activity higher than 12

7 days

Minimum TC babies = 4

Maximum TC babies = 19

Action Plans

Accepted Recommendations	Required Action	By Date	By Whom
Social care process to be made more robust	Advanced planning to be in place	Ongoing	Safeguarding /social care/midwifery team
Better staffing for full NG feeds on TC	Staffing review	Ongoing	TC management team

Overall Assurance Level

Compliance Rating	Calculation of Assurance	Achieved
Full Assurance	To be used when each standard has achieved a score of 95% or above and is rated Green	
Significant Assurance	To be used when there are only Green and Amber rated findings (although where there are a significant number of Amber rated findings, consideration will be given as to whether in aggregate the effect is to reduce the assurance level given)	✓
Limited Assurance	To be used when there is a small ratio of Red and Amber to Green rated findings	
Very Limited Assurance	To be used when the ratio of Red rated findings are greater than the Amber and Green	

November 2023
Number of term and late preterm admissions(numbers)

Term admissions 33

Preterm admissions 10

Term admissions causes (numbers)

- **Resp disease – 13**
- HIE suspected/confirmed – 2
- Jaundice – 0
- Hypoglycaemia – 1
- Monitoring – 2
- Cong anomaly – 0
- Sepsis suspected – 2
- Readmission for transfer – 2
- Social - 0

- Other- (specify)

- Congenital abnormality suspected/confirmed – 1
- Cardiovascular disease – 1
- Other feed related issue – 1
- IUGR/SGA – 2
- Other cardio/respiratory issue – 3
- GIT disease – 1
- NAS – 1
- Poor feeding/weight loss - 1

Term - SCBU days that could have been delivered on TC

- SCBU days on NICU-total 51 days
- could have been on TC-total -4
- Reason-Low weight/unexplained delay

Late preterm babies- causes of admission(numbers)

- Resp disease – 6
- Hypoglycaemia - 2
- Jaundice – 0
- Absent end diastolic flow - 0
- Prematurity – 1
- Other (specify) – 1x infection suspected

Preterm (34-37 weeks) - SCBU days that could have been delivered on TC

- Preterm days of SCBU on NICU – total 37
- Total days could have been on TC - 5
- Reason –NG feeds/mum no longer on PNW

Number of days TC activity higher than 12

12 days

Minimum TC babies = 7 babies

Maximum TC babies = 19 babies

Conclusion

- NG feeds and ability to provide this on TC is a reason for not transferring babies

- Mother not being on PNW is another common reason

Action Plans

Accepted Recommendations	Required Action	By Date	By Whom
Staffing review to provide full NG feeds on TC	TC staffing review	ongoing	Management team

Overall Assurance Level ✓

Compliance Rating	Calculation of Assurance	Achieved
Full Assurance	To be used when each standard has achieved a score of 95% or above and is rated Green	
Significant Assurance	To be used when there are only Green and Amber rated findings (although where there are a significant number of Amber rated findings, consideration will be given as to whether in aggregate the effect is to reduce the assurance level given)	✓
Limited Assurance	To be used when there is a small ratio of Red and Amber to Green rated findings	
Very Limited Assurance	To be used when the ratio of Red rated findings are greater than the Amber and Green	

December 2023
Number of term and late preterm admissions(numbers)

Term admissions 29

Preterm admissions 9

Term admissions causes(numbers)

- Resp disease – 15
- Jaundice - 2
- Hypoglycaemia - 1
- Monitoring – 3 (1x maternal drug use/social, 1x hypoglycaemia/congenital lactic acidosis, 1x suspected sepsis/poor lactates)
- Cong anomaly - 1
- Sepsis suspected - 1
- Social - 1
- Other- (specify) – 1x cardiovascular disease, 2x other neurological disease (1 admitted from Royal Albert Edward Infirmary), 1x IUGR, 1x other metabolic disease (hypernatraemic dehydration)

Term - SCBU days that could have been delivered on TC

- SCBU days on NICU - 68 days total
- Could have been on TC - 5 days total (2 babies-4 days and 1 day respectively)
- Reason-NG feeds/1 also had neurological investigations done

Late preterm babies- causes of admission(numbers)

- Resp disease – 5
- Hypoglycaemia - 2
- Prematurity – 1
- Other (specify) – Pulmonary stenosis x1
- (Note – 3 triplets included in this)

Preterm (34-37 weeks) - SCBU days that could have been delivered on TC

- Preterm days of SCBU on NICU – 47 days Total
- Total days could have been on TC - 27 days total
- Reason - NG feeds

Number of days TC activity higher than 12

9 days

Minimum TC babies = 4

Maximum TC babies = 16

Conclusions

- 5/68 SCBU days could have been delivered on TC for term babies
- 27/47 SCBU days could have been delivered on TC for preterm babies
- The commonest reason for babies staying on NICU was needing regular NG feeds- 1-3 hourly. This is not deliverable on TC with current staffing numbers.
- On 9 days, TC activity had exceeded 12-maximum of 16
- TC activity didn’t prevent transfer of babies from NICU to TC

Action Plans

Accepted Recommendations	Required Action	By Date	By Whom
TC staffing to be improved to accommodate babies on full NGT feeds	TC staffing review	Ongoing	Tracy Thompson /Jayne Case

Overall Assurance Level

Compliance Rating	Calculation of Assurance	Achieved
Full Assurance	To be used when each standard has achieved a score of 95% or above and is rated Green	
Significant Assurance	To be used when there are only Green and Amber rated findings (although where there are a significant number of Amber rated findings, consideration will be given as to whether in aggregate the effect is to reduce the assurance level given)	✓
Limited Assurance	To be used when there is a small ratio of Red and Amber to Green rated findings	
Very Limited Assurance	To be used when the ratio of Red rated findings are greater than the Amber and Green	

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

QUALITY COMMITTEE REPORT **Item**

28th February 2024 **Purpose** Approval
Assurance
Information

Title	**Floor to Board Maternity / Neonatology**
Report Author	Tracy Thompson (Divisional Director of Nursing & Midwifery)
Executive sponsor	Peter Murphy, Executive Director of Nursing. (Board Level Maternity/Neonatal Safety Champion)

Summary: To provide regular updates on behalf of ELHT (East Lancashire Hospitals Trust) maternity and Neonatal safety champions following scheduled 'floor-to-board' meetings, executive and non-executive walk arounds with other relevant trust wide patient, quality, and governance forums.
Collaboration with the quality committee board is primarily a direct focus for updates on improving maternity and neonatal safety aligning compliance, assurance and evidence of any escalation or improvements related to the National directives including the maternity incentive schemes, LMNS (Local Maternity and Neonatal System) deliverables aligned with funding streams, Ockenden immediate and essential actions and the three-year delivery plan for maternity and neonatology.

Recommendation: Quality committee members are asked to receive the report, note the contents acknowledge Maternity/Neonatology services progress and exceptions aligned with the deliverables within the time limits adding any recommendations. Any areas requiring improvement plans welcome further discussions.

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) because of ineffective workforce planning and redesign activities and its ability to attract and

		retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Related to key risks identified on Corporate Risk Register	
Related to recommendations from audit reports	
Related to Key Delivery Programmes	Clinical Negligence Scheme for Trust – Maternity Incentive Scheme (CNST-MIS) Maternity & Neonatal 3-year delivery plan
Related to ICB (Integrated Care Board) Strategic Objective	

Impact

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

Previously considered by:

1. Maternity and Neonatology 3-year delivery plan – an introduction

The three-year delivery plan published by NHS England in March 2023 (appendix 1) aims to make care safer, more personalised, and more equitable. The plan continues and aligns the findings and recommendations set out in the recent independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford (Ockenden Report, 2022) and by Dr Bill Kirkup on maternity and neonatal services in East Kent (Reading the Signals Report, 2022), previously Morecambe Bay (Kirkup Report, 2015)

The plan sets out the responsibilities specific to the Trusts, to the ICB's (integrated care boards) as a partner within an ICS (integrated care system) - the Local Maternity and Neonatal System (LMNS) is the maternity and neonatal arm of the ICS who provides assurance to the regional teams who further are responsible for the relationship between ICB's and NHS England.

The plan asks services to concentrate on four high level 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
- Standards and structures that underpin safer, more personalised, and more equitable care

Maternity and Neonatal services aim to reflect the four themes in the three-year plan as the structure for Floor to Board reports presented at Quality Committee, further informing staff and service users in the same manner. One example being the Maternity and Neonatal Newsletter to staff and service user friendly infographics as updates to be shared through the MNVP (Maternity and Neonatal Voice Partnerships) agendas alongside updates via the trust website. Direct communication with all colleagues working towards the shared goals and ambitions of the 3-year delivery plan is an essential part of our culture.

2. Theme 1 - Listening to and working with women and families with compassion

This theme is further defined by 3 objectives;

1. Care that is personalised,
2. Improve equity for mothers and babies, and
3. Work with service users to improve care.

2.1 CQC (Care Quality Commission) - Women's Experience of Maternity Care Survey 2023

On Friday 9th February 2024 CQC published the results of the 2023 survey of women's experiences of maternity care in England. The survey received responses from 25,515 women

who had a baby in January and February 2023, and it covers all aspects of maternity provision: antenatal care, care during labour and birth and post-natal care. There were 121 acute NHS trusts that took part.

ELHT Maternity Services received the feedback of this survey specific to our Trust in December 2023, as analysed and presented by the company IQVIA (appendix 2). This has been presented to relevant staff in the services at the Women and Newborn Quality and Safety Board in January and will be presented further at the Speciality Board on the 1st of March 2024.

The results include benchmark reports for each Trust, showing results for each question and how these compare to results from Trusts across the country. Also results in comparison to the previous year can be viewed to aid understanding of improvements or declines. If our Trust is an outlier for any question, with results either much better or worse than other Trusts, this will be identified in the outlier report.

Currently ELHT Maternity Services hold an action tracker aligned to the 2022 survey results (appendix 3), this has been co-produced with the Maternity and Neonatal Voice Partnership (MNVP) and is monitored aligned with CNST – Maternity Incentive Scheme Safety Action 7. Progress has been submitted within Trust Board Maternity Service Update reports routinely and to the LMNS Quality Assurance panel. ELHT will further progress with any identified continuous improvement actions from the 2022 results and will continue to engage all relevant multi-disciplinary teams in the 2023 results to inform the new Maternity CQC Survey actions.

Important to note that any themes identified via other survey user feedback routes e.g. friends and family tests, senior support and share walkarounds (SSS), the executive walkarounds, maternity safety champion walkarounds and complaints are cross-referenced to these CQC results to embed improvements to the service.

2.2 Current CQC action – Digital Videos Project

One key action from the 2022 results was to respond to the ask that ‘Mothers require more information about any changes they might experience to their mental health after having their baby.’ This along with feedback from staff and patients with regards to the vast amount of information given to women at discharge which can feel ‘overwhelming’ prompted a wider improvement piece.

Through collaboration with the Maternity & Neonatal Voice Partnership (MNVP) the proposed idea to develop a suite of digital videos covering key information for women and families at the point of postnatal discharge was commenced. This will ensure each women receives standard information; the videos will be accessible before leaving the unit allowing time for personalised

discussion and conversations with the midwives and will be available to re-visit once at home via the Badger notes app and Women and Newborn Website.

The project includes the translation of the videos into the top 5 most understood languages for our demographic.

This project has been made possible through a successful submission to the Electricity Northwest 'Extra Care Fund' submitted by the Maternity and Neonatal Project Manager. This funding allowed the project team to produce professionally filmed and edited videos covering key information topics;

- Smoking cessation
- Perineal care management
- BFI (Baby Friendly Initiative) discharge information and formula preparation
- Discharge self-medication
- Recognising sick baby + steps to take
- Register of birth at GP (General Practice) & birth certificate
- Wound care management
- Appointment /w Community Midwife, GP, health visitor & key contact numbers
- Contraception
- Car seat safety
- Safe sleeping guidance
- Emotional wellbeing and mental health information including signposting to helplines.

Filming took place on Tuesday 6th February and Friday 16th February 2024. Next steps will include further liaison with MNVP for patient feedback, subtitles, and translation to ensure inclusion and accessibility needs are met and liaison with our digital colleagues for safe storage and circulation of the videos. The project team will also work with the midwifery staff to ensure they are confident in the use of the videos, and this is included in the governance processes for consistent review of content going forward.

We hope to continue the relationship formed with Electricity Northwest to explore any further funding opportunities through their grant schemes to continue to grow this digital video library to include our antenatal and neonatal services, as their values and aims for supporting women and families align to those of our services.

This project has been collated in a succinct presentation, please refer to appendix 4.

3. Theme 2 - Growing, retaining, and supporting our workforce

The three-year plan states that 'The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability.' This theme is further defined by:

Objective 4. Growing the workforce,

Objective 5. Value and retain the workforce, and

Objective 6. Invest in skills.

3.1 Midwifery Recruitment Update

A midwifery staffing business case was submitted in 2022 following the response to the Ockenden 1 (initial 7 immediate and essential actions). The roles are as follows with an update.

Consultant Midwife 8B (1wte)	Recruited to and in place
Antenatal Clinic Service Lead 8A (1wte)	Recruited to and in place
Governance Midwife to cover PMRT, HSIB, ATAIN 8A (1wte)	Recruited to and in place
Central Birth suite Co-ordinator 7 (1wte)	Recruited to and in place
Fetal Medicine Specialist Midwife 7 (1wte)	Recruited to and in place
Fetal Monitoring Lead Midwife - 7 (0.6wte - already in post 0.4)	Recruited to and in place
Prevention Lead Specialist Midwife 7 (1wte)	Recruited to and in place
Maternal Medicine Lead	In recruitment phase
Project Support Officer	Recruited to and in place
Fail/safe officer	In recruitment phase
Consultant PAs – 3 Sessions to cover governance	Recruited and in place

A second business case has been completed to fund the requirements of the Birth rate plus findings, this will be presented at the relevant ELHT forum on the 5th of March 2024.

4. Theme 3 - Developing and sustaining a culture of safety, learning, and support

The three-year plan states that 'An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive.' This theme is further defined by:

Objective 7. Develop a positive safety culture,

Objective 8. Learning and improving, with
Objective 9. Support and Oversight.

4.1 SCORE (Safety Culture, Operational Risk, Reliability) Culture Survey – Update

As part of the Perinatal Culture and Leadership Programme, the SCORE safety culture survey was re-launched, and the findings have now been shared which allow us to understand the culture of the Maternity and Neonatal services. Team and staff attitudes can have a tangible impact on patient safety and outcomes therefore there is immense value in assessing the safety culture; the results inform local improvement plans as per (appendix 5.)

The perinatal quadrumvirate at ELHT have completed the national culture and leadership training including all scheduled coaching sessions in February 2024. Subgroups led by the Perinatal quadrumvirate to be reflected in the form of an improvement plan with regular updates of progress to continue as part of the maternity incentive scheme (MIS) safety action 9 to trust board and quality committee.

4.2 Maternity and Neonatal Away Day

The Maternity and Neonatal joint away day took place on Friday 12th January 2024. The away day was held to update colleagues on our maternity and neonatal services, understand their priorities and the challenges faced within each service and discuss ways to collaborate going forward.

The SCORE culture survey results, as above, were further discussed amongst the two teams and colleagues were invited to raise ideas for improvements against the key themes. The themes focussed on in this session include MDT communication, behaviours and teamwork and celebrating achievements and successes.

The outcomes of the day have been provided in the newsletter and circulated to all staff as per appendix 6.

5. Theme 4 - Standards and structures that underpin safer, more personalised, and more equitable care

The three-year plan states that ‘To deliver the ambition set out in this plan, maternity and neonatal teams need to be supported by clear standards and structures. This includes being enabled to implement best clinical practice for all families, having high quality data to inform the

decisions of clinicians and leaders, and having digital tools that enable information to flow.' This theme is further defined by:

Objective 10. Standards to ensure best practice,

Objective 11. Data to inform learning, and

Objective 12. Making better use of digital technology.

5.1 Saving Babies Lives v3

The Saving Babies Lives (SBL) Care Bundle is nationally defined best practice and is a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth. The requirement of the three-year plan is to implement version 3 of the Saving Babies' Lives Care Bundle by March 2024. This was supported and monitored by the Clinical Negligence Scheme for Trusts – Maternity Incentive Scheme (CNST-MIS) Year 5 safety action 6 requirement to implement 50% of each of the 6 elements and 70% overall of the SBL care bundle by 1st February 2024.

As 57 of the 70 interventions across the care bundle are currently implemented, ELHT maternity and neonatal services are at 81% implementation, and therefore compliant with the CNST – Maternity Incentive Scheme Year 5.

Table 2: An overview of the progress with the 6 elements of SBL following the LMNS QA visit in January 2024 are as follows:

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	6/10 interventions implemented and evidenced **(60%)**
Element 2 - Fetal Growth Restriction	17/20 interventions implemented and evidenced **(85%)**
Element 3 - Reduced Fetal Movement	2/2 interventions implemented and evidenced **(100%)** [1 intervention contains 4 asks)
Element 4 - Effective fetal monitoring during labour	4/5 interventions implemented and evidenced **(80%)**
Element 5 - Reducing preterm births and optimising perinatal care	24/27 interventions implemented and evidenced **(89%)**
Element 6 - Management of Diabetes in Pregnancy	4/6 interventions implemented and evidenced **(67%)**

An overview infographic depicting the progress so far within each element and the interventions remaining for implementation has been created and circulated to all Maternity and Neonatal staff to aid continued progress (appendix 7).

6. National Programmes & Investigation Report Responses – Key updates February 2024 FTB/QC

6.1 Clinical Negligence Scheme for Trust – Maternity Incentive Scheme (CNST-MIS)

ELHT Maternity Services submitted full compliance of all 10 safety actions for CNST Year 5. An overview infographic depicting the key contents of the programme has been created and circulated to staff to aid understanding of all safety actions and to ensure the work is continued. (appendix 8).

7. Recommendations

7.1 The committee is asked to acknowledge this summary paper with any exceptions and updates as an assurance that the National maternity and Neonatology agenda is being implemented as a step wise approach with both divisional and trust board assurances. This stepwise approach is in collaboration with the Local maternity & Neonatal system (LMNS), NW (Northwest) regional teams and integrated care system (ICS).

8. Conclusion

8.1 Quality, Safety, and performance are closely monitored within Maternity services here at ELHT, any immediate actions to maintain a high standard of quality and safety for mothers and families in collaboration with the maternity and neonatal safety champions is demonstrated with evidence to support any actions through scheduled bi – monthly floor to board meetings. A copy of the most recent floor to board minutes are reflected in (appendix 9)

8.2 The committee is asked to receive and acknowledge this floor to board report and to request any further information if required on behalf of ELHT maternity & Neonatology services to the maternitytransformationteam@elht.nhs.uk or contact any of the ELHT maternity and Neonatology safety champions.

Executive Maternity Safety Champion – Peter Murphy
Non- Executive safety champion – Khalil Rehman
Midwifery Safety Champion – Tracy Thompson

Obstetric Safety Champion – Martin Maher

Neonatology Safety Champions – Dr Savi Sivashankar and Ruth Dawson

Appendices

Appendix 1- Maternity and Neonatology 3-year delivery plan

2023 - 3 year mat neo plan (2).pdf

Appendix 2 – 2023 CQC Maternity Survey Results

East Lancashire 2023 Maternity presentatio

Appendix 3 – 2022 CQC Maternity Survey Action Plan

22- CQC action tracker (1).pdf

Appendix 4 – Digital Videos Project Presentation

Digital Videos Project A3.pptx

Appendix 5 – SCORE culture improvement plan

SCORE Culture Improvement Plan - F

Appendix 6 – Mat Neo Away Day Newsletter

Maternity & Neonatology Away Da

Appendix 7 – Saving Babies Lives v3 February 2024 Oversight Infographic

SBLv3 Oversight Infographic (1).pdf

Appendix 8 – CNST – MIS Year 5 Overview Infographic

CNST Yr 5 Oversight Infographic (2).pdf

Appendix 9 – Floor to Board Meeting Minutes

[1] 15.02.2023 - Floor to Board.docx

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item **41**

13 March 2024

Purpose Information

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

Summary: The purpose of this report is to provide an update on the Lancashire and South Cumbria New Hospitals Programme for the Quarter 3 period: October to December 2023.

This quarterly report is presented to the following Boards:

- NHS Lancashire and South Cumbria Integrated Care Board
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Provider Collaborative

Recommendation: It is recommended the Board:

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

Report linkages

Related Trust Goal	Deliver safe, high quality care Improve health and tackle inequalities in our community Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
Related to key risks identified on Corporate Risk Register	Risk ID: 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	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: Quarterly reports are issued to the Board.

NEW HOSPITALS PROGRAMME Q3 BOARD REPORT

1. Introduction

1.0 This report is the 2023/24 Quarter 3 update from the Lancashire and South Cumbria New Hospitals Programme (L&SC NHP).

2 Background

2.0 University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) and Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) were included in the Government's Health Infrastructure Plan in 2019 (renamed to New Hospitals Programme [NHP] in 2021). The Lancashire and South Cumbria NHP is part of cohort 4 of the Government's national New Hospital Programme for England.

2.1 The L&SC NHP offers a once-in-a-generation opportunity to develop cutting-edge facilities, offering the absolute best in modern healthcare. The New Hospitals Programme aims to address significant problems with our ageing hospitals in Preston (Royal Preston Hospital) and Lancaster (Royal Lancaster Infirmary). We also need to invest in Furness General Hospital's infrastructure in the context of its strategic importance and geographically remote location. This will provide patients with high-quality, next generation hospital facilities and technologies. Hospital buildings will be designed in a way to meet demand, while remaining flexible and sustainable for future generations. The aim is to support local communities, bringing jobs, skills and contracts to Lancashire and South Cumbria businesses and residents.

2.2 On 25 May 2023 the Government announced a record investment of more than £20 billion, ring-fenced for the next phase of the national New Hospital Programme, which brings proposals for new cutting-edge hospital facilities for Lancashire and South Cumbria a step closer. Following the May 2023 statement to the House of Commons from the Secretary of State for Health and Social Care, the local NHS was delighted to welcome the announcement of two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital as part of a rolling programme of national investment in capital infrastructure beyond 2030. This will also include investment in improvements to Furness General Hospital.

3 National New Hospital Programme

3.0 **National guidance** – as part of cohort 4 of the national New Hospital Programme, L&SC NHP will be a full adopter of national guidance e.g. Hospital 2.0, an integrated systems approach built on best practice standards and delivery solutions, enabling best-value procurement and Modern Methods of Construction (MMC). The aim of this is to drive an accelerated programme, creating transformative environments that will benefit patients and the public as a whole. A critical part of this system will be the ability to create prototypes to enable quick learning, collaboration and validation of hospital design, including new greener and safer ways of building. Further guidance regarding Hospital 2.0 is expected in Q4 2023/24 and Q1 2024/25.

3.1 During Quarter 3, the L&SC NHP team have continued to support the national New Hospitals Programme team and worked to inform the new RACI (responsible, accountable, informed and consulted) matrix being developed for all NHP projects. The L&SC NHP team also have supported an early adopter project to test the benefits of intelligent lighting in an operational hospital environment to inform our adoption of Hospital 2.0.

4 Progress against plan (for the period October to December 2023)

4.0 **Governance** - a review was undertaken in December 2023 in response to the programme transitioning from an options appraisal phase to a business case phase for the two separate projects (Royal Preston Hospital and Royal Lancaster Infirmary). The governance review acknowledged the leadership, delivery and governance requirements for the service change / consultation phase and then the capital business case phase needs to recognise the clear statutory accountabilities for the Trusts and Integrated Care Board. The Trust Boards will receive papers in February 2024 seeking approval to establish the new governance and decision-making structures.

4.1 **Potential new sites** – advisors have been appointed to progress work to determine the viability of potential new sites for a new Royal Preston Hospital and Royal Lancaster Infirmary and the L&SC NHP team has developed draft enabling works business cases focused on land acquisition. The Programme is working closely with

the national NHP to understand the detailed requirements and assurance to support completion of the business cases. In parallel, the L&SC NHP team continues to consider and assess any further sites put forward against the existing criteria.

4.2 **Public consultation planning** – the L&SC NHP team have worked with the ICB and Trust Communications and Engagement colleagues to start to scope the tasks and resource required for future pre-consultation engagement and public consultations. This includes the overarching approach to consultation, a communications and engagement strategy, and consultation and pre-consultation engagement plans. The timeline for such consultations will ultimately be determined by the critical dependencies of sites and model of care.

5 Public, patient and workforce communications and engagement

5.0 Patient representatives have been working with the Lancashire and South Cumbria NHP clinical workstream. This currently includes representation from people living in Barrow, Chorley, Kendal, Lancaster, Morecambe and Preston. The LSC NHP Clinical workstream met with patient representatives on 29 November 2023 to provide a programme update. The Programme team are looking to recruit additional patient representatives in 2024/25, working with the ICB on an approach to joint recruitment as part of the ICB citizen's reference group, with the intention of recruiting an additional 15 to 20 people.

5.1 The LSC NHP team has attended the following Trust inclusion forums in Quarter 3 of 2023/24:

- LTHTr Living with Disabilities Forum (4 October 2023)
- LTHTr Carers Forum (1 November 2023)
- UHMBT joint forum, including Carers network, BAME (Black, Asian and Minority Ethnic) network, LGBT (Lesbian, Gay, Bisexual and Transgender) network, Women leaders, and the Disability network (7 November 2023).

5.2 The LSC NHP team is in liaison with the ICB Communications and Engagement team regarding primary care involvement and engagement and is in the process of arranging attendance at upcoming sessions. The Programme team met with primary

care colleagues in Central and West Lancashire on 22 November 2023, with further sessions scheduled for Quarter 4.

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

5.4 The following new website content was published in Quarter 3:

- Join the national NHS New Hospital Programme Engagement Intensive Care Unit Workshop (10 October 2023)
- Kevin Lavery on the New Hospitals Programme (19 October 2023)
- Join the national NHS New Hospital Programme Engagement Hospital Facilities Workshop (8 November 2023)
- Phil Woodford on the New Hospitals Programme – video (6 November 2023)
- Join the national NHS New Hospital Programme Engagement Car Parks Workshop (20 December 2023).

