Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

East Lancashire Hospitals NHS Trust Board Meeting

Safe | Personal | Effective

TRUST BOARD MEETING (OPEN SESSION) AGENDA

15 MAY 2024, 13.30

SUPER BOX, JIMMY MCILROY SUITE, TURF MOOR

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

OPENING MATTERS				
TB/2024/057	**Chairman's Welcome**	Chairman	v	
TB/2024/058	**Apologies** To note apologies.	Chairman	v	
TB/2024/059	**Declarations of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Chairman	d✓	Approval
TB/2024/060	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 13 March 2024.	Chairman	d✓	Approval
TB/2024/061	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2024/062	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2024/063	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2024/064	**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/2024/065	**Patient Story** To receive and consider the learning from a patient/Staff story.	Deputy Chief Nurse	p	Information/ Assurance
TB/2024/066	**Corporate Risk Register and Risk Performance Report** To receive an update on the Corporate Risk Register and approve revisions based on the Executive Risk Assurance Group, Committees' and Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Executive Medical Director	d✓	Assurance/ Approval
TB/2024/067	**Board Assurance Framework Review** To receive an update on the Board Assurance Framework and approve revisions based on the Executive Risk Assurance Group, Committees' and the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Director of Corporate Governance	v	Assurance/ Approval
TB/2024/068	**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	Executive Medical Director	d✓	Information/ Assurance

	information on maternity specific serious incidents reporting as required by Ockenden recommendations.			
STRATEGIC ISSUES				
TB/2024/069	**Annual Plan and Annual Budget 2024-25**	Executive Director of Finance	d✓	Information/ Assurance
TB/2024/070	**Draft Patient Experience Strategy 2024-27**	Deputy Chief Nurse	d✓	Information/ Approval
TB/2024/071	**People Promise Exemplar Programme**	Deputy Director of People and Culture	p✓	Information/ Assurance
TB/2024/072	**Maternity and Neonatal Services Update** *T Thompson to attend for this item.*	Deputy Chief Nurse / Divisional Director of Midwifery and Nursing	d✓	Information/ Assurance
TB/2024/073	**Quarterly Communications Activity Report (Q1) 2024-25**	Executive Director of Communications and Engagement	d✓	Information
ACCOUNTABILITY AND PERFORMANCE				
TB/2024/074	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: a) Introduction (Chief Executive) b) Safe (Executive Medical Director and Deputy Chief Nurse) c) Caring (Deputy Chief Nurse) d) Effective (Executive Medical Director) e) Responsive (Deputy Chief Operating Officer) f) Well-Led (Deputy Director of People and Culture and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
GOVERNANCE				
TB/2024/075	**Remuneration Committee Terms of Reference Review**	Director of Corporate Governance	d✓	Approval
TB/2024/076	**Triple A Report from Finance and Performance Committee** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information

TB/2024/077	**Triple A Report from Quality Committee** To note the matters considered by the Committee in discharging its duties. a) March 2024 b) April 2024	Committee Chair	 d✓ d✓	Information
TB/2024/078	**Triple A Report from People and Culture Committee** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information
TB/2024/079	**Triple A Report from Audit Committee** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information
TB/2024/080	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
TB/2024/081	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2024/082	**Any Other Business** a) Quality Account 2023-24	Chairman Director of Corporate Governance	v v	
TB/2024/083	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2024/084	**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/2024/085	**Date and Time of Next Meeting** Wednesday 10 July 2024, 12.30pm, Venue to be Confirmed	Chairman	v	

TRUST BOARD REPORT **Item** **60**

15 May 2024 **Purpose** Approval

Title	Minutes of the Previous Meeting
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mr S Sarwar, Chairman
Date Paper Approved by Executive Sponsor	7 May 2024

Summary: The minutes of the previous Trust Board meeting held on 13 March 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

For Trust Board only: Have accessibility checks been completed? Yes

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 13:15, 13 MARCH 2024

MINUTES

PRESENT

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

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement
Mrs M Hatch	Associate Non-Executive Director
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)

IN ATTENDANCE

Mr D Byrne	Corporate Governance Officer	Minutes
Mrs B Edgar	Interim Director of People and Culture	Observer
Miss K Ingham	Corporate Governance Manager	
Mr M Pugh	Corporate Governance Officer	
Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2024/014

APOLOGIES

Professor G Baldwin	Non-Executive Director
Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary
Mrs K Quinn	Executive Director of People and Culture
Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council

TB/2024/028 CHAIRMAN'S WELCOME

Mr Sarwar welcomed Directors to the meeting. He made reference to the significant pressures that the Trust was continuing to face, with 22,000 patients coming through its urgent and emergency care (UEC) areas in February 2024 alone and extended his thanks to colleagues for their ongoing efforts and commitment in managing these. Mr Sarwar acknowledged that it was unlikely that these pressures would ease in the near future but highlighted that the Trust was managing to achieve a number of key performance metrics regardless, including the 76% target for four-hour A&E waiting times.

TB/2024/029 APOLOGIES

Apologies were received as recorded above.

TB/2024/030 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/2024/031 MINUTES OF THE PREVIOUS MEETING

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

RESOLVED: The minutes of the meeting held on 10 January 2024 were approved as a true and accurate record.

TB/2024/032 MATTERS ARISING

There were no matters arising.

TB/2024/033 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/2024/034 CHAIRMAN'S REPORT

Mr Sarwar provided a summary of his activities to Directors since the previous meeting. He confirmed that he continued to attend meetings of the Provider Collaboration Board, alongside Mr Hodgson, as well as meetings of the System Transformation Board. Mr Sarwar explained that there remained a significant focus on the financial challenges facing both individual Trusts and the wider Lancashire and South Cumbria (LSC) system. He added that there was a considerable amount of work also taking place to progress the various collaborative opportunities across LSC, including the recent appointment of a substantive Managing Director for 'One LSC' and the progression of system level clinical reconfiguration.

Mr Sarwar went on to provide a summary of highlights at Trust level. He informed Directors that the Trust had had the opportunity to welcome both the local Members of Parliament for Burnley, Antony Higginbotham and for Blackburn, Kate Hollern and to demonstrate the pressures that the organisation was experiencing and the extent to which colleagues were able to respond to the unprecedented demand being seen.

Mr Sarwar advised that he had also had the opportunity to participate in a recent 'Discover Islam' Awareness Week organised by the Trust's Inclusion and Belonging Lead, Nazir Makda, and stated that this had served as a good reminder of the organisation's zero-tolerance approach to islamophobia. He acknowledged that although these sorts of issues would still happen, it was incumbent on the Trust to respond appropriately and encourage staff to speak up if they were experiencing any kind of discrimination.

Mr Sarwar informed Directors that he had attended the most recent Blackburn with Darwen (BwD) Partnership Conference, at which the main theme had been 'no one left behind'. He noted that this theme was particularly pertinent to the Trust and its goal to treat everyone in the best way that it could. Mr Sarwar added that the conference had also played an important role in bringing together a wide range of different partners to discuss their responses to the level of demand currently being placed on them.

Mr Sarwar went on to refer to events a national level and advised that he had recently been invited to a Chairs' event held in London. He reported that there had been a strong focus on productivity, patient safety, finances and transformation and noted that the Trust was in a good position in all of these areas. Directors noted that the improvement practice in use at the Trust provided a substantial amount of assurance around competency and capacity that would enable the Trust to respond to the myriad of challenges facing it.

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

TB/2024/035 **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 explained that the Trust was in a particularly challenging part of the financial year, with it having to both achieve its targets for 2023-24, whilst also being required to plan for 2024-25. He confirmed that the Trust was in a generally good position for 2023-24 and paid credit to the teams that had worked towards ensuring that it was able to reach its performance targets. Mr Hodgson indicated that 2024-25 was likely to be just as challenging, but noted that the March 2024 budget had had some positive announcements for the NHS, with a substantial amount of funding due to be made available to strengthen the digital offerings and improve patient care.

Mr Hodgson went on to refer to the ongoing national COVID-19 inquiry and noted that module 5 had opened at the start of February 2024. He explained that this was a particularly crucial element, as it related to the procurement aspects of the national response to the pandemic. Mr Hodgson informed Directors that there were two other developments at national level, specifically the rollout of Martha's Rule and an Independent Review into failings at the Edenfield Centre at Greater Manchester Mental Health NHS Foundation Trust being led by Professor Oliver Shanley OBE. He explained that Martha's Rule was intended to provide patients and their families easier access to a second opinion regarding their care and highlighted that the Trust had already made good progress in this area, including adopting a 'call for concern 'programme to enable independent reviews of any areas of concern. Directors noted that the findings of the Edenfield Review would be shared with the Board as soon as they were available.

Mr Hodgson informed Directors that several developments had taken place at a LSC system level. He advised that this included a PCB colleague briefing that had taken place the previous week and emphasised the importance of clear communication with the staff involved in any system level developments. Mr Hodgson confirmed that the next step would be to agree a formal approval process for this with NHS England (NHSE) colleagues.

Mr Hodgson went on to provide a summary of the developments taking place at Trust level. He reiterated that the pressures on the Trust's UEC pathways remained substantial, with an average of 80 to 90 more patients per day coming into the Trust than over the same period in 2023. Mr Hodgson stated that this made the Trust continuing to achieve its four-hour performance target, whilst also improving quality, all the more impressive.
Mr Hodgson referred to the most recent rounds of industrial action taken by junior doctor colleagues in February 2024 and reported that a total of 534 outpatient and 25 inpatient appointments had needed to be rescheduled. He added that this had come at a cost of around £944,000 to the Trust. Mr Hodgson reiterated that the Trust would always respect the right of colleagues to take industrial action in this manner, but noted that it continued to cause additional disruption.

Mr Hodgson informed Directors that work was ongoing regarding the planning for 2024-25, a significant part of which was LSC and NHSE agreeing a financial plan that was acceptable for both parties. He advised that a meeting had been arranged with the NHSE Deputy Chief Executive and Chief Financial Officer, Julian Kelly, the following day, to discuss the matter further and agree a deficit plan. Mr Hodgson stressed the need for any deficit plan to be realistic and achievable, particularly in light of the range of pressures facing the Trust and the clear need to maintain quality and safety.
Mr Hodgson reported that good progress continued to be made with the implementation of the Trust's Electronic Patient Record (EPR) system, with bespoke one-to-one coaching sessions now in place for colleagues which had, thus far, received very positive feedback.

Mr Hodgson acknowledged that there was a significant amount of concern nationally around recent rises in measles cases and confirmed that the Trust had had its first confirmed case recently. He added that a number of lessons had been learned from this incident which would help to improve the management and treatment of any further cases going forward.

Mr Hodgson went on to summarise several other positive Trust headlines, including the STAR awards taking place later in the year, the naming of the Burnley General Teaching Hospital (BGTH) site as a quality provider following the completion of a national programme of audits run by the National Joint Registry and the introduction of comfort and prayer boxes as part of the Trust's ongoing commitment to improving health and wellbeing.

Mr Hodgson concluded his update by presenting Directors with the list of wards applying for SILVER status as part of the Safe, Personal and Effective Care award process, these were: wards C19, B14, B2, the Emergency Surgical Unit, the Burnley East District Nursing team and the Hartley Ward at Pendle Community Hospital.
Directors confirmed that they were content for SILVER status to be awarded to these areas.

RESOLVED: **Directors received the report and noted its contents.**
Directors approved the awarding of Silver SPEC status to the aforementioned wards/areas.

TB/2024/036 PATIENT STORY

Mr Murphy provided a brief introduction to the patient story. He informed Directors that it had been provided by the Trust's Customer Relations Officer, Jacqui Parnell, and detailed the journey of her brother Terry following a diagnosis of terminal illness. Mr Murphy added that the story also included the response from the manager of the ward on which Terry was treated, as well as their reflections on his care.

The patient story can be viewed here.

Mr Sarwar commented that the story had been a powerful one and that he was proud of the Trust and the way in which staff had been spoken about. He acknowledged that dying in hospital should never be considered an ideal outcome for any patient but stated that the compassionate way in which Terry had been cared for clearly reflected the Trust's values.

Mr Hodgson agreed and extended his thanks to Mrs Parnell for sharing her story.

Mrs Randall commented that the story had emphasised that end of life care mattered and how important it was to patients and their relatives.

Mr Murphy agreed and stressed that the Trust had no intention of resting on its laurels around continuing to improve end of life care for patients.

Mrs Gilligan stated that she agreed with the points already raised and praised the conduct of the staff members involved in Terry's care. She queried as to whether more could have been done from a system perspective to achieve Terry's wish to die at home and suggested that there was learning that could be taken from his experience.

Mr Husain concurred with Mrs Gilligan's points and acknowledged that more work was needed in the system and with the Trust's community partners around end-of-life care, adding that there had been a notable rise in the number of deaths occurring in accident and emergency areas over recent months.

Mr Murphy advised that work was underway to reduce ambulance conveyance numbers into the Trust and highlighted that patients who were at the end of their life formed a key part of a test for change currently being undertaken with the Trust's partner organisations.

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

TB/2024/037 **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 19 risks on the register, with one removed since the previous meeting (risk ID 7764 - breaches to fire stopping and compartmentalisation in walls and fire door surrounds at RBTH). Directors noted that there had been no movement in 15 risks and that four had predicted risk scores of less than 15.

Mr Husain went on to highlight that a substantial amount of work had gone into the profiling and mapping of risks in line with the Trust's strategic objectives and to align with the Board Assurance Framework (BAF) and confirmed that this process was now complete. He added that the Trust had also made the decision to continue to use its existing Datix risk management system rather than adopting the RADAR system discussed at previous meetings. Mr Husain reported that the overall number of open risks had reduced by 60% in 2023-24 when compared to 2022-23 and that there had also been reductions in the proportion of significate and moderate risks.

Mr Husain informed Directors that the scores assigned to risk ID 8839 (failure to achieve performance targets) and risk ID 8061 (management of harm from the holding list) had recently been challenged at the most recent meeting of the Executive Risk Assurance Group (ERAG)

following their reduction from 15 to 12. He indicated that the scores for both risks would be increased back to 15 in the near future.

Mr Husain referred to the discussions regarding the Trust's Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) compliance discussed at the previous meeting and confirmed that additional information had been included in the report. He provided assurances that work was underway to improve this using the currently available resources but stressed that a significant amount of time would be required to review the over 6,000 incidents that would require them. Mr Husain advised that 38 incidents had been determined to be RIDDOR reportable in 2022-22, out of a total incident number of 6,708 and that 47 had been determined to be RIDDOR reportable in 2023-24, out of a total of 5,785. He confirmed that the Trust was still aiming to achieve 95% compliance but acknowledged that its current 52% total was some distance from this, and that additional education and training would be required.

In response to a query from Mr Sarwar regarding the planned timescales for 95% RIDDOR compliance to be achieved, Mr Husain reiterated that every effort was being made to get to this total in as short a time as possible. He added that this included the Quality and Safety team looking to see how they could redistribute the workforce that would be required to get this done.

Mr Smyth commented that while the Trust should continue to do everything it could to achieve the required compliance total, it was clear that RIDDOR incidents were being appropriately reported, and that the shortfall was due to the significant delays being seen. He stated that this provided a significant amount of assurance to the Board.

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

TB/2024/038 BOARD ASSURANCE FRAMEWORK

Mr Husain referred Directors to the previously circulated document. He confirmed that it had been considered by the various sub-committees of the Board, as well as the ERAG, and that no changes had been made to any of the scores assigned to each risk.

Mr Sarwar noted that the review of the Trust's risk appetite was particularly important, as it was likely to frame a significant number of discussions that would be taking place throughout 2024-25.

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

TB/2024/039 PATIENT SAFETY INCIDENT RESPONSE ASSURANCE REPORT

Mr Husain requested that the report be taken as read and presented a summary of the salient points to Directors. He confirmed that reporting levels remained within control limits and that harm levels of all types remained below national averages, despite an increase in the level of moderate harm over the preceding three-month period. Mr Husain highlighted that there had been no breaches of Duty of Candour and that a total of thirteen Patient Safety Incident Investigations (PSIIs) had been approved and closed.

Mr Husain went on to refer to the queries raised at the previous meeting regarding the compliance levels for the national patient safety syllabus training modules and reported that the Trust had now achieved over 90% for level 1a (all staff) and 84.9% for level 2 (essential to role). He advised that compliance levels for level 1b (Boards and senior leadership) had also increased to 75% and that awareness continued to be raised through a range of forums to improve this further.

Mr Smyth commented that, from his perspective as the Non-Executive Chair of the Trust's Patient Safety Incidents Requiring Investigation (PSIRI) Panel, the extent and quality of the investigations taking place into incidents, and the learning and actions taken as a result, continued to provide a substantial amount of assurance.

Mr Sarwar noted that the distribution of learning from incidents was an important aspect of the assurance around incidents and suggested that a more detailed update on this could be provided at a future meeting of the Board. He also stated that he would like to see greater connectivity between walk rounds of clinical areas and the learning from incidents to facilitate clearer triangulation of any improvements made as a result. Mr Sarwar requested that a further discussion on the matter took place outside of the meeting

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

An update on the learning from incidents and patient safety incident investigations will be provided at a future meeting.

A further discussion on how to better triangulate the learning from incidents and any actions taken as a result will take place outside of the meeting.

TB/2024/040 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson referred to the previously circulated report and provided a summary of key headlines. She confirmed that the Trust had now completed all of its requirements for the ten safety actions relating to the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5 and that work was underway to ensure that the required data gathering arrangements would be in place by the end of month. Miss Thompson referred to the information provided in the report regarding safety action five (Midwifery Workforce) and explained that the Birthrate+ business case that was due to be presented on the 5 March 2024 had not been and would now be presented on the 19 March instead. She also highlighted that the Trust had now achieved 81% for overall implementation for the Saving Babies Lives version 3 Care Bundle (SBLv3), well above the CNST target of 70%.

Mr Murphy stated that a high level of assurance could be taken from the report provided. He informed Directors that new monthly meetings had been set up around the learning from incidents and complaints and that a subsequent programme of learning would be developed from these.

In response to a query from Mrs Sedgley regarding the ambitions outlined in the report to reduce the numbers of maternity deaths and stillbirths, Miss Thompson explained that this was monitored closely at the Perinatal Governance Board meetings but advised that updates could also be provided either at future meetings of the Trust Board or to the Quality Committee on request.

Mr Sarwar noted that maternity was an area that was still receiving a significant amount of national attention and extended his thanks to Miss Thompson and to her colleagues for continuing to provide the Board with a substantial level of assurance around the Trust's services.

RESOLVED: Directors received the report and noted its contents.

TB/2024/041 NEW HOSPITALS PROGRAMME QUARTER 3 BOARD REPORT

Mr Hodgson explained that the report had been provided to Directors for information and requested that it be taken as read. He indicated that work had now commenced through the National Hospitals Programme (NHP) team to consider the viability of new potential sites for the Royal Preston Hospital and Royal Lancaster Infirmary and emphasised the need for this to cohere with the clinical configuration work taking place across the system.

Mrs Sedgley noted that bed capacity was still some distance away from what was required and urged the need for the Trust to start leading on this work to ensure that it could be progressed.

Mr Hodgson pointed out that these capacity issues were generally related to the significant pressures currently being placed on acute providers and confirmed that there was clear recognition across the Integrated Care System (ICS) that a shift to a more out of hospital focused clinical model would be required. He went on to state that several of the assumptions around any new hospital sites were somewhat optimistic, particularly around length of stay reduction, and stressed the need for coherent conversations and to agree realistic goals going forward.

Mr Sarwar agreed that a range of ambitious assumptions were currently being made without confirmation of the resources that would be required to support them.

Mr McDonald informed Directors that meetings were already taking place with colleagues to ensure that there was good connectivity between the NHP and community transformation programmes. He suggested that a future Board Strategy Session could be used to discuss this area in more detail and address any potential concerns from Directors.

RESOLVED: Directors received the report and noted its contents.

TB/2024/042 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 January 2024. He noted that the report reflected the complexities associated with the Trust being in the final quarter of 2023-24 and the pressures being placed on it around a range of key metrics, including the four-hour A&E waiting time target, its 65-week cancer trajectory and finances. Mr Hodgson also highlighted that there had been an

increase in the Trust's mortality figures and confirmed that Mr Husain would provide a fuller explanation around this under the 'Effective' section of the report.

b) Safe

Mr Husain referred Directors to the Safe section of the report. He reminded Directors of the measles case discussed earlier in the meeting and confirmed that several potential positive contacts had been identified in both patient and staff groups, although he added that none of these had gone on to develop measles thus far. Mr Husain highlighted that there had been no further 'Never Events' reported and advised that those raised earlier in the year had all had investigations completed and lessons learned disseminated.

Mr Husain went on to report that there had been six cases of Methicillin-Resistant Staphylococcus Aureus Bacteria (MRSA). He confirmed that all cases had been thoroughly investigated, with only one determined to have been preventable. Directors noted that difficile (C. diff) infections in the Trust had gone over trajectory for 2023-24 due to a range of factors, including overcrowding in UEC areas. Mr Husain reported that the number of COVID-19 and flu outbreaks in the Trust had now started to reduce and continued to be closely managed according to infection prevention and control (IPC) guidance.

Mr Murphy informed Directors that the fill rates for registered nurse and midwife staffing had continued to improve. He explained that the next professional judgment review exercise around nursing and midwifery would be taking place in the first quarter of 2024-25.

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

c) Caring

Mr Murphy referred Directors to the Caring section of the report. He reported that the feedback coming through the Friends and Family Test in UEC areas continued to be a challenge. Mr Murphy also advised that the Trust's refreshed Patient Experience Strategy was due to be completed in the very near future and confirmed that it would be presented to the Quality Committee and to the Board in due course for ratification.

In response to a query from Mr Sarwar regarding a fall in response rates from maternity areas, Mr Murphy confirmed that work was already underway to address this.

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

d) Effective

Mr Husain explained that the Trust was currently showing as an outlier for both its Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) performance, currently standing at 1.2 and 110 respectively. He added that there had also been a shift in crude mortality due to a number of wider factors, in particular the removal of Same Day Emergency Care (SDEC) admissions from total admission numbers. Mr Husain clarified that this had resulted in the Trust's mortality denominator going down which had, in turn, resulted in increased mortality figures. He added that similar rises in mortality had been seen at a number of other organisations, including County Durham and Darlington NHS Foundation Trust.

Mr Husain confirmed that the 'red flag' areas relating to mortality, including pneumonia, secondar malignancy and cardiovascular disease, continued to be discussed and closely monitored through the Mortality Steering Group. He also informed Directors that work was underway in the Trust to educate colleagues around documentation on the EPR system to ensure that comorbidities were taken into account properly when coding took place.

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

e) Responsive

Mrs Gilligan indicated that the Trust's UEC pathways remained extremely busy, with unprecedented volumes of patients coming through the front door and many having to wait on trolleys and in corridors for extended periods of time. She highlighted that the Trust had achieved the 76% target for four-hour A&E performance in February and was on track to doing so in March. Directors noted that good progress was also being made in relation to the 28-day faster diagnosis standard for cancer patients, with the Trust achieving the required 75% standard in January, and regarding the reduction in the backlog of 62-day cancer patients, with the Trust achieving 143 in February. Mrs Gilligan pointed out that this was already below the target of 155 that the Trust had been tasked with achieving by the end of March and stated that she was fully confident that it would do so. She informed Directors that the Trust continued to have no 78-week breaches in January or February and that close micromanagement was taking place to ensure that none would occur in March.

Mr Sarwar commented that, when considering all the challenges facing the Trust over the year around its EPR, industrial action and UEC pressures, the positive operational performance figures achieved by the Trust were even more impressive.

Mr Rehman noted that the Trust had had performance figures in the red for many months, but that it was clear that there was no sense of normalisation within this and that colleagues were not becoming complacent. He added that it would be crucial to get a better sense of the changes with regard to supply and demand to be able to recognise what resource would be required to get performance back to where it was prior to the COVID-19 pandemic.

Mrs Gilligan clarified that while affordability was definitely a major contributing factor, workforce availability continued to be a significant issue. She agreed that more work was needed around modelling to get an idea of the potential costs involved in improving performance figures over the coming months and years.

Mr Hodgson explained that around 100 additional beds would be required for the Trust's performance to return to pre-pandemic levels. He stressed that this was why the activity taking place around out of hospital offerings and reducing ambulance conveyances was so important, as this would be more achievable but would still likely make a significant difference.

Mr Smyth observed that there had been a significant increase in the overall number of patients on waiting lists and requested clarification on the timeframe for when this was expected to stabilise and for reductions to be made.

Mrs Gilligan explained that it was likely that the number of patients on waiting lists was not as high as had been reported and indicated that this was due to ongoing data issues following the implementation of the Trust's EPR system. She confirmed that additional validation work was being explored to resolve the matter but stressed that there would be costs involved in doing so.

Mr Sarwar agreed that the development of local and community services would result in the best outcomes for patients and for the Trust. He added that primary care was another area that would require significant investment over the coming years and that there would need to be a sense of greater equity in general in order for the situation to improve.

Mrs Atkinson informed Directors that a new national outpatients' strategy was expected to be published at the start of the new financial year and advised that this would be one of the key

improvement priorities for the Trust over coming 12 months. She confirmed that there were other substantial pieces of improvement work taking place in other areas which would also help to improve the elective care offering for patients.

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

f) Well-led

Mr Ireland reported that sickness and absence rates in the Trust had continued to fall, from 6.6% in January to 5.9% in February, and indicated that further decreases were expected in March and April. He advised that mental health was still the most reported reason for sickness and that the Trust had recently commissioned a review around the provision of mental health services to address this. Mr Ireland referred to the earlier update from Mr Murphy around vacancies and recruitment and explained that work was taking place with other providers to ensure that the positive progress made could be maintained. He added that more work was still needed around medical vacancies and that this was ongoing. Mr Ireland reported that incremental improvements had been seen regarding appraisal rates but acknowledged that the Trust was still below threshold overall. He confirmed that staff pay progression would be relinked to appraisal and core skills compliance from the start of 2024-25 to encourage colleagues to ensure that they were fully compliant.

Mrs Brown informed Directors that a further £24,000,000 of funding had been provided by NHSE, meaning that the deficit position referred to in the report had now been reduced to just over £15,000,000. She confirmed that finance colleagues were already hard at work on the financial position for 2024-25 and indicated that a substantial savings programme would likely be required. Directors noted that the Trust had again achieved its Better Payment Practice Tariff position despite the wider challenging financial context.

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

TB/2024/043 2023 NATIONAL STAFF SURVEY SUMMARY REPORT

Mr Ireland referred Directors to the previously circulated report and provided a summary of key highlights. He reported that the overall response rate had fallen for the second year in

succession and stated that every effort was being made to understand the reasons behind this. Mr Ireland highlighted that there had been significant increases in the scores for 'We are recognised and rewarded' and 'We are always learning' but explained that this had been offset by a notable deterioration in the scores for 'We each have a voice that counts', 'We are safe and healthy' and 'Staff Engagement'. He added that 17 questions in the survey had also scored significantly worse when compared with the Picker average, with notable themes around immediate managers. Mr Ireland informed Directors that a new programme of work, titled 'Project M', was underway to develop managers and indicated that additional targeted work would be taking place going forward.

Mr Ireland went on to provide an overview of the Trust's next steps, including arranging divisional feedback workshops to discuss the survey data in more detail and further engagement with staff groups through the People and Culture Committee. He explained that the Trust's Freedom to Speak Up Guardians were working to triangulate the information provided by the survey and ensure that it was being understood properly.

Mr Hodgson pointed out that the EPR had just been implemented at the time that the survey took place and that this, along with severe UEC pressures, had likely had an impact on the survey results.

Mr Sarwar commented that the results were disappointing but stressed that they should be used by the Trust as an opportunity to learn and determine how to better engage with staff going forward.

Mrs Anderson stated that the importance of first line managers in the survey results had been clear and that she welcomed the work taking place around the 'Project M' programme.

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

TB/2024/044 **RATIFICATION OF REMUNERATION COMMITTEE TERMS OF REFERENCE**

Mr Sarwar referred Directors to the updated terms of reference for the Remuneration Committee and requested confirmation that they were content to approve them.

Mrs Edgar stated that that there were several items in the terms of reference that required further consideration, including the role of senior managers. She confirmed that she would

discuss her suggestions for amendments with Mrs Bosnjak-Szekeres at a later date so that they could be brought back to the next meeting for approval.

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

Approval for the terms of reference for the Remuneration Committee will be deferred to the next meeting pending a discussion between Mrs Edgar and Mrs Bosnjak-Szekeres regarding potential further amendments.

TB/2024/045 QUARTER FOUR 2023-24 COMMUNICATIONS ACTIVITY REPORT

Miss Wright requested that the report be taken as read. She explained that future reports would be made timelier and would include more around the day-to-day activities of the communications team, as well as more around the work taking place internally. Miss Wright highlighted that a number of significant campaigns were currently taking place and that these were all linked to the broader objectives of the Trust.

Mr Sarwar stated that it was important for the Board to get a sense of the work being done by communications colleagues, particularly as much of it was linked to the Trust's objectives. He also stressed the need for more consideration as to how communications regarding collaboration and the impact on staff and the Trust could be escalated over the coming months.

Miss Wright agreed with Mr Sarwar's points and noted that an additional 4,000 staff were due to come under the Trust as part of the One LSC Programme. She added that the level of complexity that this would introduce for the communications team was unprecedented and that a significant amount of thought would be required as to how this could be addressed.

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

TB/2024/046 TRUST CHARITABLE FUNDS COMMITTEE SUMMARY REPORT

The report was presented to the Board for information.

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

TB/2024/047 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/2024/048 QUALITY COMMITTEE SUMMARY REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2024/049 PEOPLE AND CULTURE COMMITTEE SUMMARY REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2024/050 AUDIT COMMITTEE SUMMARY REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2024/051 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/2024/052 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2024/053 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2024/0254 OPEN FORUM

Mr Murphy informed Directors that a series of questions had been submitted to the Trust around adult safeguarding and the Trust's systems and governance processes in place around this. He explained due the complexity of these queries, lengthy answers had been provided in response that would be impractical to read through in the meeting. Mr Murphy confirmed that these responses would be forwarded directly to the individual who had raised the questions and provided assurances to Directors that robust governance processes were in place.

TB/2024/055 BOARD PERFORMANCE AND REFLECTION

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

Mr Hodgson stated that he felt that the reports provided, and the discissions that had taken place, had properly reflected the complexity of the current agenda for the Trust. He added that the crux of most of the reports had also been around how to serve patients and the local population, whilst recognising that further transformation would be needed to ensure that their needs could be met.

Mr Sarwar agreed that there was a clear need for health and social care to transform over the coming years, as the current operating models would not be sustainable in the long term.

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

TB/2024/056 **DATE AND TIME OF NEXT MEETING**

Mr Sarwar informed Directors that the next Trust Board meeting would be taking place on Wednesday, 15 May 2024 at 12:30.

TRUST BOARD REPORT **Item** **62**

15 May 2024 **Purpose** Information

Title	Action Matrix
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mr S Sarwar, Chairman
Date Paper Approved by Executive Sponsor	7 May 2024

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

For Trust Board only: Have accessibility checks been completed? Yes

Previously considered by:

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 Trust 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, Partnerships and Resilience	July 2024	Update: A further update will be provided to the Quality Committee in June 2024 prior to being presented to the Trust Board in July 2024.

Item Number	Action	Assigned To	Deadline	Status
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	Agenda Item: July 2024
TB/2024/039: Patient Safety Incident Response Assurance Report	An update on the learning from incidents and patient safety incident investigations will be provided at a future meeting. A further discussion on how to better triangulate the learning from incidents and any actions taken as a result will take place outside of the meeting.	Executive Medical Director / Chief Nurse Executive Medical Director / Chief Nurse	Q1/2 2024-25 May 2024	Update: a verbal update will be provided at the next meeting. Update: a verbal update will be provided at the next meeting.
TB/2024/044: Ratification of Remuneration Committee Terms of Reference	Approval for the terms of reference for the Remuneration Committee will be deferred to the next meeting pending a discussion between Mrs Edgar and Mrs Bosnjak-Szekeres regarding potential further amendments.	Director of Corporate Governance	May 2024	Agenda Item: May 2024

TRUST BOARD REPORT **Item** **64**

15 May 2024 **Purpose** Information

Title	Chief Executive's Report
Report Author	Mrs Emma Cooke, Joint Deputy Director of Communications
Executive sponsor	Mr M Hodgson, Chief Executive
Date Paper Approved by Executive Sponsor	8 May 2024

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

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

Report linkages

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

	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	N/A	
Related to recommendations from audit reports	N/A	
Related to Key Delivery Programmes	N/A	
Related to ICB Strategic Objective	N/A	

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed? Yes/No

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 a third preliminary hearing for its investigation into 'the Impact of the Pandemic on Healthcare systems across the UK' (Module 3) in April 2024.

Module 3 will look into the governmental and societal response to Covid-19 as well as dissecting the impact that the pandemic had on healthcare systems, patients and health care workers. This will include healthcare governance, primary care, NHS backlogs, the effects on healthcare provision by vaccination programmes as well as long covid diagnosis and support.

The preliminary hearing considered procedural issues relating to the conduct of future public hearings and the Inquiry's investigations. Updates from the Inquiry Counsel on its investigations and submissions from Core Participants were also heard. The broadcast and transcripts of the hearing can be found here, as well as the previous two hearings.

The public hearings for Module 3 will run for 10 weeks in London split by a two-week break:

- Monday 9 September – Thursday 10 October 2024
- Break: Monday 14 – Friday 25 October
- Monday 28 October – Thursday 28 November

Causes of death to be scrutinised

Public protection and support for bereaved families are at the heart of a government overhaul of how deaths are certified. From September 2024, medical examiners will look at the cause of death in all cases that have not been referred to the coroner in a move designed to help strengthen our learning, safeguards and prevent criminal activity.

They will also consult with families or representatives of the deceased, providing an opportunity for them to raise questions or concerns with a senior doctor not involved in the care of the person who

died. The changes demonstrate the government's commitment to providing greater transparency after a death and will ensure the right deaths are referred to coroners for further investigation.

Record NHS cancer checks top three million in one year

The NHS has hit a groundbreaking milestone, topping three million cancer referrals in a year for the first time ever. Over the past decade, referrals have more than doubled, reflecting a proactive approach to early detection. February 2024 alone saw a 10% increase in checks, with 78% of patients receiving a diagnosis or all clear within 28 days.

Emphasise remains on the crucial role of screening and referrals in catching cancers early. Efforts extend beyond clinics, with innovative awareness campaigns in public spaces and mobile screening units continuing to drive progress. Looking ahead, the NHS aims to eliminate cervical cancer by 2040, with plans to enhance vaccination and screening.

Self-referral for tests and appointments for hundreds of thousands of patients

Around 180,000 more people a month are able to self-refer for additional services such as incontinence support or community nursing without seeing their GP, freeing up to focus for GPs to on delivering care to people who need it most.