6 Next period – Q4 2023/24

6.0 **Governance** - the L&SC NHP team and statutory bodies will implement the recommendations of the external governance review and establish the new governance structure once approved by Boards in February 2024.

6.1 **Site due diligence** - the Programme will focus on undertaking the technical due diligence assessments for the potential new sites and in parallel, progress site acquisition. The L&SC NHP team will continue working with the national NHP team to understand the business case process for site acquisition.

6.2 **Model of care –** the Programme will undertake wider engagement on a draft model of care and further discussions will take place with the clinical senate regarding the timing of expert reviews.

7 Conclusion

7.0 This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 3 of 2023/24.

8 Recommendations

8.0 The Board is requested to:

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

Rebecca Malin
Programme Director
January 2024

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

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

13 March 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 January 2024.

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 73% improvement trajectory in January but below the 76% threshold at 74.9%.
- Performance against the ELHT four hour standard was 73.78% in January.
- No patients waited over 78 weeks.
- Friends & family scores remain above threshold for inpatients, outpatients, and community.
- The Trust turnover rate continues to show a significant reduction on pre-covid levels at 6.0%.
- The Trust vacancy rate is below threshold at 4.7%.
- The Cancer 28 day faster diagnosis standard was achieved in December at 79.7%.

Areas of Challenge

- There were 7 Steis reportable incidents in January. None of these were never events.
- There were 13 healthcare associated clostridium difficile infections, 7 post 2 day E.coli bacteraemia, and 1 Klebsiellas detected in month.
- There was 1 P.aeruginosa bacteraemia identified in January, bringing the year to date total to 11 vs the annual trajectory of 7.
- The Summary Hospital-level Mortality Indicator (SHMI) has moved to above expected at 1.21, however this has been impacted by the clinical coding backlog and the removal of SDEC from SHMI data.
- There was 1 stillbirth in January.
- There were 1215 breaches of the 12 hour trolley wait standard (52 mental health and 1163 physical health).
- There were a total of 3044 ambulance attends with 1696 ambulance handovers > 30 minutes and 545 > 60 minutes. Following validation, 242 of the 545 were due to ED delays and 303 were due to non-compliance with the handover screen.
- Friends & family scores in A&E are below threshold. Scores are also just below threshold in maternity.
- The overall Trust performance from the range of patient experience surveys was below the threshold of 90% for 2 of the 4 competencies.

- Performance against the cancer 62 day standard remains below the 85% threshold in December at 72.2%.
- Performance against the cancer 31 day standard remains below the 96% threshold in December at 91.1%.
- The 6wk diagnostic target was not met at 6.9% in January.
- In January, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 71,074, which is above the trajectory.
- The number of RTT pathways over 65 weeks has increased to 899, and is above the trajectory.
- In January, there were 4,106 breaches of the RTT >52 weeks standard.
- In January, there were 2 breaches of on the day operations cancelled and not rebooked within 28 days.
- Sickness rates are above threshold at 6.6%
- Compliance against the Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 13%.
- The Trust is reporting a deficit of £35.2m for the 2023-24 financial year to date, a movement of £2.9m in the month.

No Change

- The complaints rate remains below threshold and is showing no significant variation.

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	Feb-24	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		
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		
12 hr trolley waits		Performance team		
Ambulance handovers	NWAS	Performance team		
Ambulance handovers ELHT breaches	NWAS	A&E - Adele Dibden/ Claire Ashcroft		
RTT ongoing, over 40, over 52 wks	Submitted performance	Corporate information		
RTT ongoing graphs	Submitted performance	Corporate information		
RTT admitted/non-admitted	Submitted performance	Corporate information		
RTT average wait and ongoing %	Submitted performance	Corporate information		
RTT national	NHS Statistics	Performance team		
ELHT cancer - ELHT	Submitted performance	Cancer services - Victoria Cole		New standards
ELHT cancer - national position	NHS Statistics	Cancer services - Victoria Cole		
Delayed Discharges Chart		Andrea Isherwood/ Kathryn Heyworth		
Emergency readmissions		Corporate information		Metric in development
Diagnostics % waiting over 6 weeks		Corporate information		
Diagnostic national performance	NHS Statistics	Performance team		
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		
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	13		
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	0		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	53	73		
M124	E-Coli (HOHA)	n/a	3		
M124.ii	E-Coli (COHA)	n/a	4		
M124.iv	E-Coli cumulative from April (HOHA & COHA)	129	110		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	1		
M155.ii	P. aeruginosa bacteraemia (COHA)	n/a	0		
M155.3	P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)	7	11		
M157	Klebsiella species bacteraemia (HOHA)	n/a	0		
M157.ii	Klebsiella species bacteraemia (COHA)	n/a	1		
M157.3	Klebsiella species bacteraemia cumulative from April (HOHA& COHA)	41	38		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	41.4		
M69	Serious Incidents (Steis)	No Threshold Set	7		
M70	Central Alerting System (CAS) Alerts - non compliance	0	0		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	#N/A		

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	96%		
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	30%		
C40	Maternity Friends and Family - % who would recommend	90%	90%		
C42	A&E Friends and Family - % who would recommend	90%	69%		
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	15%		
C44	Community Friends and Family - % who would recommend	90%	92%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	96%		
C15	Complaints – rate per 1000 contacts	0.40	0.16		
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Above Expected Levels	1.21		
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%	73.8%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	76.0%	74.9%		
M62	12 hour trolley waits in A&E	0	1215		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	1696		
M84	Handovers > 60 mins (Arrival to handover)	0	545		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	47.6%		
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set	57.0%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	59,892	71074		
C37.4	Referral to Treatment (RTT) 65 Weeks (Ongoing)	152	899		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	1630	4106		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	5.0%	6.9%		
C50.1	62d General Standard 85%	85.0%	72.2%		
C50.2	31d General treatment standard 96%	96.0%	91.1%		
C50.3	28d General FDS 75%	75.0%	79.7%		
M9	Urgent operations cancelled for 2nd time	0	0		
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	2		
M138	No.Cancelled operations on day	No Threshold Set	69		
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%	6.0%		
M78	Trust level total sickness rate	4.5%	6.6%		
M79	Total Trust vacancy rate	5.0%	4.7%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	75.0%		
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%	13.0%		
F9	Overtime as % of total paybill	0%	0%		
F1	Cumulative variance to planned financial performance (deficit) (£m)	£0.0	-£14.3		
F2	WRP achieved YTD - variance to plan (£m)	£0.0	-£19.5		
F3	Liquidity days	-25.8	-20.9		
F4	Capital spend v plan	85.0%	91%		
F18a	Capital service capacity	0.6	0.0		
F19a	Income & Expenditure margin	-3.5%	-6.0%		
F21d	Agency spend as a proportion of total pay bill (£m)	3.7%	3.7%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	91.6%		
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%	95.0%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	98.3%		

NB: Finance Metrics are reported year to date.

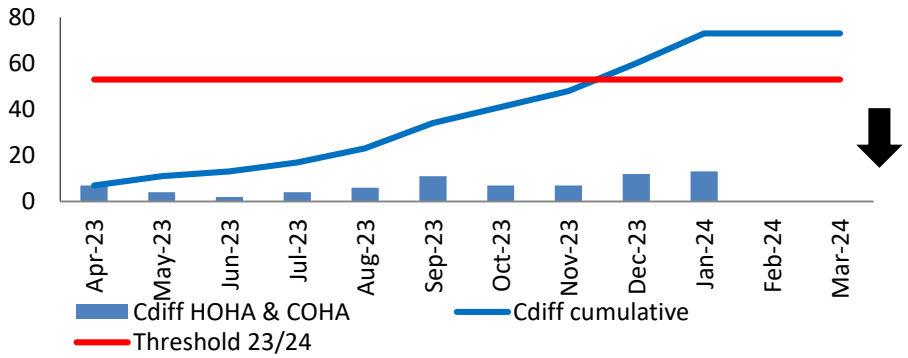
KEY

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 January. So far this year there have been 4 cases attributed to the Trust.

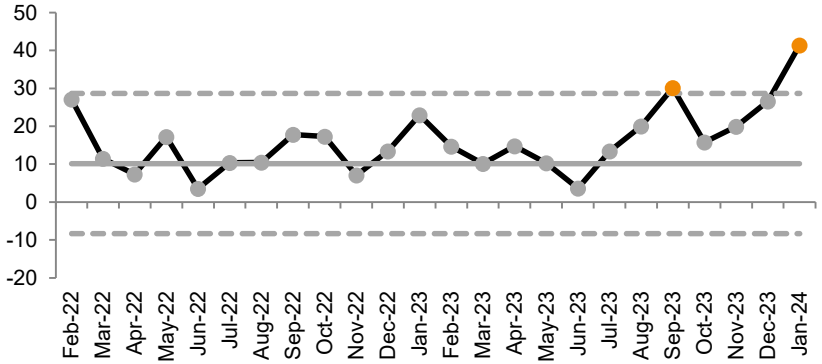
The Clostridium difficile objective for 2023/24 is to have no more than 53 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)'. The final figure for cases reported in 2022/23 was 65.

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 13 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in January; all 13 cases were HOHA.

The year to date cumulative figure is 73 (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 significantly higher than normal variation in January.

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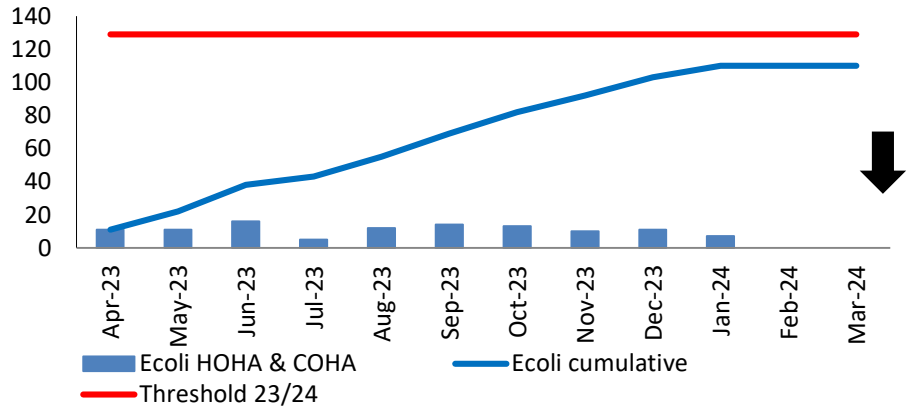
E. Coli (HOHA & COHA)

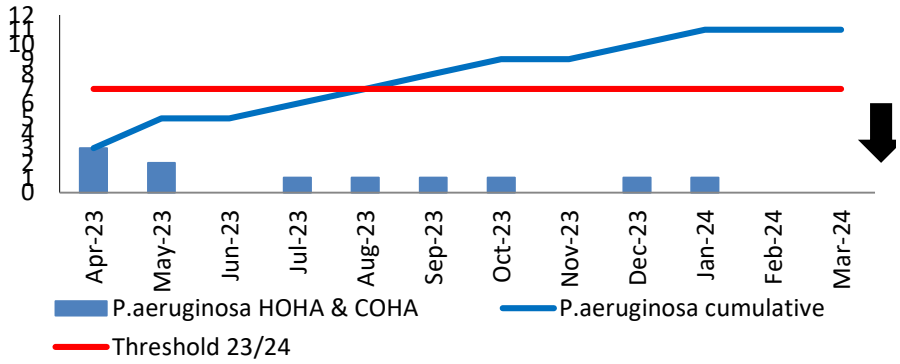


The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

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

There were 7 reportable cases of E.coli bacteraemia identified in January; 3 HOHA and 4 COHA. The year to date total is 110.

P.aeruginosa



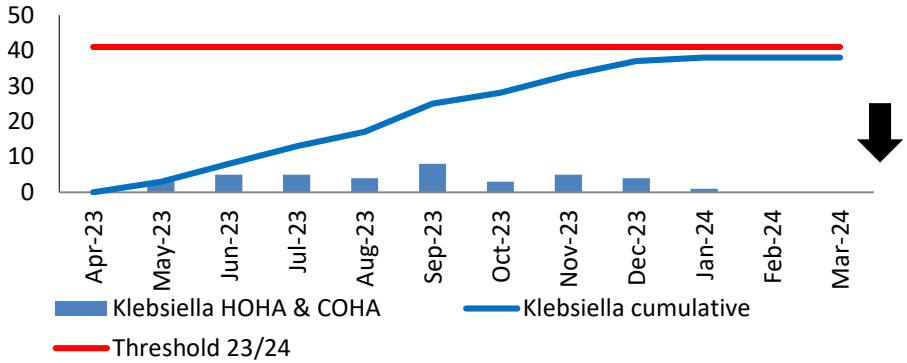
From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England.

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

There was 1 reportable case of Pseudomonas identified in January, which brings the year total to 11 vs the annual trajectory of 7.

There was 1 reportable COHA case of Klebsiella identified in January.

Klebsiella



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

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

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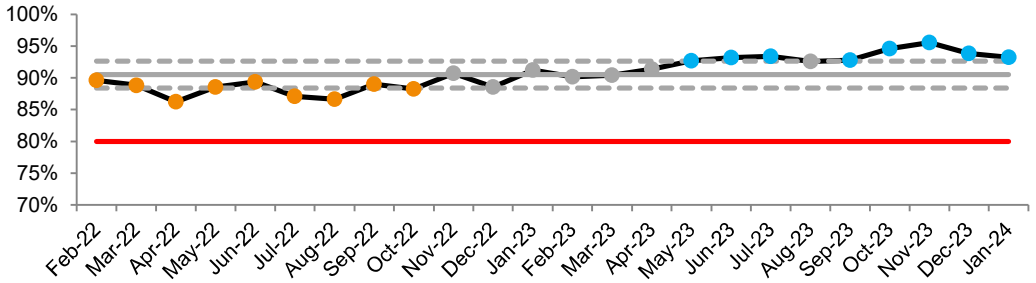
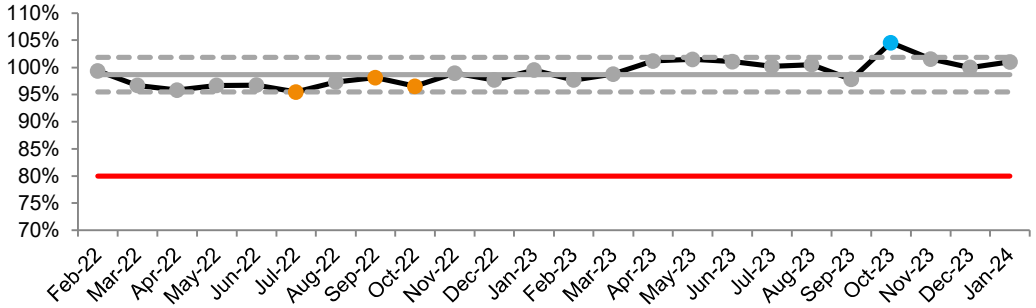
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



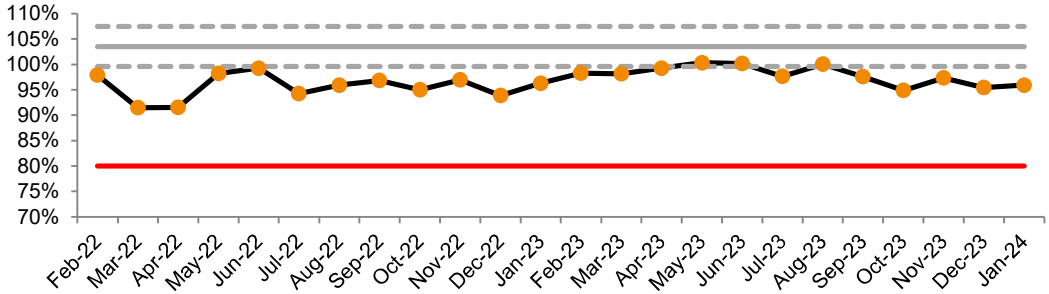
The average fill rate for registered nurses/ midwives during the day is showing improving variation when compared to the pre covid levels. Based on current variation it will consistently be above threshold.

Registered Nurses/ Midwives - Night



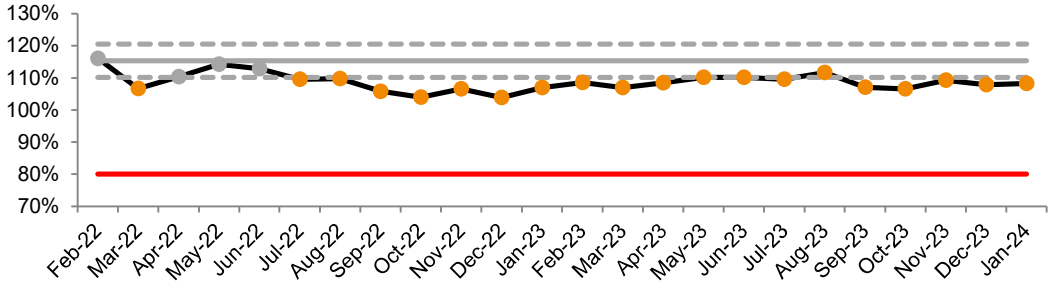
The average fill rate for registered nurses/ midwives at night is showing normal variation when compared to pre-covid levels. Based on current variation it will consistently be above threshold.

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

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Throughout the month, the planned nursing and midwifery staffing levels for the 41 inpatient wards at East Lancashire Teaching Hospitals were compared with the actual staffing levels daily. This allows the calculation of a percentage fill rate for each ward, day, and night,

The table below demonstrates average fill rates per hospital site at ELHT in January

	Day Average Fill Rate %		Night Average Fill Rate %	
Hospital site	**Registered nurses / midwives (%)**	**Care staff (%)**	**Registered nurses / midwives (%)**	**Care staff (%)**
Royal Blackburn	93.2	91.8	102	106.7
Burnley General	93.7	100.5	97.96	110
Clitheroe Community	86.1	113.7	100	101.6
Pendle Community	95.5	121.4	100	121.6
Total	93.22	95.93	101.04	108.3

Latest Month - Average Fill Rate

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Jan-24	93.2%	95.9%	101.0%	108.3%	31,392	8.19	0	4	0	1

SAFE

Monthly Trend

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)
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
Dec-23	93.4%	95.4%	100.0%	108.0%	30,111	8.52	1	2	0	1
Jan-24	93.2%	95.9%	101.0%	108.3%	31,392	8.19	0	4	0	1

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There were 41 wards included in the review.
During January there were no wards that had < 80 % fill rate for registered nurses, 5 wards that had < 80% fill rate for care staff.

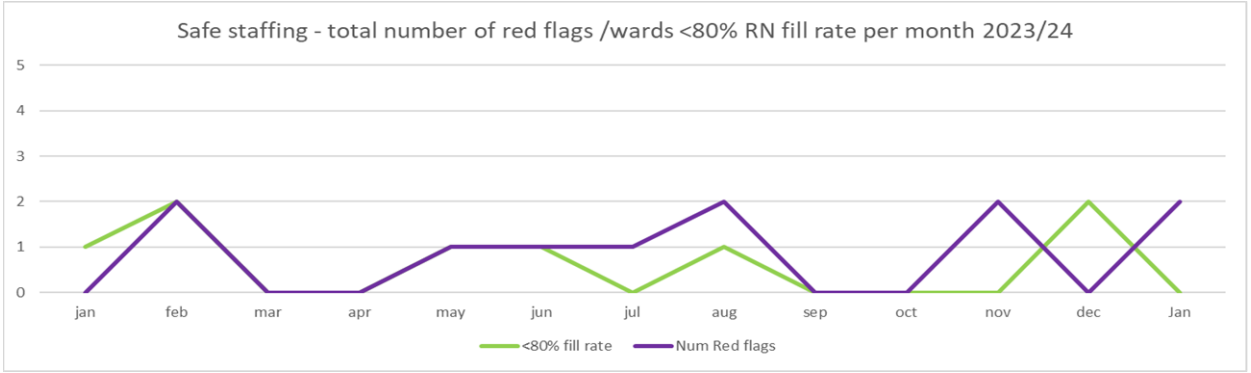
< 80% Care Staff		
Day	Children's unit	70.00%
Day	Critical Care	77.40%
Day	Gynae & Breast	73.80%
Day	NICU	69.40%
Night	NICU	74.20%

National Red Flags

No 2 national nursing red flags reported in January.
No midwifery red flags reported in January.

SAS
C18a – RN shortfall for one shift. Delays and omissions in regular checks and medication administrations. Escalated to the Matron and an RN was sent for part shift to support. No harm to patients.
MEC
B18 – HCA shortfall due to last minute sickness. Delays in medication administrations. No harm to patients.

The graph below demonstrates the number red flags and wards < 80% per month trend.



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Family Care

Maternity (Midwife to Birth Ratio)

Month	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Staffed to full Establishment	01:27	01:26	01:27	01:27	01:26	01:26	01:26	01:26	01:26	01:26
Excluding mat leave	01:27	01:26	01:27	01:27	01:26	01:26	01:26	01:26	01:26	01:27
Maternity leave	3.40	3.40	3.40	3.40	3.04	3.04	3.04	5.04	4.40	6.40
With gaps filled through ELHT Midwife staff bank	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank usage	Bank usage
Per week	18.25	16.77	21.58	17.50	20.74	19.14	22.26	16.12	15.60	24.36
Midwifery vacancies (Maternity VRS) -11wte	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	12 wte (11) Backfill for mat leave included	12 wte backfill for Maternity leave incl

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 resulting in both internal and external closures with a small number of transfers out. 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 Chief Nurse and Deputy Directors of Nursing if shortfalls in QIS or nurse cover ratios are not met with bank cover. Minimal agency use is requested following risk assessments with Director of Nursing for Family Care/ Chief Nurse oversight.
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.

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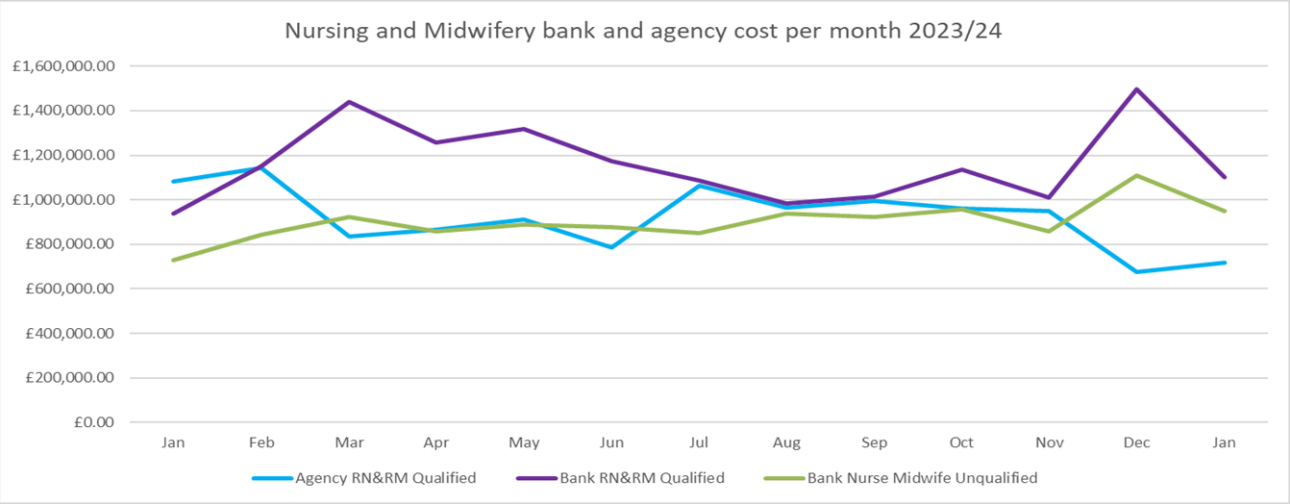
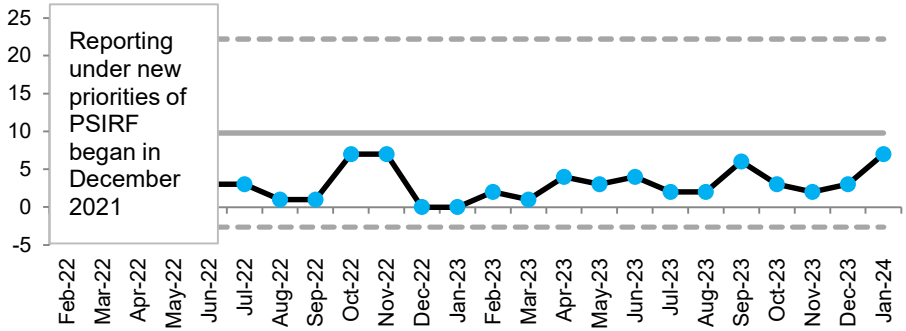
Safe staffing processes / interventions to mitigate risk
Twice daily staffing calls
The Trust has a twice daily (Monday to Friday) and daily (weekends) Trust wide safer staffing review which utilises the safe care software (Safer Nursing Care Tool) to assess staffing levels with current acuity and dependency. This is routinely chaired by a Divisional Director or Corporate Head of Nursing. The meeting is outcome focused and manages the risk across the Trust.

Recruitment / Retention Nursing and Midwifery Trust Activity overview
International Nursing Recruitment – agreed to temporarily pause the recruitment of International Nurses until April 2024. This is largely due to an evidenced reduction in appropriate band 5 nursing vacancies.
20 in April
18 in May
20 in June
20 in July
20 in August
20 in September
16 in October
16 in November
11 in December
8 in January – then pause.
HCA Recruitment / Retention - ESR data 97 band 2 WTE HCA vacancies. Recent central HCA recruitment drive saw 61 HCAs in total recruited. 42 of these are bank, 19 are permanent and will all be now in the numbers. A further central recruitment drive for HCAs is in the planning phase.
Professional Judgement – formal professional judgement currently in progress.



SAFE

Serious Incidents



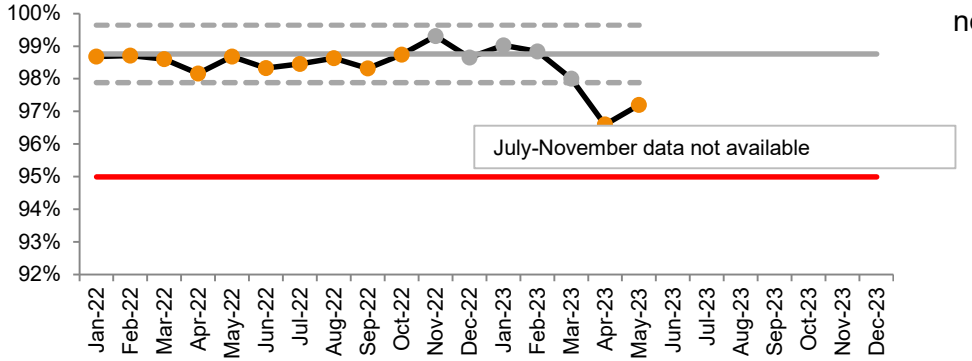
PSIRF Category	No. Incidents
Incident resulting in death	5
Neonatal death	2

There were no never events reported in January.

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

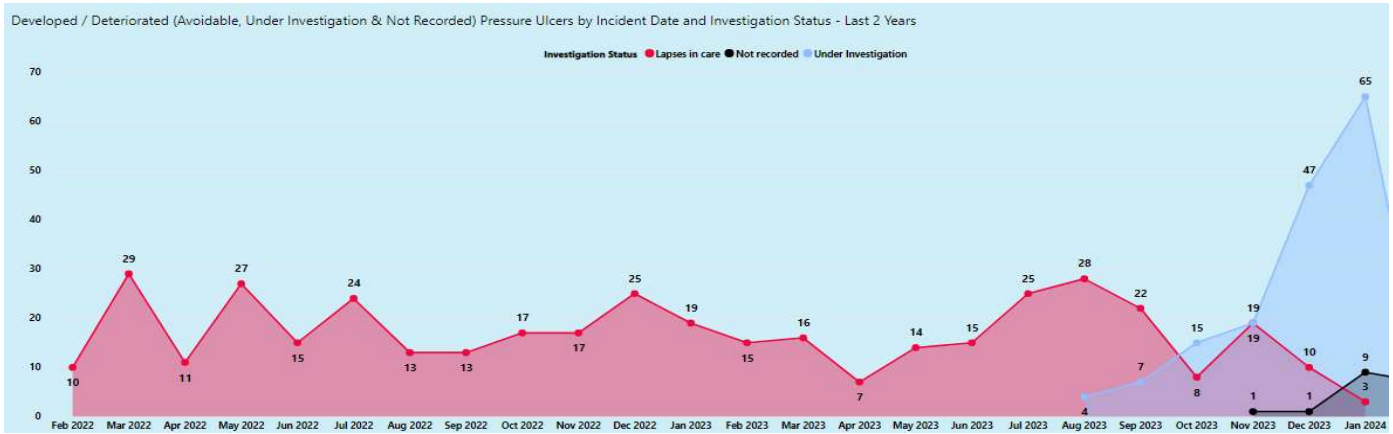


Venous Thromboembolism (VTE) assessment trend - data not available for July-December.

SAFE

Pressure Ulcers

For January 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 – 31.1.2024
2	44	73	45
3	14	6	4
4	3	9	6
Unstageable	25	33	24
DTI	53	92	71
TOTAL	139	213	150

150 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.

Mandatory e-learning for all relevant staff went live in December 2023, giving assurance that staff are equipped with the right knowledge and skills to prevent and manage both pressure damage and moisture associated damage. Current compliance against the 2 modules is 71% for the pressure ulcer module and 79% for the moisture associated damage module.

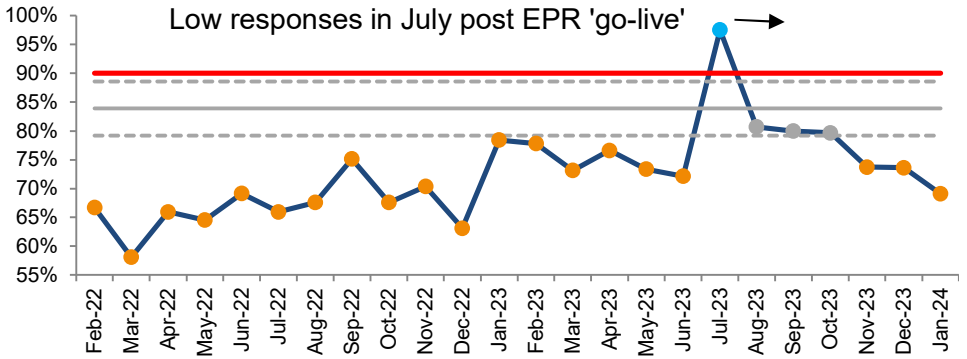
Appropriate measures are now being enacted to ensure that from 1st April 2024 the Trust will align to the new categorisation of pressure damage as recommended by the National Wound Care Strategy Pressure Ulcer Recommendations and Clinical Pathways (October 2023). Both the category DTI and Unstageable will be removed and instead unstageable pressure sores and DTI's where the skin has broken will be reported as Category 3. This will lead to an increase in the number of Cat 3 pressure sores being reported. Community Services will pilot the recommended Purpose T risk assessment tool to replace the Waterlow Risk Assessment tool once relevant changes have been made to EMIS which has an improved screening element to identify patients who are at risk.

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.

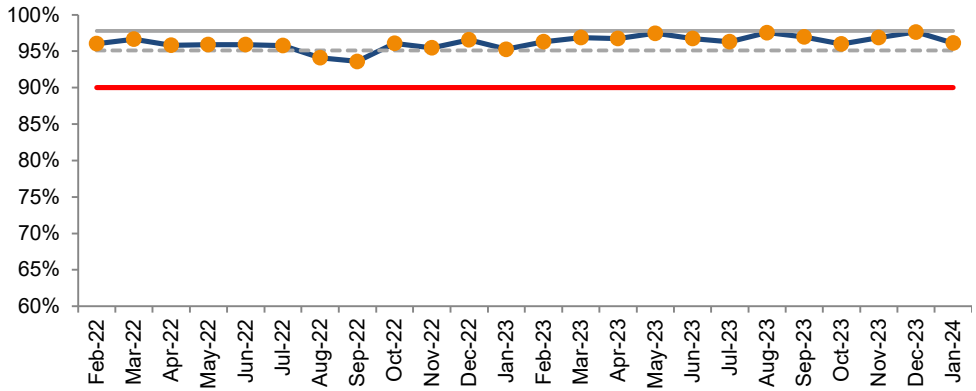
Baseline period for SPC comparison is Apr 18 - Mar 20

Friends & Family A&E



A&E scores are below threshold in December. The trend is showing significant deterioration when compared to the baseline (Apr 18 - Mar 20). Based on current variation this indicator is not capable of hitting the target routinely.

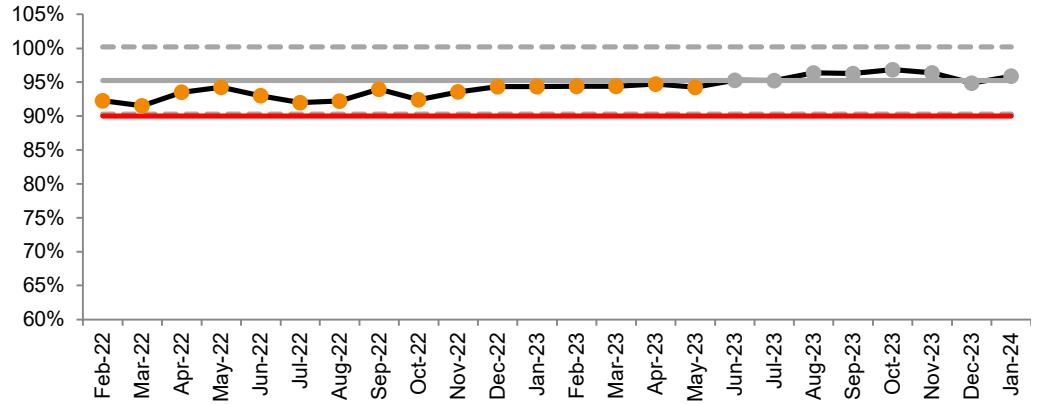
Friends & Family Inpatient



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

CARING

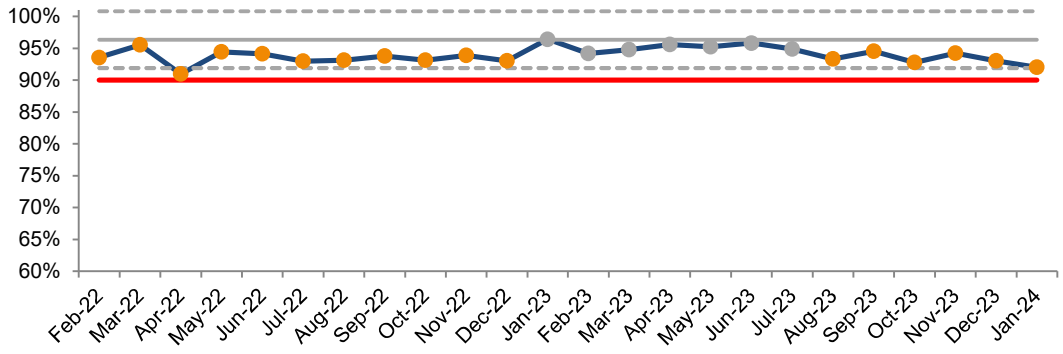
Friends & Family Outpatients



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

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

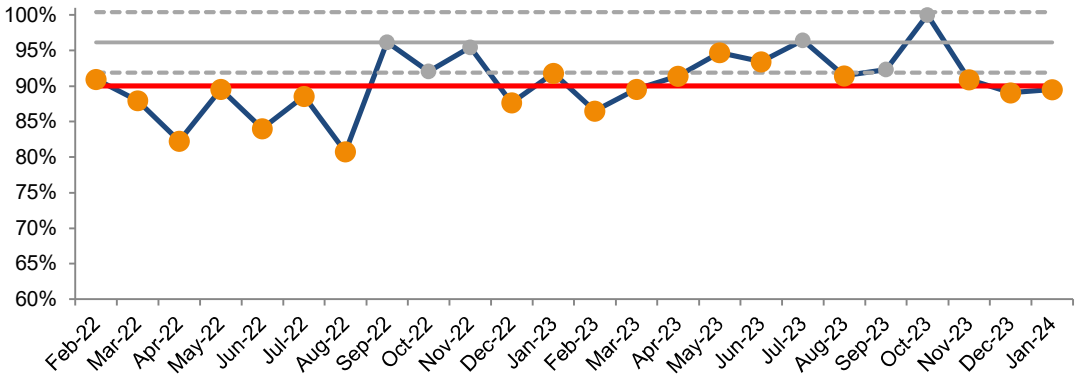
Friends & Family Community



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

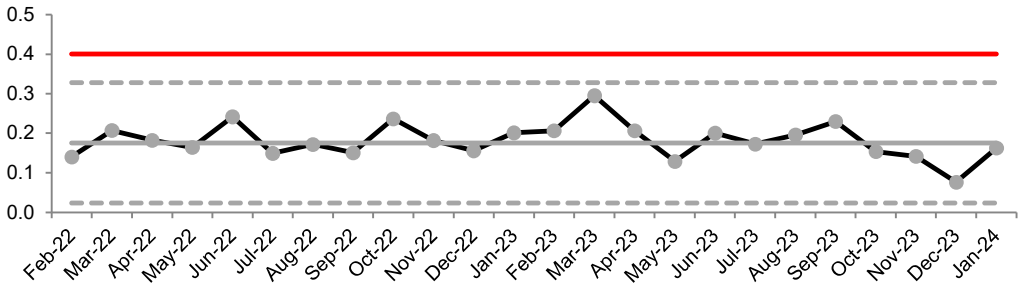


Maternity scores are just below target this month and show significant deterioration when compared to the pre-covid levels.

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

CARING

Complaints per 1000 contacts



The Trust opened 21 new formal complaints in January.

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

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

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

Patient Experience

		Dignity	Information	Involvement	Quality	Overall
Type	**Division**	Average Score	Average Score	Average Score	Average Score	Average Score
Antenatal	**Family Care**	100	-	100	95.83	97.06
Community	Community and Intermediate Care Services	93.75	93.01	91.58	94.34	92.76
Community	Diagnostic and Clinical Support	100	100	98.84	92.86	99.37
Community	Family Care	91.67	-	-	85	86.54
Community	Surgery	97.92	93.33	-	-	94.64
Delivery	Family Care	100	-	100	100	100
ED_UC	Medicine and Emergency Care	100	78.57	58.33	87.5	75.68
Inpatients	Community and Intermediate Care Services	87.29	81.05	86.71	86.27	85.42
Inpatients	Diagnostic and Clinical Support	98.44	98.2	88.89	96.1	95.32
Inpatients	Family Care	99.17	93.75	97.3	92.11	96.23
Inpatients	Medicine and Emergency Care	86.92	76.58	79.57	84.54	80.95
Inpatients	Surgery	92.56	80.73	85.88	84.91	86.18
OPD	Diagnostic and Clinical Support	98.75	95.92	100	95.24	97.15
OPD	Family Care	98.21	99.39	97.73	84.91	95.01
OPD	Medicine and Emergency Care	98.8	91.84	98.95	97.05	96.17
OPD	Surgery	97.37	96.67	97.41	100	97.41
Postnatal	Family Care	94.74	100	100	100	99.26
SDCU	Family Care	94.23	90.74	93.57	95	93.2
	Total	**93.25**	**88.84**	**89.44**	**90.84**	**90.43**

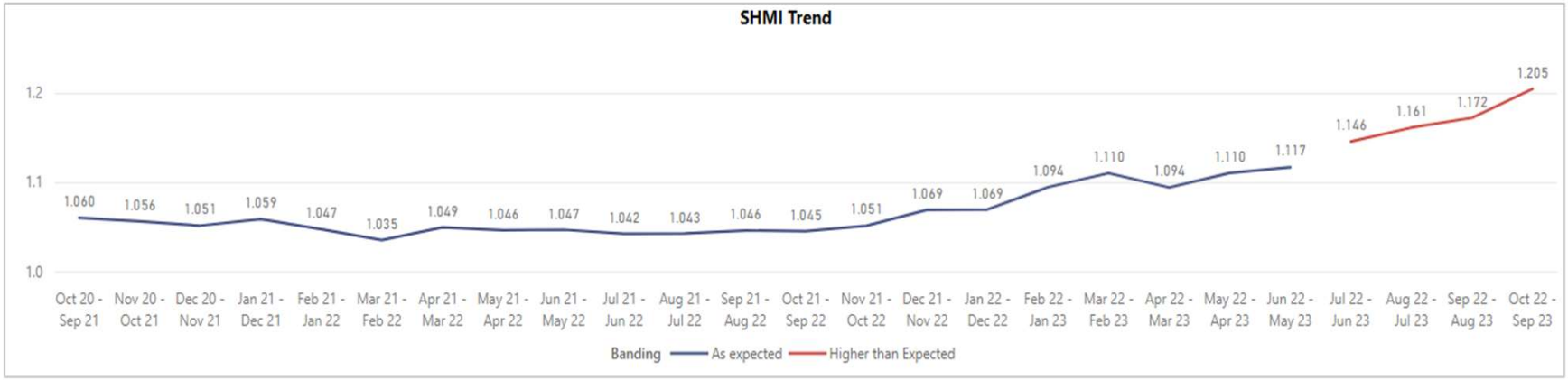
The table demonstrates divisional performance from the range of patient experience surveys in January 2024.

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 2 of the 4 competencies.

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

SHMI Published Trend



EFFECTIVE

The Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) had not been updated for several months since Cerner implementation.

In December 23, the trust submitted data externally and Summary Hospital-level Mortality Indicator (SHMI) values have retrospectively been calculated. This shows that for the most recent period (Oct 22 to Sep 23) the trust is reporting higher than expected mortality rates, at 1.21. This is also the case for the 3 previous months subsmissions.

Although the trust had been seeing an increasing trend in SHMI value, this increase is above what was expected. There are 2 main factors which we expect are contributing to the increased value. Clinical coding has a large backlog meaning that risk values cannot be accurately calculated. Since June 23, the trust has moved Same Day Emergency Care (SDEC) activity into the Emergency Care Data Set (ECDS), meaning it is not included in SHMI. This is mandated by July 2024 so not all trusts have made this transition yet. The result of this for ELHT is a large reduction in spells but not deaths, due to it being a low risk area.

The Trust has an established mortality steering group which meets monthly to review performance and develop specific action plans for any alerting mortality groups identified.

EFFECTIVE

Structured Judgement Review Summary

	Month of Death																			
Stage 1	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar 20	Apr 20 - Mar 21	Apr 21 - Mar 22	Apr 22 - Mar 23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	TOTAL
Deaths requiring SJR (Stage 1)	46	212	250	262	214	163	230	24	13	15	8	18	13	8	14	8	6			127
Allocated for review	46	186	225	212	182	140	199	23	13	14	8	13	6	3	4	3	1			88
SJR Complete	46	212	250	262	214	162	229	18	12	10	6	7	5	3	4	3	0			68
1 - Very Poor Care	1	1	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0			1
2 - Poor Care	8	19	22	34	35	22	40	5	1	2	2	2	1	1	1	0	0			15
3 - Adequate Care	14	68	70	70	65	49	75	4	4	1	4	1	2	0	1	1	0			18
4 - Good Care	20	106	133	129	103	78	106	8	6	7	0	4	1	2	1	2	0			31
5 - Excellent Care	3	18	25	29	10	12	7	0	1	0	0	0	1	0	1	0	0			3
Stage 2																				
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	41	6	1	2	2	2	1	1	1	0	0			16
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	0	2	1	1	1	1	0	1	1	0	0			8
Allocated for review	6	18	21	30	35	22	41	4	0	1	1	1	1	0	0	0	0			8
SJR-2 Complete	6	18	21	30	35	22	41	2	0	1	0	0	1	0	0	0	0			4
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0	0	0	0	0	0	0	0			0
2 - Poor Care	3	6	7	13	13	10	20	2	0	0	0	0	0	0	0	0	0			2
3 - Adequate Care	2	10	13	13	21	10	16	0	0	1	0	0	0	0	0	0	0			1
4 - Good Care	0	1	0	2	1	1	4	0	0	0	0	0	1	0	0	0	0			1
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			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	26	25	50	32	23	31	1	0	1	0	5	7	5	10	5	5	0	0	39
stage 1 requiring completion	0	-26	-25	-50	-32	-22	-30	5	1	4	2	6	1	0	0	0	1	0	0	20
Stage 1 Backlog	0	0	0	0	0	1	1	6	1	5	2	11	8	5	10	5	6	0	0	59
stage 2 requiring allocation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
stage 2 requiring completion	0	0	0	0	0	0	10	2	0	0	1	1	0	0	0	0	0	0	0	4
Stage 2 Backlog	0	0	0	0	0	0	10	2	0	0	1	1	0	0	0	0	0	0	0	4

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

There are currently 18 reviews outstanding for SJR1, 2 or LD review:

- 2 - SJR 2
- 11- SJR 1
- 5 - LD reviews

Commissioning for Quality and Innovation (CQUIN)

ELHT have 15 CQUINs (inclusive of 4 Specialist Service Schemes) relevant to services, 3 are new for 2023-24 (highlighted). The following processes are in place to enable measurement to be undertaken and meet the submission window above:
5/15 CQUINs require data collection of which 5 will be undertaken by the Clinical Audit & Effectiveness Team supported by the relevant specialty leads / service i.e. (500 Case reviews per quarter or all relevant cases where <100 meet the submission criteria). CAE team members have been assigned to support each CQUIN
5/15 CQUINs will be measured locally by the Clinical Teams / services, support from the CAE Team where required
5/15 have existing systems in place for data submission via National data collections / National Clinical Audits etc. performance reports will be shared via the relevant providers

Table 1 identifies how measurement will be undertaken for the relevant CQUINs / PSS schemes, the teams responsible for data collection /collation

Table 1: 2023-24 CCG Schemes

Ref:	Measurement Process Agreed
CCG1	Has an existing process in place for monitoring via monthly provider submission to UK Health Security Agency (UKHAS) via Import
***CCG2**	Clinical Audit of 100 patients (or all patients if <100) to be completed by the CAE Team supported by the Enhanced Recovery Team
***CCG3**	Clinical Audit of 100 patients (or all patients if <100) to be completed by the CAE Team & Antimicrobial Stewardship Group
CCG4	Outcome figures to be obtained via the Somerset Cancer Registry by the Cancer Services Team
CCG5	Clinical Audit of 100 patients (or all patients if <100) to be completed by the CAE Team in liaison with the MfOP Complex Needs & AcMed Management Team
***CCG6**	Monthly report from NHSBSA dataset, which will be made available to providers for checking and (where necessary) challenge.
***CCG7**	Clinical Audit of 100 patients (or all patients if <100) to be completed by the Acute Care Team
****CCG8**	Data to be submitted to the National Vascular Registry within 8 weeks of the end of each quarter. Quarterly reports to be provided from National Vascular Registry (NVR) including a validated assessment against SUS (Secondary Uses Service) data.
****CCG9**	Blueteq data will be assessed by the national team. Data will be validated against the HCV Patient Registry and the HCV Drugs Minimum Dataset.
****CCG10**	Reporting template to be submitted to commissioner each quarter
****CCG11**	SDM9 or CollaboRATE questionnaires to be completed on 50 or more patients across Q2 and Q4. Reporting template to be submitted to commissioner each quarter.
CCG12	Clinical Audit of 100 patients (or all patients if <100) to be completed by the CAE Team supported by the Community Services / Tissue Viability
CCG13	Clinical Audit of 100 patients (or all patients if <100) to be completed by District Nursing Team supported by the CAE Team
CCG14	Clinical Audit of 100 patients (or all patients if <100) to be completed by the CAE Team supported by the Dietetics / Community Services
***CCG15b**	Routine provider submission to the Mental Health Services Data Set (MHSDS). Monthly provider level data will be available approx. 12 weeks after each period – details will be provided via the 'Mental health CQUIN' FutureNHS collaboration platform.

Table 2 provides detail on the Scheme title, measure indicator, Leads, CQUIN Value (if incentivised or a Specialist Service Scheme), the period of calculation Upper (Max) and Lower (Min) Target percentages and the quarterly outcome and overall performance for each scheme. Compliance is RAG rated by quarter and overall performance in meeting the CQUIN target:

Table 2: 2023-24 CQUIN Schemes (Relevant to ELHT)

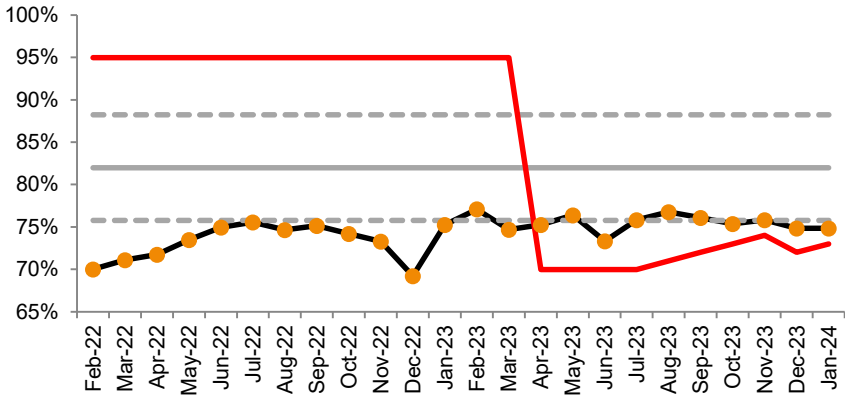
Ref:	Title of Scheme	Indicator	Lead/s	CQUIN Value	Period Calculation	Min (%)	Max (%)	Percentage Compliance (%)				Scheme performance (%)	Travel
								Q1	Q2	Q3	Q4		
CCG1	Staff Flu Vaccinations	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact	S Brewer	NA	All Quarters Quarterly average %	75	80			34.2*		34.2	
*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	76*		67	▲
*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	60*		82	▲

EFFECTIVE

**CCG9	Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	The percentage of patients commencing treatment within 4 weeks of referral to ODN	J Grassham	TBC	Quarters 1 to 4	40	75	97	96	93			95	▼
**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	36			36	▼
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	51			60	▼
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	70.4			68.4	▲

RESPONSIVE

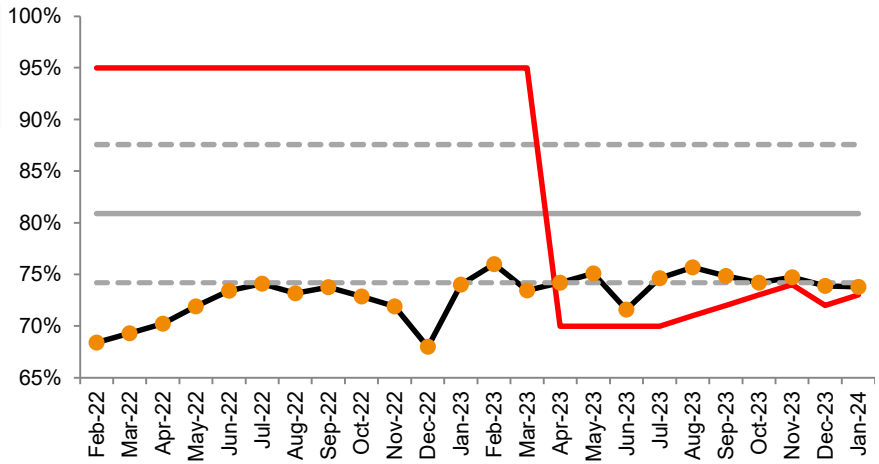
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 74.85% in January, which is below the 76% threshold and above the improvement trajectory (73%).