Across NHS services, around 200,000 people a month already self-refer for treatment for podiatry, audiology, and physiotherapy. Local services will now be able to expand the option of self-referral to other key services based on the needs of their population.

This move builds on the success of the primary care access recovery plan published in May last year.

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

Provider Collaboration Board meeting – 11 April 2024

The Provider Collaboration Board (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 April's meeting is at the end of this report as Appendix 1.

One LSC update

Following the appointment of Sharon Robson to the new role of Managing Director for One LSC, successful appointments have been made to three roles that form part of One LSC's senior leadership team. The appointments are as follows:

- Jim Collins, Head of Integrated Procurement and Supplies at University Hospitals of Morecambe Bay NHS Foundation Trust, has been appointed to the role of One LSC Chief Procurement Officer.
- Stephen Dobson, Chief Information Officer at Lancashire Teaching Hospitals NHS Foundation Trust, has been appointed to the role of One LSC Chief Information Officer.
- James Maguire, Director of Estates and Facilities at Lancashire Teaching Hospitals NHS Foundation Trust, Blackpool Teaching Hospitals NHS Foundation Trust and East Lancashire Hospitals NHS Trust, has been appointed to the role of One LSC Chief Officer Estates and Facilities.

The appointments followed a thorough, fair and transparent recruitment and selection process put in place involving colleagues from across our health system to ensure we were able to recruit the very best people to these critical roles.

All three colleagues have worked in our health system for a number of years and have a wealth of experience of leading collaborative change and supporting colleagues and teams to be their best.

Their appointments mark an important step forward in the establishment of One LSC, which will be essential to the future viability of our central services in driving quality and sustainability in the current financial environment.

The process to recruit the final two members of One LSC's management team (the directors of people services and finance) continues with interviews scheduled for the beginning of May 2024.

Transfer of physical and mental health services in Blackburn with Darwen and East Lancashire

Over the past year ELHT, Lancashire and South Cumbria NHS Foundation Trust (LSCft) and the Integrated Care Board (ICB) have been looking at how adult community physical health services and children and young people's mental health services are delivered in the area and by whom.

It's clear from this work that these services are provided by hard-working and experienced colleagues who are committed to delivering excellent care, but there is also no doubt that the current model is disjointed and could work better for our patients and their families.

We want to ensure there is consistency of service and we want everyone to experience the same high-quality care, regardless of where they live. Proposals have now been developed to:

- Transfer NHS adult community physical health services in Blackburn with Darwen from LSCft to ELHT – including the transfer of existing colleagues.
- Transfer children and young people's mental health services in Blackburn with Darwen and East Lancashire, known as ELCAS (East Lancashire Child and Adolescent Services), from ELHT to LSCft – including the transfer of existing colleagues.

Following a robust due diligence process, the business case has received formal approval by the Boards of all three organisations. The ambition is for both transfers to take place on 1 July 2024.

A summary report of the transfer of services can be found at the end of this report at Appendix 2.

A third of specialised services delegated to ICB

On April 1, 2024, LSC ICB assumed responsibility for 59 specialised services previously overseen by NHS England (NHSE). These services cater to individuals with rare and complex conditions, spanning rare cancers, genetic disorders, and intricate medical or surgical needs.

Given their specialised nature, these services require dedicated teams of skilled professionals, which means they aren't available at every local hospital. Previously, NHSE centrally managed all 177 specialised services, but now a third of these services are under LSC ICB's jurisdiction.

This transition aims to improve patient health and care, by supporting joined up care, and providing the opportunity to focus on population management, improving the quality of service, tackling health inequalities and ensuring best value.

Lancashire and South Cumbria health projects win awards

Led by the Lancashire and South Cumbria Integrated Care Board (LSC ICB), work on a successful cancer innovation pilot was given a bronze award for 'Most Effective Contribution to Improving Cancer Outcomes' at the recent HSJ Partnership Awards.

The collaboration with gastrointestinal health company, Cyted, has led to the rollout of the potentially lifesaving 'sponge on a thread' test, which can help to detect early signs of cancer in people with Barrett's - a condition which can put them at a higher risk of developing oesophageal cancer. Capsule sponge requires no sedation and can be delivered in a nurse-led clinic in about 15 minutes. It is also less invasive and generally more comfortable than an endoscopy.

Work with improvement consultants Changeology also led to a bronze award in the category for 'Best Consultancy Partnership'.

Collaborative projects led by the LSC ICB involving Changeology Group, Lancashire and South Cumbria Cancer Alliance, University Hospitals of Morecambe Bay, Blackpool Teaching Hospitals, East Lancashire Hospitals Trust and Lancashire Teaching Hospitals Trust and the North West Endoscopy Improvement Programme were also shortlisted for the 'Best Elective Care Recovery Initiative' and 'Diagnostics Project of the year' categories.

4. Local and Trust specific updates

Important news and information from around the Trust which supports our vision, values and objectives. This section of the report features reduced content due to the pre-election period (26 March – 4 May) for local elections, in accordance with NHS local election guidance.

Key Messages from Key Meetings

Chief Executive colleagues attended a national leadership event hosted by NHS England on Wednesday, May 1. From the updates provided it was clear that the Trust is already well aligned with the direction and the asks that were made by the national team. Amanda Pritchard, Chief Executive of NHS England, expressed her thanks to all colleagues for their ongoing hard work and dedication, linked directly to the progress being made and good performance on key metrics. She asked all Chief Executives to cascade messages to colleagues, which has been delivered through various Trust communications channels including Teams Brief and the CEO blog.

In addition, the Executive Team went on to meet colleagues from the Lancashire and South Cumbria Integrated Care Board (ICB) on Thursday, May 2, for the monthly Improvement and Assurance Group (IAG). Here, detailed information on performance was shared and the Trust was able to demonstrate that it is getting back to levels of pre-pandemic activity. The conversation

included information on how we ended the financial year 2023-24 well with improvements against key targets in important areas such as cancer and reducing the number of people who have been waiting over 65 weeks for treatment. ELHT was referenced nationally also as one of the only organisations to hit the target for patients to be seen in under four hours in A&E. The planning assumptions for 2024-25, which set out the amount of activity we will achieve over the next 12 months, were also well received.

Local 4 hour performance

The Trust has received a letter of congratulations from Sarah-Jane Marsh, National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer at NHS England.

The letter expressed heartfelt gratitude to the Trust, its teams, and partners for achieving the national 4-hour target of at least 76% of patients receiving timely care in the Emergency Department. ELHT was one of 38 out of 119 acute Trusts in England that met that target and at nearly 78%, the Trust was 2% higher than the national target.

She acknowledged the efforts made in increasing bed capacity, expanding same-day emergency care, changing ways of working with a greater focus on streaming and working with system partners to expanding the use of virtual wards and improve access to urgent treatment centres.

In the letter Ms Marsh emphasised the importance of sustaining these improvements while continuing to work towards broader goals outlined in the Urgent and Emergency Care Recovery Plan. She further encouraged ongoing support and collaboration in the face of upcoming challenges, recognising the importance of care and compassion in patient experiences.

A copy of the letter is at the end of this report as Appendix 3.

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 for a 96 hour continuous period between 7am on Monday 25 March and 7am Friday 29 March (Good Friday – Public Bank Holiday).

In close collaboration with colleagues and union representatives, the Trust maintained patient safety and adequate staffing levels by rescheduling certain routine and non-urgent appointments and procedures. This resulted in the majority of our services remaining operational.

Working with the broader healthcare system consistent messages to the public were issued, encouraging attendance at appointments unless advised otherwise and directing individuals to suitable pathways for health care and support.

Fire on site

A small fire broke out in the Day Unit on Royal Blackburn Teaching Hospital shortly after 4:30pm on Sunday April 8.

Lancashire Fire and Rescue Service attended the site and dealt with the fire swiftly, containing the incident to the changing room area. No patients or colleagues were injured during the incident and the Day Unit was reinstated around 12:30am, when a full deep clean was carried out.

The Trust continues to work with Lancashire Fire and Rescue Service and Lancashire Police to help them with their investigation.

EPR update

Almost 12 months on from implementing the Electronic Patient Record (EPR), we are working on continuously improving the system and user experience by making technical changes.

In April, a new outpatients MPage solution was launched to improve efficiency and make the process of recording procedures and outcomes much simpler. The solution was built in collaboration with various teams to address their concerns since go-live. Clinical informatics provided on the ground support throughout the roll out and comprehensive training videos and guidebooks were created to ensure best practice was followed. As a result, the new solution has halved the number of clicks required to perform tasks and clinicians can now record procedures, outcomes and clinics in real time.

Work to address historical unsent discharge letters remains key and great progress has been made based on feedback from primary care colleagues. Recent improvements to the transfer of care discharge letter process include alerts for nurses when letters have not been created or sent and the ability to send letters greater than five pages to GPs digitally. There are further technical fixes the Trust is working on with suppliers in addition to further end-user training.

Weekly meetings involving clinical, operational and data and digital colleagues continue to ensure thorough evaluation and safe implementation of changes and optimisation of the system.

Martha's Rule

The Trust launched Call for Concern, providing a telephone number for anyone to use if they are worried about the deterioration of a patient's condition.

A poster campaign was also developed to raise awareness on wards, with a QR code linking to detailed information on the ELHT website. The campaign was launched as national publicity raised awareness of Martha's Rule which is encouraging Trusts to introduce a process for rapid review.

0-19 Healthy Child Programme

From 1 April 2024, ELHT started to deliver the 0-19 service in Blackburn with Darwen, which provides expert advice and support to families and children. It followed a robust tender process by Blackburn with Darwen Council last year.

The 0 to 19 Healthy Child Programme covers a range of services including health visiting, school nursing and specialist infant feeding. The service was previously run by Lancashire and South Cumbria NHS Foundation Trust (LSCft).

A team of around 100 colleagues who were delivering the service on behalf of LSCft formally transferred to the Trust, joining the Family Care Division. This means schools, colleges and family hubs will not be impacted by the change, as the service will continue to be provided by the same hard-working teams.

People Promise Exemplar programme

ELHT is in the North West Cohort 2 of the people Promise Exemplar programme, along with 13 other organisations – a mix of acute, community and mental health organisations – with which the national and regional retention team at NHS England and NHS Improvement will work to deliver the interventions set out in the People Promise together in one place, at the same time in order to achieve improved outcomes and optimum colleague satisfaction and retention.

The People Promise sets out in the words of our NHS people what will most improve their working experience and make the NHS the workplace we all want it to be.

Funding was provided to selected organisation to recruit a People Promise Manager for 12 months to support the implementation of bundles of actions based around the People Promise.

The role will report into the Transformation Organisational Development and Inclusion team and the Integrated Care System (ICS) Retention Senior Responsible Officer with accountability to the NHS England Regional Retention Manager and ultimately the NHS England National Retention Programme.

Programme started with 90-day improvement cycle in February 2024, after which the Trust will submit it's 90-day return and plans for the agreed future activities. The programme has proven

benefits particularly regarding leaver rates, retention and staff survey. This supports the Trust's priorities for 2024/2025 from a people and culture perspective.

New Heart Care Unit at Royal Blackburn Teaching Hospital

A new Heart Care Unit has opened at Royal Blackburn Teaching Hospital, bringing together the Coronary Care Unit and the Cardiology Ward into a single location on Level 4.

The new cardiology facility is the result of many years of planning and development and will include a 10-bed unit for coronary care and 26 bed cardiac care ward. Patient experience will be further enhanced with the inclusion of a cardiac assessment unit and ambulatory area.

ELHT Stakeholder Event

The first Stakeholder Event of the year was held virtually on May 14 and welcomed people and organisations who have particular interest in what we do.

The event was opened by Shazad Sarwar, ELHT Chair. The executive panel provided updates including the Trust's financial position and planning process for 2024-25, our aim to becoming an intentionally anti-racist organisation, improving patient flow and integrated services, and supporting colleagues' health and wellbeing.

Joint Advisory Group (JAG) accreditation

The Royal College of Physicians and its official body the Joint Advisory Group (JAG), has re-awarded JAG accreditation to the endoscopy units at the Trust.

JAG is a voluntary scheme that focuses on standards, identifies areas for development and is based on evidence linked to clinical quality, patient experience, workforce and training.

By participating in the voluntary JAG programme the Trust's Endoscopy Service ensures that patients receive first class care. JAG accreditation verifies that rigorous, high-quality standards, used across the UK and Republic of Ireland, are met to support delivery and improvement of endoscopy services. These standards were developed by a multi-professional group of clinicians, managers, and service users. The accreditation programme is run by the Royal College of Physicians (RCP) and is dedicated to improving care quality standards.

It is the 'Gold Standard' for Endoscopy Departments and it is testament to the team that the service has met the required JAG accreditation standards.

Silver SPEC success for Hartley Ward

Congratulations to Hartley Ward colleagues who have achieved their first Silver SPEC (Safe Personal Effective Care) status. They celebrated the news with a tea party, joined by Executive Director of Service Development Kate Atkinson and Deputy Chief Nurse Jane Pemberton.

Hartley Ward is a 24-bed rehabilitation ward based at Pendle Community Hospital. Care is provided for patients who have had acute hospital admissions who are now medically optimised and require rehabilitation or complex discharge planning. The ward promotes a multi-disciplinary approach to care. As a team, colleagues pride themselves in providing safe, personal, and effective care, maintaining quality person-centred care throughout the patient's journey, promoting a positive experience for patients and families.

Patients and family are treated with the highest respect and regard, maintaining their dignity and ensuring patient safety is paramount. It is their aim to ensure the nursing assessment performance framework outcomes are achieved and that they deliver an outstanding standard of care for every patient, every time.

Veteran Aware Trust reaccreditation

The Trust was successful in achieving reaccreditation as a Veteran Aware Trust, formally recognising our commitment to the armed forces community.

The accreditation was carried out by the Veterans Covenant Healthcare Alliance (VCHA), a national NHS team. The VCHA's aim is to make sure patients from the armed forces community are not disadvantaged in terms of access to and outcomes of healthcare, as a result of their military life in line with the principles of the Armed Forces Covenant. It does this by developing, sharing and driving the implementation of best practice, while at the same time raising standards for everyone.

The accreditation recognises the Trust hard work in demonstrating its commitment to the Armed Forces Covenant and as an exemplar of the best standards of care for the armed forces community. The Armed Forces Covenant is a promise by the nation ensuring that those who serve, or who have served, in the armed forces, and their families, are treated fairly.

Youth Panel Interviewing Process

A panel of young people was invited to participate in the interviewing process for a specialty doctor in diabetes. The panel, supported by a trainee youth worker, took an active role in developing interview questions and provided valuable insights during candidate assessments. Feedback from

senior clinicians indicated candidates appreciated this innovative approach, emphasising the Trust's commitment to child and family-centred care.

Patient Experience Insights

In a separate initiative, students from Sir John Thursby Community College and Blessed Trinity RC College conducted a survey among their peers to gather feedback on our Trust's services. The survey highlighted positive aspects such as our hospitals being perceived as safe spaces and our colleagues being friendly and respectful. Areas identified for improvement, including smoking policies, parking facilities, and food services, align with existing challenges recognised by the Trust.

Star Awards update

The nominations for this year's Star Awards have closed after receiving almost 600 submissions. As the Trust moves into the judging phase of the awards, we are building on feedback from last year by inviting colleagues once again to join the judging panels. This ensures representation of the diverse roles, sites, characteristics, and backgrounds within our amazing workforce. Judging panels are scheduled for the weeks commencing May 20 and May 27.

The Star Awards is the Trust's annual recognition event, giving all colleagues, including bank and volunteers, the chance to help celebrate the amazing people who work here. The winners will be announced at a virtual awards ceremony in July, with an in-person celebration event taking place in September.

Higher Apprenticeship of the Year

Shelley Gill, from Centralised Outpatients and Admin Services was congratulated for her win at the Lancashire Apprenticeship Awards recently.

Shelley took home the coveted Higher Apprenticeship of the Year Award after being nominated by her tutor at Nelson and Colne College where she studies the ILM Level 5 qualification in Leadership and Management.

Speaking after the ceremony, Shelley commented that winning the award was a huge shock, but she was proud of her achievement. Shelley was grateful for the opportunity of the apprenticeship and thanked her tutor Julie, manager Angela Fowler and Sue Elliston, Directorate Manager.

Celebrating International Day of the Midwife

To mark International Day of the Midwife on Sunday, 5 May, colleagues, patients and the wider community have been able to nominate an ELHT midwife who inspired them or who they believed deserved recognition for going the extra mile.

The Trust held an event for all midwifes, hosted by Chief Nurse Pete Murphy, Deputy Chief Nurse Jane Pemberton and Divisional Director of Midwifery and Nursing Tracy Thompson who all expressed their thanks and gratitude to the Trust's midwives and announced the winning nominations.

The winners, including their nominations, were:

Larissa Heath

"I had a lovely midwife who I saw many times throughout my three pregnancies. Larissa was always so lovely and friendly."

Jurmi Choudury

"I'd love to nominate Jurmi - Midwife at Burnley central birth suite, she was absolutely amazing throughout her shift with us and induced me into active labour, she went above and beyond with us and really calmed our nerves, we couldn't have asked for better support."

Toni Duce

"I'd like to nominate Toni Duce. She was so supportive, gave me the best advice and empowered me to have the labour I wanted. You all do an amazing job and I take my hat off to every single one of you."

Justine Malloy

"I have moved back to ELHT as interim antenatal ward manager, Justine is the most kind, compassionate and caring manager. She has made me feel welcome to be back at the Trust and confident and well supported in my post. She cares deeply about the staff and the women in our care, everything she does is laced with kindness. She has always been and continues to be such a massive inspiration to me in my career as a midwife, I have always turned to her for advice and always know that I have the most trusting and supportive guide in her. If I can be half the compassionate leader as her, I know I've truly made it! She leads with love and that is exactly what maternity needs! Thank you, Justine, for your positivity, your kindness and for your Friday dance!"

Karen Young

"Karen from the birth centre was one of the community midwives who visited me after the birth of my twins last July. She went over and above to check I was ok after her first visit and I'm so glad she did."

The East Lancashire Royal College of Midwives branch visited maternity services to celebrate International Day of the Midwife. They provided goody bags to the midwives on duty as well as providing colleagues with refreshments and breakfast treats.

Holy Week

Services took place at both Burnley General Teaching Hospital and Royal Blackburn Teaching Hospital for colleagues to mark Holy Week. As Christians marked the special events of Jesus' life and death, Trust chaplain Joanne Macholc invited colleagues to follow His journey in a service of Stations of the Cross.

Eid celebrations

Colleagues joined together across the Trust in celebration to mark Eid. The three-day festival celebrates the completion of the fasting month of Ramadan by Muslims across the world.

The hospital charity ELHT&Me gifted toys, arts and crafts and books to babies, children and young people courtesy of the British Islamic Medical Association (BIMA) which wanted to brighten patients stay in hospital during Eid.

The gifts were donated to the community paediatric nursing team and hand-delivered to the Royal Blackburn Teaching Hospital children’s ward.

Following on from the annual Christmas cracker competition, this year the Trust introduced a similar competition for Eid called Shine a Light. In the run up to the Eid celebrations, people were asked to put forward the name of a colleague or team they would like to say thank you to.

Over 100 entries were received from which five randomly selected people were thanked with a Tower of Treats. The winners were:

- Gail Hughes in Gynaecology/domestic services – the nomination said without her the ward would not function and she is an inspiration to us all.
- Stuart Brisco in Intensive Home Support, Ward 20, Burnley General Teaching Hospital – the nomination said he is meticulous in his work and never misses a deadline.

- The non-medical recruitment team – the nomination said they always put their customers at the heart of everything they do and try to ensure the service they are giving is the best it can be.
- Raisa Pathan in the Directorate of Education, Research and Innovation – the nomination said her knowledge of the Learning Hub and her skill set are outstanding. She is a shining example of someone who lives and breathes our Trust values.
- Naffisa Aktar in the Emergency Department – the person who nominated her said she wanted to say thank you to Naffisa for giving up her own breaks to sit with a patient. She always gives the best care and attention to her patients, taking up her own time.

Charity bid winners announced

The hospital charity, ELHT&Me, provided colleagues with the opportunity to bid for up to £15,000 to positively impact patients or colleagues. The response was incredible with over 100 applications received.

Thirteen bids will receive funding, with congratulations to:

- Marsden Stroke Rehabilitation Ward: Charitable funds will support their aspirations to introduce an adaptable bike. Stroke guidelines currently suggest that patients should have three hours of motor therapy a day and 45 minutes of cardiovascular exercise to help aid neuroplasticity. The motor rehabilitation bike can be used by everyone as it adapts to each patient's strength and capabilities, so will be a valuable addition to the ward.
- Ward B14: A retreat will be created to support patients who have had major head and neck surgery and often have prolonged stays on the ward. It will provide a calm and quiet space for them to use during difficult times. The team has already raised £14,000 towards it and the additional money from the charity will now help make their plan a reality!

To support even more bids, funds from the Staff Lottery will also be allocated to:

- Dietetics: Acquiring an egg poacher for the staff room
- Emergency Department: Providing a toaster and microwave for the staff room
- Ambulatory Care: Equipping their transfusion/infusion rooms with DAB digital radios
- Cancer Research Team: Furnishing colleagues with two desk fans and a cafetiere
- Breast Screening: Installing a microwave in the staff area
- Ward 6: Securing a kettle and toaster
- Dietetics Community Base Brierfield Health Centre: Purchasing two foldable picnic benches for colleague breaks
- Ward 27: Acquiring a fridge for the staff room
- Community Admin COAS: Replacing the Christmas tree

- Family Care Divisional HQ: Investing in a fridge and toastie maker for colleague breaks
- Antenatal Ward Burnley: Providing a table and seating for the staff room.

The Staff Lottery directly rewards colleagues with over £25,000 each year in prize money, raised through monthly draws and fantastic super draws where the prize pots increase. It also raises funds for amenities across the Trust.

ENDS

Emma Cooke
Joint Deputy Director of Communications
08 May 2024

Appendix 1

Provider Collaborative Board – 11 April 2024

The Provider Collaborative Board (PCB) met on 11 April 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 Central Services and the Elective Recovery Programme were discussed under Joint Committee Working items and a PCB Reset was discussed under Strategy.

System pressures – elective recovery and cancer

Maggie Oldham was welcomed to her first meeting as the Chief Executive of Blackpool Teaching Hospitals (BTH) having previously been Deputy Chief Executive at the Lancashire and South Cumbria Integrated Care Board (ICB).

During March the system saw the highest demand for urgent care on record. Overall the system had achieved the 76% A&E target for patients seen within 4 hours, with BTH in particular having over performed which had helped the system total. The new 78% target would be challenging and a key focus for the Recovery and Transformation Board.

The Chair of Lancashire and South Cumbria NHS Foundation Trust (LSCFT) and the Chief Executive of Lancashire Teaching Hospitals (LTH) agreed to share examples of best practice in terms of how other areas were improving their urgent and emergency care offer. Involving North West Ambulance Service (NWAS) in discussions about meeting the new target and overall improvement of urgent and emergency care would be important as there was a potential adverse effect on ambulance turnaround.

Consideration was being given to the provision of an annual plan for the PCB and future integrated performance reports which would take into account proposed changes to governance and meeting cycles.

A report on elective recovery was covered as a separate agenda item.

System pressures – mental health and learning disabilities

Despite having treated 1,570 children as a result of some temporary funding received in 2023/24, the system still had 400 children who had been waiting over two years for treatment for autism. Discussions were taking place with the ICB with regard to some interim funding for the new financial year to help clear these waits before getting back to a fully commissioned state for 2025/26. As these waits are not reported through to many forums, it was agreed that it was important that this remained on the radar of PCB. It was felt that it would be beneficial for the ICB to hear from the parents of affected children,

particularly in relation to some of the unseen financial costs of these delays, arising from the need for increased input from social care and pressures on the education sector.

The transfer of East Lancashire Child and Adolescent Services (ELCAS) and adult community physical health was on track for 1 July subject to final board approvals.

The Board congratulated LSCFT for improving their system oversight rating for their finances, having now achieved SOF 2 – this along with their recent “good” rating by the Care Quality Commission was very positive for patients, the Trust and the wider system.

The management of risks between all partners needed to be the subject of further discussions with the ICB.

Finance Update

In comparison with previous years, the system had moved forward with the quality and alignment of processes and the consistency and coherence of its financial plans. Trusts underlying financial positions were now more consistently presented and understood, and all planning submission deadlines had been met with far less variance between the first and second draft submissions. Final submissions are due in the first week of May and it was recognised that there would still be more work to do after this to demonstrate how some of the remaining gaps were to be addressed.

The ICB passed on a huge thank you to all trusts for their hard work in delivering the year-end financial plan in line with what had been agreed and discussed with NHS England (NHSE). This was important in terms of credibility and confidence that the system would be able to keep making the improvements needed to reduce its overall deficit. Much progress had been made, however historic and inherited deficits within the Trusts and ICB, pressures within local government and an above target allocation that would be corrected over the coming years had left the system with a significant challenge.

NHSE North West had written to ask all trusts to implement a number of additional measures including a vacancy freeze and tighter vacancy management and enhanced non-pay controls. The three key areas that the system would be focusing on collectively and simultaneously were reducing waste and duplication; improving quality; and transformation.

Given the size of the system deficit, the Chair and Chief Execuitve (CEO) of the ICB along with the CEOs and Chairs of some of the provider Trusts would be attending a series of meetings with the NHSE Director of Finance to discuss their 2024/25 plans in more detail and further updates would be given to future PCB meetings and at the ICB Delivery Board.

Central Services Programme Board Update

Prior to the meeting, a workshop had been held with Trust CEOs to discuss some of the matters raised by individual Boards, particularly around the approach to the transformation of services and check and challenge gateways. This had been helpful in providing clarity on some areas of particular interest and concern.

Finalising the scopes for transfer remained a key priority for the programme – good progress had been made but there were still some final issues to resolve to ensure that the details were all agreed at individual Trust level.

Sharon Robson was congratulated on her appointment to the post of Managing Director of One LSC. Appointments to the Directors of Procurement; Estates and Facilities and Digital were imminent.

Notable communications activity in March 2024 included updates to Boards, executives and staff side colleagues following Central Services Executive Sub Committee and the PCB Joint Committee. The use of the Engagement Hub had seen a significant increase in the past two months with an increase in questions received and responded to directly through the hub.

Monthly Teams forums specifically for all central services colleagues, led by the operational directors, are set to start and roadshows headed up by One LSC's new Managing Director are being planned within each trust to coincide with the overarching programme plan. A video featuring the new MD had been well received, and a slide set and one page description of the programme had been produced to help managers with discussions with their teams.

A paper would come to the PCB May Committee with a number of items for approval, including the Strategic Collaboration Agreement (SCA) and its schedules; the Transition Plan; the Risk Framework and Board Assurance Framework; the final scope for One LSC; and the Financial Framework.

Elective Recovery Programme Board Update

Although Lancashire and South Cumbria did not fully eliminate 78 week waits by the end of March 2024, good progress had been made. The confirmed numbers would be available toward the end of April with the most recent forecast being 28 patients waiting over 78 weeks at year end. Orthodontics was noted as the most challenged speciality for clearing long waits. This is an agreed fragile service and discussions on the lead provider were progressing.

As of the 17 March 2024, Lancashire and South Cumbria had 1,149 65-week waits against the revised year-end trajectory of 888.

The system-wide surgical hub business case is complete and currently going through Trusts' internal approval processes. Ongoing work to develop a 'cost per case' model to increase surgical hub capacity to repatriate high-volume-low-complexity activity had been completed and was being considered by providers' Executive Teams.

The implementation of the system single Patient Tracking List has now commenced, and a marketing campaign to optometrists to influence a greater number of cataract referrals to NHS providers is due to launch shortly.

Strategy Discussion

As the landscape in which the PCB operates has grown in complexity and the PCB itself now operates under a different methodology, including the discharge of authority in its own right, a review of the way that it operates is underway.

Key drivers for review and change are the need to address assurance frameworks and reporting requirements in respect of delegated functions; alignment of strategic governance processes with ICB and Place, allowing for a clarity of roles and avoidance of

duplication; and the refinement of the operating model to respond to the PCB as a Joint Committee, including clarity of communication and decision making.

Given increased and unrealistic workloads for the CEOs across a wide range of transformation programmes, it was agreed that existing resources needed to be realigned to enable a senior co-ordination role within PCB along with the establishment of a single PMO/Governance function; there should also be a Standard Operating Procedure (SOP) for communications/decisions; the alignment of meetings and decision cycle between the Joint Committee and member Trusts; and the design of a programme of training and on-boarding to disseminate new ways of working.

A detailed discussion took place and it was agreed that more work was needed in a number of areas. Further updates would be provided to future PCB meetings.

Appendix 2

Alignment of Community (physical and child and adolescent mental) Health Services for Blackburn with Darwen and East Lancashire

Lancashire and South Cumbria ICB Board has clearly stated their ambition to have a world class, all age, community centric, integrated care system, with the four places at its heart acting as the engine room for driving transformation to improve health outcomes and experiences in response to the needs of our population.

Delivering on these ambitions requires the ICB to organise and deliver care at the most appropriate level and closest to the residents they serve. The integration of community health services (physical and mental), within places and neighbourhoods; with providers that are fully embedded within the geography; who understand the needs of their local people and who have relationships with local health, care and community assets, will ultimately drive more improved outcomes and more responsive service provision.

In line with their strategic objectives and specific objectives of the children and young people's mental health transformation programme and the transforming community care programme a proposal has now been developed to transfer two key services, Blackburn with Darwen and East Lancashire child and adolescent mental health services (CAMHS) from East Lancashire Hospitals Trust (ELHT) to Lancashire and South Cumbria Foundation Trust (LSCFT) and Blackburn with Darwen adult community services from LSCFT to ELHT.

These benefits are outlined in detail within a full business case developed jointly by the ICB and both providers and can be summarised as:

For our residents:

- More people will have access to help, advice and support when they need it
- People will get more help and support in the community to help them remain at home
- Support will be more co-ordinated and less fragmented, making it easier to navigate and get the right support at the right time
- As a result, people's experience of care will be improved.

For our system

- Improved patient outcomes and experiences by reducing fragmentation and creating a more resilient service offer;
- Equalising opportunities and clinical outcomes across Lancashire and South Cumbria;
- Improving quality, safety and clinical outcomes through a reduction in unwarranted variation in provision.

The intention of these transfers is to realign clinical service provision to the provider with the respective specialist physical health or mental health expertise with the aim of supporting improved outcomes for patients and wider clinical integration benefits realisation.

Discussions have taken place with NHS England who have confirmed they do not need to be involved in the transaction due to the lift and shift nature and contract values. However, they have been kept informed of developments for assurance and to date have offered positive feedback that they are assured as to the robustness of the process that has been undertaken. NHS England reviewed a draft of the business case on 15 March 2024 and confirmed that they felt the business case clearly described the challenges and rationale for the contract modification and that patient benefits were a theme throughout the document and that these were clear.

From a finance perspective, NHS England concluded that affordability was not presented as an issue as all partners have agreed a collaborative approach to managing the proposed service transfers, ensuring, as far as possible, cost neutrality for the system by transferring services as currently configured.

Subject to ICB and Trust board approvals and contract modifications being made, the anticipated go live date for the service transfers would be 1 July 2024 for both CAMHS and adult community physical health.

Email: martin.hodgson@elht.nhs.uk

NHS England

To:
- Martin Hodgson
- Chief Executive
- East Lancashire Hospitals NHS Trust

Wellington House
133-155 Waterloo Road
London
SE1 8UG

14 April 2024

Dear Martin,

Local 4 hour performance exceeding 76% across March 2024

I want to say a huge heartfelt thank you to you, your teams and your partners that supported the drive towards the national ambition that at least 76% of your patients in ED attendance were admitted, transferred, or discharged within 4 hours by the end of last year, providing timely access to care for the population you serve.

I know this has required significant focus and dedication, including increasing bed capacity within hospitals and expanding same day emergency care, changing ways of working with a greater focus on streaming, re-direction, direct access and clinical decision-making, and working with system partners to support the expansion and consistent utilisation of urgent treatment centres, virtual wards and urgent community response, as well as transfer of care hubs.

I have visited many organisations since I commenced in my national role, and I am very aware that much of this achievement has occurred as a result of the incredible drive and determination from everyone across the emergency care pathway. A key focus for the year ahead is to work to put this improvement on a sustainable footing, whilst continuing to deliver on the wider ambitions of the Urgent and Emergency Care Recovery Plan.

Thank you again for your hard work, and when you are thanking your teams in your own unique ways, please ensure mine are added. I see beyond the numbers into the experiences of the patients you have treated, when care and compassion are what matter most.

The year ahead will inevitably be more challenging, I look forward to working with you and supporting in any way I can.

Sarah-Jane

Sarah-Jane Marsh
National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer NHS England

TRUST BOARD REPORT **Item** **66**

15 May 2024 **Purpose** Approval
Assurance
Information

Title	Corporate Risk Register Report
Report Author	Mr J Houlihan, Assistant Director of Health, Safety and Risk
Executive sponsor	Mrs A Brown, Associate Director of Quality and Safety Mr J Husain, Executive Medical Director
Date Paper Approved by Executive Sponsor	8 May 2024

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	Mersey Internal Audit Agency (MIAA) Risk Management Audit Report
Related to Key Delivery Programmes	Care Closer to Home Placed-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	Yes	Confidentiality	No

Have accessibility checks been completed? Yes

Executive Summary

1. A summary of key points to note since the last meeting.
   a) The corporate risk register has seventeen risks. Three new risks have been approved. One risk is awaiting approval to be removed. Two risks have had risk scores challenged and increased. Eleven risks have had no movement or change in risk score. Six risks have been removed.

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 since the last meeting.
   a) The corporate risk register has seventeen risks. Three new risks have been approved. One risk is awaiting approval to be removed. Two risks have had risk scores challenged and increased. Eleven risks have had no movement or change in risk score. Six risks have been removed.
   b) A breakdown of risks by risk type shows eleven (64%) are clinical related, two (12%) are finance related, two (12%) are health and safety related and two (12%) are data and digital related.
   c) 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.
   d) System enhancements to the risk management module of DATIX are being made to improve governance, risk management controls and assurances.
   e) A more detailed summary and breakdown is included within the appendices.

Risk Management Performance Activity

5. A summary of key points to note since the last meeting.

a) Numbers of open risks held on the risk register are down from 1,709 risks in Q4 2021-22 to 682 in Q4 2023-24, a decrease of 60%.

b) Risks identified as being significant or moderate are down from 1,368 risks in Q4 2021-22 to 215 in Q4 2023-24, a decrease of 84%.

c) Risks remaining open over 3 years old are down from 1,035 risks in Q4 2021-22 to 400 in Q4 2023-24, a 61% decrease.

d) Overdue risks are down from 230 in Q4 2021-22 to 107 in Q4 2023-24, a 54% decrease.

e) 4% of tolerated risks have surpassed their review date in Q4 2023-24.

f) Clinical risks (65%) 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 (27%) followed by medical devices (17%).

h) A breakdown of health and safety risks shows the highest risk sub types relate to manual handling (34%) followed by radiation risks (23%).

i) Highest numbers of divisional risks 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 (9%) and estates and facilities (8%).

k) Numbers of estates and facilities risks are down from 193 risks in Q4 2021-22 to 54 in Q4 2023-24, a 72% decrease.

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

d) 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.

e) 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.

f) 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.

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

h) Supporting services in addressing the five hundred and eighty two 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 the effectiveness of divisional quality and safety meetings is to take place to further help mitigate those controls.

    b) The development and roll out of a 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 or of exploring system improvements to the DATIX risk management module that will better 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 inclusion of an actions required section to improve mitigation of risks, with further systems enhancements planned.

d) A number of measures have been put in place to improve risk management competencies of managers and key 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 now included as part of the workplan of the Health and Safety Committee. The coaching of managers and staff with responsibility for managing risks, along with the issue of new guidance, is helping provide a short term solution.

e) The transfer of risks to lead specialisms and subject matter experts remains on course for completion within Q1 2024-25 following an extensive consultation process.

f) Open risks on the risk register are expected to significantly decrease as more focused attention is given to the 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 risks in relation to delayed transfers, missed diagnosis and sub-optimal care is currently in progress.

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.

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 fifteen or above, 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 approved onto the corporate risk register 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

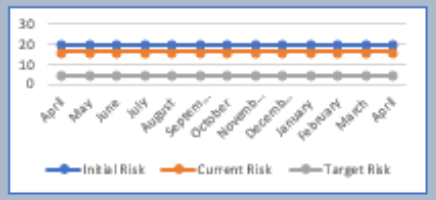
07 May 2024

CORPORATE RISK REGISTER SUMMARY										
No	ID	Where is risk managed	Title	Likelihood Score	Consequence Score	Risk Score	Exec Lead	Effectiveness of Controls	Risk Movement	Progress
1	10082	Trust Wide	Failure to meet internal & external financial targets for 2024-25	5	5	25	M Brown	Adequate	↑	New
2	10086	Family Care	Missed or delayed diagnosis if no solution for storage and transfer of echocardiogram (ECHO) images cannot be found	5	4	20	P Murphy	Inadequate	↑	New
3	9545	SAS	Failure to provide surgery due to breakdown of equipment	5	4	20	M Brown	Limited	↕	No change
4	9336	MEC	Lack of capacity can lead to extreme pressure and delayed care delivery	5	4	20	J Husain	Limited	↕	No change
5	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
6	9746	Corporate	Inadequate funding model for research, development and innovation	4	4	16	K Quinn	Limited	↕	No change
7	8941	DCS	Delays to cancer diagnosis (histology)	4	4	16	K Quinn	Limited	↕	No change
8	8839	SAS	Failure to achieve elective recovery targets *	4	4	16	S Gilligan	Limited	↑	Challenged
9	8061	Trust Wide	Management of harm from the holding list *	4	4	16	S Gilligan	Limited	↑	Challenged
10	8033	Trust Wide	Complexity of patients impacting on ability to meet nutritional and hydration needs	4	4	16	P Murphy	Limited	↕	No change
11	7165	Corporate	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	4	4	16	T McDonald	Limited	↕	No change
12	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
13	9851	Trust Wide	Lack of standardisation of clinical documentation processes and recording in Cerner	5	3	15	P Murphy	Limited	↑	New
14	8808	Corporate	Breaches to fire stopping and compartmentalisation in walls and fire door surrounds - BGH	3	5	15	T McDonald	Adequate	↕	No change
15	7008	Trust Wide	Failure to comply with 62 day cancer waiting time target	5	3	15	S Gilligan	Limited	↕	No change
16	4932	Trust Wide	Patients who lack capacity to consent to placements in hospital may be being unlawfully detained (Tolerated Risk)	5	3	15	P Murphy	Limited	↕	No change
17	8725	CIC	Lack of senior clinical decision making and inconsistent medical cover for CIC services	3	3	6	J Husain	Adequate	↓	Awaiting removal
	9771	Trust Wide	Failure to meet internal & external financial targets for 2023-24	5	2	10	M Brown	Adequate	↓	Removed
	9570	FC	No capacity for the storage of legacy ECHO images **	1	4	4	P Murphy	Inadequate	↓	Removed
	9367	FC	ECHO Images Transfer **	1	4	4	P Murphy	Inadequate	↓	Removed
	9705	SAS	Inability to provide a robust hepatobiliary (HPB) on call service	3	4	12	J Husain	Limited	↓	Removed
	9557	Trust Wide	Patient, staff and reputational harm as a result of the Trust not being registered for mental health provision	3	4	12	P Murphy	Limited	↓	Removed

***** risk scores challenged and rescored back to previous risk scores of 16
**risks integrated to form DATIX ID 10086

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: 17 Apr-24	**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

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 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.

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.
5. Work to increase compliance with RIDDOR reporting timescales is showing continuous improvement from 12% in 2021/22 to 47% in 2022/23 and 56% in 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 and 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 and Risk	Q2 2023	Delivery of RIDDOR awareness training to occupational health team completed. RIDDOR reportable occupational disease now more explicitly included within occupational health reports. New occupational health management system OPAS-G2 used to capture and inform of types of medically diagnosed occupational health related disease, infection and ill health identified as RIDDOR reportable.	G
2	Limited assurance services are benchmarking or using RIDDOR performance as an important driver in reducing the risk of untimely reporting	Improve senior management overview, involvement and insight Include RIDDOR performance as part of Quality and Safety KPI metrics Improve communication and strengthen collaborative working partnerships. Better utilisation of Divisional Quality and Safety Leads to relay and enact upon important safety critical information	Assistant Director of Health, Safety and Risk	Q2 2023	Increased senior management awareness of RIDDOR to help drive and reinforce important of ensuring legislative compliance. RIDDOR performance measured as part of Quality and Safety KPI Metrics. Collaborative working partnerships strengthened with clinical and non-clinical service specialisms and safety critical roles.	G
3	Limited assurance managers and staff are following policy or procedural controls regarding timely reporting of accidents or incidents, of this being highlighted or captured within management systems or processes or it being performance managed Delays are being experienced determining RIDDOR reportable injuries, diseases and dangerous occurrences due to the volume and complexity of accidents and incidents requiring review and investigation Limited assurance lead specialisms or subject matter experts in safety critical roles are benchmarking or using RIDDOR performance as an important driver in reducing mitigating risks or improving safety management systems, processes or behaviours	Review of incident reporting process to improve quality and quantity of accidents and incidents being reported in a timely manner. Review of incident investigation process to utilise lead specialisms and or subject matter experts more effectively when reviewing and investigating incidents within their areas of responsibility and control and of determining external reporting requirements of RIDDOR when undertaking investigations Review of triage process to avoid multiple reviews of incidents and duplication Review of health and safety team resources pending outcome of review of process	Assistant Director of Patient Safety and Effectiveness Assistant Director of Health, Safety and Risk	Q4 2024	Feedback regarding review of incident reporting, incident investigation & triage processes has been given to policy author Total numbers of health and safety related incidents requiring review and investigation by the health and 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 = 6,632 a reduction of 1% compared to the previous financial year. The process of determining RIDDOR reportable incidents and ensuring legislative compliance is extremely time consuming and heavily dependent on the health and safety team which is impacting on effective service delivery. Review of health and safety team capacity and resources in progress.	A
4	Investigations to determine RIDDOR reportable incidents are highlighting gaps in quality management systems or processes, existing policy and procedural controls and risk assessment processes not being followed by managers or staff	Gaps in quality management systems are to form part of the workplan of the Health and Safety Committee	Assistant Director of Health, Safety and Risk	Q4 2024	The development and implementation of a new health and safety strategy and framework will support delivery. The creation, utilisation and benchmarking performance of new workplace health and safety standards will form the workplan of the Health and Safety Committee in seeking assurances quality management systems are in place to ensure legislative compliance. Standards are being introduced in Apr-24. Gaps in quality safety management systems have been identified and escalated to the Health and Safety Committee and Trust Wide Quality Governance Meeting	A
5	The introduction of patient safety learning response timescales identified as part of the new national patient safety incident response framework (PSIRF) may delay incident investigations and their subsequent impact on external regulatory reporting requirements	Impact assessment being reviewed by PSIRF lead	Assistant Director of Patient Safety and Effectiveness	Q4 2024	RIDDOR awareness of patient safety lead investigators, lead specialisms and collaborative working partnerships along with attendance of the health and 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.	G
6	The replacement of DATIX with the new Total Quality Management System (RADAR) may lead to loss of organisational memory and may delay incident investigations and their subsequent impact on external regulatory reporting requirements	Impact assessment being reviewed by RADAR lead	Assistant Director of Health, Safety and Risk	Q4 2024	The implementation of a new total quality management system (RADAR) has been withdrawn and as such 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 and or duplication	Staff days lost off work as a result of injury included as part of human resources sickness management and return to work processes but is not captured or linked as part of the DATIX incident management module	Assistant Director of Health, Safety and Risk	Q4 2024	The implementation of a new total quality management system (RADAR) has been withdrawn and an impact assessment review is no longer required. System improvements to the DATIX incident management module are being explored to help support delivery	G

8	Achieve and 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 and safety accidents and incidents, thematic review and RIDDOR performance. Identify and explore challenging factors limiting progress.	Assistant Director of Health, Safety and Risk	Q4 2024	RIDDOR performance continuously monitored and reviewed as a standing agenda of the Health & Safety Committee, Quality & Safety KPI metrics. Current analysis highlighting a 50% increase in RIDDOR reportable incidents compared to the previous financial year, from 38 in 2022/23 to 57 in 2023/24. Approx 72% of RIDDOR reportable incidents are staff related, 27% patient related and 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 and staff safety strategy group (violence & aggression) are in place with the aim of reducing numbers of incidents, levels of harms and of providing assurance of their effectiveness Highest numbers of RIDDOR reportable incidents have occurred within the MEC division (c.44%) followed by Corporate Services (17%). A further breakdown by services shows Medicines for Older People and Stroke Services have the highest numbers of RIDDOR reportable incidents followed by Estates and Facilities. This may reflect current work pressures and activities. A further deep dive of awareness, education, training and competence, staff behaviours and safety culture is to be explored further. Additional challenging factors limiting progress include increasing volumes of accidents and incidents, complexity of investigations, use of lead specialisms and subject matter experts when investigating accidents or incidents within their areas of responsibility and control, use of local (handler) led investigations and resultant actions, delays in accident and incident reporting and how these are performance managed and enacted upon, competing priorities and limited resources within the health and safety team and challenges experienced by clinical services regards the provision of information due to clinical priorities and workforce pressures.	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	10082	Failure to meet internal and external financial targets for the 2024-25 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. There is insufficient funds to provide the services to the population of East Lancashire. 2. Lack of control on how funds are allocated across partner organisations 3. A 7.7% efficiency target of £57.8 million for the Trust, a level that has never been achieved previously. 4. A Trust and system financial deficit that still needs closing.	**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 Trust is fully 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 Lack of understanding of full system risks 2 Lack of airtime for discussion of the full system financial risks		
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 • External Reporting and Challenge				
Update since the last report		**New risk** The financial deficit and risk attached in meeting that deficit may mean a reduction in expenditure and headcount and remains a high risk whilst maintaining a high quality, safe and effective environment for staff and patents. **Next Review Date 2405/2024**	**Date last reviewed**	**26/04/2024**		
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				25			
			8-week score projection	**25**			
			Current issues	System wide external influences			

No	ID	Title
2	10086	**Missed or delayed diagnosis if no solution for storage and transfer of echocardiogram (ECHO) images cannot be found**

Lead	Risk Lead: Dan Hallen Exec Lead: Peter Murphy	Current score	20	Score Movement	

Description	Capacity for the storage and transfer of ECHO images from ultrasound machines used within Chronic Obstructive Pulmonary Disease (COPD) and Neonatal Intensive Care Units (NICU) services may result in missed or delayed diagnosis if no suitable clinical management and or digital storage solution can be found. The ultrasound machines currently being used have no option for the storage and transfer of images which are currently being stored on scanning machines that have very limited memory availability. Once storage limits have reached capacity and images cannot be offloaded, the machines will stop functioning. This may result in the loss of images and the potential of patients having missed or delayed diagnosis of life saving cardiac abnormalities and pulmonary pathologies which may impact on the management of care, patient safety and increased medicolegal implications if the risk is not suitably managed or controlled.	**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Additional cost implications for contract extension and a software storage solution. 2. Current ultrasound images stored on scanning machines have limited memory capacity. 3. The transfer of images to desktop, through the PACS system and via MS teams is ineffective. Attempted input of images onto PACS slows the entire system down, is too big to be sent via the image exchange portal and has limited storage availability whereby the use of MS teams is heavily reliant on the availability of consultants to attend MS team meetings. 4. Patient transfers to other Hospitals may be unnecessary, unsafe and reliant on bed availability. 5. There is limited assurance of standards issued by the Royal College of Radiologists are being used to benchmark or measure performance or compliance. 6. Additional staff training in the use of the system may be required. 7. The development of a virtual private network (VPN) tunnel is currently under trial and is not embedded as a clinical management process. 8. The cranial ultrasound scans and echocardiogram images cannot be separated and stored, with further exploration of how scans are stored required. 9. A planned strategy and system solution is being brought in by the Integrated Care Board to increase storage capacity and support the management of the risk and is awaiting implementation. 10. There is limited assurance the policy regarding the lifecycle management of medical devices is robust, is being followed or suitably performance managed. **Gaps / weaknesses in assurances** 1. Common themes from incidents relate to equipment malfunction, delays in diagnosis, clinical symptoms warranting emergency transfer of patient to another Hospital and difficulties transferring images. 2. Cerner e-PR imaging module and set up requires further exploration to determine effectiveness. 3. There is limited evidence of assurance current capacity levels are being regularly checked and monitored. 4. The Bridgehead solution identified by the Technical Diagnostics Team remains fully dependent on the release of funding and approval by the Integrated Care Board. 5. A solution offered by Siemens does not help with image sharing with other Hospitals e.g. Alder Hey Childrens Hospital and the effectiveness of direct image transfers still requires exploration. 6. Limited assurance received regarding the effectiveness of the Medical Devices Management Group in supporting the management of this risk.
Controls and Assurances in place	**Controls** 1. The existing service contract has been extended. 2. Current ultrasound images are stored on scanning machines and McKesson software is installed on NICU computers. 3. Images have been transferred via desktop, through the PACS system, out of hours and via MS teams which have prevented the transfer of a baby and safe overview of images. 4. Patient transfers to other Hospitals can be made for echocardiology review. 5. Set standards on the provision of an ultrasound service have been issued by the Royal College of Radiologists that includes key areas essential for the delivery of high quality and effective ultrasound imaging services and examinations that clinical services are expected to review and follow. 6. The organisation has a policy and or procedure in place for the lifecycle management of medical devices **Assurances** 1. Incidents regarding imaging are being closely reviewed and monitored within the family care division and linked to the management of the risk. 2. Cerner e-PR has an imaging solution module, cloud storage and PAS patient list connection that can capture, store, access and share imaging data and multimedia across the system to provide a holistic patient view 3. Current capacity levels are regularly 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. 4. The Technical Diagnostics Team within the Integrated Care Board is currently exploring costs, with Bridgehead identified as a solution, along with cardio imagery. Planning parameters and vendor response in place for viability. 5. Work is underway with software providers for a temporary solution for the storage of images that does not add to current storage capacity. An approach has been considered for Siemens to partition VNA and assist with the holding of data and or for Sectra to provide a fully functional solution until a more permanent solution is found. 6. Regular meetings are held between the Executive Medical Director, Chief Nurse, Director of Finance and Director of Operations for the Family Care Division to understand the risk and mitigations required. 7. Divisional Quality and Safety Meetings are in place to review and support the management of this risk 8. The Medical Devices Management Group Meetings are in place to provide assurances of compliance regarding the lifecycle management of medical devices.		
Update since the last report	**New Risk** **Link to DATIX ID 9570 and 9367** A digital solution is being brought in by the ICB to increase storage capacity that will better support the risk and reduction in risk scoring. **Next Review Date 01/06/2024**	**Date last reviewed**	**01/05/2024**
		Risk by quarter 2024-25	Q1: 20 / Q2: / Q3: / Q4:
		8-week score projection	12
		Current issues	System wide external influences

No	ID	Title				
3	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		Theatre items that are out of service or obsolete pose a significant risk of complete failure which will impact on service delivery and patient safety. These items include theatre stack systems and Integrated theatre solutions which are now out of service contract. Additional critical medical devices and items are also due to be without support in the short and medium term	**Gaps and potential actions to further mitigate risk**			**Gaps / weaknesses in controls** 1 No spare parts availability internally or with supplier 2 Supplier has confirmed items now obsolete and replacement parts are no longer available 3 Possibility for loan kit to be unavailable 4 Potential for equipment to break and be no longer available 5 Field Safety Notices are not applicable as failure is due to age of equipment 6 Planned preventative maintenance of equipment for obsolete items is not included as part of contractual arrangements 7 A review of the responsibilities and arrangements within the medical devices policy is required **Gaps / weaknesses in assurances** 1 Increasing numbers of incidents identified 2 Meetings of the Medical Devices Management Group have not consistently taken place to allow monitoring and overview of equipment service contracts 3 Potential failure to report incidents of equipment issues or breakages 4 Delays in progress of the task and finish group may be experienced due to financial pressures
Controls and Assurances in place		**Controls** 1 Loan kit ordered when equipment broken if available (parts and items dependent) 2 Theatre staff fully trained and competent to work the equipment 3 Specialty scheduling and theatre oversight in place 4 Service contracts in place jointly managed between EBME and Theatres 5 Policy in place for the lifecycle management of medical devices monitored by the Medical Devices Management Group **Assurances** 1 Capital bids process in place 2 Business case to propose moving to a managed service and potential solution to the risk accepted by Board 3 Good relationship with and support from EBME, supplier and company representative 4 Breakages of choledoscopes fully investigated with theatres, EBME and supplier with the outcome of investigations finding no particular trend, with some breakages due to fragility of equipment and increased complexity of cases 5 Task and Finish Group established to progress replacement of equipment and managed service option 6 Monitoring at theatre and divisional meetings 7 Monitoring of incidents linked to risk and likelihood scoring criteria 8 Regular updates to exec team				
Update since the last report		**Update 01/05/2024** **Risk score reviewed. No change in risk score** Managed service has now been approved at Trust Board. Risk score to remain the same until service has been fully implemented and equipment replaced on site. The capital cost of the equipment is now over £1.4 million as further items are now obsolete. **Next Review Date 01/06/2024**	**Date last reviewed**	**01/05/2024**		
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				20			
			8-week score projection	**20**			
			Current issues	Management of Medical Devices			

No	ID	Title				
4	9336	**Lack of capacity across the Trust can lead to extreme pressure resulting in a delayed care delivery**				
Lead		Risk Lead: David Simpson Exec Lead: Jawad Husain	**Current score**	**20**	**Score Movement**	
Description		A lack of capacity is leading to extreme pressure resulting in delayed delivery of optimal standard of care. At times of extreme pressure, increasing patient numbers across the emergency pathway makes the provision of care difficult, impacts on clinical flow, increases the risk of nosocomial infection spread as a result of overcrowding and poor patient experience leading to complaints. Staffing requirements are not calculated as standard to be able to care for increased patient numbers and complexity, with inadequate capacity within specialist areas such as cardiology, stroke etc. to ensure adequate clinical flow and optimum care.		**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. 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	
Controls and Assurances in place		**Controls** 1. Robust ambulance handover and triage escalation processes to reduce delays. 2. Operational Pressure Escalation Levels (OPEL) triggers and actions completed for ED and Acute Medical Units (AMU). 3. Established 111 / GP direct bookings to Urgent Care Centre (UCC). 4. 111 pathways from GP / North West Ambulance Service (NWAS) directly to Ambulatory Emergency Care Unit (AECU). 5. Pathways in place from NWAS to Surgical Ambulatory Emergency Care Unit (SAECU), Children's Observation and Assessment Unit (COAU), Mental Health, Gynaecology and Obstetrics and the Community. 6. ED streamer tool in place to redirect patients to an appointment or alternative service where required. 7. Daily staff capacity assessments completed and staff flexed as required. 8. Divisional Flow Facilitators established across all divisions to assist with clear escalation and 'pull through'. 9. Escalation pathway and use of trolleys in place for extreme pressures. 10. Zoning of departments to enable better and clearer oversight, staffing and ownership and isolation of infected patients, in particular, those with influenza and risks of cross contamination. 11. Corridor care standard operating procedure embedded. 12. Workforce redesign aligned to demands in ED. 13. Safe Care Tool designed for ED. 14. Full recruitment of established consultants. 15. Matrons undergone coaching and development on board rounds. 16. Reduced thresholds within critical care to support patient admissions. 17. Patient champions in post to support patients on corridors and volunteers utilised to support with non-clinical tasks. **Assurances** 1. Support provided by IHSS Ltd. in regularly reviewing admission avoidance. 2. Gold command in place to provide support. 3. Bed meetings held x4 daily with Divisional Flow Facilitators. 4. Hourly rounding by nursing staff embedded in ED. 5. Daily consultant ward rounds done at cubicles so review of care plans are undertaken. 6. Daily 'every day matters' meetings held with Head of Clinical Flow and Patient Flow Facilitators. 7. Daily visit by Infection Control Nurse to ED with patients identified as being not for corridor. 8. Increased bed capacity within cardiology. 9. High observation beds in place on AMU to support patients who require high levels of care. 10. Further in reach to departments in place to help decrease admissions. 11. Discussions ongoing with commissioners in providing health economy solutions via A&E delivery board. 12. Continuous review of processes across Acute and Emergency medicine in line with incidents and coronial process.				

<table>
<tr><td rowspan="5">Update since the last report</td><td rowspan="5">Update 01/04/2024.
Risk reviewed. No change in risk score
A robust review and oversight of improvement work is clinically and data led, with executive support provided in relation to delays. Improvements are being seen with regards quality and safety outcomes and of patient and staff care. This is evidenced in improved NAPF results and assessment ratings. A contractual change made by the ICB in relation to the private ambulance transport provider has meant that transport must be booked in the mornings for afternoon journeys which will affect same day discharge and bed management capacity

Next Review Date 01/05/2024</td><td>Date last reviewed</td><td colspan="4">01/04/2024</td></tr>
<tr><td rowspan="2">Risk by quarter 2024-25</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>20</td><td></td><td></td><td></td></tr>
<tr><td>8 week score projection</td><td colspan="4">20</td></tr>
<tr><td>Current Issues</td><td colspan="4">Recovery and restoration pressures, recruitment and retention</td></tr>
</table>

No	ID	Title
5	8126	**An electronic patient record system that is not fully implemented or optimised may compromise clinical management systems and processes, impact on patient safety, care and service provision**

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

Description	A lack of continuous optimisation and investment may lead to frustration and create disillusionment, leading to poor usage and productivity, unsafe workarounds, substandard data and ineffective clinical decision making.	**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 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 - 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,
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. - 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 - nursing inpatient admissions covering care compass, patient status overview and activity timeline, tasks to complete, admissions assessments including observations, pain assessments, EWS scoring, medicines administration and drug charts, discharge care plans, day of admission checklist, discharge planning risk assessment - inpatient admission – doctor covering doctors worklist, admission documentation including auto text example, book patient for theatre, admission clerking notes including ability to forward to other recipients and available previous documentation within record - inpatient preoperative checklist and discharge care plan (nursing) covering preoperative checklists, prior to discharge plan and discharge dashboard - discharge (doctors) covering fit for discharge, discharge documentation and summary, discharge medication and discharge letter		

	- discharge (nursing) covering day of discharge checklist, key discharge information and PM conversation discharge of patient Emergency preparedness, response and resilience - policy and procedural controls in place relating to emergency preparedness, response and resilience, major incident and business continuity planning - paper based contingencies remain in place to allow and record data capture Governance - e-Lancs managed from one command centre Digital - national data and digital strategy in place to help drive successful implementation of e-PR system - stability of existing systems i.e. clinical and patient flow system (including capture of nursing documentation), digital dictation and scanning - improved digital infrastructure, network upgrades and digital solutions including storage to maintain and manage existing systems in place to help best utilise data sets and information from e-PR system - extended contracts on existing digital systems that provide current cover - register of non-core systems capturing patient information (feral systems) - decommissioning programme of digital systems underway - IT helpdesk and self-service portal in place to help resolve technical and general issues Patient and staff safety - staff access to a wide ranging staff health and wellbeing support mechanisms e.g. occupational health and wellbeing teams, employee assistance programmes, external organisations, staff side, freedom to speak up guardians etc. Task based - improved digital infrastructure and investment in new technology and equipment e.g. connectivity, large screen monitors for status and track boards, bed planning and control centres, use of barcode scanners for medication, patient wristband supply and scanning, workstations on wheels, laptop trolleys for ward and bedside usage, medicine trolleys specifically built for ward medication dispensing, anaesthetic machines within theatres, badge readers for logging within inpatient and theatre areas, use of 24/7 device computers with access viewer software installed in clinical areas etc. - use of personalisation lab to allow customisation of system to suit individual needs e.g. doctor, allied health professional, nurse etc. **Assurances** General - digital solution meets regulatory and data set compliance requirements - system designed around national clinical requirements - back office and application support teams triage, troubleshoot and resolve issues - support with staff familiarisation and confidence on clinical management systems readily available from Cerner e-PR and e-Lancs expertise - 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		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

	- 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 <u>Digital</u> - 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 <u>Patient and staff safety</u> - no patient or staff harm at present <u>Task based</u> - 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		
Update since the last report	**Update 16/04/2024** **Risk reviewed. No change in risk score** 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 is being reviewed to take account of data submission issues and its effect on income, activity, mortality etc. The clinical informatics team are supporting operational teams to daily monitor and action issues regarding the issue of discharge letters. **Next Review Date 16/05/2024**	**Date last reviewed**	**16/04/2024**
		Risk by quarter 2024-25	**Q1** / **20**; **Q2**; **Q3**; **Q4**
		8-week score projection	**20**
		Current issues	System wide external influences

No	ID	Title
6	9746	**Inadequate funding model for research, development and innovation**

Lead	Risk Lead: Julia Owen Exec Lead: Katie Quinn / Matt Ireland	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. 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 08/04/2024** **Risk reviewed. No change in risk score.** Progress continues with the woman and children support office teams now undertaking some study finance activities, The pharmacy position has not changed and a bid to the NIHR capital fund has been submitted which, if successful, could help with the mitigation of pharmacy infrastructure pressures. A new R&I finance officer is to commence in post on 15 Apr-24 **Next Review Date 08/05/2024**	**Date last reviewed**	08/04/2024
		Risk by quarter 2024-25	Q1: 16 / Q2 / Q3 / Q4
		8-week score projection	16
		Current issues	System wide external influences

No	ID	Title				
7	8941	Delays to cancer diagnosis (histology)				
Lead		Risk Lead: Dayle Squires / Victoria Bateman Exec Lead: Kate Quinn / Matt Ireland	Current score	16	Score Movement	⇔
Description		Increased cancer reporting times in histology due to increased workload and reduced staffing numbers which impacts on patient experience, outcomes and treatment.				
Controls and Assurances in place		**Controls** 1 A 5 year workforce plan in place to support recruitment and retention 2 Locum consultant pathologist and biomedical scientist in post covering long term sickness absence and maternity 3 Triaging of cases to prioritise cancer cases 4 Breast workload referred to other Trusts within LSCFT for reporting 5 Colposcopy screening cases referred to external provider 6 Routine cases sent to external reporting services **Assurances** 1 Work is being triaged based upon clinical urgency given the information provided on the request form 2 Weekly cancer performance meetings attended by the histology and performance managers 3 Escalation process for priority cases well established		Gaps and Potential actions to further mitigate risk	**Gaps / weaknesses in controls** 1 Dissection workload not adequately covered by clinical staff 2 Activity increase higher than technical staff can complete, despite overtime and locum staff 3 Failure of equipment is adding to delays 4 Increasing volume of work marked urgent c.45% **Gaps / weaknesses in assurances** 1 There may be a backlog of unexpected cancers 2 Surges in incidents regarding histology reporting times 3 Poor escalation of issues with meetings often stood down 4 Some breaches may fall outside the control of the Trust e.g. patients breaching targets due to complexity of pathways, comorbidities and patient choice
Update since the last report		**Update 26/04/2024** **Risk reviewed. No change in risk score.** Risk has been reviewed and updated to reflect additional measures introduced e.g. recruitment and resource, review of systems and processes regarding managing capacity etc. with a view of revisiting the likelihood and consequence criteria and lowering of risk score **Next Review Date 24/05/2024**		Date last reviewed	26/04/2024	
				Risk by quarter 2024-25	Q1: 16	Q2 / Q3 / Q4:
				8 week score projection	12	
				Current issues	External influences regarding mitigation of risk beyond the control of the Trust. National shortage of histopathologists.	

No	ID	Title
8	8839	Failure to achieve elective recovery targets

Lead	Risk Lead: Michelle Montague Exec Lead: Sharon Gilligan	Current score	16	Score Movement	⇔

Description	There is a risk regarding the ability to meet national performance targets set for referral to treatment times, with non-achievement of standards impacting on delays in patient treatment. As a result of the coronavirus pandemic, all surgical specialities are currently significantly challenged for meeting Referral to Treatment (RTT). The failure of this standard means that individual patient care is impacted as patients will have to wait an extended length of time for treatment which will further impact on patient experience and treatment plans. Patients may also deteriorate waiting for treatment for extended lengths of time. As this standard is externally monitored failure may lead to organisational reputational damage and patients choosing not to be treated by the Trust.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Covid-19, Industrial Action, e-PR implementation and extended essential theatre lifecycle works has significantly increased backlogs 2. Since e-PR implementation access to accurate reporting has been challenging, whilst reports are now more readily available there are still data quality issues with reporting 3. Covid-19 has reduced efficiency of theatre capacity due to patient choice, flow in theatre and workforce pressures 4. Workforce challenges with consultants reluctant to offer additional capacity sessions to manage demand, which is impacting on available capacity, with financial constraints limiting ability to access agency staffing along with recruitment challenges in speciality areas such as respiratory, ophthalmology, dermatology, haematology etc. 5. Increased 2ww demand having an overall pressure on resources 6. Balancing managing cancer performance targets and achievement of RTT performance target remains challenging, with cancer taking priority of urgency this is negatively impacting on RTT performance 7. Service demand still remains higher than capacity in most surgical specialities impacting on overall trust achievement 8. Recovery of activity lost due to industrial action and e-PR implementation which continues to remain challenging 9. Insourcing replacement with substantive staff in endoscopy will take time for staff being trained and will impact on activity being delivered in 2024/25. 10. Whilst divisions will limit impact on patients there is no guarantee further industrial action will not affect performance **Gaps / weaknesses in assurance** 1. The miss-match in some specialities between capacity and demand 2. Reporting and data quality issues impacting on ability to understand size of waiting lists 3. Some specialties have not returned pre Cerner number due to administrative time to manage patients by clinical team whilst work is being undertaken on Mpage and review of administrative roles in Cerner 4. Unable to predict if there will be further industrial action 5. Financial constraints should additional funding be required
Controls and Assurances in place	**Controls** 1. Strong monitoring at Trust, Divisional and Directorate level 2. Action and recovery plans developed and reviewed by directorate managers including cancer and theatre utilisation 3. Planning and information produced for trajectories 4. Weekly scheduling and VMB meetings in place to maximise theatre capacity 5. Addition of priority code monitoring as part of PTL weekly meetings meaning all P2 clinically urgent patients are tracked for dates 6. WLI initiatives for theatre and clinics to close capacity vs demand gaps. 7. Robust process of performance management in place led by Chief Operating Officer and Deputy Director of Operations 8. Exception reporting embedded across all specialities where FDS standard is not met 9. Continued working across the IS sector to utilise available capacity 10. Use of Chatbot facility to support validation with a move to PEP+ to support validation of waiting lists being rolled out in 2024 across the organisation **Assurances** 1. Monitoring directorate and divisional level at directorate meetings and DMB 2. Attendance of divisional information manager at directorate meetings to provide positional updates 3. Weekly PTL meeting within division to ensure awareness of current position and to ensure controls are continuously put in place to focus on achievement of the standard. 4. Monthly performance meeting with exec team and DMB where divisional position is reported, discussed, and challenged. 5. Regular meetings with ICB colleagues and local service providers with regards capacity and demand, system planning and mutual aid 6. Regular 1:1 between directorate managers and Deputy Director of Operations of current position 7. Triad to divisional triad meetings to check performance monthly. 8. Close monitoring of elective recovery milestones - no >78 week waiters– no 65 WW by 30th Sept 2024 – reduction in DNA , 85% capped Theatre utilisation, reduction in 62 day backlog, FDS, 31 day and 62 day 9. Daily meetings with divisions re: 65WW performance, actions, and escalation 10. Close monitoring of elective recovery milestones		
Update since the last report	**Update 15/04/2024** **Risk reviewed. Risk score challenged and rescored back as 16** There remains a number of data quality issues with the reports with patients on duplicate times, Divisions are working through these but is timely and linking in with either booking, secretarial or system support to resolve. **Next Review Date 10/05/2024**	**Date last reviewed**	**15/04/2024**
		Risk by quarter 2024-25	Q1: 16 / Q2: / Q3: / Q4:
		8 week score projection	12
		Current issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title				
9	8061	Management of Holding List				
Lead		Risk Lead: Alison Marsh Exec Lead: Sharon Gilligan	Current score	16	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. 6 Process has been rolled out and is monitored daily. 7 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. 8 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 01/05/2024** **Risk reviewed. Risk score challenged and rescored back as 16** Continued increase in volume of patients and time constraints due to competing waiting list demands. Discussed in SAS PTL meeting. Some services have been able to validate however those that have not are due to time constraints as the focus is on those long waiting patients. **Next Review Date 03/06/2024**		Date last reviewed	01/05/2024	
				Risk by quarter 2024-25	Q1: 16	Q2:	Q3:	Q4:
				8 week score projection	16			
				Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
10	8033	**Complexity of patients impacting on ability to meet nutritional and hydration needs**