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

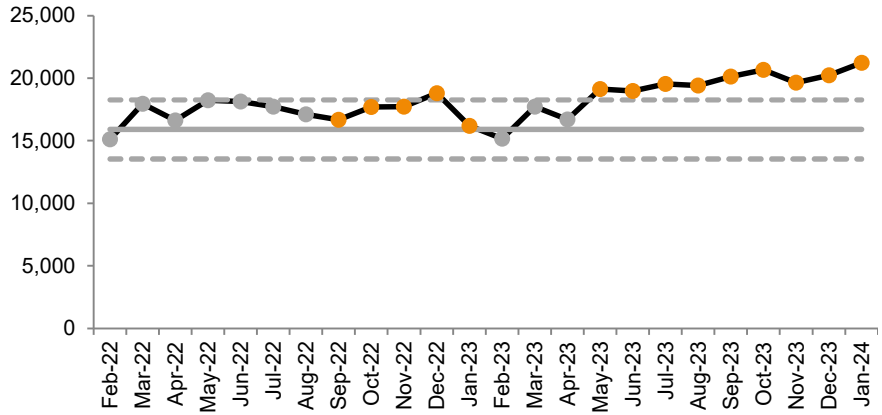
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 73.78% in January.

The national performance was 69.4% in December (All types).

A&E Attendances - Trust

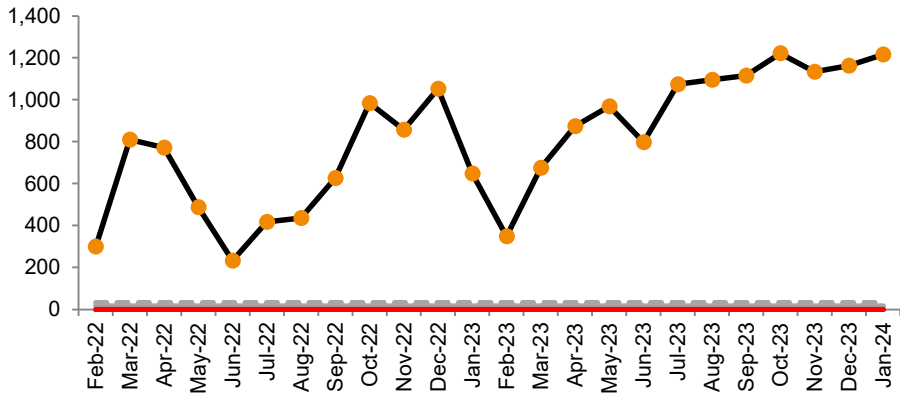


The number of attendances during January was 21,238, which is above the nornal range when compared to the pre-covid baseline.

Following NHSE guidance, the attendance count has been amended in June 23, to include the initial triage of a pre-booked appointment, which was previously excluded from the count.

RESPONSIVE

12 Hr Trolley Waits

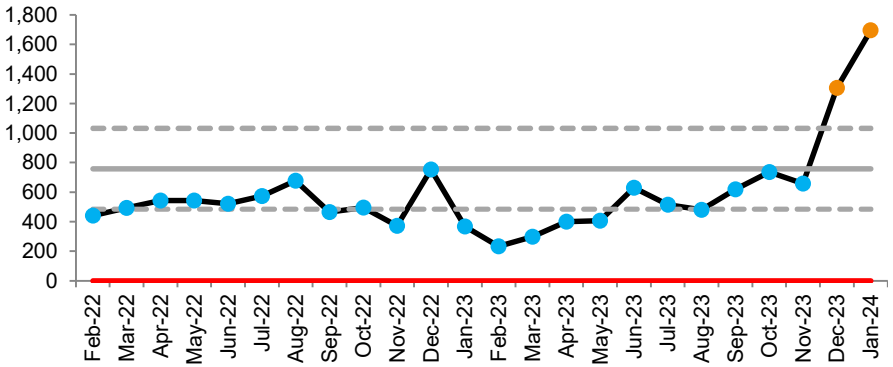


There were 1215 reported breaches of the 12 hour trolley wait standard from decision to admit during January, which is higher than the normal range. 52 were mental health and 1163 were physical health.

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	52	1163
Average Wait from Decision to Admit	44hr 29 min	31hr 12 min
Longest Wait from Decision to Admit	114hr 15min	72hr 44 min

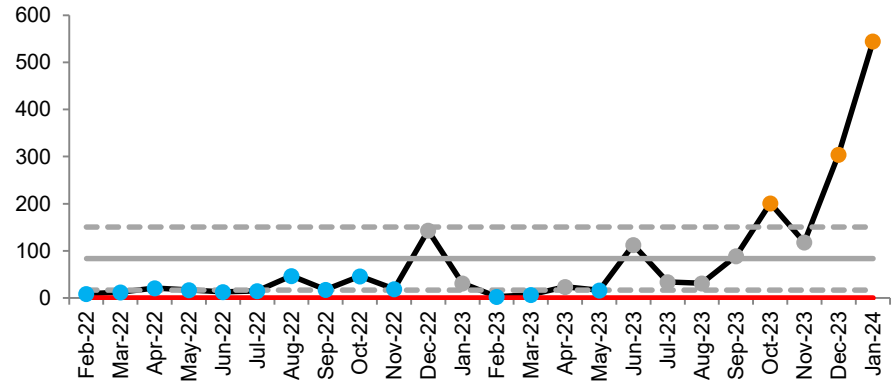
Ambulance Handovers - >30Minutes



There were 1696 ambulance handovers > 30 minutes in January. The trend is higher than pre-covid baseline levels, and based on current variation is not capable of hitting the target routinely.

There were a total of 3044 ambulance attends with 1696 ambulance handovers > 30 minutes and 545 > 60 minutes.

Ambulance Handovers - >60 Minutes



Following validation, 242 of the 545 were due to delays in ED and 303 were due to non-compliance with the handover screen.

The average handover time was 55 minutes in January.

The longest handover in January was reported by NWAS as 8hr 32 minutes and was an ED delay. We are working with NWAS to reduce longer waits due to cohorting since the introduction of the HALO system.

RESPONSIVE

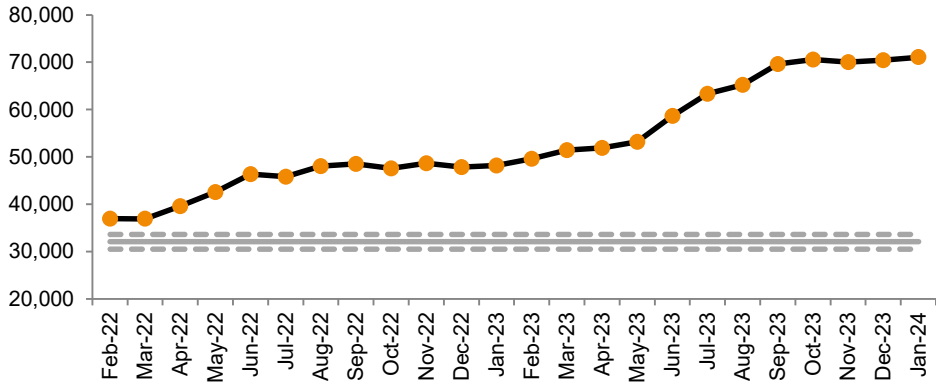
At the end of January, there were 71,074 ongoing pathways, which has increased on last month and is above pre-COVID levels.

There were 4106 patients waiting over 52 weeks at the end of January which has reduced on last month but is above trajectory.
There were 899 patients waiting over 65 weeks at the end of January 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

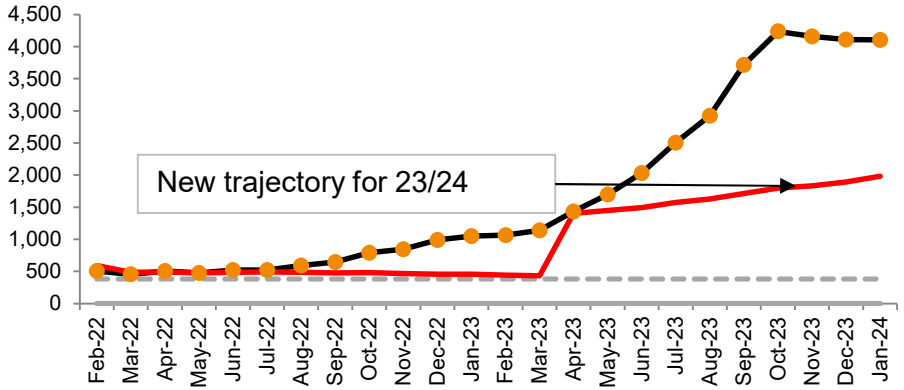
We are seeing a steady reduction in the March 24 65+ cohort and are tracking this weekly.

Trajectory
Actual

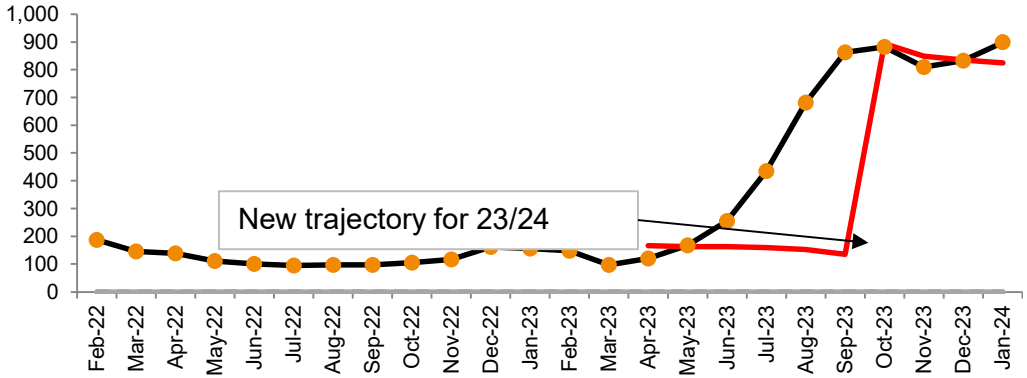
Referral to Treatment (RTT) Total Ongoing



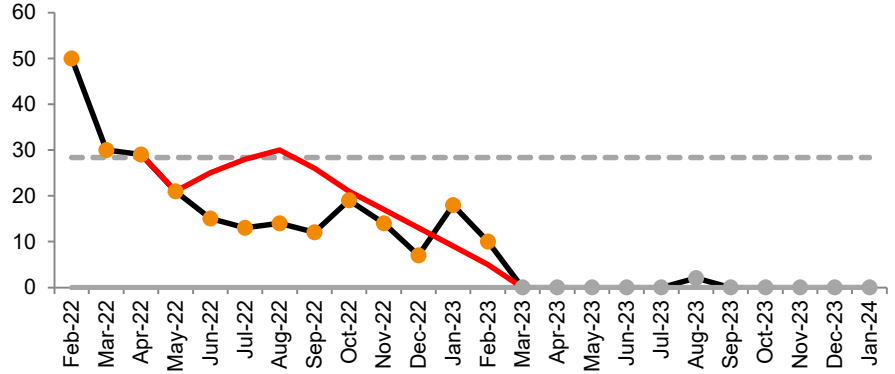
RTT Total Over 52 wks



RTT Total Over 65 wks



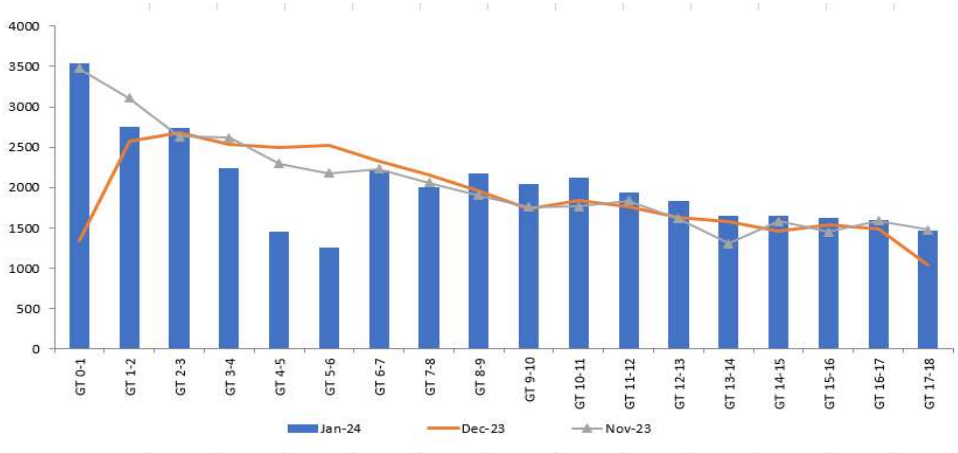
RTT Total Over 78 wks



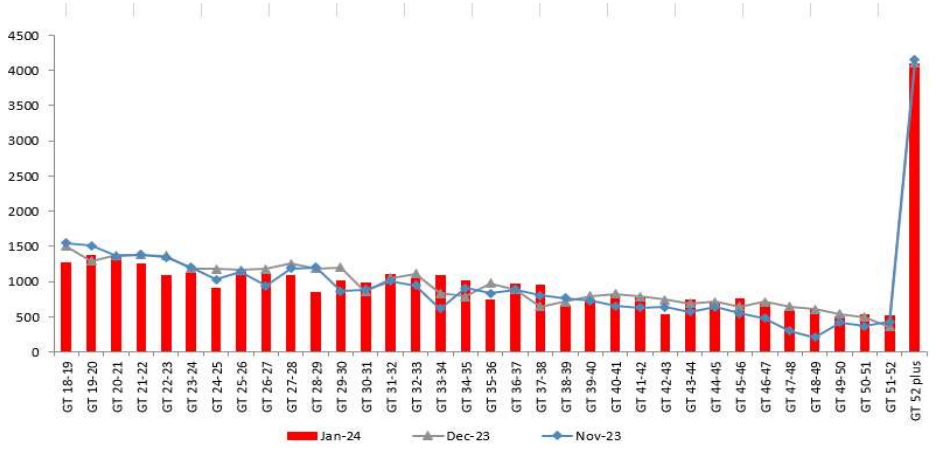
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

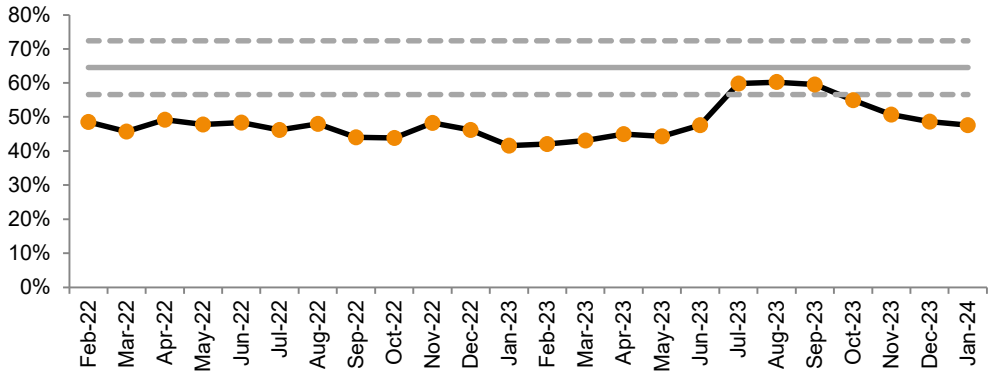


RTT Over 18 weeks

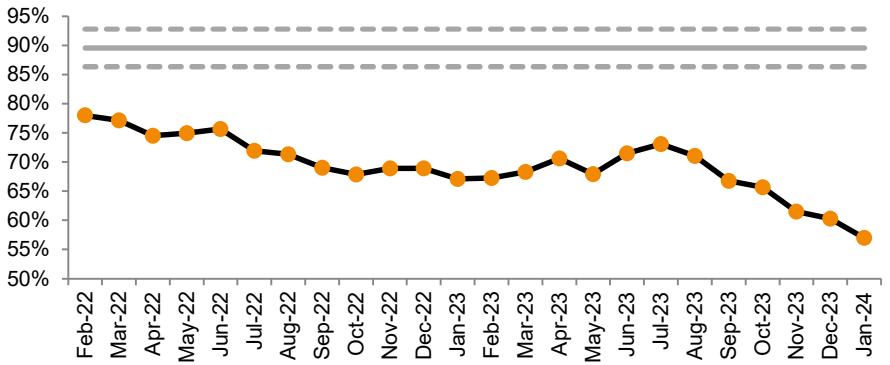


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted



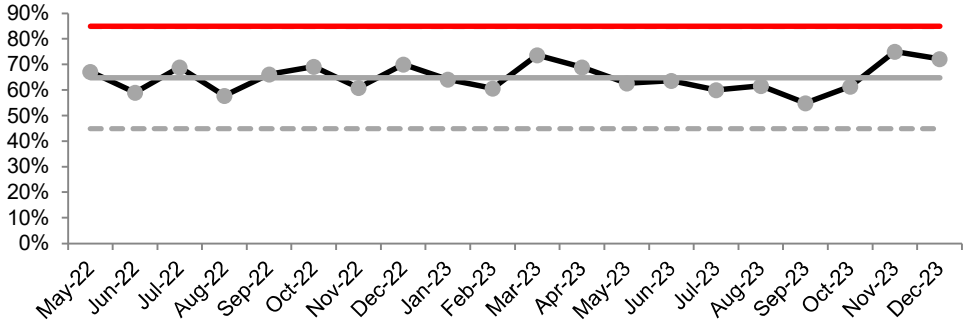
RTT Non-Admitted



RESPONSIVE

Three new national cancer standards were introduced from 1st October 23. Previously there were 10 standards, which were simplified down to 3. Although graphs show what performance would have been against the new standards, trusts were not being monitored against them prior to October

Cancer 62 day general

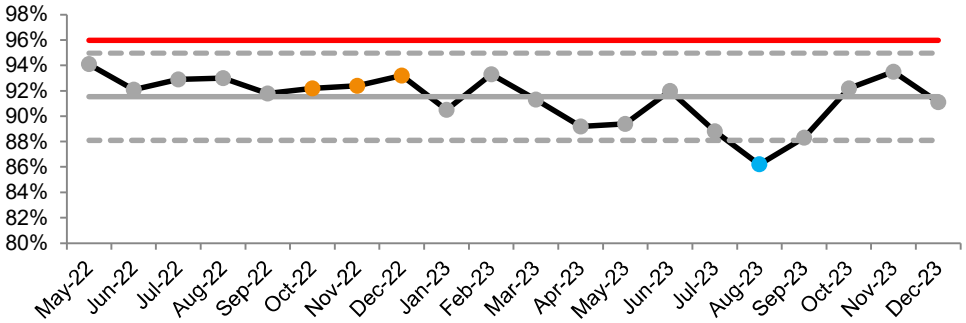


The 62 day standard was not acheived in December at 72.2%, below the 85% threshold.

National performance December - 65.9%

Based on current variation the measure is not capable of hitting the target routinely.

Cancer 31 day general treatment

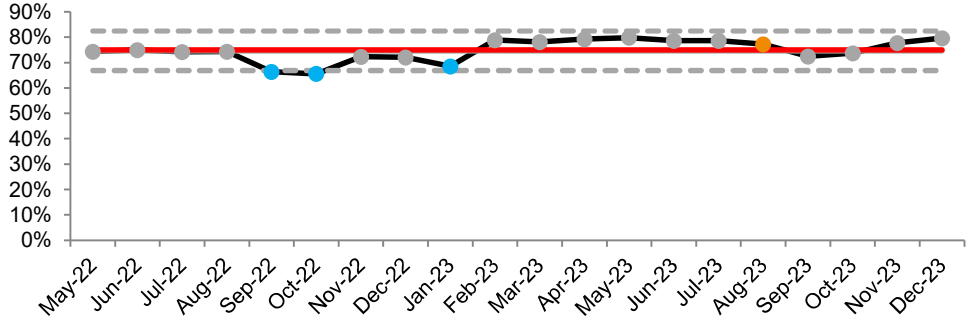


The 31 day standard was not achieved in December at 91.1%, below the 96% threshold.

National performance December - 90.2%

Based on current variation the measure is not capable of hitting the target routinely.

28 day general FDS

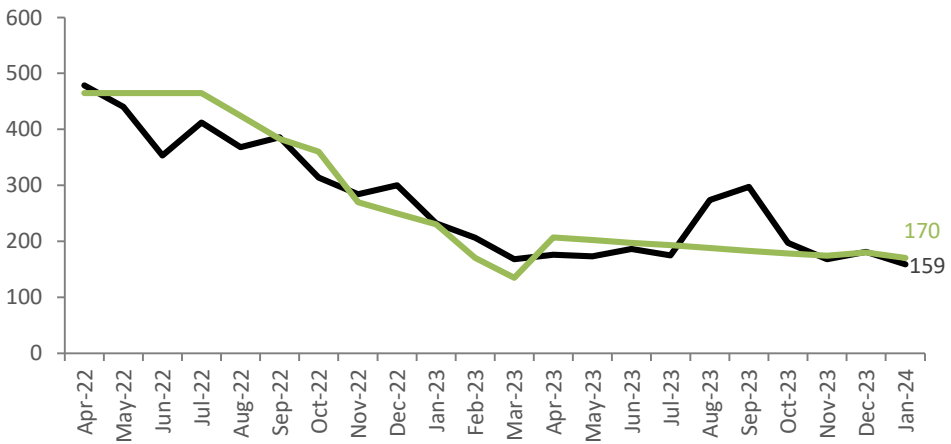


The 28 day FDS standard was achieved in December at 79.7%, above the 75% threshold.

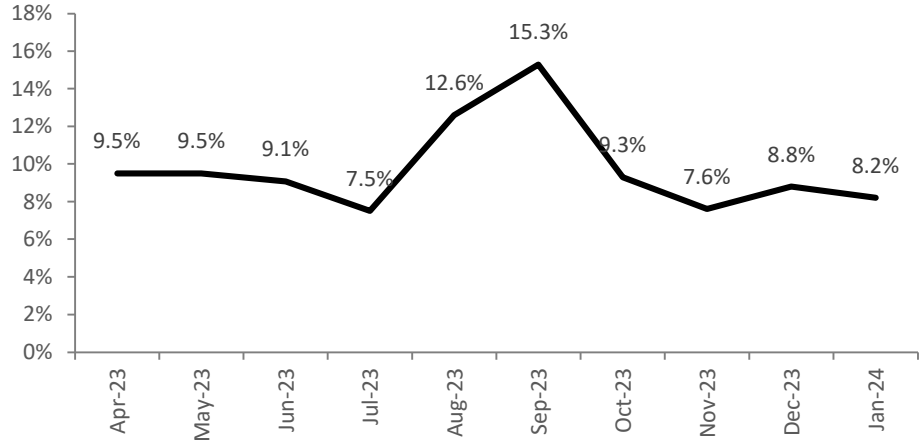
National performance December - 74.2%

RESPONSIVE

Cancer >62 day vs trajectory



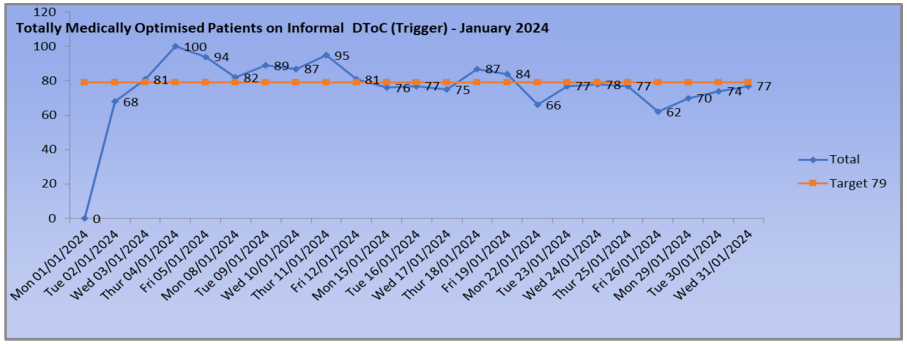
Cancer % Waiting >62days (Urgent GP Referral)



At the end of January the number of patients >62 days was 159 vs 170 trajectory. This was 8.2% of the total wait list.

RESPONSIVE

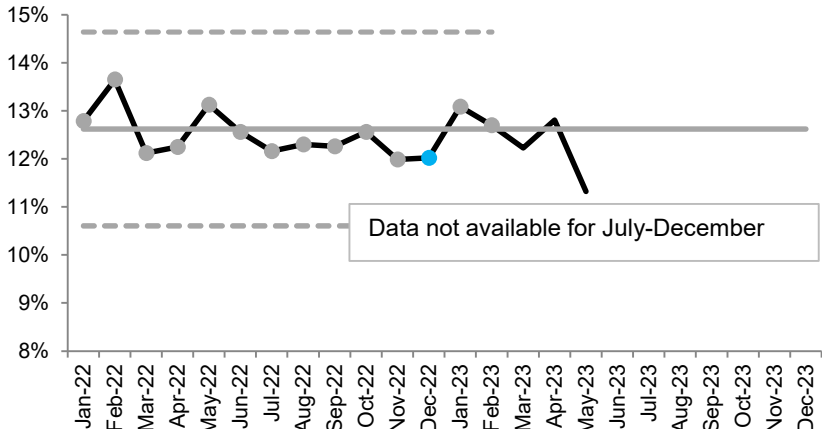
Delayed Discharges



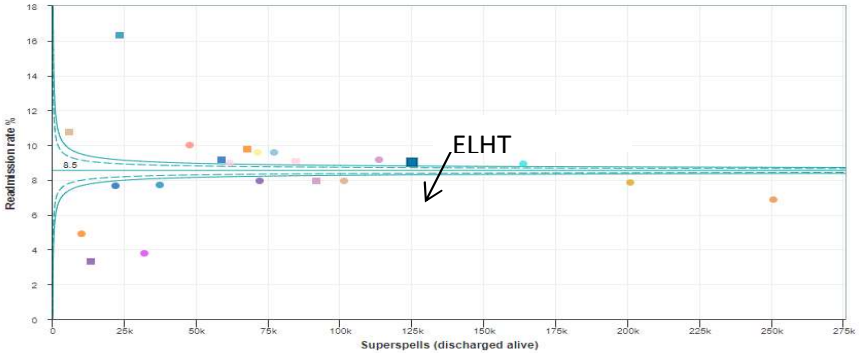
We continue to discharge patients using the rapid discharge principles set out in the Hospital discharge and community support: policy and operating model government guidance, utilising pathways 0-3. Pathways are being used to ensure patients have a discharge plan identified from admission, with pathway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

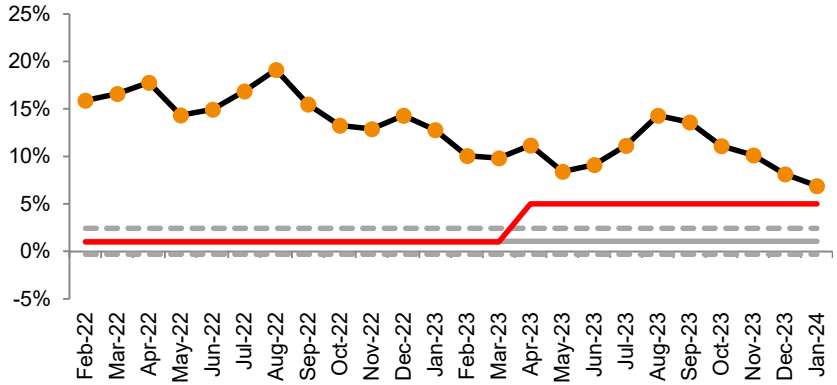


Readmissions within 30 days vs North West - Dr Foster
June 2022 - May 2023



Data not available for emergency readmission.

Diagnostic Waits



In January, 6.9% 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 26.8% in December.

RESPONSIVE

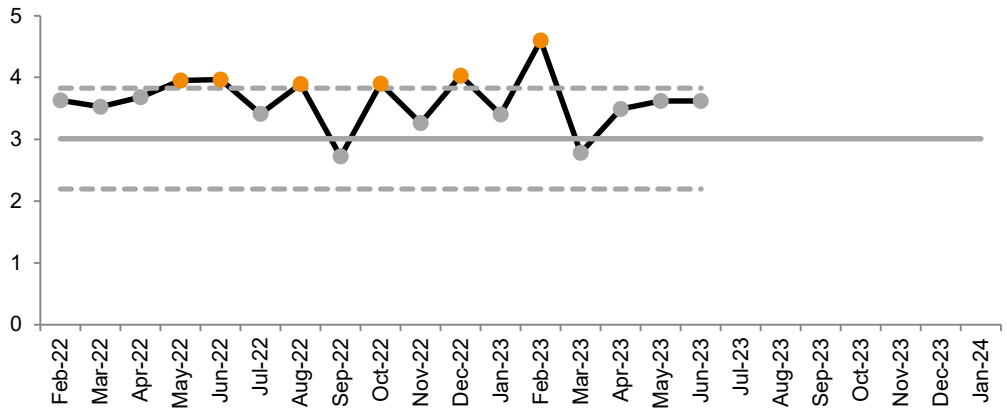
Average length of stay benchmarking

Dr Foster Benchmarking June 22 - May 23

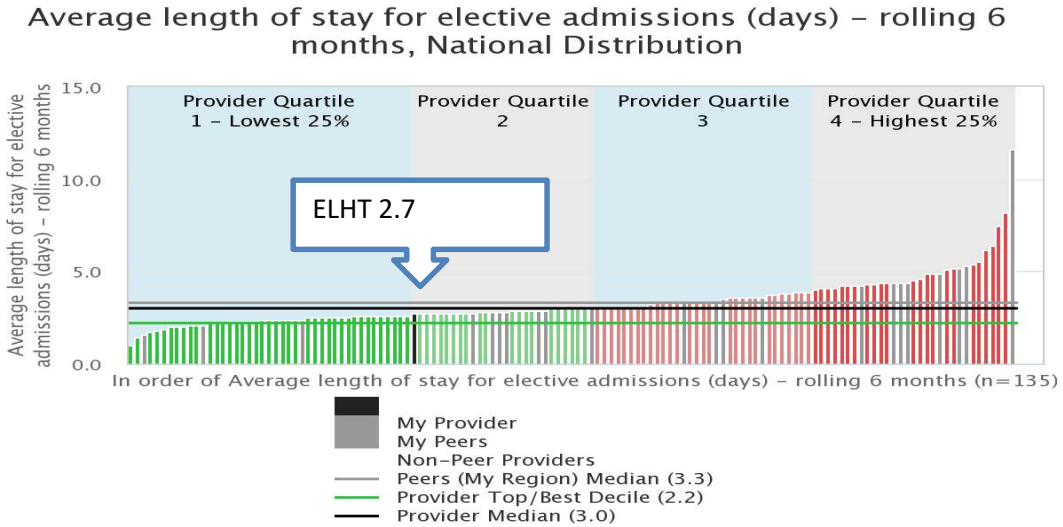
	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	62,610	10,442	52,168	3.2	2.7	-0.5
Emergency	61,620	61,620	0	4.1	4.6	0.5
Maternity/ Birth	12,500	12,500	0	2.4	2.3	-0.1
Transfer	226	226	0	7.9	24.0	16.1

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



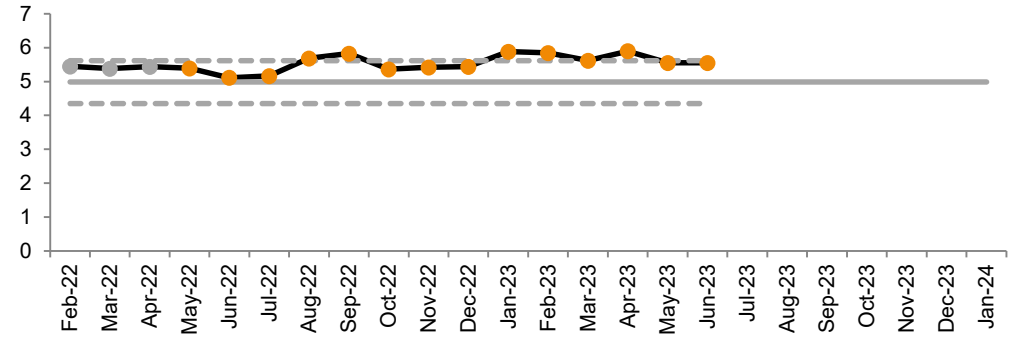
The Trust elective average length of stay is not avaiable between July-January.



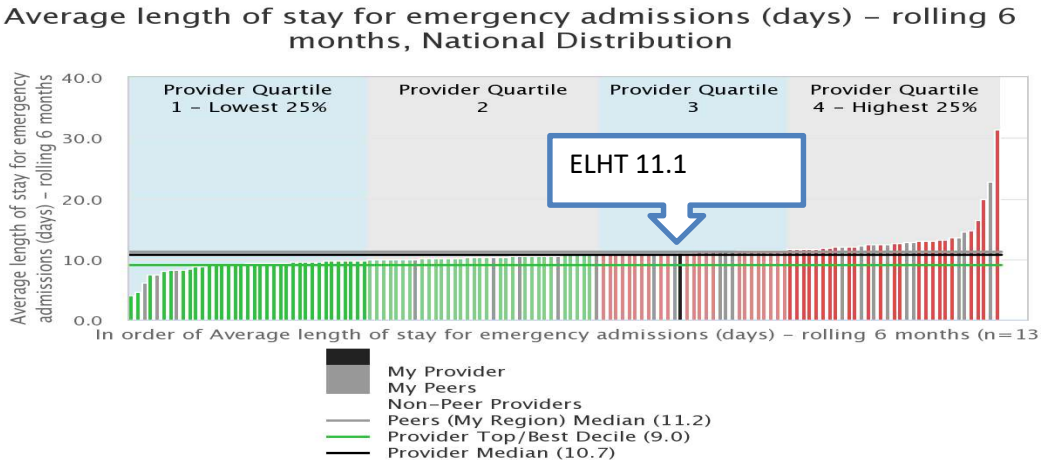
Data up to June 23 from the model health system shows ELHT in the second quartile for elective length of stay. Excludes day case.

RESPONSIVE

Average length of stay - non elective

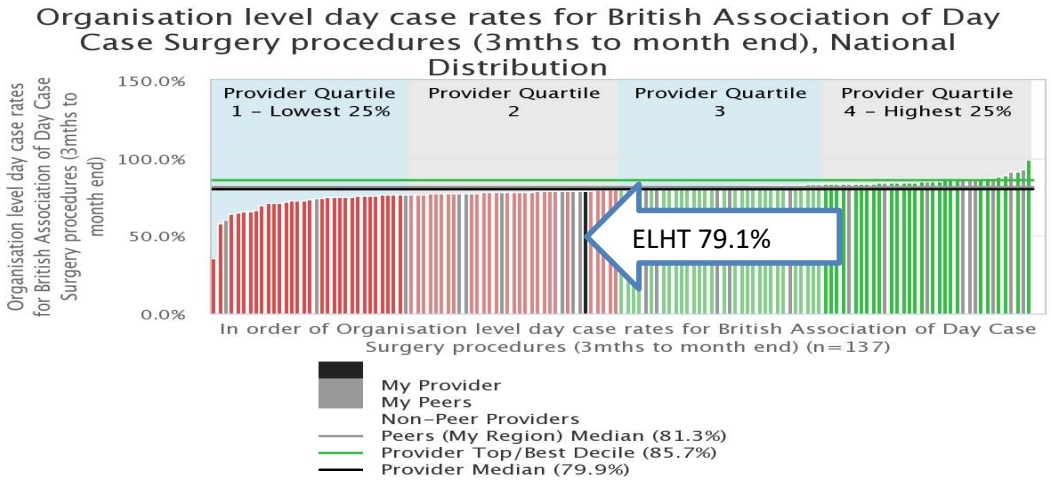


The Trust non-elective average length of stay is not available between July-January.



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.

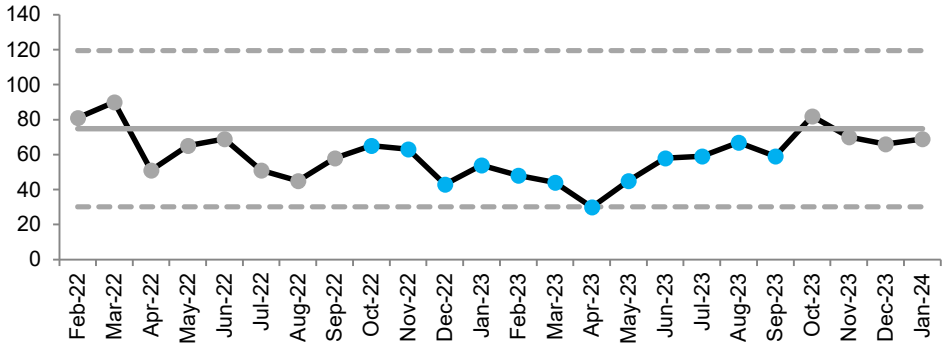
Daycase Rate



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

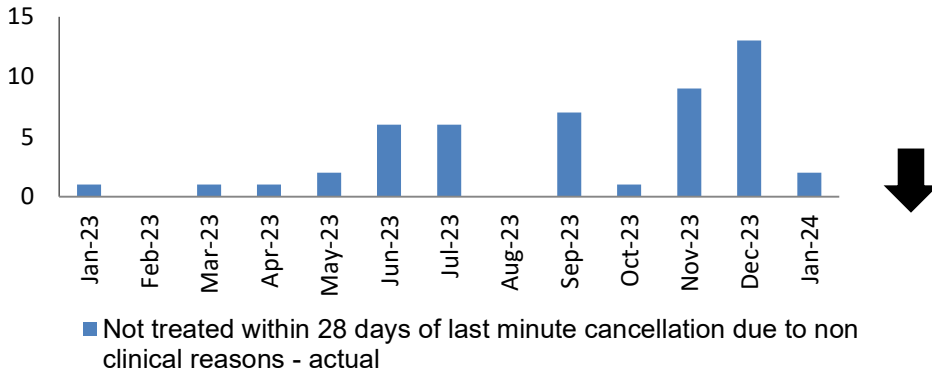
Operations cancelled on day



There were 69 operations cancelled on the day of operation - non clinical reasons, in January.

The trend is similar to pre-covid levels.

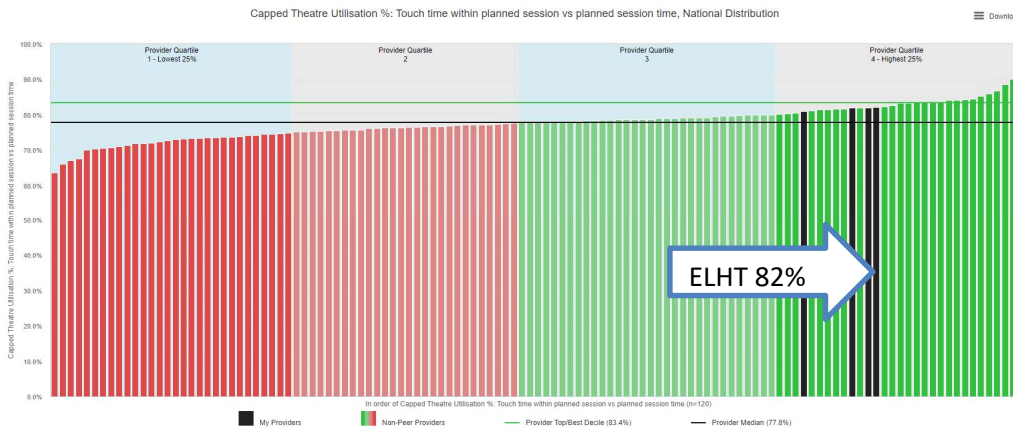
Operations cancelled on day - breaches of 28 day



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

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 82% for the latest period to 28th Jan 24. This is in the fourth quartile nationally, with 4 being the highest and 1 the lowest.

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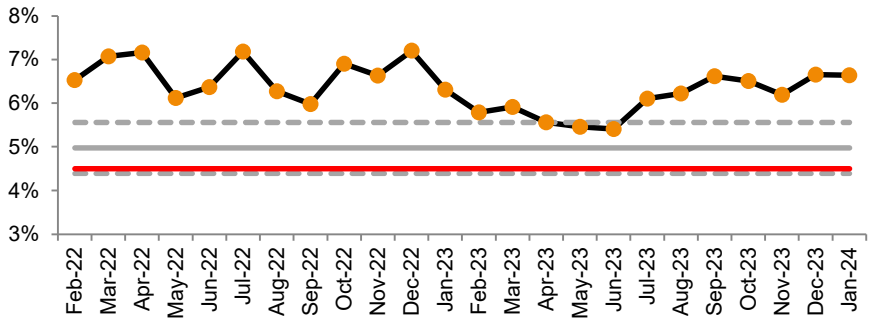
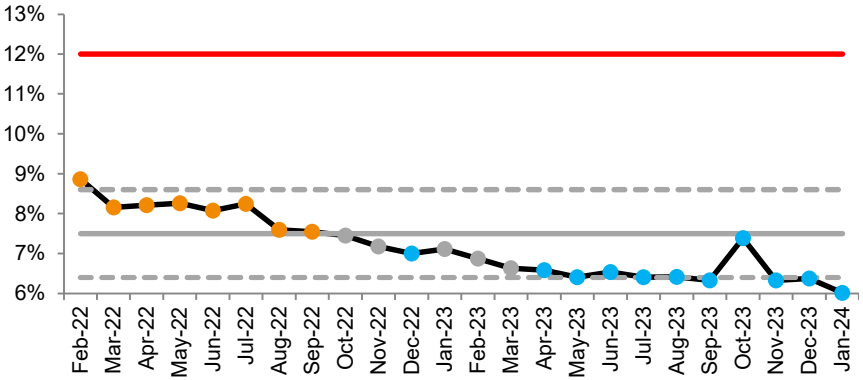
Sickness



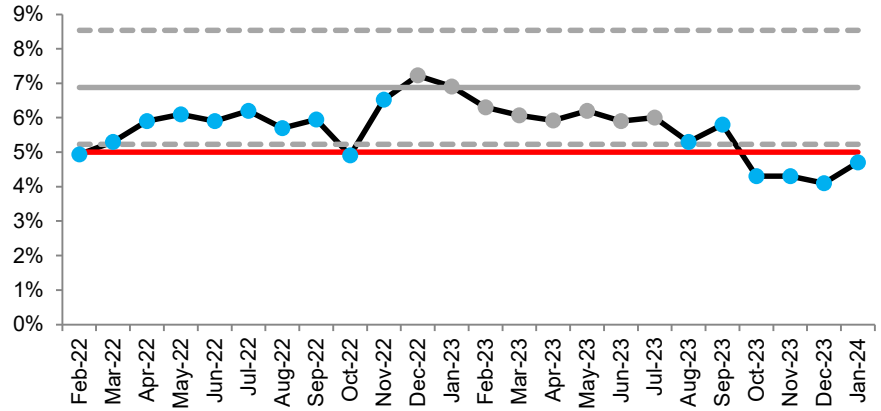
The sickness absence rate was 6.6% for January which is above the threshold of 4.5%. The trend is significantly higher than the pre covid baseline and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 6.0% in January 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 4.7% for January 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.

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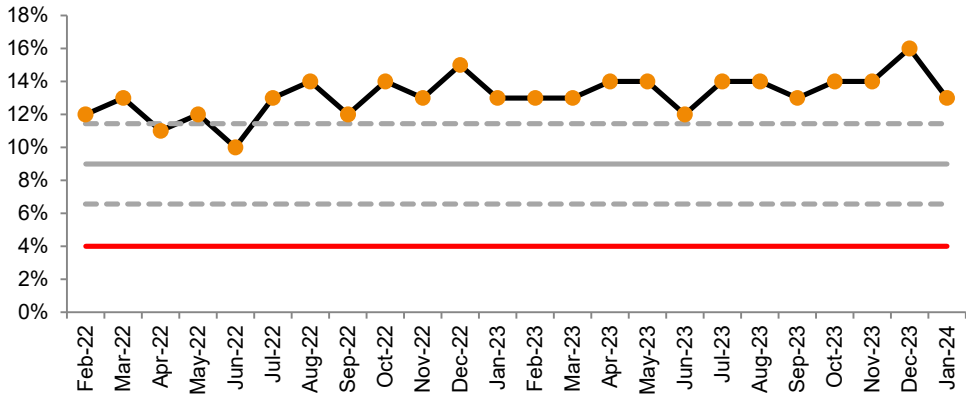
Temporary costs and overtime as % total pay bill



In January 2024, £5.8m was spent on temporary staff, consisting of £1.3m on agency staff and £4.5m on bank staff.

WTE staff worked (9.961 WTE) was 66 WTE less than is funded substantively (10,027 WTE).

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

At the end of January 24 there were 455 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	Consultants	Non consultant grades
Awaiting Signatures	131	25
Complete	20	2
Due Soon	29	15
In Progress	185	51
No Current Job Plan	8	7
Not Started	2	1
Referred Back	3	0
Uploaded	9	3
Total	387	104

As at January 2024, the table shows the numbers in each stage of the job planning process.

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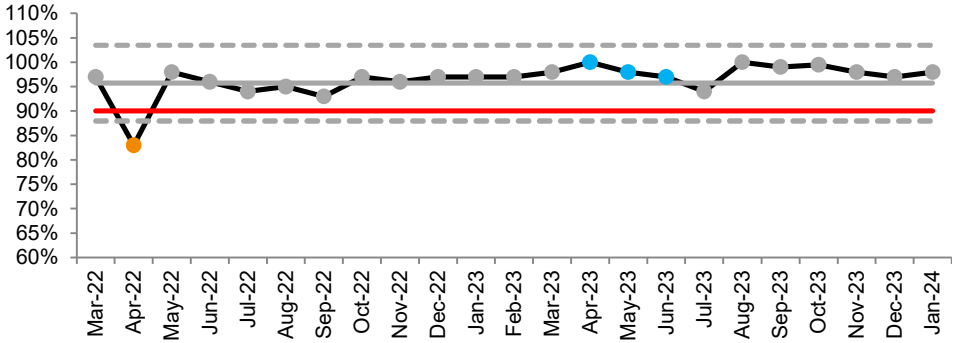
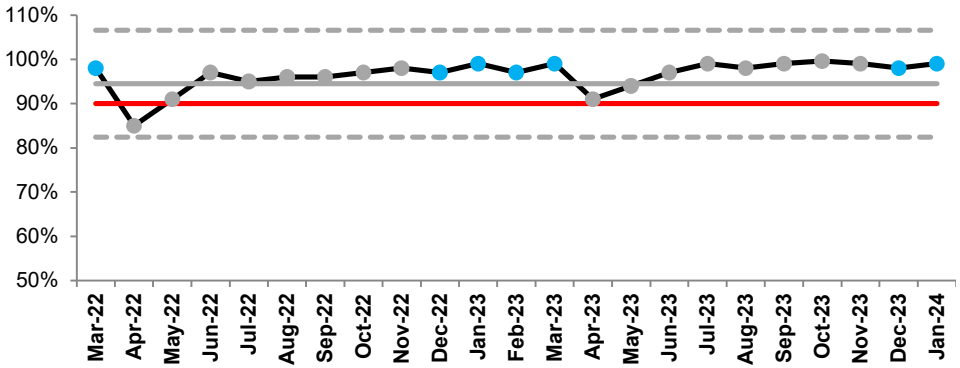
Appraisals, Consultant



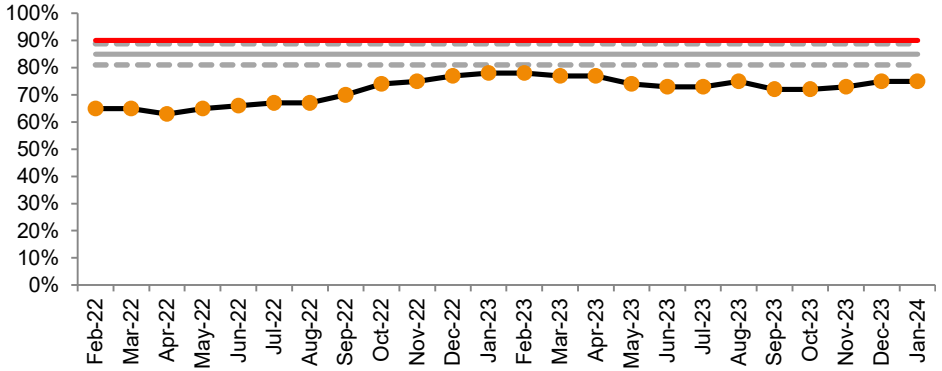
The appraisal rates for consultants and career grade doctors are reported for Apr - Jan 24 and reflect the number of reviews completed that were due in this period.

They both continue to be above target with 98% (consultant) and 99% (other medical) completed that were due in the period. 94% 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.

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Core Skills Training % Compliance

	Frequency	Target	Compliance at end January
Basic Life Support	2 years	90%	89
Conflict Resolution Training L1	3 years	90%	97
Equality, Diversity and Human Rights	3 years	90%	97
Fire Safety L1	2 years	95%	94
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%	91
Safeguarding Adults L1	3 years	90%	96
Safeguarding Adults L2	3 years	90%	95
Safeguarding Adults L3*	3 years	90%	76
Safeguarding Children L1	3 years	90%	96
Safeguarding Children L2	3 years	90%	96
Safeguarding Children L3	3 years	90%	81
Safeguarding Children L4	3 years	90%	100
Safer Handling Level 1	3 years	95%	96
Safer Handling Level 2 (Patient Handling)	3 years	95%	87

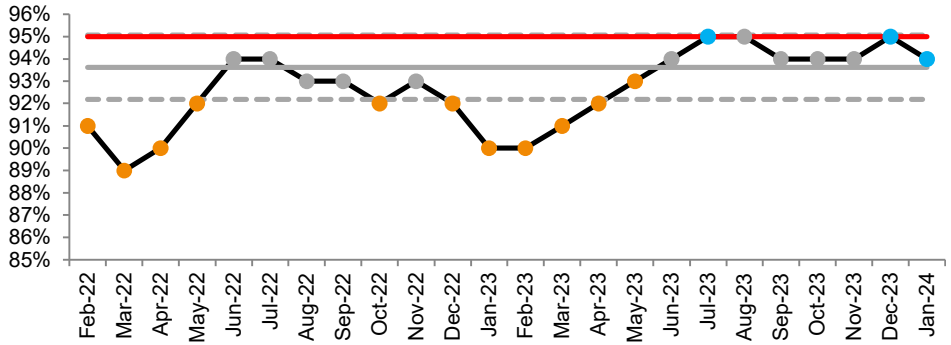
The core skills framework consists of eleven mandatory training subjects, with 19 modules in total. Training is via a suite of e-learning modules and knowledge assessments on the learning hub.

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

6 of the 19 modules are below threshold in December. 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 January which is below the 95% threshold. The trend is now above pre-covid baseline, however remains at risk of not meeting the target.

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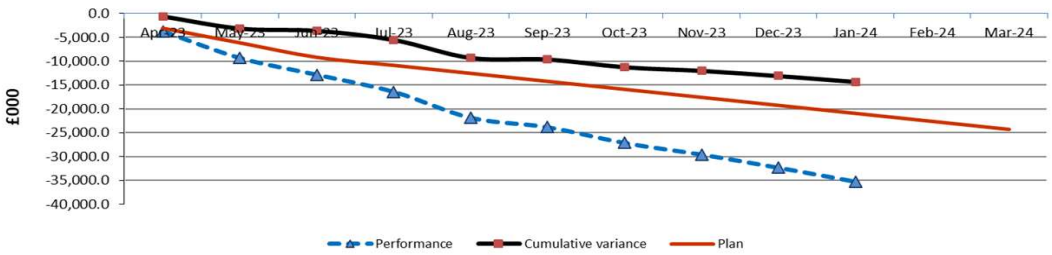
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



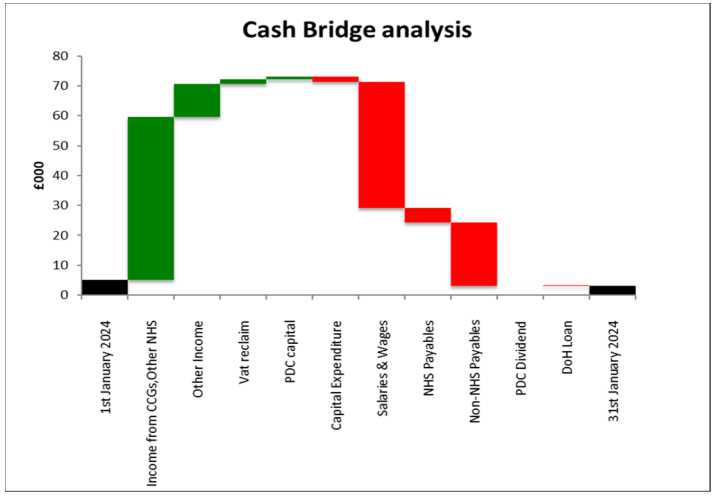
The Trust is reporting a breakeven duty deficit of £35.2m for the 2023-24 financial year to date, £14.3m behind plan.