Lead	Risk Lead: Tracey Hugill / Mandy Davies 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 21/04/2024** **Risk reviewed. No change in risk score.** Nutritional consultant role now commenced in post. IHI nutrition project has been delayed. The complex nutrition team is to be launched in Mar-24. Ward rounds and outpatient clinics now in place. Risk score to be reviewed following complex nutrition team being embedded. **Next Review Date 20/05/2024**	**Date last reviewed**	**21/04/2024**
		Risk by quarter 2024-25	Q1: **16**; Q2: ; Q3: ; Q4:
		8 week score projection	**12**
		Current issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title
11	7165	**Failure to ensure compliance with 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 determining RIDDOR reportable incidents due to increasing volume and complexity of accidents and incidents requiring review and investigation. 2. Limited assurance of policy or procedural compliance regarding timely reporting of accidents and incidents, of this being highlighted or captured within management systems or processes or it being performance managed. 3. No standardised investigation process or quality management system used to capture total days lost off work as a result of workplace accident leading to absence, avoidance or duplication. 4. New patient safety incident response framework may delay incident investigations and 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 not being utilised effectively to review and investigate incidents within their own areas of responsibility and control and of determining RIDDOR as part of investigation 7. Gaps in quality management systems or processes, policy controls and risk assessment processes not being followed by managers and staff. **Gaps / weaknesses in assurance** 1. RIDDOR performance attracting the interest of the HSE and CQC. 2. Limited assurance of RIDDOR being used to benchmark performance as an important driver in reducing mitigating risks or improving safety management systems, processes or behaviours. 3. Increasing numbers of incidents being reviewed by the health and safety team account for 25-30% of all incidents reported in DATIX and continues to significantly impact on the work and resources of the team e.g. 6,539 were reviewed or investigated in 2021/22, 6,713 in 2022/23 and 6,677 for 2023/24. 4. Current trend analysis highlighting a 55% increase in RIDDOR reportable incidents compared to previous FTYD.
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. Compliance with RIDDOR reporting timescales is improving but continues to remain challenging from 12% in 2021/22 to 47% in 2022/23 to 56% in 2023/24.		
Update since the last report	**Update 17/04/2024** **Risk reviewed. No change in risk score.** There has been a 1% decrease in numbers of health and safety incidents compared to previous financial year and a 55% increase in total numbers reportable under RIDDOR. Action plan in place to review effectiveness of safety management systems that is monitored by the Health and Safety Committee. Despite such increase, compliance with RIDDOR reporting timescales is steadily improving at currently 56% but this remains challenging and still below the threshold level of 95%. **Next Review Date 17/05/2024**	**Date last reviewed**	**17/04/2024**
		Risk by quarter 2024-25	**Q1**: 16 / **Q2**: / **Q3**: / **Q4**:
		8 week score projection	**16**
		Current issues	Systems, capacity and workforce pressures

No	ID	Title
12	6190	**Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale**

Lead	Risk Lead: Robert Sutcliffe Exec Lead: Sharon Gilligan	**Current score**	**16**	**Score Movement**	⟺

Description	Insufficient clinic capacity for patients to be seen in outpatient clinics resulting in unbooked new patients and a very large holding list of overdue patients. In some cases, there is significant delay and therefore a risk to patients. Demand far outweighs capacity, and this has been exacerbated since the COVID-19 pandemic. All patients are risk stratified (red, amber, green) but still cannot be seen within timescales with additional risk that amber patients could be become red over time etc.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Funding and insufficient staff numbers, competencies and skills mix to provide capacity. 2 Limited estates capacity and outpatient space to provide required clinics. 3 Limited opportunity to flex theatre to outpatient departments and vice versa. 4 Use of locums to support capacity sessions no longer in place due to lack of available space, gaps in competency, expertise and skills and challenges in practice regarding discharge, adding to holding list concerns. **Gaps / weakness in assurance** 1 Getting It Right First Time (GIRFT) report not yet created for patient waiting times above 25% within recommended timescales for review.
Controls and Assurances in place	**Controls** 1 An integrated eye care service is in place for specific pathways to help steer patients away from out of hospital eye care services. 2 New glaucoma virtual monitoring service in place to manage reviews and support the service. 3 Use of capacify sessions where doctors are willing and available. 4 Use of clinical virtual pathways where appropriate. 5 Action plan and ongoing service improvements identified to reduce demand. 6 A failsafe officer has been recruited to validate the holding list and focus on appointing red rated patients and those longest waiting. 7 Expanded non-medical roles e.g. orthoptists, optometrists, specialised nurses etc. 8 Additional ST's rotated for use one day per week from Aug-23 with 9 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 02/04/2024** **Risk Reviewed. No change in risk score.** 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 06/05/2024**	**Date last reviewed**	**02/04/2024**
		Risk by quarter 2024-25	**Q1**: **16**; **Q2**; **Q3**; **Q4**
		8 week score projection	**16**
		Current Issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title
13	9851	Lack of standardisation of clinical documentation process and recording in Cerner

Lead	Risk Lead: Heather Coleman Exec Lead: Pete Murphy	Current score	16	Score Movement	

Description	The introduction of Cerner e-PR has created changes in documentation processes. There are numerous ways to navigate and document in Cerner with a lack of standardisation in processes. This requires a coordinated way of standardisation and of providing policy and procedural guidance, education and support and effective ways to audit compliance of new systems and processes. A lack of standardisation could result in omission of documentation or evidence of care and or duplication of information relating to the provision of care and potential that processes no longer align to policies, standard operating procedures and national guidance.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. CNIO employment commencement 2. Change board to agree changes to Cerner 3. Staff unaware of variation of processes in Cerner at go live so all processes need review and agreement to standardise 4. Compliance audit reporting for some elements may not align to Cerner 5. Unable to set up compliance reports until agreed standardised process **Gaps / weakness in assurance** 1. Cerner change requests / staffing impact is taking time to work through and prioritise 2. Availability of lead expert to review system and advise is a timely process 3. Key processes lacking in standardisation are being identified 4. Assurances from authors of nursing risk assessments around training and policy to be presented at CRMOG
Controls and Assurances in place	**Controls** 1. Escalation process for Cerner related issues in place 2. Recruitment and appointment of CNIO now in post 3. Review of effectiveness of clinical management policy and procedural controls, risk assessment processes and care plans in place led by Head of Nursing 4. Agreement of standardisation of inpatient records 5. Documentation review held on NAPF and audit complete on mini NAPF, standardisation of information and records management now obtained and can be audited 6. Coordinated and divisional processes for escalation of issues required **Assurance** 1. Engagement groups with staff and subject leads in progress to understand the issues 2. Establishment of Clinical Records Management Group to monitor and receive assurance of compliance 3. Auditing of clinical areas being undertaken by Matrons awaiting results publication 4. Clinical documentation included as part of NAPF review reporting 5. Process of assurance by policy authors of effectiveness of policy and procedural controls and risk assessments aligned to Cerner in place		
Update since the last report	**Update 22/04/2024** **New Risk** Review of systems and processes and standardisation will help the mitigation of this risk. Solution being explored regarding an electronic document management system and dedicated team to scan and upload documents with a governance wrap around however this may incur costs and take time to implement. As an interim guidance is being circulated around the legalities of scanning and uploading documents to raise awareness **Next Review Date 22/05/2024**	**Date last reviewed**	**22/04/2024**

Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	15			
8 week score projection	15			
Current Issues	System wide influences			

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 Delays in implementing works 2 Lack of confirmation of integrity of fire door architrave surrounds and general gaps around and under fire doors 2 The adequacy of fire stopping compartmentalisation between phase 5 and adjacent building (Wilson Hey) via survey remains outstanding, with no decision made on work to progress 3 Not all locations within occupied areas have an updated fire safety risk assessment 4 The review of the effectiveness of collaborative working arrangements regarding the completion, review and sharing of fire safety risk assessments for both occupied and non-occupied areas is required
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, testing and 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 risers and fire-fighting equipment in place, tested and maintained 4 Fire safety management policy and procedural controls in place 5 Fire safety risk assessments in place for occupied (Trust) and non-occupied (Consort) areas 6 Fire safety awareness training forms part of core and statutory training requirements for all staff 7 All relevant staff trained in awareness of alarm and evacuation methods. 8 Emergency evacuation procedures and business continuity plans in place across services. 9 Fire protection remedial works and find and fix process in place and project managed 10 Random sampling and audit of project works being undertaken. **Assurances** 1 A fire safety committee has been established, chaired by an exec lead, to seek assurance and monitor progress and compliance 2 Collaborative working arrangements in place between the Trust, its partners and third parties to identify and prioritise higher risk areas, address remedial works and defect corrections to fire doors and frame sealings 3 All before and after photographic evidence of remedial works recorded and appropriately shared 4 Fire wardens in place with additional fire wardens provided by partner organisations to maintain extra vigilance, patrol common areas across hospital sites and undertake fire safety checks 5 Provision of on-site fire safety team response in place. 7 External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place. 8 Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England. 9 Independent consultant employed to review and oversee project.		**Gaps / weaknesses in assurances** 1 Lack of cooperation from partner organisations with information relating to construction drawings, test evidence and material in situ which is slowing down survey and project remedial / management works 2 Limited assurance of the robustness of fire safety management policy and or procedural controls regarding the risk assessment process and effectiveness of on-site fire wardens

Update since the last report	**Update 30/04/2024** **Risk reviewed. No change to risk score.** 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 30/05/2024**	**Date last reviewed**	**30/04/2024**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			15			
		8 week score projection	**15**			
		Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
15	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 4 Alliance provide investment and funding into problematic areas. 5 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. 6 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 12/04/2024** **Risk reviewed. No change in risk score.** Progressive improvements in performance seen with further improvements anticipated. Cancer action plan remains under monthly review with cancer performance meetings continuing weekly. A full review of PTL meetings and processes is underway following publication of recommendations. Funding priorities currently being reviewed for 2024-25 with allocation to struggling tumour sites where improvements have been identified requiring funding. **Next review date 10/05/2024**	**Date last reviewed**	12/04/2024

Risk by quarter 2023-24	Q1	Q2	Q3	Q4
	15			

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

No	ID	Title				
16	4932	**Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained (Tolerated Risk)**				
Lead		Risk Lead: Lyndsay Parsons Exec Lead: Peter Murphy	**Current score**	**15**	**Score Movement**	⇔
Description		Patients referred to Lancashire County Council and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DoLS) authorisation are not being assessed by these agencies within the statutory timescales, or at all, which means the DoLS is in effect unauthorised.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Inability of supervisory body to process assessments within set statutory provision. 2 In the absence of assessments the inability of ELHT to extend urgent authorisations beyond required timescales set at 14 days. 3 In the absence of assessments patients will not have a DoLS authorised and will not have had relevant checks undertaken to ensure they are legally detained, leading to patients being detained without authorisation as not doing so would present an even greater risk. 4 Plans to change DoLS to Liberty Protection Safeguards (LPS) remains ongoing, with no date set for their implementation or subsequent publication of new National Approved Codes of Practice. **Gaps / weaknesses in assurances** 1 Continuous increase in numbers of DoLS applications	
Controls and Assurances in place		**Controls** 1 Policy and procedures relating to the Mental Capacity Act (MCA) and DoLS updated to reflect the 2014 Supreme Court judgement ruling. 2 Mandatory training on the MCA and DoLS available to all clinical professionals. 3 Improvement plan introduced for the management of DoLS applications following internal audit to enable timely and accurate recording of applications made and to demonstrate application of MCA in absence of Local Authority (LA) review. 4 Applications being tracked by the Safeguarding Team 5 Changes in patient status relayed back to the Supervisory Body **Assurances** 1 Quarterly review of risk undertaken by the Internal Safeguarding Board. 2 Policy and procedural arrangements being adhered to by wards along with applications made in a timely manner. 3 Supervisory Body made aware of risk. 4 Legal advice and support readily available. 5 Additional support available for all ward based staff and provided by the MCA Lead and Safeguarding Team. 6 Despite challenges presented by the legal framework it is expected patients will not suffer any adverse consequences or delays in treatment etc. and that the principles of the MCA will still apply.				
Update since the last report		**Update 22/04/2024** **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 22/05/2024**		**Date last reviewed**	**22/04/2024**	
				Risk by quarter 2024/25	**Q1**	**Q2**	**Q3**	**Q4**
					15			
				8-week score projection	**12**			
				Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

No	ID	Title				
17	8725	**Lack of Senior Clinical Decision Making and Inconsistent Medical Cover for Community Intermediate Care Services**				
Lead		Risk Handler: Asif Garda Exec Lead: Jawad Husain	**Current score**	**15**	**Score Movement**	
Description		The Community and Intermediate Care Division (CIC) manage a range of Intermediate Tier services across both bed based and domiciliary settings which have developed significantly over the past few years with the expansion of the Intensive Home Support Service Team (IHSS) and Intermediate Care Allocation Team (ICAT). Mixed cover is in place across all sites, with medical staffing remaining inconsistent, leading to limited assurance that the current model of service and interventions provided remains robust and is meeting the needs of patients and staff.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weakness in controls** 1 Lack of coordinated medical oversight 2 Gaps between senior decision maker support and wards contributing to lack of forward effective medical plans 3 No succession plan 4 No robust 24hr cover arrangements across peripheral sites **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 Poor collaboration between MEC and CIC Divisions 5 No presence or influence of senior management team or senior clinicians working within CIC.	
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. 6 New GPSI frailty has started employment with second GPSI due to commence employment in May-24. **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 Focused work with individual JCF to be delivered by ward GPs and overseen by DMD 6 SHOP principles not universally well understood or implemented and targeted communications and implementation taking place with ward medical staff 5 Review and management of incidents in place.				
Update since the last report		**Update 01/05/2024** **Risk Reviewed. Risk score reduced from 15 to 9. Awaiting approval for removal from the corporate risk register.** 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 along with additional GPSI employment. No major incidents continue to be reported to date. Review of risk and risk score has taken place with senior management at the last performance meeting which has led to the risk score being reduced. **Next Review Date 01/06/2024**		**Date last reviewed**	**01/05/2024**	
				Risk by quarter 2024-25	**Q1**: 9	**Q2**:	**Q3**:	**Q4**:
				8 week score projection	**9**			
				Current issues	Recovery and restoration pressures, recruitment and retention			

TRUST BOARD REPORT

15 May 2024

Item	**68**
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

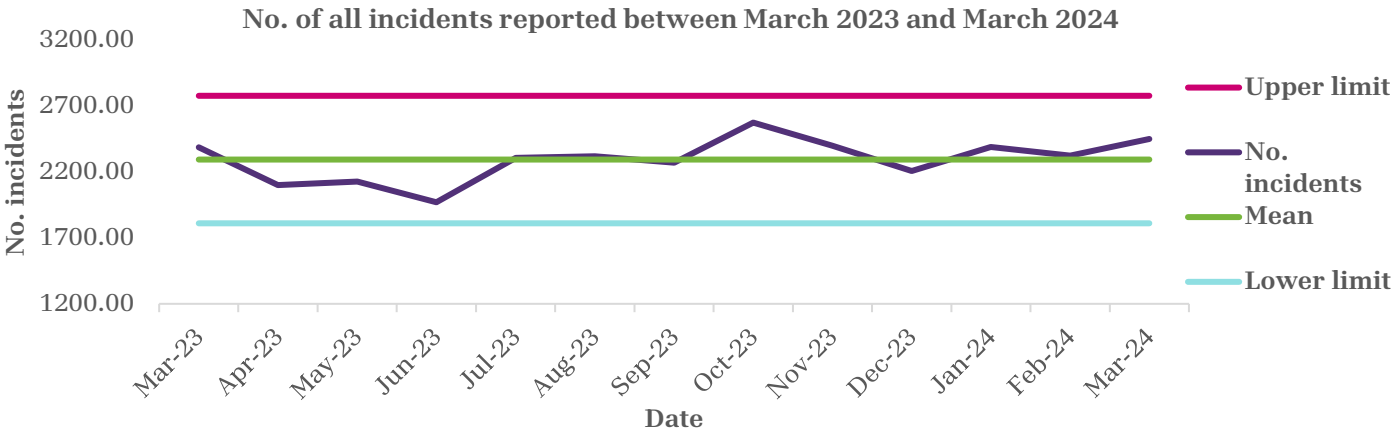
Impact

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.

Incidents resulting in death whilst low actual numbers (3 x was the highest in Aug 2023), 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 The Incidents and Policy Manager is going to begin attending the Mortality Steering group and look to better triangulate this information with Mortality data.

2. Duty of Candour

2.1 There have been **0** breaches, of Duty of Candour, as set out in CQC Regulation 20.

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 There continues to be an improvement in the number of IR2s completed withing 30 days, with overall Trust performance of 82.15%.

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 are working to continually improve the number of open PSRs and those open more than 90 days. Extra DPSIRGs have been arranged within Family Care to address the backlog. In SAS the Doctors strike in February meant that a DPSIRG meeting needed to be cancelled which delayed the review of a several PSRs.

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

5.1 In February 2024 and March 2024, the Complex Case meeting reviewed 73 incidents of which 8 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 March 2024, the Trust had 23 open PSII incidents of which 4 were being investigated by MNSI.

5.3 At the end of March 2024 there were 2 PSIIs which had 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.

5.3.2 Of the 2 PSIIs open more than 6 months. 1x has been delayed due to staff involved in the incident being on long term sick which has delayed the interview part of the investigation by 3 months. 1x has been delayed due to the availability of the advisor and sharing of Endoscopy relevant polices or SOPs in a timely manner. Both investigations have now been completed and awaiting final approval.

5.4 In February 2024 and March 2024, 9 PSII reports have been approved by PSIRI and closed.

6. Never Events PSIIs

6.1 There has been no new Never Events reported within the Trust since the last report. The Trust have reported 4 Never Events at the end of the financial year (April 2023 to March 24). On completion of the investigation and report for the Wrong Site Surgery (injection) it was agreed by NHS England to stand down as a Never Event, meaning the Trust had 3 upheld reported Never Events for 2023/24.

- *Transfusion of ABO incompatible blood component*
- *Wrong site surgery (injection)*
- *Wrong Implant*
- *Misplaced NG Tube*

6.2 All learning from the incidents have been shared across the Trust in a special Patient Safety Never Event Bulletin and all reports are available for staff to access and read on the Patient Safety Sharepoint site.

7 PSIRI Panel Approval and Learning from Reports

7.2 During February 2024 and March 2024, of the 9 approved by PSIRI Panel there were 4 new PSII reports, 3 identified learning.

7.2.1 Incident resulting in death (eIR1260296) – The report was approved with some minor amendments required. The areas identified for improvement were:

- AMU to assess and review level of compliance with the assessment and documentation of pain assessments.
- Emergency Department to review processes for escalation when an incident occurs to ensure patients, families and carers are directed to the most appropriate person to answer their questions.
- Emergency Department to ensure that they clear monitoring and visibility of compliance with regards to the level of documentation and plans of care. To implement a communication and education programme in relation to accurate and thorough documentation

7.2.2 Incident resulting in death (eIR1262611) – The report was not approved as a verbal overview of the report was given as the draft report was required for Coroner, the report was to be reviewed by the group outside of the meeting. The areas identified for improvements were:

- Ear, Nose and Throat Directorate to implement Trust wide guidance and SOP for the management and monitoring of patients presenting with severe sore throat, tonsilitis quinsy and potential airway obstruction secondary to deep space neck infections.
- Ear, Nose and Throat Directorate to ensure, where possible, all patients presenting with severe sore throat, tonsillitis or quinsy are admitted to the Ear, Nose and Throat ward, and when not possible is clearly documented, with a plan for observation and escalation.
- Life Support Team to review and strengthen processes and implement at SOP that clearly defines roles and responsibilities during a cardiac arrest.

7.2.3 Incident resulting in death (eIR1266278) – The report was not approved and required some amendments to the report and the improvement plan before being returned. The report was approved at the following meeting with a minor amendment. The areas identified for improvement were:

- Staff to be reminded to upload any evidence relied on in preliminary investigations when that information does not form part of the electronic patient record.
- Consider how patients who are waiting in the Urgent Treatment and Intervention area can be observed by Nursing Staff.
- Change request made to allow more characters to be entered in the 'ED Nursing notes' box by triage staff within Cerner.
- Remind staff to request venous blood gas checks for patients presenting with abdominal pain.
- Audit and monitor compliance of completion of sepsis bundle.
- Review and update where appropriate the resuscitation policies to ensure they reflect applicable guidance and clarify the use of the electronic patient record.

7.2.4 Each baby counts (eIR1255588/eIR1255591) – The investigation was completed by MNSI, the report was not approved as some minor amendments to the improvement plan were required. The areas identified for improvements by MNSI were:

- No safety recommendations were identified by MNSI as the findings from the information provided to MNSI did not contribute to the outcome.

8 Patient Safety Incident Updates

8.2 Lancashire and South Cumbria PSIRF Community of Practice (joint working arrangements)

8.2.1 The L&SC PSIRF group have developed a SOP for Joint Investigation Process / Guidance for PSIRF when an incident investigation involves 2 or more Trusts, will be approved at the next meeting at the end of April. This will help ensure all aspects of an investigation are covered including:

- Duty of Candour,
- TOR including identification of Lead Trust
- Staff engagement
- Timely completion
- Shared approve of report and actions.

8.3 Introduction to Human Factors Training

8.3.1 The Patient Safety Team have reviewed and updated the Trust Introduction to Human Factors Training which is now available to book on the Learning Hub. To support easier access and attendance the training has been split to two half day sessions and will be delivered over the next 12 months at RBH, BGH and via Teams.

8.4 Patient Safety Response (PSR) Training

8.4.1 AQuA have agreed to deliver 2 full day sessions via teams on Patient Safety Response investigation process and tools. The Trust is confirming dates and will share with divisions for staff to book. On completion of delivery the Trust use the training to develop its own in-house training for PSRs.

9 Mandatory National Patient Safety Syllabus Training Modules

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

Table 3: Patient Safety Syllabus Training (as of 24th April 2023)

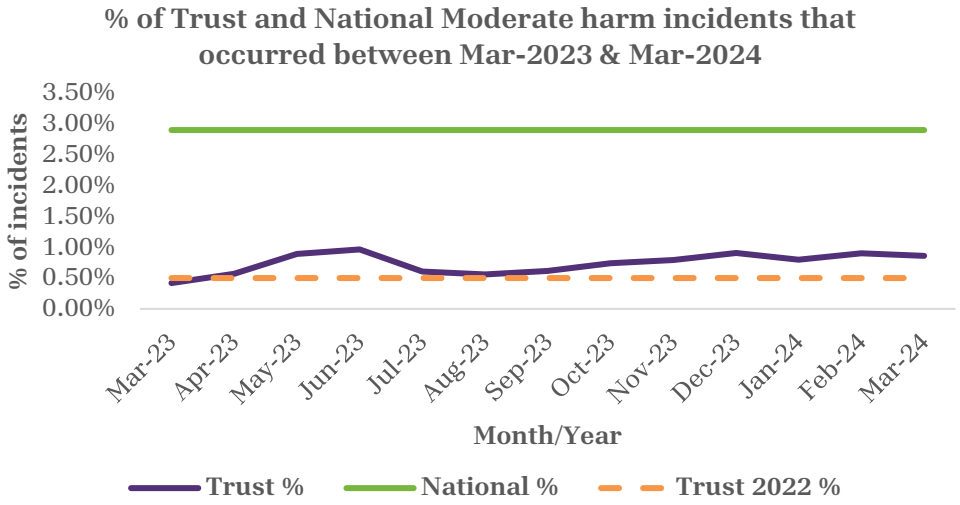
Patient Safety Training Modules	KPI Target	% of staff completed training
Patient Safety Level 1a – all staff	95%	92.1%
Patient Safety Level 1b – Boards and senior leadership	95%	82.4%
Patient Safety Level 2 – Essential to role	95%	86.3%

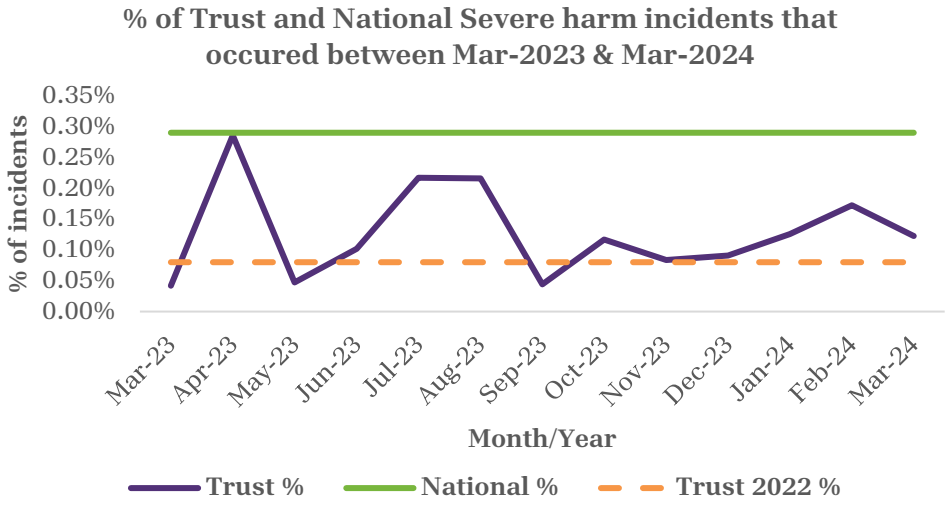
10 Maternity specific serious incident reporting in line with Ockenden recommendations

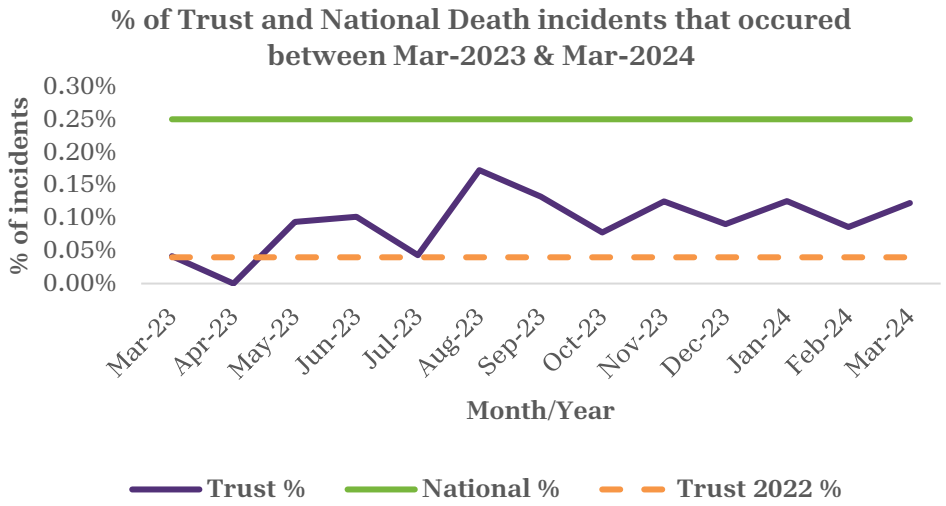
10.2 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 56 maternity related incidents have been reported on StEIS of which:

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

Appendix A: ELHT Incidents by Moderate 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 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Trend
CIC	Total IR2 reported	328	336	368	391	331	306	362	314	410	378	
	(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%	(354) 86.34%	(333) 88.10%	
DCS	Total IR2 reported	143	122	141	128	139	174	143	148	138	129	
	(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%	(101) 73.19%	(90) 69.77%	
FC	Total IR2 reported	199	238	330	253	252	348	307	245	237	221	
	(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%	(177) 74.68%	(185) 83.71%	
MEC	Total IR2 reported	959	796	883	885	877	926	880	947	947	915	
	(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%	(823) 86.91%	(762) 83.28%	
SAS	Total IR2 reported	374	386	457	385	391	542	425	346	415	397	
	(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%	(304) 73.25%	(335) 84.38%	
Corp	Total IR2 reported	68	40	70	53	78	79	78	69	82	89	
	(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%	(40) 48.78%	(44) 49.44%	
Trust Total	Total IR2 reported	2071	1918	2249	2095	2068	2375	2195	2069	2229	2129	
	(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%	(1799) 80.71%	(1749) 82.15%	

Total number of IR2s open on DATIX over 30 calendar days old						
Division	CIC	DCS	FC	MEC	SAS	Corp
No. open	41	63	36	168	182 (59*)	273

* Number of 104-day cancer breaches which require a clinical harm review and can take longer than 30 working days to complete.

Appendix B: KPI Dashboards for PSRs

Division	Number of PSRs open	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Trend >90
CIC	No. open	41	41	43	26	47	51	73	47	29	39	
	No. open more than 90 calendar days	15	5	7	6	7	2	2	7	5	7	
DCS	No. open	6	8	11	11	17	19	19	19	21	7	
	No. open more than 90 calendar days	1	1	4	6	9	4	2	3	5	2	
FC	No. open	28	35	33	27	36	43	43	40	47	40	
	No. open more than 90 calendar days	13	13	14	15	11	13	12	12	16	9	
MEC	No. open	83	118	135	157	168	141	105	107	125	94	
	No. open more than 90 calendar days	25	25	36	39	45	28	12	19	15	16	
SAS	No. open	44	49	41	49	55	57	71	76	60	56	
	No. open more than 90 calendar days	1	9	12	11	13	11	21	19	15	16	

Appendix B: KPI Dashboards for PSIIs

PSII reports (including HSIB/PMRT)	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 / Trend
No. incidents at Complex case	32	21	22	20	21	22	31	25	20	31	32	41	318
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)	3	5	39 (6)
No. over 6 months	N/A	N/A	3	6 (2)	10 (2)	10 (2)	8(2)	6(2)	7(4)	5(4)	6(5)	6(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)	23(6)	23(4)	
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)	4	5	38 (5)

TRUST BOARD REPORT

15 May 2024

Item	**69**
Purpose	Monitoring

Title	Annual Plan and Annual Budget 2024-25
Author	Ms C Henson, Deputy Director of Finance
Executive sponsor	Mrs M Brown, Executive Director of Finance
Date Paper Approved by Executive Sponsor	07 May 2024

Summary: This paper provides an overview of the 2024-25 draft annual plan and the 2024-25 annual budget showing a £30.3m deficit and the draft capital plan of £36.1m

Recommendation: To approve the content.

Report linkages

Related strategic aim and corporate objective	Deliver safe, high-quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on assurance framework	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. 9771 - Failure to meet internal and external financial targets for the 2023-24 financial year
Related to recommendations from audit reports	Assurance Framework Key Financial Controls Risk Management Core Controls
Related to Key Delivery Programmes	Finance Strategy and Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience, and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Executive Summary

1. This paper provides the detail of the draft annual revenue and capital plan for 2024-25 and asks for the Trust Board to approve the annual budget. The budget is aligned to the current draft financial plan for 2024-25.

2. The Trust has submitted a draft financial plan on 21st March 2024 of a £30.3 million deficit. A Lancashire and South Cumbria ICB plan has been submitted showing a system deficit of £198.3 million.

3. The Trusts draft financial plan for 2024-25 shows an exit run rate from 2023-24 of a deficit of £68.9m, and a gross deficit of £80.0m when additional inflation pressures are factored in for the coming year.

4. The financial strategy, which was recently approved, showed that we needed to reduce our cost base by at least 10% to become financially stable. Any plan to address this would need to be multi-year. We have assumed for the purposes of planning that we would need at least a 3-year plan based on savings of 3.3% each year to address this shortfall. In addition, a national efficiency is set at 1.1% for 2024-25. Previously the waste reduction programme was presented as £33.8m, 4.4% of operating expenditure.

5. The system plan was not accepted, and all partners have had to reduce their deficit to meet the revised system control total. This has resulted in a revised waste reduction programme of £57.8m at 7.7% of Operating Expenditure for the 2024-25 financial year, for the Trust.

6. The PFI accounting guidance change received in March 2024 has been assessed and has resulted in an indicative financial charge of £6m 2024-25. This has been matched by an allowable increase to the deficit moving to a draft revised deficit plan of £30.3m.

7. The full walk from the 2023-24 underlying financial position to the 2024-25 plan is shown below: -

	£m
2023-24 Opening Position	**(78.9)**
less: CIP	42.3
less: System Gap	12.3
Opening Plan 2023-24	**(24.3)**

2023-24 Movement from plan	
2023-24 Pressures Rec	(10.0)
2023-24 Pressures Non Rec	(8.9)
2023-24 Winter Pressures	(3.3)
2023-24 Unidentified WRP	(5.6)
2023-24 Unidentified system gap	(8.1)
2023-24 Non Rec share of £80m	23.7
2023-24 Non Rec IA Funding	2.6
2023-24 Mitigations Non Rec	18.4
2023-24 FOT	**(15.4)**

2023-24 Walk to the underlying position/exit run rate	
2023-24 Pressures Non Rec	8.9
2023-24 Pressures FYE	(1.5)
2023-24 Reversal of NR WRP achievement	(13.2)
2023-24 WRP FYE	1.3
2023-24 Reversal Non Rec share of £80m	(23.7)
2023-24 Reversal Non Rec IA Funding	(2.6)
2023-24 Reversal of Non Rec Mitigations achievement	(18.4)
2023-24 Reversal of Non Rec System Gap achievement	(4.2)
2023-24 Exit Run Rate/Opening 2024-25 Position	**(68.9)**

	£m
Recurrent Underlying Position	**(68.9)**
2024-25 Income Inflation	**13.1**
Less 2024-25 Income efficiency 1.1%	**(7.4)**
Less 2024-25 Convergence (1.09%)	**(5.8)**
2024-25 Maternity CNST (3.82%)	**1.2**
2024-25 FOT Drugs and Devices	**0.0**
2024-25 Expenditure Inflation	**(13.5)**
2024-25 Above Inflation Pressures	**(1.8)**
2024-25 Depreciation	**1.1**
2024-25 Cost Pressures	
2024-25 Changes to PFI	**(6.1)**
2024-25 Service Transfer (0-19 yr old from LSCFT)	**0.0**
2024-25 Service Transfer (Vunerable Services from LSCFT)	**0.0**
2024-25 Draft Planned Deficit exc WRP	**(88.0)**

	£m
2024-25 Draft Planned Deficit exc WRP	**(88.0)**
2024-25 WRP (is now 5.1% from 4.4%)	57.8
2024-25 Draft Planned Deficit inc a 7.7% WRP	**(30.3)**

8. The Lancashire & South Cumbria ICB NHS contract has been issued and is being reviewed but has been reflected in the draft plan with the planning guidance issued. A further financial submission will be required in May 2024.

Lancashire and South Cumbria ICB Plan

9. A £198.3m deficit plan has been submitted, with the four acute provider Trusts deficit plan at £103.1m.
10. The system position is a deficit of £198.2m and is higher than the £190m target, and includes:

    - £6.0m PFI adjustment for ELHT
    - £2.1m unallocated provider target – decision not reached on apportionment
    - £0.1m ICB above the £95m target

	BTH	ELH*	LSCFT	LTHT	NWAS	UHMB	PCB total	ICB	System
2024/25 February-iteration plan (£000s)									
Forecast out-turn	(51,825)	(43,660)	(0)	(36,766)	(2,801)	(24,277)	**(159,330)**	**(186,873)**	**(346,203)**
2024/25 March-iteration plan (£000s)									
Forecast out-turn	(24,278)	(30,311)	(0)	(24,278)	0	(24,278)	**(103,145)**	**(95,121)**	**(198,266)**
Movement from February-iteration	*27,547*	*13,349*	*0*	*12,488*	*2,801*	*(1)*	***56,185***	***91,752***	***147,937***
Variance to control totoal	0	(6,033)	0	0	0	0	**(6,033)**		

2023-24 Draft Annual Budget

11. The revised deficit budget of £30.3m is detailed below:

	£m	£m
Income from Patient Care Activities	665.3	
Other Operating Income	29.2	
Total Income		**694.5**
Employee Expenses	(489.2)	
Operating Expenditure	(213.3)	
Total Expenditure		**(702.5)**
Operating Deficit		**(7.9)**
Net Finance /and Technical Adjustments		(22.4)
Planned Deficit for 24/25		**(30.3)**

12. The budget setting principles used have been detailed in previous versions of the draft plan but have been included again for completion.

Pay Budget

13. In line with the Trusts budget setting principles, the annual budget re-costing exercise has been undertaken, with the following principles in respect of pay:

    - All staff in post as of 1st October 2023 have been costed at actual point of scale.
    - All vacancies costed at bottom of scale.
    - Over-established posts remain unfunded, with action plans to be sought to remove the posts.
    - Vacancy factor levels remain frozen and represents £4.8m 0.97% of the total pay bill.
    - Premium rates paid to agencies are not funded in the divisions budgets.
    - All on call rotas are funded.
    - All enhancements are funded.
    - All allowances are funded.
    - Pay awards (2.1% as per the guidance) and clinical excellence awards are funded.
    - The annual pay re-costing exercise and incremental drift has resulted in a pressure of £0.84m.
    - Employers' national insurance and pension contributions are funded.
    - A 22% uplift is applied to all registered nurses and health care assistants on the wards to cover annual leave, training, and sickness.
    - The 5% uplift relating to sickness will be budgeted on a bank subjective code to reflect bank costs incurred due to sickness.

14. The key change to previous years relates to reflecting sickness within the ward establishments as bank rather than as substantive.

15. Ward budgets include a 22% uplift to both the budget and the establishment. This reflects the amount of time staff may be unavailable. The 22% is made up of 14% Annual Leave, 5% Sickness and 3% Study leave. The 5% Sickness will be vired to the bank budget rather than substantive budget. This is to improve the management of sickness in a more transparent manner. This is being worked through with the Chief Nurse and will be updated in the opening budgets.

16. The Apprenticeship Levy has been adjusted in line with the pay assumptions and will be budgeted at £2.4m based on 0.5% of the pay bill.

17. Guidance includes a reduction in the agency ceiling of 3.2% (from 3.7% in 2023-24) of the pay bill at £16m and a reduction of £3.0m in this financial year. This has been reflected in our plans.

18. The proposed pay budget is shown below:

Employee Expenses	£m	£m	WTE
Non Medical - Clinical Substantive Staff			
Registered nursing, midwifery and health visiting staff	131.7		2,885.4
Allied Health Professionals	30.3		701.9
Other Scientific, Therapeutic and Technical Staff	13.3		336.4
Healthcare Scientists	7.7		133.9
Support to Clinical Staff	58.0		2,049.8
Total Non Medical - Clinical Substantive Staff		**241.1**	**6,107.3**
Medical and Dental Substantive Staff			
Consultants (including Directors of Public Health)	61.8		379.8
Career / Staff Grades	26.1		261.0
Trainee Grades	23.1		411.5
Total Medical and Dental Substantive Staff		**111.0**	**1,052.3**
Total Non Medical - Non-Clinical Substantive Staff		**89.9**	2,576.7
Total Substantive Staff		**442.0**	**9,736.2**
Bank Staff		28.8	0.0
Agency and Contract Staff		16.0	
Apprenticeship Levy		2.5	
Total Employee Expenses		**489.2**	**9,736.2**

Non-Pay Budget

19. All non-pay budgets have been uplifted for inflation of 1.7%, except for drugs which has increased by 0.4% in line with national planning assumptions.

20. Non pay inflation is funded in line with current guidance, this will be added as a ‘lump sum’ for divisions to allocate appropriately.

Non Pay Inflation	£000
Community & Intermediate Care	55.0
Corporate Services	370.9
Diagnostic & Clinical Support	431.2
Education, Research & InnovN	73.5
Estates & Facilities	553.6
Family Care	269.6
Medicine & Emergency Care	294.5
Surgical & Anaes Services	316.8
Primary Care	1.7
Total Non Pay Inflation	**2,366.8**

21. Inflationary pressures for Energy (5%), PFI Contract (5.3% RPI), Rent (5.3% RPI) and Rates (5.3%) are based on actual / best informed forecast to date.

22. The NHS Litigation Authority (NHSLA)/CNST annual premium has been confirmed at £26.0m for the coming year. This represents an increase of £2.5m; (10.74% up from 2023-24). This is a significant increase in year and higher than other Trusts in LSC. Additional income from the ICB if £1.2m has been allocated and reduces the pressure to £1.1m

23. The proposed non pay budget is shown below:

Operating Expenditure	£m
Purchase of Healthcare	4.9
Non-executive directors	0.2
Supplies and services – Clinical	48.2
Supplies and services - General	7.9
Drugs	46.8
Consultancy	0.3
Establishment	6.2
Premises	27.2
Transport	0.9
Depreciation	21.0
Amortisation	3.4
Movement in credit loss allowance on receivables and fin	0.2
Audit fees and other auditor remuneration	0.1
Clinical negligence	26.5
Research and Development	1.9
Education and Training	2.1
Lease Expenditure	4.7
Charges to Operating Expenditure	10.3
Other	0.4
Total Operating Expenditure	**213.3**

Income & Activity

24. The Income budget is shown below broken down by Patient Care Revenue and Other Operating Income.

	£m	£m
Income from Patient Care Activities	665.3	
Other Operating Income	29.2	
Total Income		**694.5**

25. All non-recurrent income streams are assumed to be recurrent whilst the ICB decides how they will be allocated under the new framework, including the Elective Recovery Fund, Virtual Ward funding and income related to Covid and Covid testing.

26. This means that there will be no additional income from LSC ICB for non-ERF activity over 2023-24 income levels in the February iteration plans. This also means that additional UEC monies are not reflected in our plans. System wide agreement on this will need to be made during forthcoming contracting meetings.

27. The same principles have been applied for non-LSC ICB income.

28. The Divisions have produced a realistic assessment of what activity could be undertaken in 2024-25, factoring in several productivity improvements which have been reflected in the final submission, summarised in the table below:

Activity Type	24-25 Activity
Day Case	**57,591**
Elective	**8,370**
Outpatient New	**204,400**
Outpatient Follow Up	**266,692**
Outpatient Procedures	**132,166**
A&E Total Atts	**253,741**
Non Elective - 0 LoS	**2,126**
Non Elective - 1+ LoS	**32,506**
Same Day Emergency Care	**44,803**

29. As in the previous financial year 2023-24 the divisions were allocated additional resources funded through ERF to support the Bridge Plan activity to be delivered. The plan has been costed at £7.4m and is detailed in Appendix A.

30. Convergence reflects the national policy of recovering funding from systems that are "overfunded" when comparing the current ICB allocation versus the national funding formula allocation. Pre-COVID, the LSC CCGs in aggregate were "on target". The ICB is now c6% over target, which equate to £206m at the end of 2023-24. The reason for moving from "on target" to "over target" in 4 years because of the additional funding put into systems during COVID. This has resulted in a further £5.8m reduction to the Contracts.

31. Tariffs have been uplifted in line with the ICB planning guidance and Patient Care Income is summarised below:

Income from Patient Care Activities	**£m**
NHS England	65.9
Integrated Care Boards	589.2
Total Commissioner Income	**655.1**
NHS foundation trusts	0.8
Local authorities	4.1
Non-NHS: private patients	0.2
Non-NHS: overseas patients (non-reciprocal, chargeable	0.4
Injury cost recovery scheme	1.5
Non-NHS: other	3.3
Total Income from Patient Care Activities	**665.3**

32. The 2024-5 Commissioner Income is categorised as follows:

	ERF	Non ERF Variable	Fixed	Other	Total Contract	Non Contract	Total
	£m	£m	£m	£m	£m	£m	£m
Lancashire & South Cumbria ICB ex Dental	111.3	35.3	405.3		**552.0**	19.6	**571.5**
Lancashire & South Cumbria ICB Dental	7.5		3.0		**10.4**		**10.4**
Greater Manchester ICB			0.0	4.5	**4.5**		**4.5**
West Yorkshire ICB			0.0	1.5	**1.5**		**1.5**
LVA ICB			1.3		**1.3**		**1.3**
Total ICB	**118.8**	**35.3**	**409.6**	**5.9**	**569.6**	**19.6**	**589.2**
NHSE Specialised Commissioning			0.0	57.7	**57.7**		**57.7**
NHSE Public Health incl DESP ex Dental			0.0	4.8	**4.8**		**4.8**
NHSE Central Team	0.0	3.4	0.0	0.0	**3.4**		**3.4**
Total NHSE	**0.0**	**3.4**	**0.0**	**62.5**	**65.9**	**0.0**	**65.9**
Total Commissioner Income							**655.1**

33. Included within the categories are the following points of delivery:

- ERF
  - Outpatient New
  - Outpatient Procedures
  - Day Case
  - Electives

- Variable non-ERF
  - Outpatient Radiology
  - Radiology Direct Access
  - Outpatient Procedures (no national price)

- Fixed
  - UEC (A&E, NEL and SDEC)
  - Outpatient Follow Ups
  - Pathology Direct Access
  - Block Contracts

34. Other operating income has been increased by 1.9% for 2024-25 and now totals £29.2m summarised below:

Other Operating Income	£m
Research and Development	2.2
Education and Training	17.0
Non-patient Care Services	5.4
Car Parking Income	1.0
Catering	1.2
Other Income	1.9
Donations of physical assets and peppercorn leases	0.5
Total Other Operating Income	**29.2**

35. Investment income of £703k is included in the Net Finance and Technical adjustments budget.

Service Developments

36. Following the successful tender, the 0–19-year-old service has been included from April 2024, this has assumed to be cost neutral.

37. The impact of the following service transfers are excluded at present apart from Diabetes, Complex Case and Lymphedema services (annual cost of £0.6m) which transferred over to ELHT from 1st March 2024 following a review of vulnerable services

    - BWD Adult Community Services
    - Albion Mill
    - ELCAS

Waste Reduction Programme (WRP)

38. The waste reduction programme has been increased to £57.8m which is 7.7% of Operating Expenditure, since the previous submission, to meet the control total. The target will sit in the divisions and the approach is hybrid approach. All reduction in expenditure in the divisions is aligned to a key delivery programme as shown below, work is ongoing to identify a full programme and the delivery of the programme.

Key Delivery Programme	Senior Responsible Officer	2024-25 000s
Urgent and Emergency Care Improvement	Tony McDonald	6,000
Elective Pathway Improvement	Sharon Gilligan	5,450
People Plan Priorities	Kate Quinn	6,250
Quality and Safety Improvement Priorities	Jawad Husain / Pete Murphy	3,863
eLancs Programme	Michelle Brown	1,000
Care Closer to home / Place based partnerships	Tony McDonald	800
Provider Collaborative	Kate Atkinson	3,500
Tackling Health Inequalities	Tony McDonald	0
R&D, Education and Innovation	Kate Quinn	1,025
BAU	Michelle Brown	10,223
Sustainability	Michelle Brown	3,403
Estates	Tony McDonald	3,500
TOTAL		**45,014**
Target (7.7% of Op Ex)		**57,787**
Unidentified		**-12,773**

39. The summary below shows category, progress of schemes and level of risk

Status	£000	WTE	%
Fully Developed	14,117	350.00	24%
Plans in Progress	23,322	215.00	40%
Opportunity	7,575	35.00	13%
Unidentified	12,773	0.00	22%
Total	**57,787**	**600.00**	**100%**

Risk	£000	WTE	%
Low	14,117	350.00	24%
Medium	43,670	250.00	76%
Total	**57,787**	**600.00**	**100%**

Category	£000	WTE	%
Pay	26,605	600.00	46%
Non Pay	18,409	0.00	32%
Unidentified - Pay	11,543	0.00	20%
Unidentified - Non Pay	1,230	0.00	2%
Total	**57,787**	**600.00**	**100%**

Category	£000	WTE	%
Pay (inc unidentified)	38,148	600.00	66%
Non Pay (ink unidentified)	19,639	0.00	34%
Total	**57,787**	**600.00**	**100%**

40. The 2024-25 WRP indicative divisional targets are noted as:

WRP Target (7.7%)	£m
Community & Intermediate Care	3.3
Corporate Services	4.2
Diagnostic & Clinical Support	8.5
Education, Research & InnovN	1.2
Estates & Facilities	5.0
Family Care	6.9
Medicine & Emergency Care	11.6
Surgical & Anaes Services	11.2
Primary Care	0.2
Central	5.7
Total WRP Target	**57.8**

41. Governance of the Waste Reduction programme has changed in 2024-25 with the Waste Reduction and Delivery and Assurance group now overseeing the programme by way of bi-weekly financial recovery meetings.

42. This group feeds into Finance Assurance Board which is chaired by the Chief Executive.

Budget pressures and developments

43. Through the annual budget setting round, budgetary pressures were put forward by the divisions.

44. The table below summarises the divisional financial expenditure position at month 11 after adjusting for WRP and pay vacancy factor:

2023-24 Divisional Expenditure	**M11 Var £m**	**FOT £m**
Community & Intermediate Care	(1.0)	(1.0)
Corporate Services	1.2	1.3
Diagnostic & Clinical Support	3.6	4.0
Education, Research & InnovN	2.3	2.5
Estates & Facilities	(4.4)	(4.8)
Family Care	(1.9)	(2.1)
Medicine & Emergency Care	(13.7)	(14.9)
Surgical & Anaes Services	(0.8)	(0.9)
Primary Care	(3.7)	(4.0)
Total 2023-24 Divisional Expenditure	**(18.3)**	**(20.0)**

45. Over recent years the annual budget at a divisional level is quite removed from the current run rate and 2023-24 outturn. To help with the message that we need to reduce expenditure and headcount a different approach has been agreed for 2024-25, realigning divisions budgets to the M11 Forecast outturn.

46. The following lump sum allocations are to be made to the divisions to align run rates and the budget. It is clearer to see any reduction in costs is aligned.

2024-25 Pressures Funding	FOT £m	Funding £m
Community & Intermediate Care	(1.0)	1.0
Corporate Services	1.3	0.0
Diagnostic & Clinical Support	4.0	0.0
Education, Research & Innov'N	2.5	0.0
Estates & Facilities	(4.8)	4.8
Family Care	(2.1)	2.7
Medicine & Emergency Care	(14.9)	14.9
Primary Care	(0.9)	0.0
Surgical & Anaes Services	(4.0)	4.0
Total 2024-25 Pressures Funding	**(20.0)**	**27.4**

47. Allocating the above pressures funding increases the budget to in line with the 2023-24 forecast outturn and any improvements in expenditure from this in 2024-25 can be taken as a WRP.

48. Pressures for funding in Family Care increases to £2.7m to take account of the ELCAS service transfer to LSCFT in July.

49. The financial plan in 2024-25 is the most challenging yet, hence the realignment of the annual budget in line with actual expenditure will assist in the ask to reduce expenditure in the financial year.

50. Any further future pressures should be covered by reducing expenditure elsewhere in the division.

Workforce

51. The workforce plan in March 2025 is 9,870 wte, this is a movement of 57 wte since the March submission. This is made up of an increase in the starting point from March forecast outturn and March actual position of 192.4 wte. The revised plan assumes a further wte reduction through WRP of 250 wte to mitigate the increase of 192.4 wte detailed below:

March Submission	Mar 24 FOT	Mar 25 Plan	Change from Mar 24
Staff Group	**wte**	**wte**	**wte**
Substantive	9,347.8	9,387.5	39.7
Bank	676.1	432.2	-243.9
Agency	170.7	108.8	-61.9
Total	**10,194.6**	**9,928.5**	**-266.1**
Change from previous quarter			**-266.1**
Service Transfers / One LSC			84.3
WRP WTE Reduction			-350.4
Total	**0.0**		**-266.1**

April Submission	Mar 24 Act	Mar 25 Plan	Change from Mar 24
Staff Group	**wte**	**wte**	**wte**
Substantive	9,422.4	9,232.2	-190.2
Bank	815.4	551.4	-263.9
Agency	149.3	87.3	-62.0
Total	**10,387.1**	**9,870.9**	**-516.1**
Change from previous quarter			**-516.1**
Service Transfers / One LSC			84.3
WRP WTE Reduction			-600.4
Total	**0.0**		**-516.1**

Movement between submissions	Mar 24 Act	Mar 25 Plan	Change from Mar 24
Staff Group	**wte**	**wte**	**wte**
Substantive	74.6	-155.3	-230.0
Bank	139.2	119.2	-20.0
Agency	-21.4	-21.5	0.0
Total	**192.4**	**-57.6**	**-250.0**
Net Movement			**-57.6**

Capital

52. The capital allocation available to Lancashire and South Cumbria distribution by Trusts has yet to be confirmed, the depreciation figures including are draft in this iteration.

53. The Trusts indicative plan is £36.1m.

54. The key investment will be the final phase of the Emergency Village development, The completion of the conversion of Trust Headquarters back into a clinical space and the next phase of the theatre electrical work.

55. The HASU and Hybrid Theatre schemes would be reliant on external funding.

56. Any other key developments would also be reliant on external funding.

57. As it stands, the ask of the capital programme exceeds the funding and will be agreed on a risk basis. The three workstreams, Estates, Digital and Medical Equipment are working on a three-year replacement capital programme,

2024-25 Draft Capital Plan	2024-25 Plan £000's
Estates	
Emergency village - ED Paeds and Majors into CCU (Urgent Treatment into CCU)	2,822
Emergency village - Coronary care and D Floor (514)	486
Emergency village - Electrical Infrastructure	215
Theatres electrical upgrade	1,376
CDC	324
HASU	2,205
TIF- Hybrid theatres	1,600
Trust HQ conversion	1,625
E&F Capital Staffing	320
Total Estates	10,972
Digital	
Total Digital	1,590
Total EBME	200
Total Contingency / Other	694
TOTAL	**13,456**
Right of Use Assets	
Total Right of Use Assets	20,084
Donated Assets	500
Total other	500
Total PFI Lifecycle Costs	2,123
GRAND TOTAL	**36,163**
FUNDING STREAMS	
Internally generated resources	
Use of cash reserves	9,209
Depreciation	24,412
Less: capital element of payments relating to PFI schemes	(13,966)
Less: IFRS16 adjustments	11,533
Less: annual loan repayments	(200)
Donations	500
Public Dividend Capital	4,675
GRAND TOTAL	**36,163**

Cash

58. Given the requirement to maintain a minimum cash balance of £2.5m and a cash balance of £11.6m as of 31 March 2024, the planned deficit for 2024-25 means that the Trust would need interim PDC revenue support equal to the planned deficit to maintain its minimum cash balance.

59. The key variable factor in the cash forecast is the total delivery of WRP and the level of cash releasing savings delivered. The table below summarises the best, likely and worse case scenarios on delivery of WRP and the impact on PDC required

	2024 - 25 Cash Forecast				2024 - 25 Cash Forecast		
	Best Case £m	Likely Case £m	Worst Case £m		Best Case £m	Likely Case £m	Worst Case £m
Status				**2024-25 Plan**	(30.3)	(30.3)	(30.3)
Fully Developed	14.1	14.1	14.1	WRP Target 2024-25	57.8	57.8	57.8
Plans in Progress	23.3	23.3	23.3	Unidentified WRP	0.0	(12.8)	(12.8)
Opportunity	7.6	7.6		Undelivered WRP	0.0	0.0	(7.6)
Unidentified	12.8			Non Cash Releasing WRP	0.0	(9.0)	(7.5)
Total WRP	**57.8**	**45.0**	**37.4**	**Total Shortfall in WRP Delivery**	**0.0**	**(21.8)**	**(27.8)**
Cash Releasing	57.8	36.0	30.0	PDC Required to maintain cash balance	(30.3)	(30.3)	(30.3)
Non Cash Releasing (20%)		9.0	7.5	Additional PDC Required	0.0	(21.8)	(27.8)
Total WRP	**57.8**	**45.0**	**37.4**	**Total PDC Required in 24-25**	**(30.3)**	**(52.1)**	**(58.1)**

60. Under the best-case scenario, the trust will need PDC equivalent to the forecast planned deficit. This assumes 100% delivery of WRP, and all the schemes are fully cash releasing

61. For the likely case, the assumption is unidentified WRP is not delivered and 80% of delivered schemes are cash releasing.

62. Worst case scenario modelling assumes unidentified WRP, and schemes currently shown as opportunity are not delivered and 80% of delivered schemes are cash releasing.

Key Risks

63. Key risks included within the financial plan, include
    - the level of efficiency (this would impact the finance and workforce plan)
    - inflation assumptions
    - the cost v income of Elective recovery,
    - the cost of non-Elective pressures; and
    - ongoing industrial action (this would impact the finance and workforce plan)
    - In year unplanned pressures

Conclusion

64. Following the recommendation from the Finance and Performance Committe on the 29th April 2024, the Trust Board is asked to approve the annual budget for 2024-25.

Appendix A – ERF Bridge Plan 2024-25

Division	Directorate	Scheme Summary	WLI	Bank / Locum	Existing Staff	Insourcing	New Case for 24/25	Total	Recurrent	Non Recurrent
Cases approved in 23/24 that will continue										
SAS	All	WLI in SAS (Reduced cost from last year)	1,300,000					1,300,000		1,300,000
SAS	Urology	UIU improvement case			221,413			221,413	221,413	
SAS	Elective Admissions	Additional staff to support activity			220,363			220,363	220,363	
SAS	ENT	Additional consultant			135,000			135,000	135,000	
SAS	Trauma & Orthopaedics	E-trauma system					50,000	50,000		50,000
MEC	Digestive Diseases	Endoscopy activity		497,000				497,000		497,000
MEC	Digestive Diseases	RDC nurses			140,000			140,000	140,000	
MEC	Digestive Diseases	Bank Consultant (replacing agency)		150,000				150,000		150,000
MEC	Digestive Diseases	Increased clinics/ RAS Gastro			54,000			54,000	54,000	
MEC	Cardiology	Bank band 2 admin			17,092			17,092	17,092	
MEC	Cardiology	Band 7 Technicians			119,702			119,702	119,702	
MEC	All	Medical secretary support		78,082				78,082	78,082	
MEC	All	WLI in MEC for those specialities not identified in additional below	240,000					240,000		240,000
FCD	Paediatrics	Consultant			228,729			228,729	228,729	
FCD	Gynaecology	Consultant			303,360			303,360	303,360	
Corp	RTT	Validation			78,296			78,296	78,296	
E&F	All	E&F costs to support activity		205,707				205,707	205,707	
DCS	Outpatients	To support activity		423,312				423,312		423,312
DCS	Radiology	To support activity		400,000				400,000		400,000
DCS	Pathology	To support activity		400,000				400,000		400,000
DCS	Pathology	Band 6 BMS in Histopathology			50,770			50,770	50,770	
DCS	Rheumatology	Band 6 Nurse 19 Hours			25,723			25,723	25,723	
DCS	Haematology	Band 7 Nurse 20 Hours			31,920			31,920	31,920	
DCS	Chronic Pain (Existing)	IPS contract - delivers 1008 daycase. Cost dropped from last year.				130,000		130,000		130,000
Total Cases approved in 23/24			**1,540,000**	**2,154,101**	**1,626,368**	**130,000**	**50,000**	**5,500,469**	**1,540,000**	**3,590,312**
New Bridge Plan cases for 24/25										
SAS	Gen Surgery	Gen Surgery Business Case to support 52 wks reduction and increase activity- 1 consultant					308,200	308,200	308,200	
SAS	Gen Surgery	Cancer Alliance funding - Additional BAN (Bowel Assessment Nurse) and Consultant 1 WTE - unfunded Cancer Alliance posts from April			291,300			291,300	291,300	
SAS	Maxfac	Case for 52 weeks delivery x 1 consultant					341,850	341,850	341,850	
SAS	Urology	2yr fixed term consultant		414,166				414,166		414,166
MEC	Gastro	Capacity Work	115,200					115,200		115,200
MEC	Diabetes and Endocrinology	Capacity Work	63,250					63,250		63,250
DCS	Rheumatology	WLI Capacity sessions (additional to last year) - 10 x supersaturdays included in plan	50,000					50,000		50,000
FCD	Gynae	Outpatient treatment as op Procs					41,000	41,000		41,000
FCD	Gynae	Addtional Gynae consultant and inpatient support team					250,700	250,700	250,700	
Total New Bridge Plan cases 24/25			**228,450**	**414,166**	**291,300**	**0**	**941,750**	**1,875,666**	**1,192,050**	**683,616**
Total			**1,768,450**	**2,568,267**	**1,917,668**	**130,000**	**991,750**	**7,376,135**	**1,768,450**	**4,273,928**

TRUST BOARD REPORT **Item** **70**

15 May 2024 **Purpose** Approval / Assurance / Information

Title	Draft Patient Experience Strategy 2024-27
Report Author	Mrs M Almond, Senior Patient Experience Facilitator and Mr B Williams, Assistant Director of Patient Experience
Executive sponsor	Mr P Murphy, Chief Nurse,

Summary: The strategy outlines the Trust's intentions and approach to engage patients, carers, the public and staff in supporting and influencing the Trust's approach to patient safety, care and experience.

Recommendation: The Board are asked to scrutinise, support and if acceptable, ratify the strategy delivery across the Trust.

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.
Related to key risks identified on Corporate Risk Register	N/A
Related to recommendations from audit reports	N/A

Related to Key Delivery Programmes	N/A
Related to ICB Strategic Objective	N/A

Impact

Legal	Yes	Financial	No
Equality	Yes	Confidentiality	No

Previously considered by: Quality Committee – April 2024

Draft Patient Experience Strategy 2024-27

1. Overview

1.1 The accompanying Draft Patient Experience Strategy 2024-27 sets out the Trust's conviction and aspiration to embed and build upon its engagement with patients, carers, the public and staff in supporting and influencing the Trust's approach to patient safety, care, and experience.

2. Current activity

2.1 The Trust currently draws upon several patient experience metrics that informs the organisation's fundamental understanding of how patient's and carers perceive their care and experience. Some of these metrics are Friends and Family Test feedback, National mandated surveys (Children, Maternity, Inpatient and Emergency Care), complaints, concerns, compliments, patient stories, and the bereavement survey. These patient experience touchpoints are monitored through the Trust's Patient Experience Group, but also inform other meetings such as the Patient Safety Group and End of Life and Bereavement Care Steering Group.

2.2 The Trust's focus on patient experience is also scrutinised, supported, and influenced by the organisations' Public Participation Panel, whose members are embedded in numerous corporate governance meetings that monitor the delivery of safe, personal, and effective care; in addition to service development initiatives. Furthermore, at any one time the Trust works collaboratively with patient representative organisations such as N-Compass (advocacy) and Healthwatch, to ensure the organisation genuinely remains patient-centric.

3. Development

3.1 One of the key aspirations of the Patient Experience Strategy is to bolster the influence of patients, carers, and other key stakeholders, through ensuring they represented in all decision-making governance meetings. Equally, those working with the Trust are properly briefed and engaged to pro-actively contribute to meeting discussions.

3.2 As you will note, the Strategy has considered the Trust's Quality Priorities in identifying key workstreams, such as improving the care, safety and experience of people who have dementia or a learning disability. As well as maternity and Interpreting and Translation services. In addition, to the introduction to Patient Safety Partners to augment PPP members contribution, and help the Trust address the expectation of patients against their actual experience.

3.3 The strategy will also explore how the Trust can develop the skills of the staff to consistently deliver good patient experience.

4. Recommendation

4.1 The Board are asked to scrutinise, support and if acceptable, ratify the strategy delivery across the Trust.

Barry Williams,
Assistant Director of Patient Experience

8th May 2024

East Lancashire Hospitals NHS Trust
A University Teaching Trust

ELHT Patient Experience, Engagement and Involvement Strategy

2024 – 2027

Engage

Influence

Safety

Contents

Foreword

Delivering the highest quality healthcare to our local communities is at the heart of everything we do. We pride ourselves in delivering **Safe**, **Personal** and **Effective** care that contributes to improving the health and lives of our communities and it is our aim to be in the top 20% of Trusts for overall patient experience.

At East Lancashire Hospitals NHS Trust, we understand that improving the experience for patients, carers and families is fundamental to everything we do.

Delivering excellent care requires the experience of our patients, carers, and families to be considered at every opportunity, and must be embedded in the leadership, culture and operational processes of the Trust.

This Patient Experience, Engagement and Involvement Strategy sets out our ambitions and key objectives to improve patient experience at East Lancashire Hospitals over the next 3 years.

Patients and carers can provide invaluable insights into the quality and delivery of care and through this strategy we detail how we will work collaboratively with patients, their carers and families and the public, using their knowledge of what the process of receiving care feels so we can drive continuous quality improvement and ensure our services are the very best they can be for our patients.

We look forward to working with patients, staff, carers, local communities and stakeholders to deliver this strategy.

Peter Murphy,

Chief Nurse

Martin Hodgson,

Chief Executive

Who we are:

As a leading provider of integrated healthcare services across East Lancashire and Blackburn with Darwen, we deliver a wide range of health services to a population of 566,000 people, many of which live in several of the most socially deprived areas of England. Our services cover an area of approximately 1,211 square kilometres.

We employ over 10,000 people, working across five hospitals and various community sites within our six geographical areas. These areas are Blackburn with Darwen, Burnley, Hyndburn, Pendle, Ribble Valley and Rossendale.

As well as providing a full range of acute, secondary and community services, the Trust is also a specialist centre. The specialist services provided are for hepatobiliary, head and neck and urological cancer services, as well as cardiology and vascular services. In addition, the Trust is a network provider of Level 3 Neonatal Intensive Care.

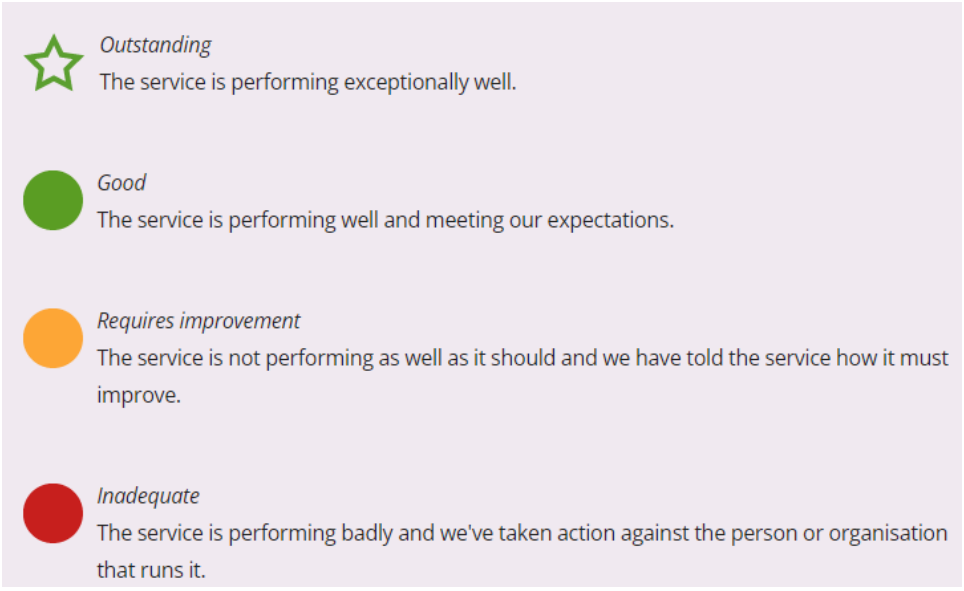
The Trust currently has 1,041 beds and treats over 700,000 patients a year from the most serious of emergencies to planned operations and procedures, using state-of-the-art facilities.

Our absolute focus on patients as part of our vision “to be widely recognised for providing safe, personal and effective care” has been demonstrated in the Trust’s continued progress and being rated ‘Good with areas of outstanding’ by the Care Quality Commission (CQC).

NHS CQC framework

The CQC assessment framework is built on their 5 key questions and well-known rating system and is what they use to set out their views of quality and make judgements. The CQC 5 standards are: safe, effective, caring, responsive and well-led.

There are 4 ratings the CQC give to health and social care services:



ELHT latest inspection: 28 August to 27 September 2018 - Report published: 12 February 2019

Domains	Rating	Scale
Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Requires Improvement	
Well-led	Good	
Use of resources	Good	
Combined Rating	Good	

ELHT Vision and Values – our aims

The foundation of the Quality Strategy 2023-25 is aligned to deliver the Trust's Strategic Framework captured below. Our vision and objectives are key to our operating principles and improvement priorities which help to guide the way we work and what we strive to achieve. Our values underpin those, ensuring our services are the very best they can be for our patients and our environments are respectful and supportive for all. The Patient Experience, Engagement and Involvement Strategy is a crucial strand in meeting the challenges of our aims.

We know that building upon the quality of care provided to our patients and communities will improve the chances of positive health outcomes. The Trust's Strategic Framework sets three overarching commitments.

Putting Quality at the heart of everything we do – Delivering Safe, Personal and Effective Care.

Our quality commitments focus on initiatives that will:

- **Provide Safe care** - Reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.

- **Provide care that is Personal** – Deliver patient-centred care which involves patients, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety.

- **Provide Effective care** – Deliver consistently effective and reliable care, based on best practice which is delivered in a culture that encourages and enables innovation to **Improve** outcomes.

As well as being closely aligned to the Quality Strategy 2023-2025, our Patient Experience, Engagement and Involvement Strategy is also supported by:

- Behavioural Framework Strategy
- Clinical Strategy
- Continuous Improvement Strategy
- Equality, diversity and inclusion objectives

What is patient experience, engagement and involvement and why is it important?

A patient's experience starts at the very first contact with the healthcare system and this includes their families, loved ones and carers who are also affected by the patient's experience.

Patient experience, engagement and involvement means taking every opportunity to hear from the people who use our services, their families, carers, and visitors and encouraging their active participation in shaping the way the Trust provides its services.

This includes involving people who use our services in decision-making about their care, seeking, listening to, and acting on feedback about their experiences in an inclusive way, and including people who use our services on boards and committees making decisions about changes and improvements to our services.

Engaging and involving patients, families, and carers will enable us to:

- Continually improve our services.
- Improve outcomes in patient care.
- Design more efficient services.
- Deliver care that people want in a way that works best for them.