The Trust is reporting a deficit of £35.2m for the 2023-24 financial year to date, a movement of £2.9m in the month.

The Trust is now working to a revised forecast deficit for 2023-24 of £40.8m.

The forecast overcommitment has been mitigated, largely as a result of slippage on the capital scheme to convert Trust HQ to ward space, slippage on the D Floor at RBTH and the theatres electrical upgrade.

Cash



The Trust's cash balance is £3.0 million as at 31st January 2024.

The cash balance on 31st January was £3.0m, a reduction of £2.0m compared to the previous month. This position is supported by £32.5m of Public Dividend Capital (PDC) revenue support with a further £6.6m to be received in the final two months of 2023-24.

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 volume of non-NHS invoices remains a challenge.

The Waste Reduction Programme achievement is £25.3m at month 10, £19.5m behind plan. It has been necessary to non-recurrently support this position by £9.2m.

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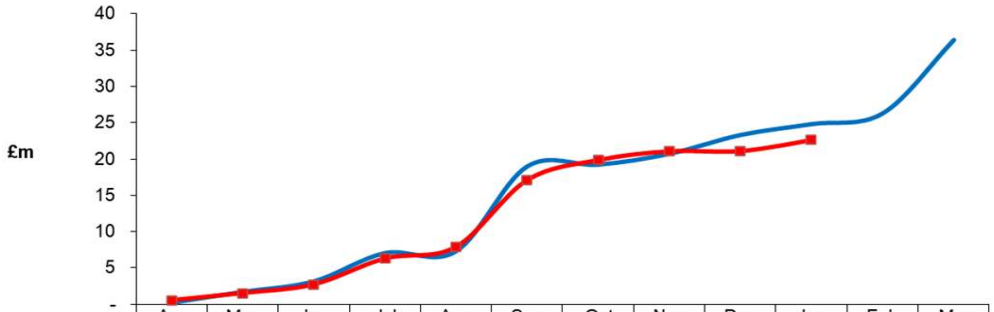
Capital expenditure

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	36.47
Actual	0.54	1.54	2.72	6.31	7.90	17.12	19.91	21.13	21.15	22.67		

The Trust is £2.2m behind planned capital spend as at 31st January 2024.

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	5,327	16,332	5,497	21,829	48,530
Medicine & Emergency Care	1,247	1,135	0	1,206	1,176	2,382	1,294
Community & Intermediate Care	2,242	25	0	109	2,157	2,266	410
Surgical & Anaes Services	1,106	0	0	300	806	1,106	1,338
Family Care	658	158	0	0	816	816	809
Primary Care	10	10	0	0	20	20	30
Diagnostic & Clinical Support	850	820	113	0	1,782	1,782	1,058
Estates & Facilities	3,478	1,184	989	1,083	4,568	5,651	622
Corporate Services	2,640	274	1,053	813	3,154	3,967	387
Education, Research & Innov'N	150	15	10	0	174	174	140
Total	28,880	3,621	7,491	19,843	20,149	39,993	54,618

Schemes to the value of £25.3 million have been transacted in the year to date. Additional identified schemes will be assessed for delivery

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **43**

13 March 2024 **Purpose** Information

Title	**Released under Embargo: must NOT be shared with anyone outside of the organisation prior to 9:30am on Thursday 7 March 2024**: 2023 National Staff Survey Summary report
Report Author	Mrs L Barnes, Associate Director Staff Wellbeing & Engagement
Executive sponsor	Mrs K Quinn, Executive Director of People and Culture

Summary: This report summarises the findings from the 2023 NHS Staff Survey for East Lancashire Hospitals Trust (ELHT).
Recommendation: Board members are asked to note the 2023 National Staff Survey Report, the key findings identified and the next steps in our continuous drive to improve colleague experience and engagement throughout 2024.

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	No	Financial	No
Equality	No	Confidentiality	Yes

Previously considered by:

Executive summary

1. This report summarises the findings from the 2023 NHS Staff Survey for East Lancashire Hospitals Trust (ELHT). Colleagues are asked to note the 2023 National Staff Survey Report, the key findings identified and the next steps in our continuous drive to improve employee experience and engagement throughout 2024.

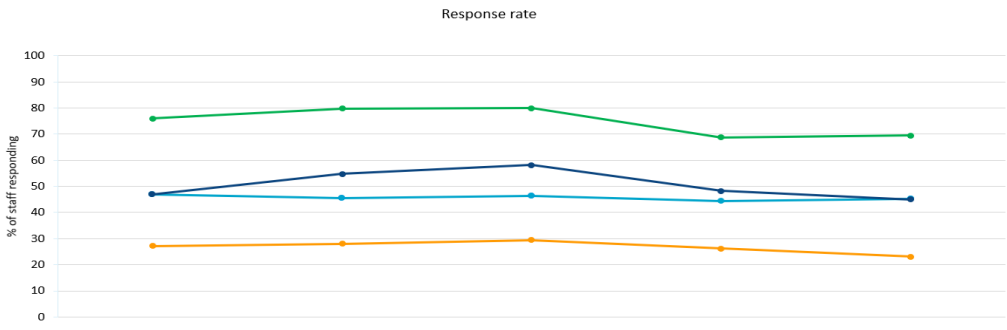
Background

2. The NHS Staff Survey is an official statistic ran to the highest standards of quality and accuracy. It is one of the world's largest workforce surveys and is considered the key performance indicator of staff experience and engagement in the NHS.
3. The refresh of the survey from 2021 was the most significant change for at least a decade. From 2021 the questions in the NHS Staff Survey are aligned to the People Promise. The move to link questions to the NHS People Promise themes means comparison with data prior to 2021 is very limited.

Introduction to the ELHT 2023 NHS Staff Survey results

4. For reference the 2023 ELHT NHS Staff Survey Report can be viewed via appendix 1.
5. The Trust undertook a full census in 2023, a total of 9779 staff were eligible to complete the survey. 4396 staff returned a completed questionnaire, giving a response rate of 45% which is equal to the national average of 45% for Acute and Community Trusts in England, and compares with a response rate of 48% (4461) in the ELHT 2022 survey.
6. This is a deterioration of 3% from the previous year's response rate and an indicator that staff engagement through employee voice has deteriorated within the last 12 months. Taking a longer-term analysis over the last five years- the response rate has deteriorated for 2 consecutive years.

Figure 1: below details the response rate trend over the last 5 years:



	2019	2020	2021	2022	2023
Your org	46.92%	54.81%	58.10%	48.28%	44.95%
Highest	75.96%	79.77%	79.95%	68.69%	69.45%
Average	46.93%	45.43%	46.38%	44.46%	45.23%
Lowest	27.20%	28.09%	29.47%	26.17%	23.03%
Responses	3942	4795	5265	4461	4396

7. Figure 2 below details the response rate by division and compares with 2022 response rates. Corporate and MEC divisions improved their response rate in 2023, whilst all other areas deteriorated for the second consecutive year.

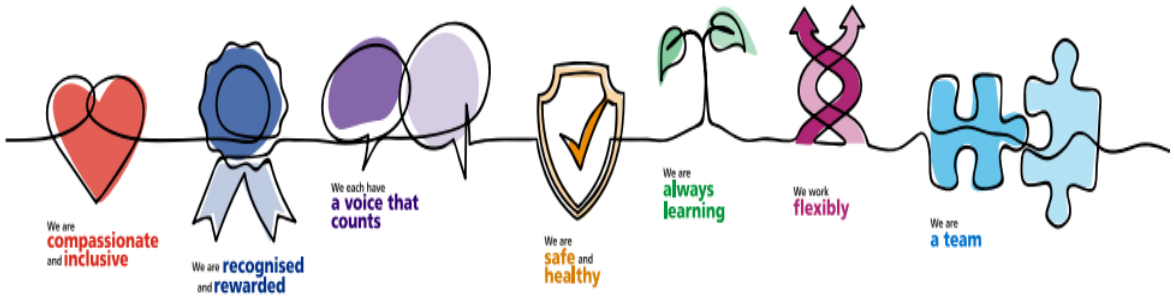
Figure 2: below Return rate by division:

Locality	Response rate 2022	Response rate 2023
Corporate Services	71%↓	72%↑
Diagnostics & Clinical Support	54%↓	48%↓
Estates and Facilities	49%↓	42%↓
Family Care	50%↓	46%↓
Medicine & Emergency Care	33%↓	34%↑
Community & Intermediate Care Services	44%↓	43%↓
Education, Research & Innovation	76%↓	72%↓
Surgical and Anaesthetics Services	47%↓	41%↓
Trust Overall	**48%↓**	**45%↓**

Summary of Themes

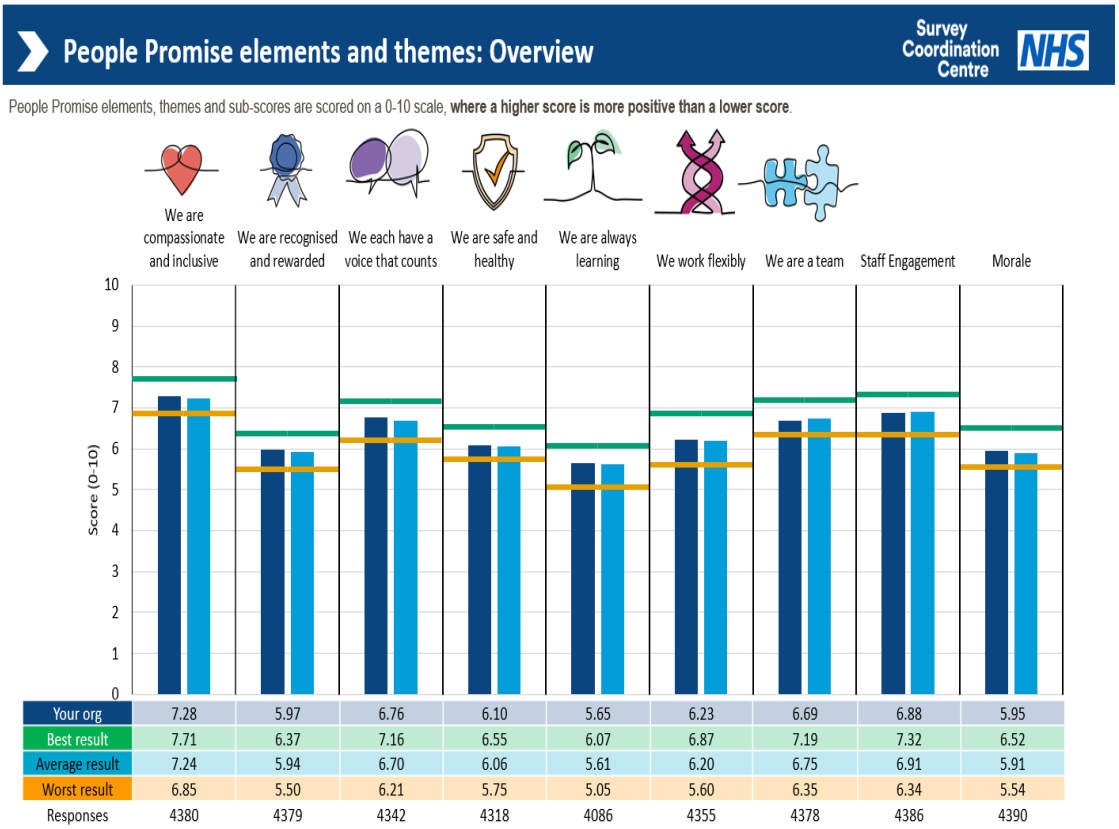
8. The National Staff Survey Benchmark report for East Lancashire Hospitals Trust contains results for themes and questions from the 2023 NHS Staff Survey, and historical results back to 2019 where possible. These results are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations (see appendix 1 for the full report).

9. The 2023 survey questions are aligned to the People Promise and measured against the seven People Promise elements depicted in the graphic below and against two of the themes reported in previous years (Staff Engagement and Morale).



10. The nine themes are scored consistently on a 0-10pt scale with 10 being the best possible score. As in previous years the question level data is presented in percentage scores.
11. The Trust staff satisfaction responses scored above average for 7 out of 9 themes when compared with all Acute and Community Trusts.
12. The Trust staff satisfaction responses scored below average for 2 out of 9 themes- "We are a team" and "Staff Engagement".

Figure 3: below outlines the theme results:



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.28	5.97	6.76	6.10	5.65	6.23	6.69	6.88	5.95
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	4380	4379	4342	4318	4086	4355	4378	4386	4390

Statistically significant changes

13. Figure 4 below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023. The table details the organisation's theme scores for both years and the number of responses each of these are based on. The final column contains the outcome of the significance testing: indicating if the 2023 score is a statistically significant change higher or lower than last year's score.

14. The table below demonstrates 2 themes with statistically significant changes that are higher when tested using a two-tailed t-test with a 95% level of confidence. The themes demonstrating the significantly higher scores compared to last year are: "We are recognised and rewarded" & "We are always learning". Demonstrating a significant improvement in these themes.

15. The table below demonstrates 3 themes with statistically significant changes that are lower when tested using a two-tailed t-test with a 95% level of confidence. The themes demonstrating the significantly lower scores compared to last year are: "We each have a voice that counts", "We are safe and healthy" & "Staff Engagement". Demonstrating a significant deterioration in these themes.

Figure 4: Significance testing – 2022 v 2023 theme results:

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	7.33	4451	7.28	4380	Not significant
We are recognised and rewarded	5.88	4449	5.97	4379	Significantly higher
We each have a voice that counts	6.88	4409	6.76	4342	Significantly lower
We are safe and healthy	6.18	4415	6.10	4318	Significantly lower
We are always learning	5.48	4262	5.65	4086	Significantly higher
We work flexibly	6.16	4424	6.23	4355	Not significant
We are a team	6.70	4445	6.69	4378	Not significant
Themes					
Staff Engagement	7.01	4451	6.88	4386	Significantly lower
Morale	6.03	4451	5.95	4390	Not significant

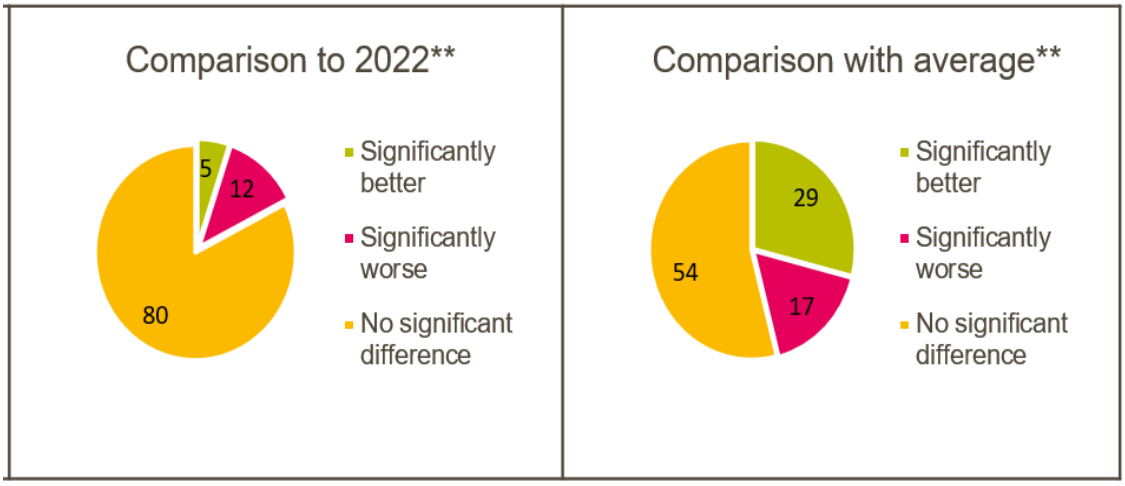
Question level comparisons

16. A total of 118 questions were asked in the 2023 survey. 113 questions can be compared historically between 2022 and 2023. Our results include every question where the organisation received at least 10 responses (the minimum required).

17. The historical comparison pie chart below demonstrates that 5 questions scored significantly better, 80 questions no significant difference and 12 questions significantly worse when compared with ELHTs 2022 questions.

18. When compared with the Picker average 29 questions scored significantly better, 54 questions scored no significant difference and 17 questions significantly worse.

Figure 5: Question level historical and Picker average comparison:



Comparison with 2022 (ELHT vs ELHT)

19. The 5 questions ELHT scored significantly better compared to 2022 historical comparisons are:

- ✓ q3i Enough staff at organisation to do my job properly.
- ✓ q4c Satisfied with level of pay.
- ✓ q14d Last experience of harassment/bullying/abuse reported.
- ✓ q23b Appraisal helped me improve how I do my job.
- ✓ q23c Appraisal helped me agree clear objectives for my work.

20. The 12 questions ELHT scored significantly worse compared to 2022 historical comparisons are:

- × q2b Often/always enthusiastic about my job.
- × q2c Time often/always passes quickly when I am working.
- × q3g Able to meet conflicting demands on my time at work.

- q3h Have adequate materials, supplies and equipment to do my work.
- q11a Organisation takes positive action on health and well-being.
- q13c Not experienced physical violence from other colleagues.
- q14c Not experienced harassment, bullying or abuse from other colleagues.
- q16b Not experienced discrimination from manager/team leader or other colleagues.
- q20a Would feel secure raising concerns about unsafe clinical practice.
- q25a Care of patients/service users is organisation's top priority.
- q23d If friend/relative needed treatment would be happy with standard of care provided by organisation.
- q25e Feel safe to speak up about anything that concerns me in this organisation.

Figure 6: Most improved vs most declined scores based on historic comparison:

Most improved scores	Org 2023	Org 2022
q4c. Satisfied with level of pay	33%	28%
q14d. Last experience of harassment/bullying/abuse reported	53%	48%
q23b. Appraisal helped me improve how I do my job	26%	22%
q3i. Enough staff at organisation to do my job properly	34%	32%
q23c. Appraisal helped me agree clear objectives for my work	35%	33%

Most declined scores	Org 2023	Org 2022
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	60%	64%
q3h. Have adequate materials, supplies and equipment to do my work	60%	63%
q20a. Would feel secure raising concerns about unsafe clinical practice	71%	74%
q11a. Organisation takes positive action on health and well-being	61%	64%
q25e. Feel safe to speak up about anything that concerns me in this organisation	62%	64%

21. For the first time in many years ELHT scored worse than the Picker average on several questions. The 17 questions ELHT scored significantly worse compared to the 2023 Picker average are:

- q2a Often/always look forward to going to work.
- q2b Often/always enthusiastic about my job.
- q3e Involved in deciding changes that affect work.
- q7g Team deals with disagreements constructively.
- q9a Immediate manager encourages me at work.
- q9b Immediate manager gives clear feedback on my work.
- q9c Immediate manager asks for my opinion before making decisions that affect my work.
- q9d Immediate manager takes a positive interest in my health & well-being.
- q9e Immediate manager values my work.
- q9f Immediate manager works with me to understand problems.

- q9g Immediate manager listens to challenges I face.
- q9h Immediate manager cares about my concerns.
- q9i Immediate manager helps me with problems I face.
- q11e Not felt pressure from manager to come to work when not feeling well enough.
- q13b Not experienced physical violence from managers.
- q24c Have opportunities to improve my knowledge and skills.
- q25d If friend/relative needed treatment would be happy with standard of care provided by organisation.

Figure 7: Top 5 scores vs bottom 5 scores based on Picker average comparison:

Top 5 scores vs Organisation Average	Org	Picker Avg
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	55%	48%
q22. I can eat nutritious and affordable food at work	61%	55%
q15. Organisation acts fairly: career progression	62%	57%
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	60%	56%
q19c. Organisation ensure errors/near misses/incidents do not repeat	71%	67%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q11e. Not felt pressure from manager to come to work when not feeling well enough	73%	77%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	55%	59%
q9h. Immediate manager cares about my concerns	67%	70%
q9g. Immediate manager listens to challenges I face	68%	72%
q3e. Involved in deciding changes that affect work	49%	52%

22. Based on the initial high-level analysis a few key themes shine through in the data as areas for targeted improvement. These include: manager development, building psychological safety to speak up, job demands and resources, managing conflict in teams.

Next steps

23. The following steps will be taken over the coming weeks:
    a. National staff survey virtual feedback workshops will be completed for all Divisions to help divisional leads and managers better understand their data and support them to identify strengths and challenges. The workshops will be facilitated by the Picker Institute on the below dates:

Division	Date	Time
SAS	27th February 2024	11am-12pm
Corporate	27th February 2024	2pm-3pm
Family Care	28th February 2024	11am-12pm
CIC	29th February 2024	11am-12pm
E&F	5th March 2024	11am-12pm
MEC	6th March 2024	11am-12pm
DCS	7th March 2024	11am-12pm

b. A dedicated national staff survey share-point page will be available to support access to all report findings, further information, helpful documents and data to support divisions to further interrogate and investigate at a team, department, directorate and divisional level.
c. The findings and perspectives from colleagues will be discussed at the Employee Engagement and Experience Sponsor Group chaired by the Chief Executive on the 8th March 2024.
d. Divisional leaders will create their co-produced action plans based on the survey data aligned to the NHS People Plan, People Promise and crucially staff feedback. The agreed divisional action plans will be discussed and monitored via the divisional performance meetings.
e. Divisions will also report progress made towards achieving their objectives and sharing best practice at the Employee Engagement and Experience Sponsor group throughout 2024.
f. The Inclusion Lead, Organisational Development Team and Freedom to Speak Up Guardians will triangulate data to better understand the experience of our diverse workforce particularly in relation to the WRES/WDES to ensure we address any inequalities with help by the participation and support of our staff networks.
g. The People and Culture Team will ensure their objectives are aligned to addressing any Trust-wide themes as part of their strategic plans for 2024. Outputs and progress will be monitored via the People and Culture Committee. The initial staff survey report will be discussed at the People and Culture Committee on the 4th March 2024.
h. A communications plan will be devised and deployed throughout the Trust and externally following the lifting of the national embargo on the 7th March 2024 at 9.30am.
i. The staff survey report will be discussed at Part 2 of Trust board on the 13th March 2024.

Conclusion

24. The 2023 National Staff Survey Report highlights some areas of improvement, along with several areas for further improvement and themes to target for 2024. It is disappointing to see our position deteriorating but reflective of the challenges faced across the Trust over the last 12 months.

25. Together the ELHT team will commit to driving forward an evidence based participative approach to collectively action the areas we need to improve upon prior to the next survey commencing in September 2024. We will also celebrate and share good practise of those areas that are excelling in employee engagement and experience within teams and Divisions throughout 2024.

Lee Barnes, Associate Director Staff Wellbeing and Engagement 26th February 2024

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **44**

13 March 2024 **Purpose** Approval

Title	Ratification of Remuneration Committee Terms of Reference
Executive sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance

Summary: The terms of reference for the Remuneration Committee have been reviewed in line with their current work plans and best practice. They were reviewed by the Committee on the 19 January 2024 and are presented to the Board for ratification.

Recommendation: The Board is asked to consider and ratify the revised terms of reference for the Remuneration Committee.

Report linkages

Related Trust Goal

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

Related to key risks identified on Board Assurance Framework

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

2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.

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

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

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

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to here.
Related to ICB Strategic Objective	State which ICB Strategic Objective the paper relates to here.

Impact

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

Previously considered by:

TERMS OF REFERENCE: REMUNERATION COMMITTEE

Constitution

The Trust Board has established this Committee to be known as the Remuneration Committee. The Committee will report to the Trust Board. The Committee has overarching responsibility for the remuneration of, arrangements for the appointment of, and agreement of termination packages for Executive Directors. The Committee has the authority to appoint short term, outcome focused sub-committees but does not routinely receive reports from other sub-committees.

Purpose

The Committee has authority to determine, in consultation with the Chairman and the Chief Executive of the Trust:

- the policy on the remuneration of Executive Directors
- the specific remuneration packages for each of the Executive Directors including pension rights and any compensation payments
- the arrangements for the appointment of individuals outlined above
- the termination packages of any individual outlined above.

Duties and Responsibilities

In determining the remuneration and termination packages and the remuneration policy, the Committee has a duty to keep in mind:

- firstly, the desirability of the maintenance throughout the Trust of a competitive, fair remuneration structure which operates in the interests of, and to the benefit of, the financial and commercial health of the Trust
- secondly, ensuring the members of the executive management of the Trust are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the success of the organisation.

The Committee will receive an annual report from the Chief Executive on the remuneration and pay packages of the very senior staff that are not Executive Directors and are not on the Agenda for Change pay grades. The Chief Executive is responsible for:

- the remuneration of other very senior employees who are considered by the Committee

to hold key positions within the Trust and whose remuneration package is, or is considered appropriate to place, outside the provisions of the Agenda for Change framework

- the remuneration of other employees who are considered by the Committee to hold key positions within the Trust who are employed to perform specific short- term functions on a semi-consultancy basis.

Committee Authority/Delegated Authority

The Committee is authorised through/with the assistance of the Director of Corporate Governance/Company Secretary to:

- seek any information it requires from any employee in order to perform its duties
- obtain any outside legal or other professional advice including the advice of independent remuneration consultants
- secure the attendance of external advisors at meetings and to obtain reliable up to date information about remuneration in other Trusts.