How we do this

We actively engage with and encourage feedback from patients, their carers and supporters in a variety of ways, including:

- Friends and Family Test (FFT) and local patient experience surveys
- Patient stories / videos
- Participation in the national patient experience survey programme
- NHS website, Care Opinion, and social media
- Complaints, concerns, and soft intelligence
- Executive quality walk rounds & Senior Support and Share (SSS) visits
- Public Participation Panel (PPP)
- Engagement with students at local schools
- Healthwatch and local stakeholders
- Patient Led Assessment of the Care Environment (PLACE)
- Nursing Assessment & Performance Framework (NAPF) to assess the quality and safety of care being delivered within the organisation.

How do we measure this?

Success can be measured in several ways including:

Complaints – number received, themes and trends

Percentage of positive & negative FFT responses – themes and trends

Increased responses to FFT and local surveys

Number of compliments received

Evidence of increased co-production

Percentage compliance for the Patient Experience related elements of the N.A.P.F

Patient Safety Incidents

CQC inspections / rating

CQC National Inpatient Survey

6 key questions to improve

The Trust participates in the CQC national programme of patient satisfaction surveys which is designed to capture views of representative samples of patients in a systematic way from all eligible NHS Trusts in England. The survey is carried out every year and contains a set of questions designed and tested to provide insight into people's experiences and to highlight areas where individual providers could improve how they provide services.

The Adult Inpatient Survey samples 1250 consecutively discharged inpatients, working back from the last day of November who had a stay of at least 1 night in hospital.

Full benchmark reports for all Trusts are available on the CQC's website - https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey

It is our aim to be in the top 20% of Trusts for overall patient experience. In order to achieve this, the Trust will be focussing on the following areas to measure improvement:

1. **Admission to hospital – are patients being admitted and treated in a timely and effective way?**

2. **Food – are patients being provided with a choice of food to meet varying dietary requirements and are patients receiving the assistance they need?**

3. **Involvement - are patients and / or their family or carers involved in all conversations about their care and provided with information in a way that they can understand?**

4. **Environment / Cleanliness – are patients and / or their families / carers satisfied with the cleanliness of wards and departments?**

5. **Discharge from hospital – are patients, their family or carers involved in the planning and discussions about leaving hospital and provided with clear and understandable information?**

6. **Feedback – are all patients being provided with the opportunity to give their views on the quality of their care?**

Patient Experience Achievements

Our previous Patient, Carer & Family Experience Strategy 2018/2021 included objectives to ensure we listen and learn from patient and carer feedback. Although challenged through the pandemic, there have been many achievements, and this new strategy looks to build on those successes and strive to achieve further over the next three years. Achievements include:

- Supported by Healthwatch Blackburn with Darwen, worked with a group of young people to review and provide feedback on design ideas for the Children's Unit at Royal Blackburn Hospital, with the development of adolescent bays within the unit.

- Established links with a local secondary school, working with a group of students to develop a survey which they undertook with their fellow students, to find out what young people think about coming to hospital. Findings presented by the students to Executive Directors and senior staff at the Trust.

  As a result of the feedback from the students, the following actions have been taken:

  - Additional activities - The Trust Charity ELHT&Me have provided books and puzzles for patients.
  - Wi-Fi – installation of additional Wi-Fi boosters to improve the Wi-Fi on the children's medical unit and provision of an additional games console.
  - Food – changes to the menu, additional options, and snacks available.

- Worked collaboratively with colleagues in Estates & Facilities and Paediatrics to train students at a local high school to enable them to undertake mini-PLACE assessments (Patient Led Care Assessments of the Care Environment) on the Children's Unit at Royal Blackburn Hospital.

- The Paediatric Team have established links with a number of charities focusing on improving the patient experience for children and their families, including:

  - Sophie's Legacy, a charity set up in memory of Sophie Fairall, who sadly died aged 10 years old, to implement her wishes to improve the experience of children when admitted to hospital and their families. Sophie's wish was for 7-day play staff and for parent/carers to be offered meals - https://www.sophieslegacy.co.uk/

- Milly's Smiles, a charity established to help improve the journey of children newly diagnosed with cancer. More specific is the support the charity offers post bereavement for families which ELHT have the opportunity to signpost to. This support is available even if the child or young person had a different condition - https://www.millyssmiles.org/

- Established a Diabetes Youth worker to enable engagement with under-served young people with diabetes to improve health outcomes.

- Working with people with previous lived experience, implemented Hope Boxes – memory boxes which aim to minimise the trauma parents experience when they are separated from their baby at birth due to a court decision. The boxes help keep connection whilst final decisions are made, promote maternal identity, reduce stigma and promote choice and control. A National Safeguarding Star for outstanding practice from NHS England was awarded to the midwives who led this initiative.

- Introduced two Emergency Department Navigators to support young people between 10 – 30 years of age who attend with an injury relating to violence or who present with signs of criminal or sexual exploitation. The Navigators work with these young people to build a therapeutic relationship and provide support both inside and outside of hospital, with the aim to reduce serious violence in the local community and improve young people's lives.

- The establishment of a Public Participation Panel (PPP) in 2019 which is well embedded within the organisation. PPP members help the Trust build on established relationships between health professionals, patients, carers, and the public. They ensure we are putting the voice and needs of patients at the forefront of decision making and that the views of patients, carers and families are represented at all levels of the organisation. Members meet monthly and are actively involved in several meetings and projects, some of these being:

    - Nutrition and Hydration Group – working to ensure we consistently deliver and improve nutrition and hydration for vulnerable adults.

    - End Of Life Care Strategy & Operational Group – enabling our staff and developing processes to consistently deliver excellent care for our patients, and their loved ones during their last days of life.

    - Member of the core group which provided oversight and assurance in relation to the development and delivery of a high-quality care model for the rehabilitation of patients diagnosed with Covid-19, who as part of their hospital admission, required care in the Intensive Care Unit.

    - Member of the Trust's Patient Experience Group – contributing to the review, monitoring and challenge of patient experience at the Trust

    - Involvement in focus groups for the recruitment to senior Trust positions

    - Review of patient information leaflets

- Patient participation in a Bariatric Improvement Project Task and Finish Group aiming to improve the experience of care for bariatric patients admitted to hospital.

- During the pandemic, we formed an EHLT Stakeholder Experience Forum – which consists of several local patient representative groups; the overall purpose of the Forum is to ensure that East Lancashire Hospitals NHS Trust has a relationship with and understands the views of key stakeholders and enables them to influence the delivery and direction of the patient experience and complaints services to ensure high quality, effective service is provided to the satisfaction of users.

- We implemented Virtual Quality Walk rounds – these allowed members of the Executive Team and external stakeholders such as Healthwatch to speak to frontline staff and their patients throughout the pandemic. Learning about the staff's team morale, experiences, leadership, challenges, learning, compassion and what it's been like to be a patient receiving the service.

- Establishment of an End of Life and Bereavement Team providing a 7-day service, improving the patient experience and support available for families. The End of Life and Bereavement Team have:

    - Held a community engagement event with the local Muslim community to gather feedback and provide information and education around issues including DNAR CPR.
    - Introduced volunteers to sit with patients who are dying and who don't have any family members.
    - Developed and launched a bereavement survey to capture feedback from families about the quality of care provided in the last days of life.

- Our Chaplaincy & Spiritual Care Services offer a 24/7 service across all hospital sites, to meet the pastoral, spiritual and religious needs of patients and their families/carers. They have:

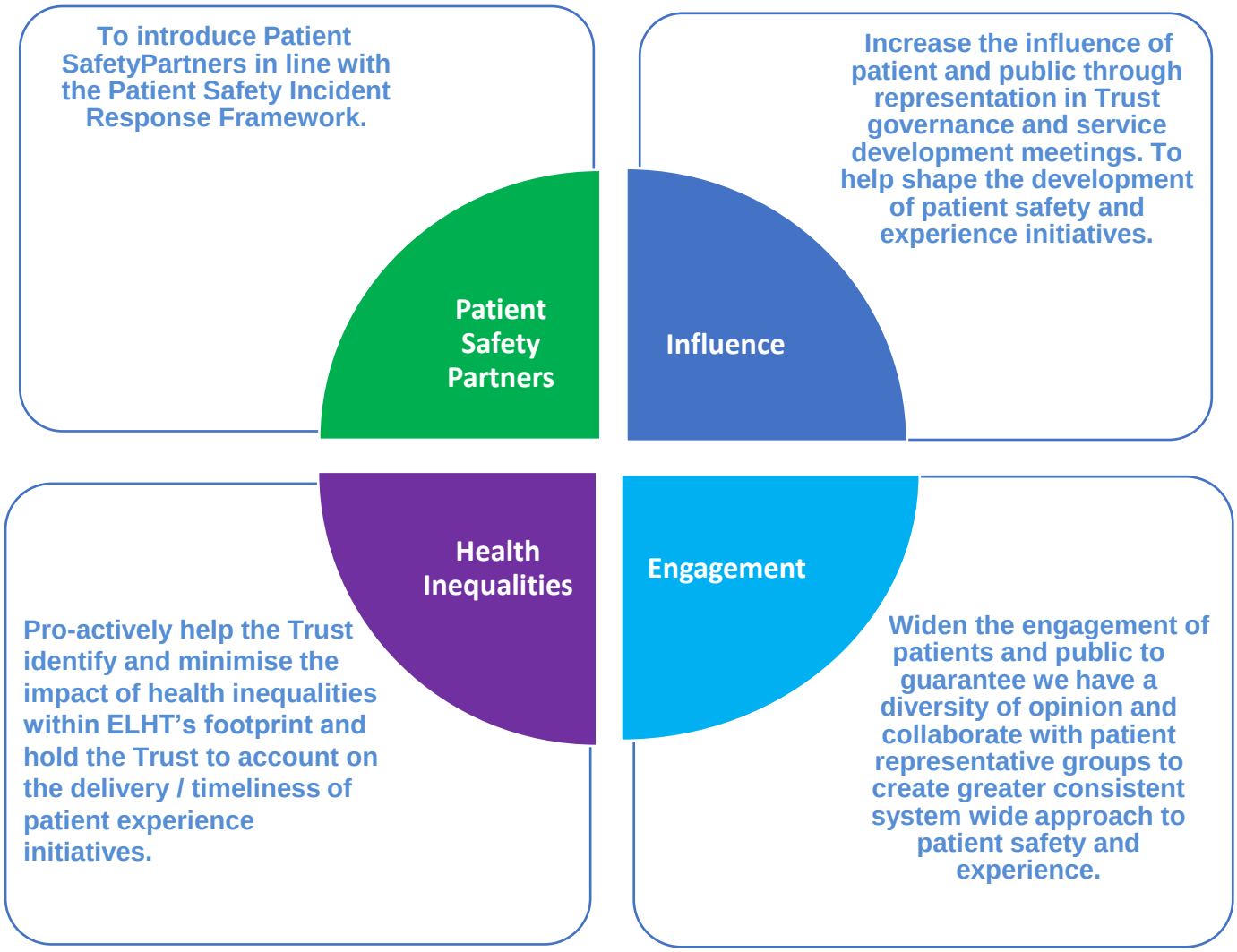
    - Developed a new Spiritual Care Centre at Burnley General Hospital.
    - Seen an enhancement of the Therapy Dog Service which in the year to December 2023 has seen Alfie (the Therapy dog) visit over 1200 patients at the bedside, across 400 ward visits.
    - Introduced the "Friendly Faces Volunteer Project" which provides for a volunteer to visit patients who do not have any family or close friends to visit them. This reduces isolation and loneliness, provides emotional support and a listening presence.

- The Alcohol Care Team have:

    - Recruited a volunteer as a patient representative on the Alcohol Steering Group.
    - Worked collaboratively with Healthwatch Lancashire to gather qualitative feedback and information from service users.

Our framework at a glance

Our Framework for 2024-2027 is focused on setting out our aims to develop and strengthen our collaborations with our communities and their influence in delivering our four key aims that support the Involvement/Personal aspect of the Quality Strategy.



Consultation with Partners

In developing this strategy, it was important for us to consider what our existing quantitative experience metrics were indicating and equally, to focus our attention on the qualitative metrics provided by our patients, the public, external key stakeholders, such as Healthwatch, and staff. Through this approach we can best identify how and where we allocate the Trust's human and financial resources to obtain the greatest benefit for our consumers and staff.

We engaged the key stakeholders who helped shape the Trust's 2018-21 strategy to tease out what we needed to strengthen within our current patient experience work. Also, to identify what new matters required attention.

The engagement sessions were carried out via Microsoft Teams due to the then Covid-19 pandemic restrictions in place. We were joined by representatives from Healthwatch Blackburn with Darwen, and Lancashire; Blackburn with Darwen Carers Service; East Lancashire Hospitals NHS Trust Public Participation Panel and Bangor Street Community Centre, Blackburn.

The overarching themes / requests from the discussions were:

- For the Trust to ensure it continues to provide meaningful responses to project reports with action plans that we revisit within an agreed period of time.

- For patient and carer representative groups to meet regularly and be part of engagement plans that the Trust would like them to look into – this may be commissioned, or not, depending on agreement from management.

- ELHT to collaborate with patient and public advocacy groups to promote and share key messages for each other's services through approaches such as leaflets, events, and website.

- The Trust to continue to identify and support carers and in doing so, increase referrals to carers services; to ensure they are part of the treatment and discharge planning and for carers to be treated as expert by experience in the care of their loved ones.

- ELHT to continue to listen and respond to the needs of children with Special Educational Needs and Disability (SEND) and their parent/carers.

- To ensure patients and carers are consistently included in decisions of wellbeing around physical and mental health.

- The Trust to continue to develop a consistently high-quality care for patients with dementia; a learning disability, or who are on the autism spectrum disorder (ASD).

- The Trust to continue to develop effective and supportive hospital discharge which both the patient and their family/carers feel involved in.

- Effective engagement and involvement with our LGBTQ+ community

- Sharing learning from patient stories and complaints more visibly with patients and the public so that they can see the Trust as a learning organisation.

- Proactively working with the local community, patient representative organisations and staff to remove health inequalities.

- To ensure there remains a diversity of patient and public opinion within the Trust that influences service provision and development.

- Triangulate patient experience data with other governance data, including Legal Service to strengthen a full understanding of patient experience.

What Matters To You?

What matters to you aims to encourage more meaningful conversations between staff, patients, families, and carers to gain a better understanding of the things that are really important in people's lives to facilitate and improve the patient experience.

Focussing on what really matters to people can have a big impact. It can help establish relationships, and helps staff understand the person in the context of their own life and what is important to them, helping them work together to identify the best way forward.

The Trust is currently re-designing the "behind the bed" boards to capture specific demographics and patient safety alerts. In addition, there will be space for patients to contribute what they expect the organisation to deliver around their specific personal goals.

Our Patient Experience & Involvement Implementation Plan

1. Engagement

Our Aim: To continue to strengthen what we know is important to our patients, their relatives, and our staff in terms of the care and experience provided. Whilst we know quantitative data gives us a particular insight, we won't simply stop there, as we seek to develop our understanding of patients', and relatives, overall interactions within the Trust, community health and social care ecosystems. We remain committed to strengthening patients, carers and patient representative groups influence, thus ensuring a genuine telling impact in the delivery and development of our services.

How can we achieve this?	How can we measure success?
Community Engagement • Proactively engage with patients, the public and key stakeholders collaborating with charities, religious and patient representative organisations. • Strengthen and widen the diversity of the Trust's engagement and collaboration within the local community through direct and indirect outreach work. • Support and influence staff to consistently engage with their patient groups and external stakeholders; developing their understanding of how best undertake patient experience surveys and involving patients on the identified actions from the feedback.	Evidence of increased engagement of third sector organisations within the Trust, influencing service and policy developments, presence at governance and committee meetings. Engagement and collaboration with a wide range of local community groups. Up to date internal SharePoint page providing staff with best practice guidance and information regarding patient and carers engagement.

Public Participation Panel • Grow the membership of the Trust's Public Participation Panel to help broaden their participation in more decision-making meetings and development projects. • Work with Voluntary Services Team regarding the recruitment of PPP members. • Liaise with ELHT Communications Team for support to actively promote the role and contribution of PPP within ELHT to patients and the public.	Evidence of active participation of PPP members in decision making meetings and development projects. Increased membership of Panel, representative from the communities within the East Lancashire footprint. Increased awareness of PPP activity in the patients and the public and staff through the Trust website and staff intranet
Stakeholder Forum • Increase the membership of the Trust's EHLT Stakeholder Experience Forum; the Forum is comprised of patient representative organisations. The Forum provides an opportunity to share initiatives, work on collaborations and raise emerging themes regarding the patient and carer experience within the Trust's services.	Broad representation and participation of patient representative organisations Membership of the group is diverse and representative of people in the local community.
Carers • Engage with carer organisations and Trust staff to build upon the engagement of carers in the care of the patients they represent. • Develop information for carers to signpost to available services.	Greater carer satisfaction experience. Reduction of incidents involving patients who have carers. Contribution to a Carers Charter for the regional Integrated Care Board & local Carers Charter in place. Information leaflet for carers Information on Trust website
Digital Technologies • Work with staff to explore and utilise digital technologies to help engage and patients and the public. • Utilise Performance and Informatics and Communications Team to support engagement and share information with our patients and carers of hospitals services.	Staff will have an understanding and ability to utilise different digital technologies to support their patient engagement activities. Evidence of digital technologies incorporated in patient surveys and engagement. The number of views on the website. An increase in patient and public engagement and awareness of the Trust activities

End of Life Care and Bereavement • Ensure staff understand the features of the new electronic patient record (EPR) which support end of life / bereavement care. • Ensure that each dying patient has an "individual plan of care" in place which reflects their wishes and those of their loved ones. • Strive to achieve the patients place of care and place of death • Facilitate rapid end of life discharges from the hospital to patients preferred place of care • Development of a nursing individualised plan of care after death document. • Utilise the data from EPR regarding Last Days of Life care plan. • Use patient experience data to inform and improve end of life and bereavement care. • Hold regular engagement events / meetings to support local communities.	The new EPR supports optimal end of life and bereavement care. NACEL Audit (Hospital) District Nursing Community Dashboard Feedback relating to end of life and bereavement care. Dashboard to capture all information & feedback relating to end of life and bereavement care established. Information utilised to identify common themes and trends to ensure improvement work is focused on the right aspects.

2. Influence

We know that encouraging patients, carers, and the public to be involved in their treatment and provision of care can enhance outcomes, perceptions, and experience for patients, carers, and their relatives.

Our Aim: to strengthen the patient, carers, and the public voice, in their day-to-day interactions with staff, through to increasing their presence in corporate and divisional meetings at all levels.

This approach aligns with the NHS National Patient Safety Strategy in "involving patients, their families and carers and other lay people in improving the safety of NHS care".

How can we achieve this?	How can we measure success?
Partnership Working & Co-Production • Work with staff to support best practice in providing meaningful engagement opportunities for patients and the public. Those opportunities for partnership working will be communicated via the Trust website and other communication channels, including via external partners. • Where appropriate, patient / public representatives will be involved in appropriate groups and meetings throughout the Trust.	Evidence of promotion of partnership and engagement opportunities. Evidence of increased patient representatives in Corporate and Divisional meetings. Evidence that the outcomes from patient involvement activity have

• We will brief and support participants on how to gain the most of their attendance and empower them to pose the 'why' question. • Co-production - Improvement work will be supported by using patient views and involving service users from the start to the end of projects that affect them. • Quality Improvement Team to identify projects and develop a process for patient involvement. • We will work with our patients and patient representative groups to influence and drive improvements to patient care and experience with our colleagues within Lancashire and South Cumbria Integrated care systems. • We will implement a formal "you said, we did" programme to drive listening and improvement. • Review the process for recruiting patient and public assessors to support the Patient Led Assessments of the Care Environment (PLACE).	been taken into consideration in the decision-making process. Evidence of increased co-production with patient representatives fully involved in projects from beginning to end. Evidence of action resulting from feedback. Pool of patient, public and staff assessors available to undertake PLACE assessments.
Children and Young People • Provide opportunities for children and young people to contribute to shaping and improving services that affect them; continuing to work with local schools across the ELHT footprint and with CAMHS, parents and carers, local authorities and children representative organisations in supporting the involvement and to ensure a diverse representation of health needs. • Fully embed the process for students from local schools to participate in mini-PLACE assessments across all children's areas. • Develop and embed a process for children and young people to be involved in the recruitment of staff to child focused roles. • The Right to Choose – support 16/17-year-old patients to have a say in whether they are treated in an adult or children's ward, and ensuring they receive the right care from the right team. • Encourage a more direct focus on parental feedback, reviewing feedback to identify themes and improvements. • Paediatric Team to continue working with:	More children and young people are directly participating in key organisational aspects such as patient safety, experience, training, and recruitment. Students from local schools / colleges invited to participate in the annual PLACE assessments. Children and young people led focus groups incorporated into the recruitment process. Greater parental satisfaction experience

○ Sophie's Legacy in collaboration with our Quality Improvement Team to implement the aims and wishes, particularly the provision of 7-day play specialists and food for parents. ○ Milly's Smiles to develop post bereavement support to parents and siblings.	Patient data feedback Improved experience for bereaved families
Development of staff We will seek to influence the development of managers within the Trust to ensure they remain conscious of best practice in terms of patient engagement in all aspects of service developments and delivery.	Best practice in patient engagement is integrated into all levels of leadership training within the Trust.

3. Patient Safety Partners

The Trust has aligned the Quality Strategy with the NHS National Patient Safety Strategy (July 2019) in doing so we have adopted the framework for involving patients and the public in patient safety. We consider this a fundamental aspect of genuinely having patients and the public influence every facet of how the Trust view and deliver care to patients, interacts with their supporters and staff.

The framework sets out how NHS organisations should involve patients in patient safety.

There are two parts to the framework

- Part A: Involving patients in their own safety
- Part B: Patient safety partner involvement in organisational safety

(Source: NHSE)

Patient Safety Partners are patients, carers, family members or other lay people who are recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation.

The role of a Patient Safety Partner (PSP) is to:

- Support a culture which is 'patient-centred'.
- Support the development of high-quality patient and public engagement.
- Work collaboratively with Trust staff to identify problems and apply creative and innovative thinking in developing solutions.
- Actively influence the strategic direction of the Trust.

Progress to delivery

In April 2022 we started to lay the foundations of the implementation of Patient Safety Partners within the Trust. In doing so we established links with Trusts who were in advance in their introduction of PSPs; to understand the challenges and approaches required to bring the roles into realisation, whist sharing best practice.

We commenced with briefing staff and external patient representative organisations about PSPs and approached community groups, charities, religious organisations.

We have received firm expressions of interest from people who come from a wide diversity of experiences. As we move towards the implementation stage, we are confident that our PSPs will provide the Trust with a degree of challenge, representing the patient voice, through various activities in safety governance.

Our Aim: To have members of the public support the Trust's delivery of the Patient Safety Incident Response Framework.

How can we achieve this?	How can we measure success?
Ensure that Patients are involved at the heart of the Patient Safety Incident Framework (PSIRF) PSPs will work closely and collaboratively with a range of staff for particular areas of work and projects.	Complete recruitment, induction and welcome of Patient Safety Partners. • PSP participation and involvement in trust wide projects • PSPs will be embedded into the various safety committees and groups that support patient safety. • PSPs will support ad-hoc advisory groups as and when required to support patient safety improvement projects. • PSPs Working with teams and services to consider how to improve safety. • PSPs Involvement in relevant staff patient safety training. • PSPs membership of safety and quality committees whose responsibilities include the review and analysis of safety data.

4. Health Inequalities

What are health inequalities?

The term health inequalities is used in many ways but essentially it refers to the systematic disparity in the health care people receive or the status of sections of the populations health due for instance to their economic situation.

Health inequalities are often preventable, unfair and can have detrimental effects on an individual / communities such as:

- Poor quality and experience of care, resulting in low levels of patient satisfaction
- Substandard differences in health outcomes due to systemic discrimination

Lancashire & South Cumbria have some of the highest rates of socio-economically deprivation in the North West and nationally. This places a greater emphasis on the Trust to proactively work with patients, the public, external organisations, and the regional Integrated Care Systems (ICSs) and Integrated Care Board (ICB) to identify and minimise health inequalities.

Connecting with diverse sections of our local community is pivotal in our renewed attempts to minimise health inequalities. Through this partnership we can develop approaches that produce the most meaningful outcomes, whilst balancing short, medium, and long-term actions.

Our Aim: To pro-actively help the Trust identify and minimise the impact of health inequalities within ELHT's footprint.

How can we achieve this?	How can we measure success?
• We will contribute to and support the Integrated Care Board (ICB) with new approaches to tackling health inequalities. • We will actively identify key priorities through collaboration with patient representative	Through the establishment of a Health Inequalities Committee, identify key priorities to address health inequalities.

organisations, voluntary, statutory, and private sectors • Analysis of patient experience quantitative and qualitative data from sources such as concerns, complaints, internal and external surveys, risk and incident data, Friends and Family Test, and audits will help inform where we target our resources. • We will work with the Equality, Diversity & Inclusion team to ensure the protected characteristics of the patients we care for are consistently captured by staff, to assist the Trust's understand of who is having what type of experience.	Working with partners on health initiatives to address health inequalities. The number and type of initiatives that ELHT are participating in. Increased responses to FFT and local surveys from patients with protected characteristics.
Interpreting and Translation Services • Easy to follow booking guidelines to be available on OLI and by QR Code • Feedback to learn from patients lived experience of using interpreters. • Rectify Technological challenges for video interpreting, for example, availability of IT Kit • Access to training to be delivered in-house, covering the whole scope of services on offer and how to use services more efficiently, supporting trust waste reduction programme (WRP) • Training to be available to staff 24/7 via improved online offer, slide deck presentation, guidance notes, learning packages. • Complaints will be taken seriously and escalated to the provider. • Re-establish the Accessible Information Standards (AIS) Group	• Reduced incidents relating to translation. • Increased staff and patient satisfaction with interpreting service. • Feedback from training sessions • Improved KPIs: 95- 97% for spoken word; 99% for BSL. • More uptake of service offer • Complaints will be investigated and reported on Improved communication with patients in languages and formats that enable them to be fully involved.

Learning Disability & Autism

It is well known that people with Learning disability and/or autism have historically experienced inequality when accessing health services (and continue to experience worse outcomes than people who do not have a Learning disability and/or autism (4th Annual Report from LeDeR, 2020).

Our ELHT Learning Disability & Autism Delivery plan 2024-2029 has been produced by the ELHT learning disability and autism nursing team following consultation with key stakeholders in East Lancashire Hospitals Trust and self-advocate groups from across Blackburn and Darwen and East Lancashire. The plan is informed by information collated from the NHS England and NHS Improvement Learning Disability Improvement

Standards and Learning from lives and deaths - People with a learning disability and autistic people (LeDeR): Action from learning report 2021/22.

The delivery plan sets out our how ELHT will drive improvements for patients with a learning disability and or autism and for whom care is often complex and admissions to hospital challenging.

Our Aim: To improve the care and experience of people with learning disabilities and autism. In doing so, minimise those patients featuring in accounts of poor experience and incidents.

Key Actions	Measure of success and impact
Respect and protect people's rights: • We will have a flagging system that informs patient care. • We will promote the use of Hospital passports. • We will record your reasonable adjustment needs. **Ensure inclusion and engagement:** • We will participate in the completion of the national patient survey, respond to complaints and facilitate opportunities for patient feedback via local self-advocate events. **Develop our work force:** • Provide training for our staff in Learning disability and autism. **Promote patient safety:** • We will continue to work collaboratively with the regional and national LeDeR team by contributing to the mortality reviews and action any recommendations made by the LeDeR and to improve patient safety of people using our services. • We will respond to national patient safety guidance that support the needs of people with Learning disability & autism	Local learning disability and autism care documentation audit as well as completion of The NHS England – Learning Disability Improvement Standards. The monitoring of compliance with our mandatory training requirement will be provided to our safeguarding committee.

2024-2027 Dementia Delivery Plan

We strive to ensure our that our most vulnerable patients and their supporters receive consistently good care and experience. Our Dementia Delivery Plan seeks to improve the experience of people living with dementia and their carers.

The strategy is still in the engagement phase and is likely to change as time goes on.

Objective: Improve the experience of people living with dementia and their carers by raising the quality of care delivered and access to support.

Intended Outome: Improved care and experience of people living with dementia and their carers, reduction in the incidence of harm and poorer outcomes for this patient group.

Key Actions	Measure of success and impact
1. Improve identification and diagnosis of people living with dementia Improve the flagging / identification process of people living with dementia. Contribute to a project that also identifies carers within ELHT settings. Improve access to diagnosis of dementia and post-diagnostic care. **2. Improve the quality of care and reduce harm for people living with dementia in hospital settings** Creation of a dementia dashboard to monitor the incidence of harm occurring to people living with dementia using ELHT services, analyse themes and action inconsistencies in care. Improve access to meaningful activity within ELHT. Continue to promote dementia friendly environments across ELHT by completing PLACE assessments, NAPF assessments and utilising dementia friendly design tools. Ensure research opportunities are offered to people living with dementia and their carers.	Measures of success include: Local Dementia care documentation audit as well as contribution to the National Audit of Dementia. The monitoring of compliance with our mandatory training requirement will also be provided to our safeguarding committee and the Dementia Strategy Group. The desired impact of delivering these objectives will improve the experience of people living with dementia and their carers who use ELHT services. If successful, there will be a higher rate of diagnosis and referral into support services in our patient population. There will also be a reduction in harmful incidence and an increase in advance care planning discussions. ELHT's workforce will also have a greater ability to meet the needs of people living with dementia and their carers by being upskilled in line with national training frameworks.

3. Listen, involve and engage people with dementia and their carers Improve access to third party organisation referrals. We will respond to complaints and facilitate opportunities for patient feedback via local self-advocate events. **4. Develop a skilled and effective workforce to champion compassionate, safe, personal and effective care** Provide training for staff in line with the Dementia Standards training framework. Ensure Dementia Champions are empowered to act as advocates for people living with dementia. **5. Improve Advance Care Planning, palliation and end of life care for people with dementia** Increase the number of Goals of Priorities of care / Advance Care Planning discussions provided across ELHT People living with dementia who are reaching the end of their life will be referred to the palliative care team and reviewed within 24 hours.	

Emergency Department Patient Experience strategy

The extreme challenges facing the Urgent and Emergency Care system do impact on the ability to meet patients' needs in a timely and effective way.

The Urgent and Emergency care system is a complex system with an array of different factions and multiple organisations and providers. There is no 'one size fits all' cure to make the system better, nor one single solution that will improve it.

Our healthcare teams are doing all they can to ensure patients are provided with the right care, in the right place, at the right time. However, there needs to be a constant review of what patients are telling us, and how we can support their needs whilst managing their expectations.

Our Aim: to meet patient expectations and deliver information to our patients in a different way, whilst simultaneously reviewing and learning from patient feedback

How can we achieve this?	Measure of success?
Information & Communication Develop information / improve communication for patients, family and carers regarding the patient journey – what to expect, what will happen when they attend the Emergency Department / Urgent Care Centres	Information on Trust website is easily accessible and up to date Visual displays in the Urgent Treatment centres / Emergency Department. Screens in the department displaying patient information about the patient journey / who is who. Development of a patient information leaflet. Second telephone for relatives to manage demand. Call bells for each corridor space within the Emergency Department
New Emergency Department footprint To develop a suitable, fit for purpose and high-quality environment that supports the delivery of the outstanding urgent and emergency health care services, improving patient flow and supporting patient-centred care.	Patients are streamed through the most appropriate pathway. Reduction in unnecessary admissions Reduction in formal complaints Increase in positive FFT feedback
Patient feedback / concerns and complaints Ensure that patients / relatives / carers have the opportunity to raise any concerns whilst they are in the department and that these are dealt with and resolved there and then. Staff to contact patients / relatives & carers to discuss concerns and complaints over the telephone with the aim of a quick resolution. Patient experience feedback is reviewed monthly to identify any themes and trends and areas for improvement.	Introduction and promotion of “Tell me today” campaign. Reduction in formal complaints Matron or Assistant Matron visible in the department Mon-Sunday between the hours of 07:00-18:00 so patients, relatives and staff can ask questions or raise issues/successes. Increase in positive responses for FFT
Workforce Review and support junior workforce with expectations and standards	Plan developed and implemented to support and manage behaviours and expectations

Maternity & Neonatology Patient Experience Strategy

The objectives are informed by the requirements within key national reports and programmes; Mat Neo 3 Year Plan Theme 1: 'Listening to Women and families', CNST Safety Action 7 'User Feedback, and Equality & Equity: Guidance for local maternity systems.