The Committee has authority to commission reports and surveys that it considers necessary to fulfil its obligations.

Membership

The Committee shall be constituted of the Trust's Chairman and at least four other Non-Executive Directors. One of the voting Non-Executive Directors, other than the Trust Chairman will chair the Committee

Associate Non-Executive Directors can also be members of the Committee, but will not have the right to a vote

No individual will be involved in any part of a meeting at which decisions as to their own remuneration will be taken.

In Attendance

The Chief Executive, Executive Director of People and Culture and the Director of Corporate Governance/Company Secretary will normally be in attendance at the meetings. The Executive Director of Finance will be invited to attend meetings as required.

Frequency

At least two meetings will be held annually. Additional meetings will be convened by the Director of Corporate Governance/Company Secretary at the request of any member of the Committee.

Quorum

The Chairman of the Committee and two Non-Executive Directors are required to ensure quoracy. A quorum must be maintained at all meetings.

Members are expected to attend at least 75% of the meetings throughout the year. In the unusual event that a member of the Committee cannot attend the following are the delegated deputies:

- Chair of the Committee – any other voting Non-Executive Director, but not the Trust Chairman
- Chief Executive – Deputy Chief Executive
- Any other Executive Directors, who would normally be in attendance or in attendance because of the nature of the agenda items, may be deputised for by their deputy or another senior manager within their corporate structure if required.

Regular Reports

Chief Executive's Annual Appraisal including Annual Appraisal of Executive Directors Report

Annual Executive Salary Benchmarking Report (including NHS VSM salary benchmarking data if available at the time of the report)

Annual Report on the Remuneration of Very Senior Staff

Annual Fit and Proper Persons Test Report

Reporting

The Committee will report to the Trust Board.

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board Business Cycle. The Committee will provide an annual report on its activities within the Trust's Annual Report. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

Committee Services

Lead Director: Chief Executive

Secretarial Support: Corporate Governance Team

TRUST BOARD REPORT

13 March 2024

Item	**45**
Purpose	Information Action Monitoring

Title	Quarter Four 2023-24 – Communications Activity Report
Executive sponsor	Miss S Wright, Joint Executive Director of Communications

Summary: This paper outlines proposed activity delivered by the communications team, along with other colleagues, in Q3 and that planned for Q4.

It provides an opportunity to input into the plans and highlights where colleagues can get involved.

Recommendation: Trust Board is asked to:

- Note the plans in place
- Identify where they could be improved
- Raise any gaps in service provision or support
- Approve the plans

Report linkages

Related Trust Goal	Deliver safe, high-quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on assurance framework	1. The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2. The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter. 3. The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive. 4. The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

1. SUMMARY

This paper sets out the key activities planned by the communications team for delivery this quarter – January to March, 2024.

It does not include the day-to-day support work ongoing by the team which includes things like:

- Regular bulletins
- Media management
- Proactive public relations
- Support for divisional communications requirements
- Management of social media channels or the website
- Development of the staff app or private Facebook group
- The CEO blog or Teams Brief

The list above is not exhaustive but gives examples of business-as-usual activity, albeit this is continuously improving and evolving in content and reach.

2. OBJECTIVES

- Note the plans in place
- Identify where they could be improved
- Raise any gaps in service provision or support
- Approve the plans

The paper aims to give advance warning to the Trust Board about upcoming activity. The quarterly report will also include completed activity from the previous quarter.

3. PREVIOUS THREE MONTHS

Key data for October 1 – December 31

Social media and website highlights

We continue to grow our presence on social media. Facebook remains the Trust's most popular corporate platform in terms of engagement. We continue to monitor changes being made globally to X (formerly known as Twitter) to ensure it is still a viable platform for ELHT but we are actively discouraging teams from setting up new profiles.

Key data for October 1 – December 31

elht.nhs.uk website	
Page views	724,000 (6% increase on previous three months)
Visitors to the elht.nhs.uk site	272,756 (15% increase on previous three months)

ELHT Facebook	
Followers	21,700 (up 244 since last quarter)
Total reach (number of people who may have been seen our posts)	489,220
Total engagement (likes, shares and comments)	10,085

ELHT X (formerly known as Twitter)	
Followers	10,600 (up 88)
Total impressions from (number of times our posts may have been viewed)	102,884
Total engagements	1,039

ELHT LinkedIn	
Followers	8,725 (up 107)
Total impressions	42,504
Total reactions	807

Nextdoor	
Number of posts	9
Number of Members as of 31 December	65,551
Total impressions (number of times our posts may have been viewed)	36,711
Total engagement (reactions, link clicks, shares and comments)	131

Communications activity

The following communications activity was a focus during quarter three of 2023/24. This list does not include the business-as-usual activity noted above or some campaigns which have continued into quarter three of 2023/24 and are therefore referenced in item 4.

- **MENTAL WELLBEING CAMPAIGN –** In response to the results of a mental health survey, a campaign was implemented with easy to access information about mental health support and waiting times for each service offered. Posters, featuring colleagues, were distributed around the Trust's site and information about different support available is being highlighted through internal communications channels. The campaign was launched with a takeover of Teams Brief, including a live mindfulness session.

- **MONEY SAVING SUGGESTION SCHEME –** An internal campaign was developed encouraging colleagues to do their bit to save energy, waste and costs. It All Adds Up was launched via Teams Brief, with each Executive Director sharing tips, which was followed up with related content and tips in each subsequent news bulletin. Colleagues were asked to share their money saving tips and over 150 were submitted, including requests to turn down heating, changes to volumes being ordered and calls to switch off unused appliances.

- **INDUSTRIAL ACTION** – Work continued to share messages over the periods of recent industrial action in December 2023 and January 2024, with both internal audiences and the public. The messages, agreed across the Lancashire and South Cumbria system, reminded communities to continue to attend appointments unless advised otherwise and to use health services appropriately.

- **WINTER PRESSURES AND SYSTEM-WIDE PLAN –** A joint winter communications plan co-produced by the communications teams in the organisations making up the Provider Collaborative Board launched in earnest. The plan focuses 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, messages were reinforced across the system including via social media channels, websites, internal communications, local press and via ICB Place teams liaising with stakeholders, local authorities, businesses and other key partners.

- **WHY NOT HOME, WHY NOT TODAY / ED PRESSURES** – A key focus of activity was on patient flow and discharge as our emergency pathways continued to be challenged. Our internal updates spotlighted new activity that had taken place, along with more personal messages about people working in areas supporting patient flow. In the run-up to Christmas, this took on the annual Ho-Ho-Home for Christmas theme.

- **CHRISTMAS CAMPAIGN –** Alongside the Ho Ho Home for Christmas activity, a morale boosting campaign took place to raise spirits in the run up to Christmas. A dedicated page on OLI highlighted activity taking place across the Trust, from children's choirs to Christmas fairs. In additional, colleagues were encouraged to submit nominations for their Christmas crackers, with 12 people winning a tower of treats. Over 1,100 nominations were put forward.

- **SPEAK UP MONTH –** Key messages were shared about the importance of speaking up and an appeal was made for more Freedom To Speak Up ambassadors, which led to 25 colleagues coming forward.

- **VACCINATION CAMPAIGN –** Details of drop-in sessions and hub activity were promoted on a regular basis to encourage more colleagues to come forward for vaccination, along with details of a special community vaxathon and other activity organised by the Occupational Health team.

- **FESTIVAL OF INCLUSION –** The Communications team supported equality and diversity leads to bring their exciting programme of activity and events to life on various communication channels.

- **STAR AWARDS CELEBRATION EVENT** – To conclude our Star Awards, an informal event was held for winners to be presented with their trophies and certificates. This helped bridge the gap between the virtual announcement of winners and a face to face celebration.

- **EPR IMPLEMENTATION** – The focus remained on supporting colleagues with the transition to the EPR system, particularly concentrating on communicating the importance of creating discharge letters properly in more targeted ways. Promotion of Cerner Optimisation Coaching, weekly 'tips and tricks' and ward walkabouts remained a priority as a way of upskilling colleagues and sharing learning across the organisation.

- **MFA** – The digital communications team supported the data and digital division with the roll out of Multi-Factor Authentication (MFA) throughout November and December. Key information was shared Trust-wide along with updates on progress and when the project had finished. All colleagues are now registered for MFA.

- **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.

- **EMERGENCY THEATRES DOCUMENTARY** – Agreement was made to take part in the filming of a new documentary series about the Trust's emergency theatres produced by Proper Content for Channel 4. The series will highlight the work of the theatre team to keep emergency surgeries running, the quality of care, the varied caseload, with the stories of patients and loved ones at the heart.

  Preparations were conducted, involving engagement activities and orientation sessions for the production and film crew. Background checks, protocols and logistics were also carried out with rigours processes put in place to protect patients privacy and dignity, and colleagues professional integrity.

- **AWARENESS DAYS –** The team has continued to support a wide range of awareness days during quarter three, including:

  - Baby Loss Awareness Week
  - International Fraud Awareness Week
  - Pancreatic Cancer Awareness Month
  - Speak Up Month
  - Celebrating Community Services Week

  Activity included social media support, video production and photography to ensure relevant messages were shared both within the Trust and with patients, visitors, family members and partner organisations.

4. PROPOSED ACTIVITY Q4 2023/24

Below is a snapshot of some of the key activity which will be undertaken by ELTH Communications Team during quarter four - January to March, 2023.

- **SERVICES TRANSFORMATION –** communications plans and support is being provided as part of the development of plans to transfer some services with system partners. As opportunities to engage and subsequent decisions are made about the future of services, updates will be shared internally, on the website, with service users and a review of current marketing materials, such as posters and leaflets, will be carried out to ensure key information, such as email addresses and websites are kept updated.

- **MONEY SAVING CAMPAIGN –** It All Adds Up will continue in 2024, with particular emphasis on any suggestions that have been implemented. A dedicated intranet page will highlight ideas put forward that have generated a response from teams or departments. The campaign is also being adopted by other Trusts in LSC.

- **MENTAL HEALTH SUPPORT –** Different wellbeing support available to colleagues will continue to be highlighted as part of our pre-Christmas campaign 'you're not OK, let's talk about it'. In addition, support will be provided to the Well Team's Colleague Care Month by amplifying their messages regarding events and support.

- **WINTER PRESSURES** – The joint winter communications campaign mentioned above will continue to be implemented during quarter four. Communications teams from across Lancashire and South Cumbria have combined resources to create supporting graphical, written and video content on a range of messages including:

  - Bank holiday advice
  - Falls prevention
  - Living with long-term conditions
  - Mental health
  - Primary care messages
  - Respiratory conditions
  - Self-care

  All messages are designed to support the aims of prevention, signposting and self-care. They are being shared by many partner agencies as well as being used on our own channels. ELHT will be developing a series of animations to support this.

- **WHY NOT HOME, WHY NOT TODAY / ED PRESSURES** – Our primary focus will remain on managing patient flow and discharge during the ongoing challenges to our emergency pathways. Internal communications will consistently highlight real-time updates on new activities, featuring more personalised messages about individuals contributing to areas supporting patient flow. External messages will provide information on alternative pathways: how to get the right help, at the right place and at the right time. As we approach the Easter season, these updates will align with the annual Home for Easter theme.

- **EMERGENCY CARE MOVES** – Working with colleagues in our emergency pathways and partner organisations, communications activity will be produced to support the temporary moves of our Urgent Treatment Centre and Ambulatory Emergency Care Unit. The moves will help relieve pressure in the Emergency Department and make more space available to improve the experience of our patients and the working environment of our colleagues.

- **CHARITY £15K GIVEAWAY –** As part of a Christmas campaign, our charity ELHT&Me asked colleagues how £30k should be spent. A total of £15k was given away in daily prize draws. The other £15k will form the basis of a campaign where teams can bid for funding for an initiative that will improve the patient experience. The communications team will work with the charity to raise awareness and encourage submissions.

- **STAFF SURVEY RESULTS -** A national embargo on the results of the NHS Staff Survey will be lifted in this next quarter. Communications activity will support the Well Team as they share key results both internally and externally as divisional big conversations are organised and encouraging teams to develop targeted plans for future improvement.

- **CLINICAL PORTAL DISCONTINUATION –** Activity will continue to support the Clinical Informatics team in raising awareness of the discontinuation of clinical portal in January 2024. The focus will be on promoting the benefits of using the new, ICS-wide Shared Care Record within the EPR system and outlining the clinical safety risk associated with using the old system.

- **INTRANET –** Work will begin in collaboration with the Data and Digital team to improve the intranet and bring it in-house. Migrating from the current external platform to SharePoint will reduce costs, improve functionality and to provide a more personal experience for users. Engagement with clinical and non-clinical colleagues will be key to the success of the project.

- **KIT AMNESTY –** A campaign to encourage colleagues to return unused and unwanted equipment such as laptops, mobile phones and desktops will begin in January 2024. ‘Do your bit, return your kit’ messages will run weekly and will be interlinked will colleagues’ suggestions as part of the ‘It All Adds Up’ campaign.

- **WEBSITE ACCESSIBILITY** – On the back of a recent cabinet office audit of our public-facing website, we now need to find a solution for ensuring all documents hosted on the website are accessible or created as a webpage. Training for regular website contributors including communications, patient experience and corporate governance will take place this quarter as we aim to convert all PDFs to webpages by June 2024.

- **ONE LSC –** The Trust's Communications team works with its counterparts across Lancashire and South Cumbria primarily through a Director of Communications working group and a Head of Communications working group which meets regularly. Campaigns and best practice are routinely shared – the Trust has to date shared information with this group including information related to its Staff Survey, vaccination and It All Adds Up campaigns. Most recently, the One LSC Engagement Hub has launched with information shared in communications channels, a centrally managed portal for sharing information and best practice among teams collaborating across the system. This joint working will continue in quarter four.

- **OFFICIAL OPENING OF THE SPIRITUAL CENTRE** – Arrangements will commence on the official opening of the new spiritual centre located on the Burnley General Teaching Hospital site in March 2024. Working with the Chaplaincy and Spiritual Care Services, communications activity will also ensure increased awareness of the new facility in the run up to the Ramadan and Easter celebrations.

- **CAUSE OF DEATH DOCUMENTARY** – Filming of the third series will continue in this quarter, following the successful second series of Candour's remarkable documentary for Channel 5. Support will continue to ensure filming access is provided and the production runs smoothly.

- **EMERGENCY THEATRES DOCUMENTARY** – Filming for the upcoming 'The Critical List' documentary series, produced by Proper Content for Channel 4, is scheduled for three weeks in January 2024. Comprehensive access agreements and filming protocols will been drafted and mutually agreed to ensure the safe capture of footage of patients and their relatives, colleagues, and the Trust. The series is expected to be broadcast in late Summer or early Autumn. A communications plan will be developed to maximise on the series airtime to showcase the Trust, colleagues and roles, linking to job opportunities.

- **MATERNITY VIDEO SERIES** – Following a successful bid for grant funding from Electricity North West, a series of videos will be produced to support new parents. They will form part of a suite of resources parents can access providing helpful tips, advice and information. Filming and editing will take place in this quarter.

- **AWARENESS WEEKS** Ongoing activity will take place to support and promote key awareness days involving relevant areas of the Trust. In this quarter this will include National Apprentice Week, Overseas NHS Workers Day and International Women's Day. Colleagues will be encouraged to organise their own activities and events that can then be promoted by the communications team.

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the plans in place
- Identify where they could be improved
- Raise any gaps in service provision or support
- Approve the plans

ENDS

Shelley Wright

Executive Director of Communications

19/01/24

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **46**

13 March 2024 **Purpose** Information

Title	Trust Charitable Funds Committee Summary Report
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mr R Smyth, Committee Chair

Summary: The report sets out the summary of the papers considered, and discussions held at the Trust Charitable Funds Committee meeting held on 23 November 2023.

Recommendation: The Board is asked to note the report.

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	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

() Finance and Performance Committee Summary Report

Meeting: **Trust Charitable Funds Committee**

Date of Meeting: **23 November 2023**

Committee Chair: **Richard Smyth, Non-Executive Director**

ITEMS APPROVED

- Members approved the minutes from the meeting held on 17 July 2023 as a true and accurate record.

ASSURANCE RECEIVED

1. Financial Performance Report for April 2023 - October 2023

The latest financial performance report for ELHT&Me was presented to members. It was noted that the current fund balance stood at just over £2,000,000, with £573,000 of income received to date. The Committee was informed that forecast income for the year was expected to be very close to the £1,000,000 threshold that would require a full audit of the Charity's accounts, which would to additional costs of between £15,000 and £20,000.

2. Audited Annual Report and Accounts 2022-23

The Committee received the audited Annual Report and Accounts for ELHT&Me for 2022-23. It was confirmed that no issues had been raised during the audit process and that total income had amounted to £839,000. A discussion on the future aims and goals of ELHT&Me took place and members agreed that further discussion these in more detail.

The Committee:

Agreed for a session to be arranged in January 2024 to discuss the future aims and goals for ELHT&Me in more detail.

3. ELHT&Me Fundraising and Performance Report Q2 2023-24

The latest ELHT&Me Fundraising and Performance Report was received and noted by the Committee.

4. ELHT&ME Charity Hub and Retail Outlet Update

The latest report from the ELHT&Me Charity Hub and Retail Outlet was presented to members. Members noted that the Retail Outlet had surpassed its initial income estimates and that this success was due in large part to the efforts of volunteers.

5. Options for Charity Hub Equipment Purchase

A series of options were presented to the Committee relating to the use of profits from the Charity's Retail Hub for the purchase of medical equipment.

The Committee:

Agreed for the proposals presented to be taken through the Trust's Medical Devices Steering Group for discussion with senior clinicians and to be brought back to the next meeting for further consideration.

6. Trading Subsidiary Proposal

The Committee was informed that due to the better-than-expected income results for the Charity's Retail Hub, it would be required to register for VAT and form a limited trading company. It was agreed for the proposal to be put forward to the Trust Board in January 2024.

7. Review of Committee Terms of Reference

The recently revised and updated Terms of Reference for the Committee were presented to members for ratification.

The Committee:

Confirmed that they were content to recommend the Committee terms of Reference to the Trust Board for approval.

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.

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **47**

13 March 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 18 December 2023, and 29 January 2024.

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: **18 December 2023**
Committee Chair: **Liz Sedgley, Non-Executive Director**

ITEMS APPROVED

- Members approved the minutes from the meeting held on 27 November 2023 as a true and accurate record.

ASSURANCE RECEIVED

1. Finance Reporting

Members were informed that on 22 November 2023, the Lancashire and South Cumbria (LSC) system had submitted a revised forecast system financial deficit of £198.5 million. Members noted that this was a deterioration of £118.5 million from the original £80 million deficit plan. Furthermore, the Trust's position had deteriorated from £24 million to £39 million, however the revised forecast had not yet been accepted by NHS England.

Members were informed that the acute Trusts within the system had originally agreed to submit a deficit of £24.2 million each, however once the position had been submitted, additional funding had been given to the system which was not shared equitably between all acute Trusts. It was noted that this had only been allocated to Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB), with East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BTH) not receiving any funds.

Members were updated on the potential for additional financial risks, including the potential for additional expenditure and loss of income related to the implementation of the EPR system, additional expenditure relating to operational pressures around the Emergency Department, the impact of not receiving any UEC funds, impact of industrial action, and impact of any future pay awards. Members were informed that the Trust still did not have a signed contract with the Integrated Care Board. In addition, the shortage of cash and cost to borrow would negatively impact the Trust.

Members were assured of the actions being undertaken to try to achieve financial recovery including halting all non-essential spend which was reviewed at the weekly Non-Pay Control group, weekly Divisional and Trust wide Workforce Control Groups, all training and travel reduced or stopped, a recruitment freeze, all remaining annual leave accrual to be utilised, no accruals under £5,000, and no accruals over 6 months.

Members were updated on the pay analysis for the Trust, noting that the 2022/23 pay costs were £510 million, however the forecast for 2023/24 would be £517.4 million. Members were advised that there had been pressures as a result of the industrial action and increased demand across the UEC pathway. Furthermore, investments had been made into the recruitment of international nurses and for Endoscopy staff.

Members were updated on the Trust's Month 8 position to the end of November 2023, noting that there was a deficit of £29.5 million. Members were advised that there were low cash reserves, and that the Waste Reduction Programme (WRP) was currently £20.9 million against the planned position of £54.6 million. Members noted that the "green" schemes for the year had a value of £27.3 million, and that there was a total identified value of £39.8 million, of which £19 million was recurrent savings. Ms Henson commented that capital spend was at £21 million.

Members were informed that the current cash balance for the Trust was £4.4 million, and that an additional request for Public Dividend Capital (PDC) borrowing had been submitted for Quarter 4. Members were updated on the Better Payment Practice Plan (BPPC), noting that the Trust was achieving the target to pay 95% of invoices on time by value for the financial year to date. It was noted that cash pressures continued to impact the Trust's ability to pay all suppliers within 30 days.

2. Improvement Update

Members were provided with an update on the work to review and improve Bank and Agency usage across LSC. Members were informed that work had commenced in September 2022 with a Value Stream Analysis event over 3 days, with the aim being to reduce agency usage and increase bank usage, reduce off framework use, have shared understanding of the problem and a consistent and collaborative approach.

Members noted that this would result in a single rate card, along with increased quality for patients, safer staffing levels, increased staff morale and improved control over payments to agencies.

Members were updated on the 3-day improvement event, noting that this was an opportunity for the Trusts involved to come together to understand the current data and processes and help to identify issues and opportunities for improvement. It was noted that the event had been useful and provided an opportunity for people to meet in person and build relationships.

Members were informed that following the event, a number of quick wins were identified, along with a set of system level and Trust level actions. Members noted that from the 57 internal actions identified, 38 had been completed, with 15 ongoing and 4 temporarily paused for a future improvement event. Members were advised that the work undertaken had significantly reduced the level of agency staff being used across the system.

3. Integrated Performance Report (IPR)

Members were informed that the 4-hour performance for Accident and Emergency (A&E) continued to be above trajectory. Members noted that ambulance handover data was not available due to data quality issues and that the Trust was working with the North West Ambulance Service (NWAS) in order to resolve the issues. Members were updated on the Trust's Cancer performance, noting that the 62-day backlog had returned to trajectory by improving grip and control from September 2023. Members were informed that the majority of issues with Teledermatology had been rectified and performance for the service was recovering with targets likely to be achieved by March 2024.

Members were updated on Endoscopy activity, noting that this was a good example of grip and control, improvement and being appropriately resourced. Members were informed that the booking team had been invested in which had enabled more patients to be scheduled for appointments.

Members were updated on the Referral to Treatment (RTT) 65-week target, advising that a revised plan had been submitted with the year-end position having 628 patients remaining. Members were informed that this equated to 305 patients for Gynaecology, 277 for Digestive

Diseases, and 46 for Hepatology, with other services being forecast to have 0 breaches at year end.

Members were informed that activity levels within Outpatients were now performing well, noting that activity had previously been impacted due to the Cerner implementation.

4. Community Services Transfer

Members were informed that the teams had undertaken a tremendous amount of work over the past 6 weeks with regards the due diligence and identified 462 points of due diligence to work through. Members were informed that work on the legal due diligence was progressing with the deadline for documents being 18 December 2023.

Members were advised that there had been one gateway assessment at which, only one workstream was passed, noting that further information was required in order to satisfy the Key Lines of Enquiry (KLOE).

Members were updated on the progress made against the due diligence, noting that a session had been held with the central team, including good representation from Quality and Safety colleagues. Members were informed of an issue where the services transferring from Lancashire and South Cumbria NHS Foundation Trust (LSCFT) used a number of different methods to record clinical data, including paper and 3 digital systems which were not compatible with the ELHT digital platforms. It was confirmed that work was taking place to ensure that a quality and clinically safe service would be provided following the transfer.

Members were advised that 6 workstreams remained unassessed due to information still to be received from LSCFT, with the next review would take place towards the end of December 2023. It was confirmed that financial due diligence was taking place with a number of queries being raised between the providers. Members noted that there had been a detailed review of the workstreams in order to identify an initial list of potential recurrent and non-recurrent issues.

5. Albion Mill

Members were informed that work continued on developing a 12-month proof of concept proposal., with work continuing on the due diligence process related to Albion Mill. Members noted that the 3 areas that had been identified that would require a specific focus to de-risk

were Estates, Digital and Data, and Workforce. It was noted that work was progressing to increase the number of open beds from 5, up to 15 in order to support Winter pressures.

Members were informed members that the full due diligence report would provide a summary of the financial, legal and operational due diligence that had taken place, along with the full workstream due diligence covering all aspects of service delivery, and the key risks and issues and how these would be de-risked.

6. Corporate Risk Register

Members were informed that a new risk relating to funding for research and innovation in the Trust had been added. Mrs A Brown commented that risk had been presented at the Risk Assurance Meeting and that it was impacting on service. Members were informed that one risk had been removed due to improvements having been made with nurse staffing, and that the risk relating to the holding list had had its rating reduced to 12. Members were informed that there had been a reduction in the number of risks and significant improvements made to the number of open risks and noted that there had been a reduction of 58% for risks that were over 3 years on the risk register, and overdue risks had reduced by 52%.

7. Board Assurance Framework

Members were informed that the Executive Directors had reviewed the Board Assurance Framework (BAF) and revisions had been made to specific Committee risks 1, 3 and 5.

8. Clinical Negligence Scheme For Trusts (CNST)

Members were informed that this item would be presented to the Finance and Performance Committee in February 2024, following review by the Executive team.

9. 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.

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: **29 January 2024**
Committee Chair: **Liz Sedgley, Non-Executive Director**

ITEMS APPROVED

- Members approved the minutes from the meeting held on the 18 December 2023 as a true and accurate record.

ASSURANCE RECEIVED

1. Finance Reporting

Members were informed that there was significant risk in the 2023/24 position for both ELHT and the system, however a lot of work had taken place to enhance the grip and control as evidenced through the Divisional performance meetings. Members noted that there was a high level of scrutiny across Lancashire and South Cumbria (LSC) with a focus on the exit run-rate and a reduction in whole time equivalent (WTE) staffing.