		Intended Outcome	Key actions and Measures	
Objective 1	Empower maternity and neonatal staff to deliver personalised care by having the time, training, tools, and information required.	Staff who are trained and confident to deliver personalised care with effective use of the EPR systems to record and monitor this. *(3 Yr Plan Theme 2 & Theme 4)* Adequate time within consultations to allow for personalised discussions to take place. *(3 Yr Plan Theme 1)*		● E-learning module specific to use of Badgernet/ Badgernotes EPR to support staff to utilise the system effectively specifically the Support Conversations to record Personalised Choices & Care **^ Measures: Staffing training compliance, staff confidence using the system to ensure direct, standardised discussions with patients take place to ensure personalised care plans are completed throughout their pregnancy journey.** ● Review of key consultations to assess if adequate time is available to hold personalised discussions, where extra time is identified workforce review to reflect this to ensure all time is accounted for and staffed appropriately. **^ Measures: Consultation time available X average time of personalised care discussions & workforce modelling** **Objective Outcome Measure: (Ockenden 1 IEA5 Q30) Audits of care records to ensure personalised care is reflected in the actual management plans.**
Objective 2	Ensure that women are provided with practical support and information that reflects how they choose to feed their babies.	Sustainability plan to continue with achievements aligned to the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding. Maternity services achieved this accreditation in 1998	THE BABY FRIENDLY INITIATIVE unicef UNITED KINGDOM	● Continue to enhance the feeding information available via continuous improvement work e.g. the Infant Feeding Postnatal Discharge Digital Video and the Neonatal Breast Milk Expressing Diary. **^ Measures: Results of the Mother Audits** **Objective Outcome Measure: Results of Annual Experience of**

		with GOLD status in 2017 as the first in the UK to do so with successful re-accreditation to date. Neonatology achieved BFI full accreditation in 2022. *(3 Yr Plan Theme 1)*		**Care Maternity CQC Survey related questions B15 'during your pregnancy did midwives provide relevant information about feeding your baby?' E03 'Did you feel that midwives and HCPs gave you active support and encouragement about feeding your baby?'**
Objective 3	Work with Maternity and Neonatal Voice Partnerships (MNVPs) to ensure all groups are heard, including those most at risk of experiencing health inequalities.	MNVP will have a clear understanding of the demographics of our service users and therefore established links into key communities to provide consistent feedback to our services. Focus on BAME, Bereaved Families, Neonatal Families, High Deprivation areas. *(3 Yr Plan Theme 1/ CNST SA 7)*		● Develop alongside the MNVP the workplan of priorities for the upcoming year identifying key co-production projects informed by this. **^ Measures: No of achieved projects X MNVP service user feedback** ● Continue to support MNVP lead / representatives to identify service users with lived experience to attend relevant forums to provide feedback including use of the engagement sessions schedule and feedback tracker. **^ Measures: No of sessions attended/ communities reached by MNVP lead/s and quality of feedback received and evidenced to analyse and inform key themes for co-production.**
Objective 4	Provide services that meet the needs of the local populations, paying particular attention to health inequalities.	Service data and feedback collated and analysed by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds and improve care. *(3 Yr Plan Theme 1/ CNST SA2)*		● Dashboard/ reporting portal in development to include breakdown of key data by ethnicity & deprivation deciles. **^ Measure: No. of key maternity & neonatal metrics which can be analysed by ethnicity and deprivation decile groups. Quality of ethnicity data with the EPR system as monitored by the MSDS CNST Safety Action 2.** ● Monitor data showing use of language translation services via DA Languages Services and ensure needs are being met in terms of resources being available in key languages for our population/ translation services available for care contacts. **^ Measures: MNVP feedback, DA languages data of service use, CQC survey annual feedback, incidents/ complaints relating to translation needs.** ● Monitor training delivered to staff

				specific to use of language and translation services **^ Measures: Staff training compliance and staff confidence in using translation services and aiding service users with language needs**
Objective 5	Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.	Maternity & Neonatal service will have a clear understanding of the demographics of our service users to ensure we have representative feedback to our services to inform service transformation. Focus on protected characteristics and Core20PLUS5. *(3 Yr Plan Theme 1)*		● Stillbirths and Neonatal Deaths Society (SANDs) peer review (2024/25) to take place of Maternity & Neonatology services to inform of any required improvements to the bereavement services **^Measures: Peer review results and improvements achieved.** ● Use of feedback from various channels such as; MNVP feedback, complaints/ incidents/ claims triangulation, Maternity CQC survey, Friends & Family Tests to identify overall themes and therefore prioritise co-production work to improve the overall patient experience of the Maternity and Neonatal Services. **^ Measure: CNST Safety Action 9 reporting of service using the Perinatal Quality Safety Measures minimum data set.**
Objective 6	Provide information to service users in accessible formats to support all above objectives and enhance service users ability to make informed choice and decisions in their care.	Information provided to women across a variety of formats: leaflet, website, Badgernotes push notifications, posters in key areas etc. will meet the requirements of the Accessible Information Standard *(3 Yr Plan Theme 1)*		● Adhere to robust governance processes for the consistent review dates of patient information leaflets, ensuring they are available in accessible formats. **^ Measure: Number of leaflets available X review dates of contents X languages resource is available in.** ● Effective website upkeep via an embedded update schedule managed by the Maternity & Neonatal Project Support Officer in liaison with clinical leads across the service **^ Measure: Number of website pages and log of update dates/ content changes. Peer review of website content by MNVP representatives as per Ockenden 1 ask.**

Martha's Rule

In all we hope to achieve through this strategy, ensuring the voice of the patient, their carers and supporters, and staff to maintain safety is amplified is our main thread. For this reason, the Trust is proud to introduce Martha's Rule from 1 April 2024.

"Martha Mills (pictured) died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to promptly, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier". (NHS England)

From this and other similar tragic losses associated to the management of deterioration, comes the implementation of 'Martha's Rule' by the NHS England, to "ensure the concerns of the patient and those who know the patient best are listened to and acted upon" (NHS England February 2024).

The Trust's has called this escalation, 'Call for Concern' and the process has been rolled out across inpatient settings only, including information on the Trust's Intranet website, and posters around the organisation. It is hoped this approach will provide another level of assurance for patients, their supporters and staff.

How can we achieve this?	Measure of success?
Develop information / improve communication for patients, family, and carers regarding Martha's Rule – what to expect, what will happen when they use the call line.	Information on Trust website is easily accessible and in different languages. Call for Concern posters visible on all inpatient wards. Monitoring of contact/cases and feedback from users of the service reviewed within the Trust's Patient Experience Group and Nursing and Midwifery Forum.

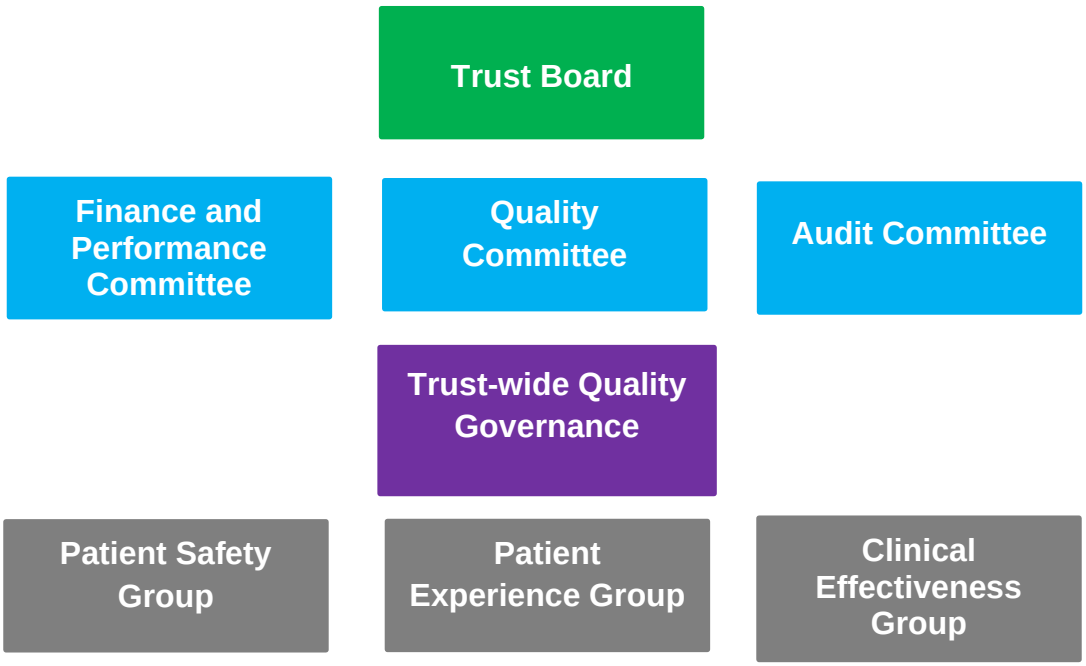
Monitoring Patient, Carer and Family Experience

This strategy is applicable to all areas of the organisation. The Trust expects that all staff will embrace this strategy and demonstrate the key principles through the care and service that is delivered, whilst demonstrating Trust values in all that we do.

Assurance Monitoring

Quality Governance is the combination of structures and processes both at and below Trust Board level to ensure and assure the quality of our services, together with systems to monitor and assure the Trust Board of Directors. These are listed below.

Progress and performance against this strategy will be monitored through the Patient Experience Group and reported through the Trust-wide Quality Governance to Quality Committee.



Board of Directors

The Board of Directors has overall responsibility for the services that we deliver and is accountable for operational performance as well as the implementation of Strategy and policy. A quality dashboard is reported monthly to the Board of Directors as part of the Integrated Performance Report (IPR). Where possible we include performance indicators to measure and benchmark our progress against each quality improvement priority and local quality indicators.

Quality Committee

The Quality Committee provides assurance to the Trust Board of Directors in respect of clinical quality and patient safety, effectiveness and experience through robust reporting and performance monitoring.

Trust Wide Quality Governance (TWQG)

The progress of each priority is reported on a quarterly basis to the Trust-wide Quality Governance Group which reports monthly into the Quality Committee. Operational implementation of the commitments will be monitored routinely through the Patient Safety, Patient Experience and Clinical Effectiveness Groups which report monthly to TWQG. Divisional representation and Heads of Corporate services are standing members on the TWQG.

Patient Experience Group

Established as a sub-Group of the Trust Wide Quality Governance this is the group responsible for providing assurance that there is effective monitoring and oversight of patient experience across all spheres of Trust activity and that improvement of patient experience is at the heart of the work of the Trust. Chaired by the Trust's Deputy Chief Nurse, it is the Trust wide operational focus for accountability for patient experience for quality governance within corporate and the Divisions.

This group combines an overview focus on complaints management with feedback from patients and their carers/families. This group monitors the Friends and Family Test results, Annual Patient Survey feedback themes and links with key partners such as Healthwatch to maintain direct links with community groups.

Glossary of terms

Accessible Information Standards (AIS) – a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

Board / Committee – standing committees that are subsidiaries of the Board of Directors (Trust Board)

CAMHS – Child and adolescent mental health services

Collaboratively – Two or more people or groups working together

Commitment – an agreement or pledge to do something in the future

Communities – a group of people that have a particular characteristic in common

Co-production – working in partnership with patients, their carers, staff and wider partners

Care Quality Commission (CQC) – the independent regulator of health and social care in England

Data – facts and statistics collected together for reference and analysis

Digital – electronic technology

Electronic patient record (EPR) – a method of storing medical records and notes electronically

Evidence – the available body of facts or information indicating whether a belief or proposition is true or valid

Feedback – the transmission of evaluative or corrective information about an action, event or process to the original or controlling source

Friends and Family Test (FFT) – created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. A quick and anonymous way to give views after receiving NHS care.

Healthwatch – an independent body who have the power to make sure NHS leaders and other decision makers listen to feedback and improve standards of care

Health Inequalities – the unjust and avoidable differences in people's health across the population and between specific population groups

Integrated Care Board (ICB) – a statutory body with responsibility for NHS functions & budgets.

Integrated Care Systems (ICSs) – geographical partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, coordinate and commission health and care services

Objective – a thing aimed at or sought; a goal

Patient Engagement – the facilitation and strengthening of the role of those using services as co-producers of health, and health care policy and practice.

Patient Experience – what the process of receiving care feels like for the patient, their family and carers.

Patient-Led Assessment of the Care Environment (PLACE) – a yearly inspection of the non-clinical aspects of healthcare settings undertaken by teams made up of staff and members of the public (known as patient assessors

Protected Characteristic – in the Equality Act 2010, nine characteristics were identified as protected. These are characteristics where evidence shows there is still significant discrimination in employment, provision of goods and services and access to services such as health

Public Participation Panel (PPP) – a group of patients, carers and members of the public who work with the Trust to ensure we are putting the voice and needs of patients at the forefront of decision making, and that views of patients, carers and families are represented at all levels of the organisation

Patient Safety Partners (PSPs) - patients, carers, family members or other lay people who are recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation

Stakeholder – a person with an interest or is affected by something, an employee, service user, supplier or investor

Strategy – a plan of action designed to achieve a long-term or overall aim

Survey – is a method of gathering information and feedback using relevant questions

Theme – an underlying message, subject or idea

Trend – a general direction in which something is developing or changing

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East Lancashire Hospitals NHS Trust
A University Teaching Trust

NHS England

NHSE People Promise Exemplar Programme

An introduction and overview for the Trust Board

15 May 2024

Executive Summary

These slides provide the Trust Board with background on the People Promise Exemplar Programme. The Trust was selected to be part of Cohort 2 and as such we have had investment from NHS England for a post to support the activity for 12-months. Our Executive Director of People and Culture, CEO and Chair all supported our application.

The origins of the People Promise belong to the NHS People Plan and the engagement activity carried out with staff about what matters to them. The aim is to improve employee experience and retention, which was an increasing concern as the NHS with vacancy gaps, challenges in retaining experienced colleagues, and newly qualified staff, particularly during their first two years.

Cohort 1 was very successful nationally, with reduction in leavers and turnover, and improvements across staff survey people promise themes. In our system LSCFT (cohort 1) saw significant improvements in their staff survey (e.g. an increase of 5% in those recommending the Trust as a place to work).

Our People Promise Manager will coordinate and lead a programme of work for 12 months based on self-assessment and analysis of data. As part of a regional and national Network, Jane Wilkinson will share best practice and use QI techniques to see if through our implementation of the People Promise we can make a positive impact on a range of measures. This supports our people plan priorities.

Our 90-day submission to NHS England outlines the priorities that we will take forward and includes a detailed project initiation document (See appendix 1).

The Board is asked to:

- Note the benefits of the People Promise Programme and the requirements of the national programme
- Review and approve our PP priorities that were submitted at the 90-day (along with the PID)
- Note the feedback that we have received from various groups in respect of positioning the People Promise
- Help us to land, socialise and progress the PP programme.
- Receive regular reports through the People and Culture Committee on our progress aligned to the national reporting schedule.

People Promise Exemplar Programme

Key points:

- Nationally funded NHS England programme.
- Application made in 2023 with HRD, CEO and Chair support.
- Selected organisations funded for a Band 8A People Promise Manager (PPM), to support implementation of bundles of actions based around the People Promise.
- Support and sharing of best practice across regional and national PPE organisations.
- Intention to create sustainable cultures and systems where people stay and thrive; therefore, improving retention. This aligns to the requirements of the Long-Term Workforce Plan.
- Programme started with 90-day improvement cycle in February 2024.
- Funding runs for 12 months from appointment of PPM,
- Jane Wilkinson appointed to role and commences on 01/05/24.
- Role will report into the Transformation OD & Inclusion team and the ICS Retention SRO with accountability to the NHS England Regional Retention Manager and ultimately the NHS England National Retention Programme.
- Governance will be through Staff Sponsorship group and People & Culture Committee.
- The People Promise Manager will also report to the Executive Directors until the Executive SRO returns to work.
- Provides opportunity to pilot, test, embed and align retention and engagement activities linked to current priorities.
- The programme has proven benefits including on leaver rates, retention and staff survey. This supports our priorities for 2024/2025 from a people and culture perspective.
- LSC system – LSCFT improved staff survey and leaver rates, nursing employer of year, developed business case to retain PPM.
- The Trust is required to submit its 90 day return and take forward an agreed bundle of activity.

The People Promise came from NHS staff

- The **People Promise** was launched in July 2020 in the People Plan 2020/21
- It is based on significant staff engagement on the basis that they are the experts on what it is like to work in the NHS
- It aligns with other research such as the government's Good Work Plan (2018) in response to the 2017 Taylor review of employment practices in the UK
- In 2021 the NHS Staff Survey (completed by 648,000) was redesigned to align with the 7 elements of the People Promise, alongside Morale and Engagement.
- The **NHS Long Term Workforce Plan** sets out how we must build on the actions in the NHS People Plan, and make the People Promise a reality for all our staff.

People Promise

This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone.

The themes and words that make up Our People Promise have come from those who work in the NHS. People in different healthcare roles and organisations have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace.

For many, some parts of the Promise will already match their current experience. For others, it may still feel out of reach. We must all pledge to work together to make these ambitions a reality for all of us, within the next four years.

The people best placed to say when progress has been made are those who work in the NHS. From 2021 the annual NHS Staff Survey will be redesigned to align with Our People Promise.


BOARD LEVEL OWNERSHIP AND ENGAGEMENT
1
2
3
4
CONTINUOUS QUALITY IMPROVEMENT APPROACH
ENSURING EQUALITY AND DIVERSITY
?!
RELATIONSHIPS, PEER LEARNING AND COLLABORATION
EIGHT DRIVERS FOR RETENTION - WHAT CAN EMPLOYERS DO TO HAVE THE BIGGEST IMPACT ON STAFF RETENTION?
ENSURING YOUR APPROACH TO STAFF EXPERIENCE AND THE NHS PEOPLE PROMISE FOSTERS RETENTION
DEDICATED RESOURCE AND CAPACITY
%
DATA-DRIVEN APPROACH
EQUIPPING LINE MANAGERS AND COMPASSIONATE LEADERSHIP
NHS Employers
Published March 2024 © NHS Employers nhsemployers.org
Lim

People Promise Exemplar Programme

Understand root causes & challenges of retention → **Develop evidence-based solutions aligned to the People Promise** → **Measure impact and use the evidence base to drive further improvement**

Cohort 1 - 23 Trusts (4 NW)
Cohort 2 – 116 Orgs (14 NW)

- Appoint a People Promise Manager
- A range of NHS Trusts
- All 7 regions

National evidenced-based assessment tool

- A structured approach to develop local bundle
- Agreed set of priorities

Engagement and Communications

- Agenda anchored at Board Level
- Exec Roundtables
- Present at national events
- Visits to exemplar trusts

Spread & Scale

- Develop economic case
- Develop case studies/blogs/films
- People Promise in Action Week
- People Promise Accreditation
- Business as Usual

5 |

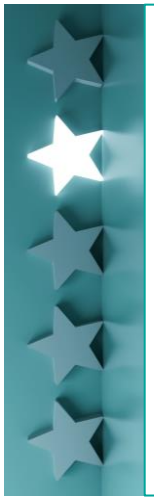
North West Cohort 2 | Pennine Care FT | Manchester University Foundation Trust | Bolton NHS Hospitals NHS Foundation Trust | Wirral Community NHS Foundation Trust | Warrington & Halton NHS Trust | East Cheshire NHS Trust | Cheshire & Wirral Partnership NHS Trust | Countess of Chester NHS Foundation Trust | NW ICBs joint bid | University Hospitals of Morecambe Bay | Blackpool Teaching Hospitals NHS Trust | East Lancashire Hospitals NHS Trust | North-West Ambulance Service | Liverpool Women's NHS Foundation Trust

People Promise Exemplar Impact – Cohort 1

Em Wilkinson-Brice – NHSE Director for Staff Experience and Leadership Development

"Hypothesis was, that through the Exemplar Programme, a bundle of interventions can have a demonstrable impact on retention.

This has been proved, with a dedicated person in place, board and Exec buy in and organisational commitment, change and improvement is possible."



Drivers for success

- ✓ **Board level ownership and engagement**
- ✓ Self-assessment process and data-driven approach
- ✓ Quality improvement approach
- ✓ Relationships, peer learning and collaboration
- ✓ Flexibility and tailoring of the process.
- ✓ Dedicated resource
- ✓ People Promise Bundle
- ✓ Access to relevant data and resources

Cohort One Successes

- ✓ Stay conversations introduced
- ✓ Flexible working increases
- ✓ Flexible working surgeries
- ✓ Lower vacancy rates
- ✓ Improved rest facilities
- ✓ Improved informal engagement
- ✓ Suggestion & innovation forum
- ✓ Improved recognition practices

National headline achievements

- ✓ On average, all-staff leaver and turnover rates in exemplar orgs reduced more than that of non-exemplar orgs.
- ✓ Programme achieved a 12.9% reduction in leaver rate after 6 months of implementation, this decreased slightly to 9.1% and 10.4% at the 12 and 16 month marks, respectively.
- ✓ Exemplar leaver rates declined faster than non-exemplars.
- ✓ 16 out of 23 Trusts exemplar Trusts saw improved staff survey results across all PP elements and themes

All Cohort One have a sustainability plan to continue the work and many have now successfully made the business case to make their people promise managers permanent.

90 day Improvement Process

We are here

30 day (end Feb)	60 day (end March)	90 day (end April)
Data review including NHSE self assessment tool / staff & NPP surveys / exit questionnaires, leaver reasons / rates / turnover data. Other relevant data.	Map strengths / challenges across the people promise, agree high level bundle of priority areas for focus by the PPM. Complete summary data & high-level plan return to NHSE. (see slides 4 & 5 for template return.	Finalise and submit delivery plan/Project Initiation document outlining plans for the 12-month period, including baseline metrics.

ELHT 60 day summary report

Outcome of Data review

Self-Assessment Tool key themes:

- Low level of progress across a number of questions, all linked to inconsistency (and sometimes lack of) 1-1's between line managers and their staff. Also linked to lack of information / insight into reasons for leaving and lack of proactive retention conversations.
- Whilst Flexible working has been heavily promoted, progress towards our ambition of reaching level 5 on the Timewise Flexible Maturity Curve (organisation encourages and celebrates Flex) is slower than anticipated. Variation across the Trust with some areas still at level 2 (accommodates when requested).

Self-Assessment Tool key themes:

- High rate of turnover from staff aged 21-30, with reason for leaving for 46% of this cohort not recorded.
- Higher number of leavers in certain staff groups:
  - Add Prof Scientific and Technic
  - Additional Clinical Services
  - Administrative and Clerical
  - Estates and Ancillary

Staff Survey results areas of focus:

- Flexible working – slight improvement in overall organisation satisfaction against Flex scores, however this varies significantly across Divisions.
- 2 questions score lower than national average.
- Answers to all questions relating to 'Your manager' rated lower than national average scores in respect of "We are compassionate and inclusive"
- As a staff group, significant lower levels of satisfaction from Healthcare Scientists across a number of PP domains, particularly low for appraisals / we are always learning scores.
- High levels of burnout from we are safe and healthy scores for nursing and midwifery staff group.
- For all protected characteristic groups reported, relatively high number of staff preferred not to identify and across all characteristics, these groups show lower levels of satisfaction than Trust average.

Any other data source key themes (exit questionnaires, additional focus groups):

Only 17% of colleagues leaving ELHT in Q1-3 (2023/2024) completed **Moving On Surveys** – limited insight into reasons for leaving which does not help focus retention activity.
- reflects low engagement around retention

WRES – inclusive recruitment and career development

WDES - presenteeism, reasonable adjustments, reporting of B&H

From Q4 **NQPS** scores (unable to drill down on Model Hospital Data):

NQPS scores	Data period	Provider value	Peer average	National value
Employee Engagement score	Q4 2023/24	6.5	6.6	6.5
Advocacy score	Q4 2023/24	6.2	6.5	6.4
Involvement score	Q4 2023/24	6.8	6.7	6.4
Motivation score	Q4 2023/24	6.5	6.7	6.7

ELHT 60 day summary report

Outcome of Data review

Key findings:

- Inconsistency / lack of 1-1's between line managers and their staff.
- Limited insight into reasons for leaving and lack of proactive retention conversations. Only 17% of colleagues leaving ELHT in Q1-3 (2023/2024) completed Moving On Surveys.
- Progress towards ambition of reaching level 5 on the Timewise Flexible Maturity Curve, slower than anticipated. Slight improvement in overall organisation satisfaction against Flex scores, however this varies significantly across Divisions. 2 questions score lower than national average.
- Staff survey answers to all questions relating to 'Your manager' rated lower than national average scores in respect of we are compassionate and inclusive.
- As a staff group, significant lower levels of satisfaction from Healthcare Scientists across a number of PP domains, particularly low for appraisals / we are always learning scores.
- High levels of burnout from we are safe and healthy scores for nursing and midwifery staff group.
- For staff grouped by protected characteristic, high numbers of staff 'preferred not to' disclose and for all of these groups, satisfaction levels were significantly lower than organisational average.
- High rate of turnover from staff aged 21-30, with reason for leaving for 46% of this cohort not recorded.
- Higher number of leavers in certain staff groups:
  - Add Prof Scientific and Technic
  - Additional Clinical Services
  - Administrative and Clerical
  - Estates and Ancillary

ELHT 60-day summary report

Identified projects / themes for People Promise Manager

We are compassionate and inclusive:

Lead on key (priority) development sessions to be included in new Management Development pathway programme, to include:

- Awareness and benefits raising of ways to engage and lead compassionately and inclusively:
  - expansion of flexible working (including spread and scale of existing Flex approaches)
  - regular 1-1's, linked to launch of new appraisal approach (including review and spread and scale of new approach to 1-1's / STAY conversations/ wellbeing conversations)
  - understanding of managers role in supporting retention (including STAY conversations and understanding reasons for leaving/ wellbeing passport)
  - importance of creating sense of belonging and understanding (and promoting disclosure of) protected characteristics, linked to inclusive recruitment and supporting reasonable adjustments.

We are always learning:

Understand culture and workforce related work already underway with Healthcare Scientist team:

- Provide additional support as needed linked to learning and appraisals.

We are recognised and rewarded:

Investigate (through listening and engagement activity) retention risks with 21-30 year old colleagues and identify solutions.

We are safe and healthy:

Investigate opportunities to support work of wellbeing team and Clinical Lead for Retention, Resilience and Experience in reducing burnout for nursing and midwifery colleagues in a defined area as a pilot.

Exemplar Cohort 2 Timeline 24/25

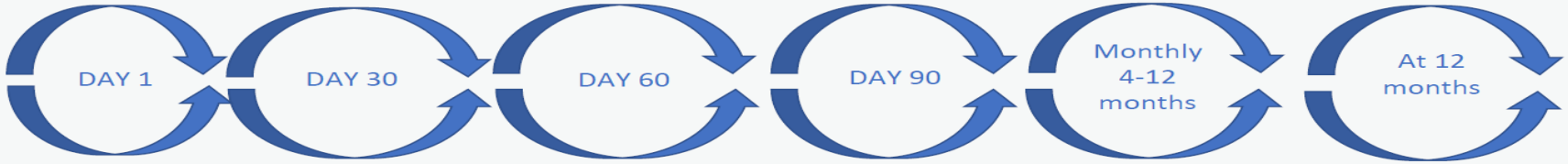
Key: National Team | Regional Team | Trust/PCN

Jan 24 | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25

Cohort 2

- SAT & Intervention Refresh
- Launch Event
- Educational Webinars
- MOU
- Funding Transfer
- Programme Launch
- People Promise Manager Recruitment
- People Promise Manager CoP and SRO CoP
- Ongoing support for organisations/Systems including sessions with PPMs and wider stakeholders
- Monthly reporting through regional team: highlight report to include relevant impact metrics

Programme Lifecycle – Key steps



Key system outputs required

DAY 1	DAY 30	DAY 60	DAY 90	Monthly 4-12 months	At 12 months
Signed off outline delivery plan / critical milestones.	• Local diagnostic completed using assessment tool and data deep dive – summary of key retention focus areas, hot spots for organisation and local drivers shared.	• Retention drivers fully understood, and People promise 'priorities' identified. Mapped on a 'driver diagram' / logic model. Draft plan shared and feedback provided.	• People promise implementation plan / PID shared and agreed for remaining period. KPI's confirmed including tracking of the NHS leaver rate.	• Monthly brief highlight report reviewing progress, risks, issues and outcomes.	• End of programme review started (*to include KPI progress and outcomes). Establish BAU processes to continue to provide retention focus, reporting through to your People Board.

Regional teams to provide monthly update to relevant People Board and National team on month 1-4 milestones.

Regional teams to review highlight reports, assess relevant metrics and provide regional update to National team.

Share learning, case studies and impact. Commitment to Regional and National communities of practice.

People Promise Exemplar

- **Socialisation and awareness**
  - How can we all get behind this work to have maximum impact?
  - Building the awareness of people promise and having an impactful campaign
  - People Promise induction for line managers
  - Leadership and management newsletter
- **Sustainability and alignment**
  - Alignment to wider people agenda – updated people plan 2024/25
  - Staff survey action plan and sponsor group
  - Building the business case for post 2025/26 – cohort 1 Trusts had funding for 2 years and many have made the case for the role sustaining beyond the programme.

Introducing our new People Promise Manager

People Promise

"My name is Jane Wilkinson and I am currently the Head of HR for ELHT and I am also the Chair of the Mental Health Network. From the 1st May I will be taking on the new and exciting role of People Promise Manager for the Trust.

The new People Promise Manager roles are funded by NHSE and are intended to accelerate and uphold the NHS's commitment to its workforce in individual organisations, centred around promoting employee well-being, inclusion, engagement, satisfaction and drive cultural change to improve in these areas. This role serves as a bridge between management and frontline staff, ensuring that the Trust's promises and commitments to its workforce are not only upheld but also continuously improved upon.

116 People Promise Managers have been appointed across the country, with 14 of these in the North West region. This provides me with the opportunity to collaborate and share best practice with colleagues and organisations both regionally and nationally, as well as support from NHSE leads over the 12 months of the project. I am really looking forward to this challenge and working with as many colleagues, staff organisations and networks as I can to progress our commitment to the People Promise.

My first priorities are to

- *do an honest assessment of where we are as an organisation in relation to the People Promise;*
- *identify what good work has already been done that we can build on;*
- *identify where we can make a real difference to our colleagues working lives and also*
- *to look to see what we can learn from other Trusts.*

I hope you will join me in this journey and spare me 5 minutes of your time to talk to me about your experiences when you see me in your workplace and meetings. But also feel free to contact me with any ideas, thoughts, invitations to join your team discussions and any feedback".

Thank you,

Jane

Did you know that the staff survey results report performance by People Promise theme?

These results are available by Trust, Divisions, Services and Teams. We can also see performance through other lenses such as protected characteristics.

Take a look here

Feedback so far:

- People promise brand awareness
- How we position considering current challenges (retention v's workforce reductions etc.)
- Inclusion of flexible retirement info in the flex offer and guidance and support for line managers

The People and Culture Committee are asked to:

- Note the benefits of the People Promise Programme and the requirements of the national programme
- Review and approve our PP priorities that were submitted at the 90-day (along with the PID)
- Note the feedback that we have received from various groups in respect of positioning the People Promise
- Help us to land, socialise and progress the PP programme.
- Receive regular reports from the PPM on our progress aligned to the national reporting schedule.

Thank you

TRUST BOARD REPORT **Item** **72**

15 May 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)
Date Paper Approved by Executive Sponsor	7 May 2024

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 six of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. (Appendix 1 - CNST year 6 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 and programmes 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 with celebrations noted.

Recommendation: The Board of Directors are asked to.

- Receive and discuss the CNST-MIS update, all compliance reports, and recommendations for year 6 quarter one
- Provide bimonthly reporting to ELHT trust board with any barriers that may impact on the implementation and longer-term sustainability plans and deliverables aligned with the maternity and neonatology safety
- Discuss any safety concerns with Trust board members aided by floor to board agendas further guided by the Executive and non- executive board safety champions.

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

1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South

Related to key risks identified on Board Assurance Framework		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 six 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

Green indicates progressing without concern

Orange indicates barriers/ risk to compliance identified

Red indicates non-compliance identified

Safety Action	Progress	Progress update to present & Comments
1. Perinatal Mortality Review Tool (PMRT)		● All deaths from the 8th of December 2024 (start of the Y6 reporting period) required deadlines have been met with 100% compliance. See dashboard in report below. ● Q4 PMRT report submitted to Trust Board. This covers Jan-Mar 2024 reporting.
2. Maternity Services Data Set (MSDS)		● July 2024 will be the month reviewed for compliance of this safety action. ● Continued review of the published scorecard monthly. See most recently published monthly dashboard below.
3. Transitional Care (TC)		● Q4 TC Audit Jan-Mar complete and submit to Trust Board. ● Main cause of term admissions to NICU identified via audit is respiratory disease – further audit and QI (Quality Improvement) work commenced.
4. Clinical Workforce		● Locum SOPs (Standard Operating Procedure) in place aligned with CNST Y5 requirements. ● Q4 Jan-Mar 2024 Consultant attendance audit complete. ● Anaesthetic team have been briefed with requirement to produce 1 month rota evidencing compliance to ACSA standards. ● Neonatal Nursing workforce action plan to be continued as submitted to Trust Board during CNST Year 5 reporting period. ● **Identified risk** – Neonatal Medical workforce. CNST Year 6 includes requirement for the consultant rota to meet BAPM standards. It has been identified that an action plan will need to be complete for this ask.
5. Midwifery Workforce		● Birthrate+ exercise was completed using August-October 2021 data and the final report was published September 2022. This therefore meets compliance of being within previous 3 years. ● **Identified risk** - Current staffing budget does not reflect established identified via Birthrate+ as required. Action plan is in place as per CNST Year 5 and Business Case remains in progress. ● Birthrate+ acuity app continues to monitor compliance with supernumerary labour ward co-ordinator and 1:1 care in labour. Substitute coordinator added for CNST year 6 with a defined escalation plan.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 81% overall implementation. ● Further progress and sustainability of current implementation continues with close oversight from Obstetrics Clinical Director.
7.User Feedback		● MNVP workplan 2024-25 is currently under review by MNVP lead – to be ratified May 2024. ● Engagement schedule in place for MNVP lead to attend sessions and gather feedback.

		● **Identified Risk -** Review of MNVP capacity and a deputy MNVP lead role to engage with community and gain feedback underway with Healthwatch to ensure ELHT have equitable resource. ● 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) (Friends and Family Test) results. ● Themes identified via the above group are shared with MNVP lead for co-production of improvements.
8. Training		● Fetal Monitoring training, multi-disciplinary emergency training (PROMPT) and Newborn Life Support training all monitored for required attendance via this safety action. ● **Identified Risk:** a formal plan will need to be in place demonstrating how a minimum of 90% of neonatal medical staff who attend neonatal resuscitations have a valid resuscitation council NLS certification by year 7 of MIS and ongoing. Currently our FY2 junior doctors, of which there are 8 each rotation, do not hold this certification.
9. Board Assurance		● Floor to Board bi-monthly meetings with Board-level, maternity, and neonatal safety champions in place. ● Perinatal Quality & Surveillance Model (PQSM) March 2024 data set submitted with additional rationale regarding 3rd&4th degree tear data. ● Triangulation of claims, incidents, complaints – update included ● Culture Improvement plan – update included
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Assurance from governance leads that all requirements for MNSI reporting are met.