Members were informed that the Trust had submitted draft planned deficit for 2024/25, including a 4.4% waste reduction programme (WRP) of £43.6 million, comprised of the national efficiency target of 1.1%, and a third of the 10% 3-year efficiency target. It was noted that the LSC Integrated Care Board (ICB) contract had not yet been confirmed, and planning guidance had not yet been issued nationally and so any planning had been based on assumptions.

Members were informed that the Trust had started the 2023/24 financial year with a gross deficit of £78.9 million and that the Trust had submitted a planned deficit of £24.3 million on the assumption that savings of £54.6 million would need to be released. Members were advised that the savings figure was made up of a 5.76% WRP and a system gap of £12.3 million, however there were no plans as to how the system gap would be achieved at the start of the year and the Board were not able to be assured. Members noted that the draft WRP had identified £25 million out of a £33.9 million target. Members were informed members that a Quality Impact Risk Assessment (QIRA) needed to be undertaken for all WRP before savings would be accepted, with all QIRAs needed to be signed off by the end of March 2024.

Members noted that due to a number of factors, including the additional cost of industrial action, the forecasted outturn figure was £40.3 million. It was explained that during 2023/24, the Trust had seen an additional £10 million of recurrent pressures, and had needed to invest a further £4.5 million due to Emergency Department (ED) pressures and £1 million for additional security coverage. Members noted that the Trust had forecast that additional income was not expected to be able to cover the position.

Members were updated on the Month 9 position, noting that on 22 November 2023, the LSC ICS had submitted a revised forecast deficit position of £198.5 million, a further deterioration of £118.5 million from the original £80.0 million deficit plan. It was explained that there were a significant number of risks to the Trust achieving the position, including the potential for additional expenditure relating to operational pressures in ED, the impact of future pay awards, and the non-achievement of WRP. Members were informed that the Divisional positions had improved by £4 million since November.

Members were informed that the cash balance at the end of December 2023 was £5.1 million, and that confirmation had been received that the application for £17.1 million of Public Dividend Capital revenue support had been successful. It was noted that this had increased the total level of funding for 2023/24 to £39.1 million.

Members were informed that the Better Payment Practice Code continued to be met with 95% of invoices paid on time in the financial year. Members noted that there was a £2 million pressure for capital schemes, however work continued to try and mitigate this.

Members were advised that the Trust had requested to be excluded from the Elective Recovery Fund (ERF) clawback mechanism for 2023/24 due to data issues relating to the Cerner Electronic Patient Record (EPR), and that discussions with the ICB with regards to a review into the Block Contract continued.

2. Improvement Update

Members were provided with an update on the improvement work taking place within Outpatients to increase adoption of the Cerner Electronic Patient Record (EPR). It was explained that a task force had been established to undertake a full “current state” analysis across the specialties, and that a full end to end review of EPR Outpatient workflows was

undertaken with experts from Cerner on 31 October 2023, following which, 69 areas of improvement had been identified.

Members were informed about improvements to Clinical processes, explaining that the end-to-end review undertaken on 31 October had identified a number of opportunities to improve and streamline clinical process. Members were advised that a new clinical outpatient guidebook had been developed and was due for publication soon. Furthermore, ongoing education and training was being provided to the teams.

Members were updated on the current position for outpatient coding, noting that there was lost income due to a lack of consistently coding across all areas. Members were informed that work was taking place to capture activity, including the creation of a quick visual guide to outpatient procedure coding was being developed and would be placed in each clinic room to guide clinicians on the correct use of workflows.

It was confirmed that the Outpatient EPR Improvement group continued to meet every 2 weeks and reported to the EPR Programme Board. Furthermore, the group had Executive oversight.

3. Integrated Performance Report (IPR)

Members were informed that there had been an increase of 83 attends in January 2024 compared with the previous year, and that the 4-hour A&E target was at 71.12% as of 24 January 2024. Members noted that there had been an increase in the longest and the average ambulance handover times, and that the Trust had been working with the Hospital Ambulance Liaison Officer (HALO) in order to cohort patients and release crews.

Members were informed that there had been an increase in the number of patients requiring care in Resus between September 2023 and January 2024, however this was now starting to reduce. Members were informed that there had been a significant increase in mental health presentations and that the Trust continued to work with Lancashire and South Cumbria NHS Foundation Trust (LSCFT).

Members noted that the Trust had hit the Referral to Treatment trajectory for patients having waited no longer than 65 weeks in December 2023 with 833 against a target of 835, with work continuing to reduce this value to 0.

Members were informed that the Trust had missed the 62-Day Cancer target in December 2023 with 172 against a target of 170. It was noted that the trajectory would be achieved in January 2024 and the teams continued to work hard. Members noted that the Cancer Fast Diagnosis Standard continued to remain on track. Members were updated on theatre productivity, noting that further usage of the Elective Centre at BGH would be explored.

4. Community Services Transfer

Members were informed that the full business case was being developed, and any outstanding areas of due diligence were being completed. Members were informed that with regards to operational due diligence, all risks had now been approved with the exception of digital and data. Members were directed to the Legal due diligence report, noting that there were several risks due to information not yet having been received.

Members were updated on the plans to transfer community services to the Community EMIS system which would mitigate, risk, safety and contractual issues. Members were informed that all parties were working to collectively resolve and risks identified to data that was currently being recorded on paper. Members noted that a solution had been identified for part of the problem, however work continued to mitigate the rest of the issue to enable Community EMIS to be used.

Members were informed that any issues identified through the due diligence process had been factored into the delivery plan for mobilisation, have there were still significant amounts of work to undertake.

Members were advised that there was a financial shortfall in the current draft for Community Services. Furthermore, clarity was being sought with regards community locations due to 2 properties having their leases expiring during the year.

5. Albion Mill

Members were updated on the work taking place for Albion Mill, noting that work continued on the due diligence process whilst also developing the mobilisation plans. It was confirmed that a number of issues had been identified and that the legal team had recommended undertaking further reviews given other longer term terms risks with Albion Mill.

Members were informed that the lease details had been received from LSCFT and were being reviewed by the ELHT Legal team. Members were advised that Albion Mill had risks related to digital, however although these were not as significant as those for the Community Services transfer, they still remained a key issue for mobilisation for 1 April 2024.

Members were informed that the workstream assessment would not be signed off until all the fine detail had been worked through and that further updates would be provided to the Committee for assurance. It was noted that although Community services would be using Community EMIS, the Albion Mill site would need to use the Cerner EPR in line with other bed-based services at the Trust.

Members were advised that a comprehensive due diligence process had been undertaken to ensure that detail provided to the Trust was correct and that as work continues on the approval process, a mobilisation plan for Q1 in the new financial year would need to be produced.

7. Winter Plan Spend Review

Members were provided a brief update on winter spend, noting that due to winter pressures, the Trust had needed to mobilise additional escalation trolleys on a number of wards at Royal Blackburn Teaching Hospital (RBTH), in addition to utilising overflow corridors and some of the Elective Centre capacity. It was noted that that this had all contributed towards additional cost for the Trust.

8. PWE GP Practices – Deep Dive Review

Due to time constraints, this item was deferred to the February 2024 meeting of the Finance and Performance Committee.

9. Private Finance Initiative (PFI) Update

Due to time constraints, this item was deferred to the February 2024 meeting of the Finance and Performance Committee.

10. System Issues

Due to time constraints, this item was deferred to the February 2024 meeting of the Finance and Performance Committee.

11. Committee Self-Assessment Feedback

Due to time constraints, this item was deferred to the February 2024 meeting of the Finance and Performance Committee.

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

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **48**

13 March 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 31 January 2024.

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).	

(48) Quality Committee Summary Report

	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: **31 January 2024**
Committee Chair: **Catherine Randall, Non-Executive Director**

ITEMS APPROVED

The minutes of the previous meeting held on 1 November 2023 were approved as a true record of the meeting.

ASSURANCE RECEIVED

1. Patient / Staff Safety

Members received an update on the pressures currently being seen in the Trust's Urgent and Emergency Care Pathways. It was noted that the numbers of inpatients in the Trust had stayed consistently above capacity which had, in turn, led to further prolonged waits in the Emergency Department (ED). Members were informed that several actions had been taken to alleviate these pressures, the most significant of which was a temporary move of the Trust's ambulatory care function to outpatient areas, and the subsequent move of urgent care into ambulatory care areas to increase capacity. It was highlighted that rises in infectious diseases, including flu and COVID-19, was exacerbating many of the issues being seen, both within patient and staff groups. It was also confirmed that work was taking place with colleagues at Lancashire and South Cumbria NHS Foundation Trust to manage a rise in mental health related pressures.

2. Hospital Standardised Mortality Ratio Update

The Committee received an extensive update from the Head of Client Partnership for Telstra Health UK, Anna Roger, on its mortality data and performance. Members noted that the Trust's Hospital Standardised Mortality Ratio (HSMR) and Standardised Mortality Ratio (SMR) had both been statistically 'higher than expected' from June 2022 to May 2023 but that this had been offset by a marginal decline in the Trust's relative risk value over the same period. It was highlighted that the Trust's expected mortality rates had peaked at 1.9% following the onset of COVID-19 but that current rates had now fallen back to pre-pandemic levels. The Committee was informed that the relative risk for pneumonia mortality had increased from June 2022 onwards, in contrast to other organisations in the local region and that there were

a range of contributing factors behind this. Members received a summary of several proposed changes to the HSMR measure over the coming months and how these could potentially affect the Trust's performance going forward.

The Committee:

Agreed for a further 'deep dive' into mortality to take place at a future meeting of the Committee.

3. End of Life and Bereavement Service Update

An update was provided to the Committee on the progress made with the ongoing development of the Trust's End of Life and Bereavement Service. Members noted that good progress had been made against a range of ambitious targets, the most significant of which was the implementation of a seven-day specialist palliative care service. It was reported that there were a number of issues relating to the implementation of the Trust's Electronic Patient Record system and that plans were in place to develop and implement new key performance indicators later in the year.

The Committee:

Agreed for future updates on the End of Life and Bereavement Service to be provided to the Committee on quarterly basis.

4. Waiting Lists and Resultant Harms

Members received a report that provided an overview of the potential estimated harm to patients as a result of experiencing significant waiting times. It was explained that although there was no definitive evidence to indicate that harms were rising as a result of the significant waiting times being experienced by some patients, it was also not possible to provide total assurance that they were not. Members were informed that harms was an area that was due to be assessed by the Trust's internal auditors in 2024-25 and that a Red, Amber, Green (RAG) rating process was in place to ensure that patients with the most urgent needs were not placed onto holding or waiting lists. They also acknowledged the complications involved in reviewing harms and that it was better for clinical time to be utilised on seeing treating patients to reduce the potential for harms to occur.

5. Nursing Assessment and Performance Framework (NAPF) Update – Annual Report

The latest annual report for the Trust's NAPF programme was provided to the Committee. Members noted that 84% of the 68 areas assessed during the year had been rated as amber or above, with five wards receiving gold accreditation following its introduction earlier in the year and that the support visits to areas receiving following red assessments had been strengthened. They were also informed that a substantial piece of work was underway to further develop the NAPF and expand for use by multi-professional teams.

6. Patient Safety Incident Response Framework (PSIRF) Report

Members received the latest report for the PSIRF programme and were presented with a summary of key highlights. It was reported that the Trust was performing well in two of the three training modules relating to national patient safety but that the other was falling behind at 73%. Members noted that an additional communications push would be taking place over the coming months to address this. It was also noted that the delays with incident reviews that had been reported at previous meetings had not improved as quickly as had been hoped and that divisions had been asked for action plans to hit the required targets and a timeframe for when this was expected to be achieved.

7. Harms Reduction Programme Closure Report Update

Members were provided with a report that was intended to serve as an introduction to a significantly more detailed report that would be provided to the Committee at a future meeting which would lay out the process of closing down the Harms Reduction Programmes that had first been introduced in the Trust around ten years prior. It was explained that this decision had been taken as much of the information previously covered by the Harms Reduction Programme now formed part of the Patient Safety Incident Response Framework (PSIRF).

The Committee:

Agreed for the full Harms Reduction Programme Close Report will be presented to the Committee at a later date.

8. Clinical Strategy Update

An update was provided to Committee on the Trust's Clinical Strategy. Members noted that the version being presented was different in a number of key ways to previous iterations, with

a particular focus on the idea of 'hospitals without walls' and a number of other key developments linked to urgent and emergency care. Good progress was reported in the development of the Strategy, particularly considering the significant pressures on the Trust over recent months. Members were informed that a number of key goals had been moved into future years due to financial pressures which had, in turn, enabled a stronger focus on other more urgent priorities. It was confirmed that future updates on the Clinical Strategy would be provided on a six-monthly basis going forward.

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

Members proposed that the issues around the Trust's mortality performance raised earlier in the meeting were escalated to the Trust Board for further discussion.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **49**

13 March 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 8 January 2024.

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

(49) People and Culture Committee Summary Report

Meeting: **People and Culture Committee**
Date of Meeting: **8 January 2024**
Committee Chair: **Trish Anderson, Non-Executive Director**

ITEMS APPROVED

The minutes of the previous meeting held on 6 November 2023 were approved as a true record of the meeting.

ASSURANCE RECEIVED

1. Staff Story

The Committee received a story from Maria Camenzuli, a senior mental health practitioner, working within the East Lancashire Child and Adolescent Service (ELCAS). Mrs Camenzuli spoke of her time in the Trust as someone with a 'hidden' disability and the difficulties that she experienced in getting support from colleagues as a result.

Members recognised that there was still a substantial amount of work to do in the Trust to improve the culture around disability and to ensure that colleagues with more complex needs could be properly supported. It was noted that additional capacity in the Trust's equality, diversity and inclusion team would allow more support to be given to the range of staff networks in place to address these issues.

2. Update on Flexible Working

An update on the work taking place to develop the Trust's flexible working offer was provided to the Committee. Members were informed that good progress had been made over the previous two years, with a range of new approaches taken to flexible and agile working across the Trust. It was noted that there were a number of challenges that would need to be addressed over the coming months and that additional funding had been allocated to assist with these efforts. Members also recognised the importance of addressing the cultural element of flexible working going forward, as there there was a lingering perception of unfairness from some colleagues who had not been able to take advantage of similar offers during their careers.

3. Professional Nurse Advocate Programme

Members received a summary of the Professional Nurse Advocate (PNA) programme, introduced following the onset of the COVID-19 pandemic, that was intended to provide additional health, wellbeing, and development support to nursing colleagues. It was explained that the programme had been previously fully funded by NHS England (NHSE) but that this would be stopping soon, which would require alternative funding arrangements to be put in place. Members noted that other work also underway to ensure that staff had the time to take part in restorative clinical supervision sessions.

4. People and Culture Performance Dashboard

An update was provided to the Committee on the development of the Trust's renamed Culture and Belonging Dashboard which, when finished, would provide complete data around equality, diversity and inclusion, vacancies and staff gaps and a full overview of the Trust's Anti-Racism project. Members noted that there were a number of risks and challenges associated with the dashboard, including ensuring the security and privacy of sensitive data and the additional reporting requirements for some teams.

The Committee:

Confirmed that it was content for full development of the pilot dashboard to commence and for a further update to be provided to the Committee in May 2024.

5. Equality, Diversity and Inclusion Update

Members received an update on the work being undertaken to implement the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan. It was confirmed that work had already commenced on the six high impact actions associated with this Plan. Members noted that it would provide the Trust with a clearer framework on EDI and the importance of ensuring that this was spread out across the organisation so that it could start to be embedded.

6. Freedom to Speak Up Guardian Report

The Committee received the latest iteration of the Freedom to Speak Up Guardian report. Members noted that that over 1,4000 concerns had been raised through the service from April 2016 to September 2023 and highlighted that 21 new Freedom to Speak Up (FTSU) Ambassadors were due to officially commence in post later in the month. The Committee was also informed that a survey had been carried out during October 2023 to determine if staff felt

that they were able to speak up, with just under half of respondents confirming that they had already spoken up in the past and 91.2% confirming that they would know how to do so if needed. Members noted that a meeting with the Care Quality Commission (CQC), in relation to a wider Well-led review of the Emergency Department, was planned for later in the month.

7. Corporate Risk Register Report

The Committee received the latest iteration of the Corporate Risk Register. Members noted that two new risks, relating to theatre equipment and the Trust's Electronic Patient Record (EPR) system, had been added since the previous meeting.

8. Board Assurance Framework (BAF)

The revised BAF was presented to members for approval.

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.

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **50**

13 March 2024 **Purpose** Information

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

Summary: The report sets out the summary of the papers considered, and discussions held at the Audit Committee meeting held on 16 October 2023.

Recommendation: The Board is asked to note the report.

Report linkages

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

Related to key risks identified on Corporate Risk Register	9557 Patient, staff and reputational harm as a result of the Trust not being registered as a mental health service provision. 9336 Lack of capacity can lead to extreme pressure resulting in a delayed care delivery. 8033 Complexity of patients impacting on ability to meet nutritional and hydration needs. 7165 Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). 8808 Burnley General Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke. 7764 Royal Blackburn Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke. 4932 Patients who lack capacity to consent to placements in hospital may be unlawfully detained 8061 Management of Holding Lists 9336 Lack of capacity can lead to extreme pressure resulting in a delayed care delivery. 8941 Potential delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology. 6190 Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales. 8839 Failure to achieve performance targets. 7008 Failure to comply with 62-day cancer waiting time target. 5791 Failure to recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance. 9771 - Failure to meet internal and external financial targets for the 2023-24 financial year
Related to recommendations from audit reports	All recommendations
Related to Key Delivery Programmes	Care Closer to Home/Place-based Partnerships, Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement People Plan Priorities Finance Strategy and Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money.

Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Meeting: **Audit Committee**
Date of Meeting: **16 October 2023**
Committee Chair: **Khalil Rehman, Non-Executive Director**

ITEMS APPROVED

- Members approved the minutes from the meetings held on 10 July 2023 as true and accurate records.

ASSURANCE RECEIVED

1. Management Response to Limited Assurance Report: Medical Sickness

Members were updated on the actions that had been undertaken following the limited assurance internal audit report on medical sickness. It was explained that three of the actions had been completed, and that the remaining four actions were still outstanding and formed part of a wider piece of quality improvement work being undertaken.

2. Cerner Electronic Patient Record Update

Members were informed members that 121 days had passed since the go-live of the Cerner Electronic Patient Record (EPR) system. It was noted that over 10,000 incidents had been reported via the IT Service Desk, and over 350 change requests had been recorded in the period covering both pre and post go-live.

Members were advised that updates were provided at the weekly EPR Programme Board and noted that the Cerner team would be visiting the Trust on 31 October 2023 to re-review and the clinical and non-clinical workflows associated with Outpatients. Members were advised that from talking to other Trusts that had implemented the same EPR system, Outpatients was a difficult area to get right.

Members were informed that a dataset was being reported to NHS England due to data quality issues related to the go-live. It was confirmed that this was being worked through and the first batch of coded activity was now being reported.

3. Financial Sustainability Checklist Update

Members were informed that there were 72 financial measures that were assessed and graded between 1 and 5, with anything ranked between 1 and 3 requiring an action plan.

Members were informed that of the 72 measures, 16 had been scored between 1 and 3 and that only 1 required further work. It was noted that this linked with the long-term financial plan and that significant levels of work continued to take place within the Trust and across the wider system.

4. Internal Audit Progress Report

Members were informed members that reasonable process was being made to complete audits and that the Internal Auditors were on track to deliver the Head of Internal Audit Opinion (HOIAO) in April 2024. She commented that MIAA were involved with the system level work regarding Bank and Agency, and had been undertaking benchmarking around controls. Mrs Warner stated that a report would be provided to a future Audit Committee meeting.

Members were advised that the Healthcare Financial Management Association (HFMA) were undertaking a review of the Audit Committee handbook and that this would be a full update to be published by the end of 2023.

Members were informed that benchmarking was being undertaken regarding Board Assurance Frameworks (BAFS) and that a more focussed piece would be undertaken for the Lancashire and South Cumbria system with the report issued when available.

Members were updated regarding the audits into the Trust's I.T. systems and equipment.

5. External Audit Update

Members were informed that the Trust had appointed Mazars for a further 2-year period.

6. Anti-Fraud Service Update

Members received a summary of the work being undertaken by the Anti-Fraud service. Members were informed that referrals had been received for staff that had worked in other places whilst signed off as sick at the Trust, and that proactive work would be undertaken to try and prevent this.

Members were informed that 29 fraud prevention notices had been shared with the Trust, including phishing and impersonation tactics.

Members were updated on the referrals received by the Anti-Fraud team, noting that 6 had been carried forward from the last period, with an additional 10 being received in the current period. Members were advised that 6 of these were now closed, whilst 1 had been opened as an investigation. Furthermore, 4 remained open pending further enquires.

Members were informed that an assessment regarding the counter-fraud standards had been undertaken with the Trust currently having 2 amber outcomes. Members noted that these were in relation to access to fraud e-learning, and conflicts of interest.

7. System Issues

Members were updated members on the system-wide financial position, noting that as a system it was between £200 and £300 million away from plan. Members were informed that the forecast outturn position would need to be updated, however there was some debate as to when this would be reported. Members were informed that work continued with the ICB team to identify the potential for the future, noting that the financial plan would not be achieved in this financial year. Members were advised that an external company had been commissioned by the Trust to assist with planning. Members were advised that the national team wanted to reduce system funding due to convergence.

Members were informed that the Trust had been selected as the host for the One Lancashire and South Cumbria (LSC) Central Services work. It was noted that what this would mean for the Trust had been discussed at a recent Trust Board meeting, including the identification of risks, and that she had been in a session prior to the meeting to discuss how this would work. Members were informed that the Trust had met with Lancashire Teaching Hospitals NHS Foundation Trust (LTH) to discuss East Lancashire Financial Services (ELFS) and payroll.

8. Waivers Report

Members were informed that although the Trust had worked hard to reduce the number of waivers, as contracts were aligned across LSC, it was likely that there would be an increase in the number of them.

9. Corporate Risk Register

Members were informed that 6 new risks had been added to the Corporate Risk Register (CRR), with 11 having no movement in score. Members were updated that 1 risk was

waiting for approve to be removed from the register and that this would happen following the Executive Risk Assurance Group meetings. Members were advised that since the previous report, 7 risks had been removed from the register. It was noted that there were currently no risks on the CRR relating to the Cerner EPR system due to the previous risk relating to the Trust not having an EPR, however a new risk would be created regarding the ongoing work associated with its implementation.

Members were informed that work on the Risk Management Framework continued, with the number of open risks reducing by 74%. Furthermore, profiling of risks continued in line with the organisation's strategy and objectives. Members noted that work continued to reduce the number of tolerated risks, with the Risk Assurance Meeting providing challenge to Divisions with risks scored at 15 and above.

10. Register of Interests

Members were reminded that it had been agreed that the full register of interests would be presented to the Audit Committee twice a year. It was noted that there was still work to be undertaken to improve the compliance levels and members anticipated that when the next register was due to be presented, these improvements would be evidenced.

11. Committee Self-Assessment

Members were informed that the self-assessment was based on the guidance provided within the HMFA Audit Committee handbook and requested members and attendees to consider how the committee functioned.

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

Members were informed that the LSC Audit Committee Chairs had discussed the rewrite to the Audit Committee handbook that was being undertaken by the HFMA. Furthermore, there had been a brief discussion about the potential for one auditor for the system, however the consensus had been that it would likely result in resource issues should a potential provider undertake the work.

13. Quality Committee Minutes

This item was presented for information only.

14. Finance and Performance Committee Minutes

This item was presented for information only.

15. Information Governance Steering Group Minutes

This item was presented for information only.

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

No items were raised for escalation the Trust Board or Sub-Committees, but the Committee remained concerned for the challenges faced in the current financial year which continue to be discussed at Committee and Trust Board level.

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
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TRUST BOARD REPORT **Item** **51**

13 March 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 10 January 2024.

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: **10 January 2024**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meetings held on the 8 November 2023, 11 November 2023 and 13 December 2023 were approved as true and accurate records.

ITEMS DISCUSSED

At the meeting of the Trust Board on 10 January 2024, the following matters were discussed in private:

a) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.
b) Round Table Discussion: BwD Community Services Transaction and Albion Mill
c) Round Table Discussion: Site Operational Pressures
d) Round Table Discussion: Publication of NHS England Statement on Information on Health Inequalities Letter (28 November 2023)
e) National Planning Guidance 2024-25 (including letter from Kevin Lavery, ICB Chief Executive)
f) Financial Recovery Plan Update
g) Central Services Update, including Governance Processes
h) Pathology Collaboration Update
i) CQC Mental Health Registration Update
j) Never Events Update
k) Lessons Learned from LTH CQC Inspection
l) Emergency Preparedness Resilience and Response Progress Update
m) Industrial Action Update
n) Fire Remediation Programme Update: Burnley General Teaching Hospital
o) Fire Remediation Programme Update: Royal Blackburn Teaching Hospital
p) Nosocomial Infections Update
q) Electronic Patient Record Progress Overview
r) Responsible Officer's Report to Trust Board Regarding Doctors with Restrictions
s) Industrial Action Update

ITEMS RECEIVED FOR INFORMATION

None.

TRUST BOARD REPORT		**Item**	**52**
13 March 2024		**Purpose**	Information
Title	Remuneration Committee Summary Report		
Executive sponsor	Mr S Sarwar, Chairman		

Summary: The list of matters discussed at the Remuneration Committee meetings held on 19 January 2024 and 2 February 2024 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

Meeting: **Remuneration Committee**
Date of Meeting: **19 January 2024**
Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meetings held on the 8 November 2023 and 10 January 2024 were approved as a true record of the meeting.

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 19 January 2024, the following matters were discussed in private:

a) Revised Terms of Reference

Meeting: **Remuneration Committee**

Date of Meeting: **2 February 2024**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meetings held on the 19 January 2024 were approved as a true record of the meeting.

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 2 February 2024, the following matters were discussed in private:

a) Executive Pay