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 PMRT Cases

* 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	Jul-2[illegible]	Aug-2[illegible]	Sep-2[illegible]	Oct-2[illegible]	Nov-2[illegible]	Dec-2[illegible]	Jan-2[illegible]	Feb-2[illegible]	Mar-2[illegible]
SAFETY ACTION 1	PMRT01a	Total Number of Stillbirths (= 24 weeks)		2	1	1	1	2	1	1	1	1
	PMRT01b	Number of Neonatal Deaths		2	2	0	0	3	1	0	1	1
	PMRT01c	Number of late fetal loss between 22+0 and 23+6 weeks		0	0	1	0	0	0	0	1	0
		Total Eligible Cases		4	3	2	1	5	2	1	3	2
	PMRT02a	a) i Number of cases reported to MBRRACE within 7 days		4	3	2	1	5	2	1	3	2
			100%	100.0%	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		4	3	2	1	5	2	1	3	1
			95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	*
	PMRT05a	c) ii Number PMRT published reports by 6 months		4	3	2	1	3	0	0	0	0
			60%	100.0%	100.0%	100.0%	100.0%	60.0%	*	*	*	*
	PMRT05c	Number PMRT published reports not due		0	0	0	0	2	2	1	3	2

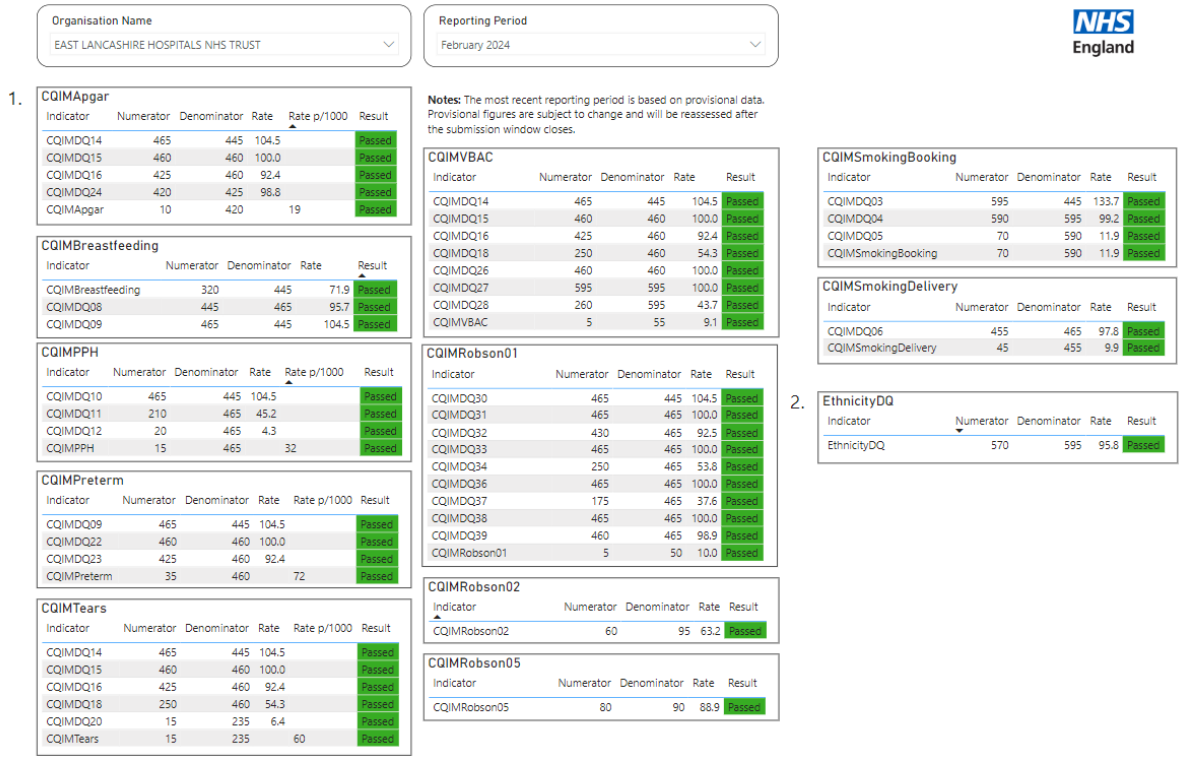
The reporting period for CNST Year 6 includes all eligible cases from 8 December 2023 to 30 November 2024.

As demonstrated via the above PMRT dashboard, all required time limits have been met within this period.

CNST Year 6 continues the requirement for quarterly reports to be submitted to Trust Board, Quarter 4 covering January-March 2024 data is submitted as per appendix 2. This includes detail of all deaths, reviews and action plan, confirmation of compliance to the above requirements and compliance to the further requirement: *'For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?'*

Please note the action plan as depicted in the quarter 4 report details some actions which are logged as 'overdue'. Assurance has been gained from the consultant obstetrician lead that these actions are progressing with their oversight and a full update will be achieved via the scheduled PMRT meeting on the 10th of May.

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



Organisation Name: EAST LANCASHIRE HOSPITALS NHS TRUST

Reporting Period: February 2024

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	465	445	104.5		Passed
CQIMDQ15	460	460	100.0		Passed
CQIMDQ16	425	460	92.4		Passed
CQIMDQ24	420	425	98.8		Passed
CQIMApgar	10	420		19	Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	320	445	71.9	Passed
CQIMDQ08	445	465	95.7	Passed
CQIMDQ09	465	445	104.5	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	465	445	104.5		Passed
CQIMDQ11	210	465	45.2		Passed
CQIMDQ12	20	465	4.3		Passed
CQIMPPH	15	465		32	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	465	445	104.5		Passed
CQIMDQ22	460	460	100.0		Passed
CQIMDQ23	425	460	92.4		Passed
CQIMPreterm	35	460		72	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	465	445	104.5		Passed
CQIMDQ15	460	460	100.0		Passed
CQIMDQ16	425	460	92.4		Passed
CQIMDQ18	250	460	54.3		Passed
CQIMDQ20	15	235	6.4		Passed
CQIMTears	15	235		60	Passed

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.

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	465	445	104.5	Passed
CQIMDQ15	460	460	100.0	Passed
CQIMDQ16	425	460	92.4	Passed
CQIMDQ18	250	460	54.3	Passed
CQIMDQ26	460	460	100.0	Passed
CQIMDQ27	595	595	100.0	Passed
CQIMDQ28	260	595	43.7	Passed
CQIMVBAC	5	55	9.1	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	465	445	104.5	Passed
CQIMDQ31	465	465	100.0	Passed
CQIMDQ32	430	465	92.5	Passed
CQIMDQ33	465	465	100.0	Passed
CQIMDQ34	250	465	53.8	Passed
CQIMDQ36	465	465	100.0	Passed
CQIMDQ37	175	465	37.6	Passed
CQIMDQ38	465	465	100.0	Passed
CQIMDQ39	460	465	98.9	Passed
CQIMRobson01	5	50	10.0	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	60	95	63.2	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	80	90	88.9	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	595	445	133.7	Passed
CQIMDQ04	590	595	99.2	Passed
CQIMDQ05	70	590	11.9	Passed
CQIMSmokingBooking	70	590	11.9	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	455	465	97.8	Passed
CQIMSmokingDelivery	45	455	9.9	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	570	595	95.8	Passed

The “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series, as above, publishes each month and this is used to evidence sustained compliance to the 11 data quality measures and further ethnicity data quality measure as required.

July 2024 will be the month submitted into CNST Year 6 evidence to evidence compliance for this reporting year. This will be available to view on the above scorecard in October 2024.

2.2.3 Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

‘Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice 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.’

Q4 (January-March 2024) data review and audit presentation is submitted as per appendix 3 and finds significant assurance against compliance.

'***Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.'***

As indicated in the findings of the Transitional Care audit, the most prevalent cause of term admission to NICU is respiratory disease:

- January 2024 - 24 term admissions to NICU - 12 main cause of respiratory disease - 12/24 (50%)
- February 2024 - 17/32 (53%)
- March 2024 - 7/20 (35%)

To further review this key cause and inform improvement ideas a focussed audit has been commenced to review term admissions due to respiratory disease alongside reviewing data such as caesarean section rates, indications, and outcomes. The findings will be presented at the joint maternity and neonatal audit meeting in July 2024 and following this an improvement project will be registered as per the CNST requirement.

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

'Has the Trust monitored 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 when a consultant is required to attend in person?'

Q4 January-March 2024 data has been reviewed in line with the above requirements and finds the below:

Obstetrics Condition	No. of Patients			Consultant Attendance	Comments
Caesarean birth for major placenta praevia / abnormally invasive placenta	13			13	Screened all placenta praevia so higher number than previous audit
Caesarean birth for women with a BMI >50	1			1	
Caesarean birth <28/40	5			4	27+3week twins, delivered by ST 7 who had been signed off for preterm LSCS. Consultant informed
Premature twins (<30/40)	2			1	27+3 week twins, delivered by ST 7 who had been signed off for preterm LSCS. Consultant informed
4th degree perineal tear repair	1			1	
Eclampsia	0			0	
PPH >2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage protocol has been instigated	6			6	
Gynaecology					
Any laparotomy					

This details one case of premature twins born 27+3 by caesarean section where consultant was not in attendance. Upon review, this was performed by a ST7 doctor who has been signed off via specialised training for preterm caesarean sections and the consultant on call was informed.

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 (detailing August-December 2023 data) was submitted to January 2024 Trust Board. The next report (detailing January-July 2024) will be submitted to September 2024 Trust Board.

This report stated the ask for Birth rate plus requirements for staffing establishment as reflected in the September 2022 recommendations. The business case for the deficit in funding is completed with an outcome awaiting panel discussions.

CNST Year 6 now states that the Birthrate+ exercise must have taken place in the previous 3 years. As this was complete using August-October 2021 data with report findings published in September 2022 – ELHT are compliant to this ask currently. To sustain this compliance in preparation for future CNST reporting years we must liaise with Birthrate+ to conduct a further review 2024-25 to be scheduled timely.

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?

'Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.'

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%)**

Meetings with the LMNS have been diarised throughout the CNST Y6 reporting period as below, this provides the forum to meet the ask '*continued quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle.'*

- 19th June 2024
- 11th Sept 2024
- 6th Nov 2024
- 8th Jan 2024

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

'Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.'

ELHT maternity service have provided and maintained an engagement schedule since CNST Year 5 including dates and times of clinics, sessions and events which highlight if the attendance is likely to be from BAME (Black, Asian, Minority Ethnic) or high deprivation service users or those who have experienced bereavement or neonatal services. This allows the MNVP lead to engage with our service users and encourages engagement that is representative of both our geographical area and demographic mix.

Currently, Healthwatch are reviewing the capacity of the ELHT MNVP lead as we have experienced a reduced ability for the lead to attend such sessions and therefore gain meaningful feedback, due to competing pressures on their time including LMNS level responsibilities. There is a proposal to introduce a deputy MNVP lead role being reviewed currently by Healthwatch with ELHT maternity service input which would increase capacity for service user engagement and feedback gathering.

'Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member'

The invitation to the bi-monthly Floor to Board meeting of the safety champions has been extended to the MNVP lead as a member going forward, the MNVP lead attended on the 4th of April 2024 as evidenced within the minutes of the meeting (appendix 4). The Terms of Reference is currently under review and will be submitted to Trust Board when ratified.

'Evidence of a joint review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as a coproduced action plan.'

A full update on the progress of responding to the CQC maternity survey has been discussed with the safety champions as per the Floor to Board meeting minutes (appendix 4) and as submitted within the Quality Committee Floor to Board report (item 2.1) in April 2024 as a sub-committee of Trust Board (appendix 5). Following this update we have discussed this further with the MNVP and agreed initial action to include focussed feedback collation by the MNVP

lead and representatives regarding identified survey themes: 'feeling left alone during early labour,' 'gaining the help you need during labour,' and 'postnatal care.'

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

The three elements of training monitored via the Maternity Incentive Scheme remain as per previous years:

- **Fetal monitoring and surveillance (in the antenatal and intrapartum period) training** – 90% attendance for midwives, obstetric consultants and all other obstetric doctors who contribute to the obstetric rota. March 2024 dashboard shows 99% compliance for all relevant groups.
- **Maternity emergencies and multi-professional training (PROMPT)** – 90% attendance for obstetric consultants and doctors, midwives, maternity support workers, anaesthetic consultants and doctors who contribute to the on-call rota in any capacity. March 2024 dashboard shows an average of 96% attendance, all groups above 90%.

  A new ask for 70% attendance for non-obstetric anaesthetics doctors who contribute to the on-call rota in any capacity – this will be added to the dashboard for monitoring.
- **Neonatal basic life support** – 90% attendance for neonatal consultants, junior doctors (who attends any births), neonatal nursers (who attend any births), advanced neonatal nurse practitioners, and midwives.

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 March 2024:

Perinatal Quality Surveillance Dataset

East Lancashire Hospitals NHS Trust
A University Teaching Trust

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

Perinatal Data

Metric	Standard	Nov 23	Dec 23	Jan 24	Feb 24
1:1 care in labour	100%	100%	100%	100%	100%
Stillbirth rate	<4.4/1000	2.03	3.87	1.9	2.15
Term admissions to NICU	<7%	6.52%	4.86%	4.85%	4.85%
Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	3.29%	3.36%	3.42%	3.46%
3rd/4th degree perineal tear	<5%	2.78%	3.58%	5.69%	5.58%

Staffing/Training

Metric	Standard	Nov 23	Dec23	Jan 24	Feb 24
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%

Term admission to NICU:
An increased trend was identified in 2023 - this has since reduced to under the 7% threshold and continues to be closely monitored. The last 3 months have shown a stable rate of term admissions.
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.

3rd/4th degree perineal tears
There has been an increase in the number of tears on the last 2 months – these are being monitored and investigated on a monthly basis for any trends or themes.

Training Compliance:
The average for training compliance across all staff groups remains >90% attendance, the anaesthetic team have since reached 100% attendance at PROMPT as required and agreed by the action plan submitted to CNST Y5.

Feedback

Metric	Standard	Nov 23	Dec 23	Jan 24	Feb 24
Service user feedback (MNVP)		0 sessions attended	1 sessions attended	0 sessions attended	1 sessions attended
FFT satisfaction rated as good	>90%	88.83%	89%	89%	86.78%
Number of level 4 complaints	-	4	0	3	0
Executive safety walkaround	Bi-Monthly	NICU	N/A	N/A	N/A
Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	Antenatal Clinic	N/A	N/A	N/A

External Reporting

Metric	Oct 23	Nov 23	Jan 24	Feb 24
Maternity incidents graded moderate or above	3	0	6	2
Cases referred to MNSI	1	2	1	2
Cases referred to coroner	0	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

CNST

Metric	Nov 23	Dec 23	Jan 24	Feb 24
Progress with CNST 10 safety action compliance				

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

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. A focus group was held in Great Harwood in February.

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 0 level 4 complaints in February.

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

MNSI referral:
There has been 2 cases referred to MNSI in February – one was a cooled baby; The MRI scan showed no evidence of Hypoxic Ischaemic Encephalopathy (HIE) therefore the referral was rejected. One was the death of a woman who was 6 weeks pregnant, and cause of death was pulmonary embolism. This case has been accepted for investigation.

CNST:
The next year's CNST standards are being published at the beginning of April. A pre-release statement states that the PMRT monitoring period will run from the end of last year's period as a key change to the guidance,

This dataset has been reviewed and discussed with safety champions as per the Floor to Board minutes (appendix 4). The 3rd/ 4th degree tear rates for January and February 2024 have breached the 5% threshold, the scorecard data as below portrays a view of this metric over the past 12 months and has been updated to include March 2024 –

which shows a return to rates within threshold.

Reporting Month	March 2024													
	Division of Family Care - Section 3 - Maternity Scorecard												* = Data not relevant for month n/a = Data not available at time of report	
Reporting Measure		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	Monthly Trend
Percentage of 3rd/4th Degree Tears	G <5% R >5%	3.31	1.54	3.60	2.16	4.95	3.79	3.27	3.73	2.78	3.58	5.69	5.60	2.56	

To further understand the data, a bespoke audit and review of 3rd and 4th degree tears is underway as lead by a consultant obstetrician to be reviewed in collaboration with an analysis of the cases undertaken by the perinatal pelvic health specialist lead midwife. The findings of this will be discussed and reviewed for assurance or escalation through to Trust Board once complete.

'Is the Trust's claims scorecard is reviewed alongside incident and complaint data.'
The Trust has identified a need to review the categories available within the incident and complaints reporting system (DATIX); the Divisional Director of Midwifery attended the Trust-wide workshop regarding a review of complaints categories on the 18th of April. A bespoke multidisciplinary (MDT) workshop to review the obstetric and maternity incidents categories is scheduled for Wednesday 8th May.
These activities will improve the recording of incident and complaints, and therefore improve the ability to identify themes from the reports available from the system.

'Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.'

The culture improvement plan as informed by the results of the SCORE culture survey is monitored and lead by the Maternity and Neonatal Quadrumvirate, who meet monthly with a direct focus on safety and culture listed within the agenda.
Further communication channels are being explored for use to ensure the results and themes of the survey have been disseminated widely and understood by all staff such

as a podcast led by the Quadrumvirate and area leads, a visual infographic of key themes and improvement ideas and use of the Share to Care meetings/ staff feedback forums as a standardised approach.

A focussed piece of work identified in alignment to the themes evident from patient feedback (see Safety Action 7) is with regards to staff morale and culture in postnatal ward and the impact on patient experience. Culture conversations with individual staff as coached by the Recruitment and Retention leads, specific liaison with the MNVP lead to drive further patient feedback and co-production and leadership from the Matron and Ward Manager in discussing existing issues such as visiting on the ward are all underway.

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.

A detailed overview of cases within the reporting period to present are provided in the in the document submitted in appendix 6.

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.

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

May 2024

Appendix 1 – CNST-MIS Y6 Guidance

MIS-Year-6-guidance .pdf

Appendix 2 – Q4 PMRT Report

Quarterly PMRT report Q4 (1).docx

Appendix 3 – Q4 Transitional Care Audit

TC audit Jan - March 2024 (1).pptx

Appendix 4 – Floor to Board meeting minutes April 2024

[2] 04.04.2024 - Floor to Board (2).doc

Appendix 5 – Floor to Board Quality Committee Report April 2024

Floor to Board Report Quality Committee Ap

Appendix 6 – MNSI Reporting Overview

CNST SA 10 Year 6
May 24 update.docx

Maternity (and perinatal) Incentive Scheme

Year Six

Conditions of the scheme

Ten maternity safety actions

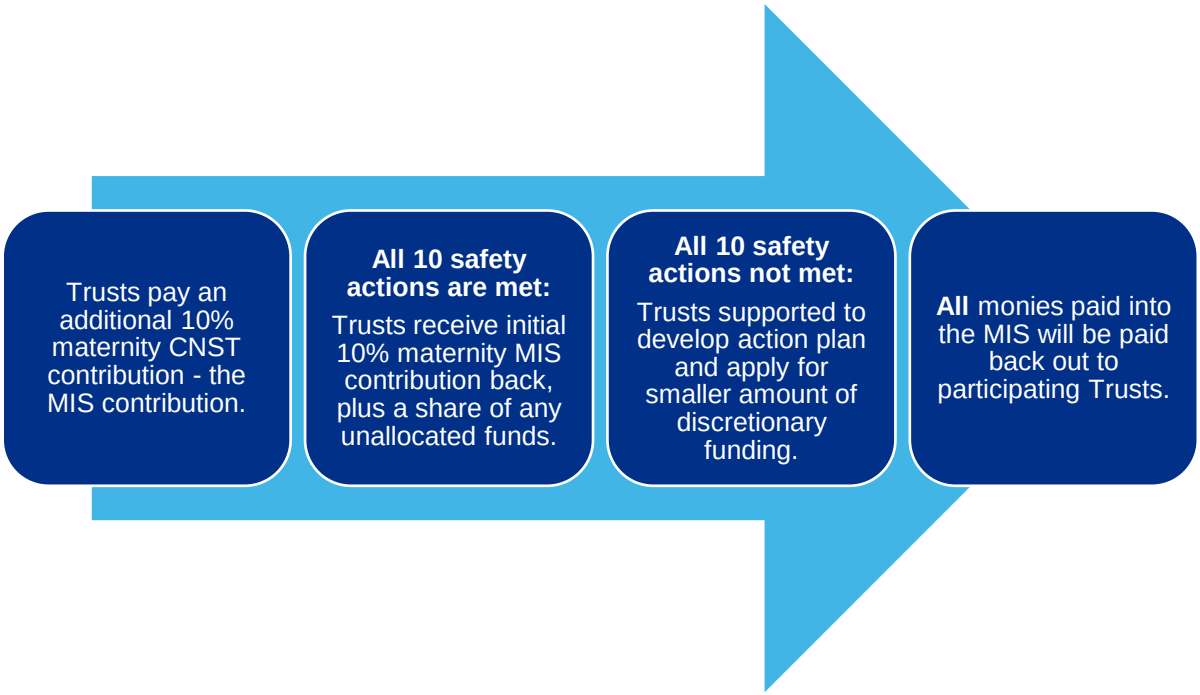
Additional guidance

Contents

Introduction

Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

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



The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigation Programme (MNSI).

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they 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 MIS 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 MIS fund and is subject to a cap decided annually by NHS Resolution.

MIS year six: conditions

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon** on **3 March 2025** 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 must then give their permission to the Chief Executive Officer (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.
- The Trust's CEO must sign 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 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2025.

  ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) 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.

The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates from 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 MIS results. See 'Reverification'.

NHS Resolution will publish the outcomes of the MIS verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

External verification

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c).

NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

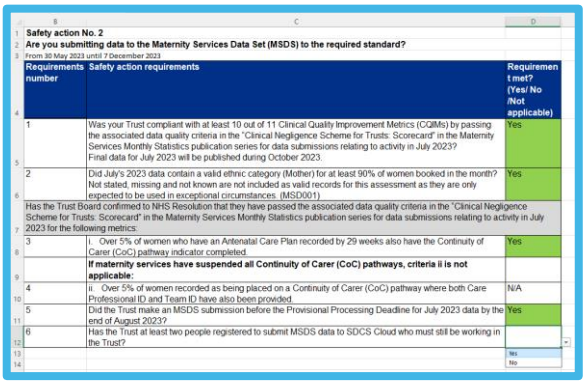
National Neonatal Research Database (NNRD), MNSI and **NHS Resolution** for the number of qualifying incidents reportable (safety action 10, standard a).

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.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year.

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided internally in the Trust to support the Trust Board decision only. This will not be reviewed by NHS Resolution unless requested. See 'Reverification'.
- On the Board Declaration form Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.



Safety action No. 2

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

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing 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.	Yes
2	Did July's 2023 data contain a 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)	Yes
Has the Trust Board confirmed 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:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	N/A
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	

- 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 **12 noon 3 March 2025** 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 AO of Clinical Commissioning Group/Integrated Care System.
- The Board declaration form will be made available on the MIS webpage during the MIS reporting period.

'What Good Looks Like'

Trusts are reminded to retain all evidence used to support their compliance position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described below) 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 via nhsr.mis@nhs.net prior to the 3 March 2025.
- The Board declaration form must be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.
- Submissions and any comments/corrections received after 12 noon on 3 March 2025 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 Trust's control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- The NHS Resolution MIS clinical team 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.
- Appeals must be made in writing to NHS Resolution on the agreed template within two weeks of the final notification of results. Information on how to do this

will also be communicated to all Trusts when the confirmed MIS results are sent out.

Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a smaller amount of funding to support progress. To apply for funding, such Trusts must submit a completed action plan together with their completed Board declaration form by 12 noon on 3 March 2025 to NHS Resolution nhsr.mis@nhs.net.

Action plans submitted must be:

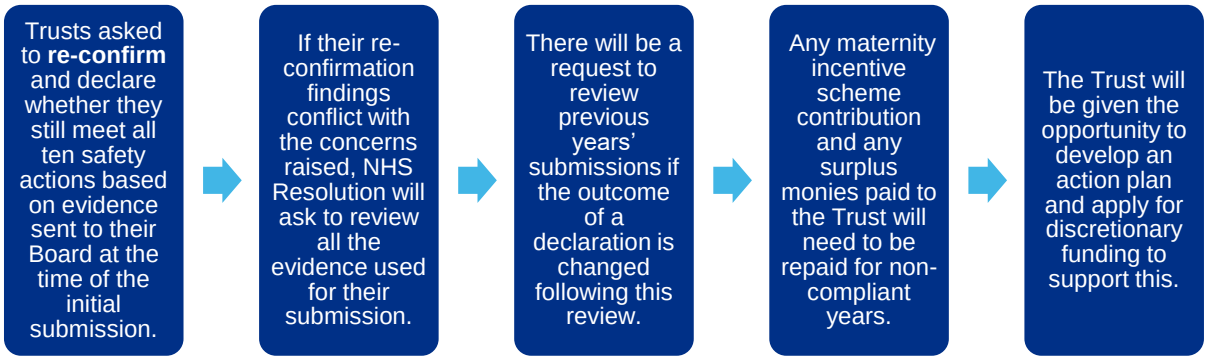
- Submitted on the action plan template in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and will enable the financial calculation of the funding requested.
- Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE).
- Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
- Action plans should not be submitted for achieved safety actions.

Ruth May, NHS England Chief Nursing Officer wrote to NHS Trusts on 8th April 2021 confirming that commissioners must ensure that any funding awarded to implement the agreed action plan for improvement is ringfenced for the maternity service to support the delivery of the action plan.

Reverification

Reverification is initiated if a concern is raised that a Trust Board may have incorrectly declared compliance with one or more of the ten safety actions' sub-requirements within the MIS. This may be identified through whistleblowing or following a CQC report that may call into question the original declaration. This concern may relate to any completed year of the MIS.

In the first instance, Trusts are asked to complete their own internal review of the evidence that was used to support their compliance for the relevant year at the time of submission. This must be the same evidence that was used to inform the Trust Board at the point of declaration. Trusts will be given the opportunity to downgrade their position at this point.



If following their own internal review, the Trust remains confident that their compliance declaration was correct, the Trust will be asked to provide all of their supporting evidence to NHS Resolution. A full review of the relevant evidence will then be undertaken by two members of the MIS clinical team.

Following this review, any Trusts found to have mis-declared compliance will be notified and will be required to repay the funds originally awarded to them for that MIS year. They will be asked to develop an action plan to introduce safety improvements and work towards full compliance, and they will be advised to bid for discretionary funding to support this action plan. Any discretionary funds agreed must be spent on the improvements in the agreed plan. Any amount of discretionary funding agreed will be deducted from the total MIS rebate amount repayable to NHS Resolution.

If a mis-declaration has been identified (as above), reverification of the previous MIS year will automatically be initiated. When a further mis-declaration is identified, this process will then be repeated for the previous year. This process will be limited to impact the current MIS year, and the two preceding historical MIS years only.

Any funds retrieved from non-compliant Trusts will be redistributed to all Trusts that achieved compliance for the applicable MIS year. This redistribution must take place within the same financial year that NHS Resolution receives the funds.

Need Help?

If you have any queries or concerns regarding any aspect of the MIS, please contact the MIS clinical team on nhsr.mis@nhs.net. There is a new FutureNHS MIS workspace where queries can be submitted and additional information and resources will be provided.

To ensure you receive all correspondence relating to the MIS, please add your name to the MIS contacts list.

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

Required Standard

a) **Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.

b) **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.

c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 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 and published within six months.

d) **Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.

Minimum Evidence Requirement for Trust Board

Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical guidance regarding the introduction of the NHS Submit a Perinatal Event Notification system - SPEN). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT.

A report should be received by the Trust Executive Board each quarter 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 by 3 March 2025.

NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications. MBRRACE-UK/PMRT will take the data extract for verification on 1 February 2025.

Relevant Time period

From 8 December 2023 to 30 November 2024

Link to technical guidance

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 MSDS-only (see technical guidance) 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 2024. Final data for July 2024 will be published during October 2024. 2. July 2024 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).
Minimum Evidence 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.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Required Standard
a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice Or Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards. b) Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.
Minimum Evidence Requirement for Trust Board
Evidence for standard a) to include: **For units with TC pathways** • Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04. **For units working towards TC pathways** • An action plan signed off by Trust and LMNS Board for a move towards the TC pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.
Evidence for standard b) to include: 1. By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team. 2. By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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 certificate of eligibility (CEL) 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 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 be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist 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. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**
   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
   roles-responsibilities-consultant-report.pdf 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 BAPM national standards of medical staffing.

or

the standards are not met, but there is an action plan with progress against any previously developed action plans.

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.

or

The standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal ODN.

Minimum Evidence Requirement for Trust Board

Obstetric medical workforce

1) Trusts/organisations should audit their compliance via Medical Human Resources.

   Information on the 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.

3) Trusts/organisations should be working towards developing standard operating procedures, 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 senior 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. This can be a representative month of the rota.

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 ODN.

Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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 has been completed within the last three years.

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 a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

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 Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

Minimum Evidence Requirement for Trust Board

The midwifery staffing report submitted will comprise evidence to support a, b, c and d 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 on duty at the start of every shift and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.

Relevant Time period

From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard
Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.
Minimum Evidence Requirement for Trust Board
Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include 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, neighbouring Trusts and NHS Futures where appropriate. *The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard

1. Trusts should work with their LMNS/ICB to 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 (published November 2023) including supporting:

   a) Engagement and listening to families.

   b) Strategic influence and decision-making.

   c) Infrastructure.

2. Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

Minimum Evidence Requirement for Trust Board

1.

a) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

b) Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member, (Trusts should work towards the MNVP Lead being a quorate member), such **as:**

- Safety champion meetings
- Maternity business and governance
- Neonatal business and governance
- PMRT review meeting
- Patient safety meeting
- Guideline committee

c) Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as:

- Job description for MNVP Lead
- Contracts for service or grant agreements
- Budget with allocated funds for IT, comms, engagement, training and administrative support
- Local service user volunteer expenses policy including out of pocket expenses and childcare costs

- If evidence of funding support at expected level is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.

2. Evidence of review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as an action plan.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.

Relevant Time period

From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard
90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.
Minimum Evidence Requirement for Trust Board
*See technical guidance for details of training requirements and evidence.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 1 December 2023 to 30 November 2024

Link to technical guidance

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Required Standard

a) All Trust requirements of the PQSM must be fully embedded.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

Minimum Evidence Requirement for Trust Board

Evidence for point a) and b)

- Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice.

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the **perinatal** leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.

- Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

- Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. 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 1 July 2024.

- Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, 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) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.

Evidence for point c):

Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:

- Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.

- Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Verification process

All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025.

Relevant Time period

From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Required Standard
a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024. b) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024. c) For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that: i. the family have received information on the role of 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 Evidence Requirement for Trust Board
Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. Trusts' reporting will be cross-referenced against the 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 B and C(i) there is a requirement to complete field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
Relevant Time period
From 8 December 2023 to 30 November 2024

Link to technical guidance

Technical Guidance

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.	
SA 1(a) – Notify all eligible deaths	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal deaths 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 the Submit a Perinatal Event Notification system (SPEN) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through SPEN and this information will be passed to MBRRACE-UK. It will still then be necessary for reporters to log into the MBRRACE-UK/PMRT system to provide the surveillance information and to 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 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 2024.
SA 1(b) – Seek parents' view of care	
We have informed parents that a local review will take place and they have been asked if they have any feedback 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' feedback, perspectives, and any 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' feedback and 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 feedback 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 their feedback at 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 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.
SA 1(c) – Review the death and complete the review	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: d) Late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) e) Stillbirths (from 24+0 weeks' gestation) f) 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 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 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 Trust 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 long turn-around time?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than six months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death, complete and publish the report using the information you have available. When the PM 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 six 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 PMRT verification 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 2 April 2024 and 30 November 2024 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 verification process?	Trusts should review all eligible deaths using the PMRT as a routine on-going process, irrespective of the MIS timeframe and verification process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 6 MIS requirements.
What happens when an MNSI (formerly 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 MNSI (formerly HSIB). Your local review using the PMRT should be started (to identify any early and immediate learning which needs to be actioned) but not completed until the MNSI report is complete. You should consider inviting the MNSI reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the MNSI review to be incorporated into the PMRT review. Depending upon the timing of the MNSI report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an MNSI investigation is taking place, and this will be accounted for in the external verification process.

SA 1(d) – Report to the Trust Executive Board	
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 of time defined by the user. 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 completed reviews over a period time which can be generated within the PMRT by authorised PMRT users for a user-defined period 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 completed and 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'.

Technical Guidance for Safety Action 2	
What are the 11 "MSDS-only" CQIMs in scope for this assessment?	These include: • Babies who were born pre-term • Babies with a first feed of breastmilk • 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 booking • 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 These do not include the following as they rely on linkages between MSDS and other datasets: • Babies breastfed at 6-8 weeks • Babies readmitted to hospital <30 days after birth
Some CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on those for three months?	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2024 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 "CNST: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.
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

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 Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: 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?	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

Technical Guidance for Safety Action 3	
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.
How can we evidence progress towards a transitional care service?	A current action plan with specified timescales and progress against these should be reviewed by the Trust and LMNS Boards before the submission deadline
How do we identify our themes of unplanned term admissions?	All term admissions will be reported through DATIX/LFPSE (as per local implementation of PSIRF) and themes identified through this intelligence. ATAIN proforma reviews are no longer mandated.
Who should be involved in the quality improvement initiatives?	The team should include members of maternity and neonatal multidisciplinary team including liaising with service user representative (MNVP) and support sourced from Trust quality improvement and service improvement teams if required.
How do we register our quality improvement initiative?	This will vary depending on local Trust policy. In the absence of any Trust policy, evidence of registering the quality improvement initiative, could be documented in the safety champion minutes.
What is considered as evidence of an update on the quality improvement initiative?	Evidence should include: 1) a presentation to the LMNS which includes an aim statement, measures, change actions and outcomes. 2) Discussion with safety champions and noted in the minutes at least once before the end of the reporting period.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ 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) The Handbook of Quality and Service Improvement Tools: the_handbook_of_quality_and_service_improvement_tools_2010-2.pdf (england.nhs.uk)

Technical Guidance for Safety Action 4	
a) Obstetric medical workforce guidance	
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 2024. 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?	No.
Where can I find the documents relating to short term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
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 2024 and prior to submission to the Trust Board.
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?	No.
Where can I find the documents relating to long term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG

How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors taking compensatory rest after non-resident on call?	Trusts should have 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 have 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 have this as evidence that they are working towards compliance.
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?	Yes. However while this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
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	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans

element of safety action 4 if 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 (MIS Team) or workforce@rcog.org.uk (RCOG).	
b) Anaesthetic medical workforce guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard 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.
c) Neonatal medical workforce guidance	
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 BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)	
NICU **Neonatal Intensive Care Unit**	All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics. Trusts that have more than one NNU providing IC or HD care should have separate cover at all levels of medical staffing appropriate for each level of unit. **Tier 1**

	Rotas should be European Working Time Directive (EWTD) compliant and have a minimum of 8 WTE staff Units with more than 7000 deliveries should have more than one Tier 1 medical support **Tier 2** EWTD compliant rota with a minimum of 8 WTE staff NICUs undertaking more than 2500 IC days per annum should augment their Tier 2 medical cover (more than one staff member per shift) **Tier 3** Minimum of 7 WTE consultants on the on-call rota with 24/7 availability of a consultant neonatologist NICUs undertaking more than 2500 IC days per annum should provide two consultant led teams during normal working hours. Neonatal consultant staff should be available on site in all NICUs for at least 12 hours a day, generally expected to include two ward rounds/handovers For units undertaking more than 4000 IC days per annum, consideration should be given to 24-hour consultant presence All NICU consultants appointed from 2010 should have CCT in Neonatal Medicine.
LNU **Local Neonatal Unit**	Where LNUs have a very busy paediatric/neonatal service and/or have neonatal and paediatric services that are a significant distance apart, the above staffing levels should be enhanced. The threshold should be judged and monitored on clinical governance grounds such as the ability consistently to attend paediatric or neonatal emergencies immediately when summoned. Units with more than 7000 deliveries should have more than one Tier 1 medical support.

	Tier 1 Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition. **Tier 2** Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff. **Tier 3** Consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN. At least one LNU Tier 3 consultant should have either a CCT in neonatal medicine or neonatal SPIN module (if this was available during training). All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).
SCU **Special Care Unit**	**Tier 1** Rotas should be EWTD compliant (58) and have a minimum of 8 WTE staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery. There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7. **Tier 2** Shared rota with paediatrics comprising a minimum of 8 WTE staff. Tiers 1 and/or 2 may be able to be covered by appropriately skilled nursing staff

	Tier 3 A minimum of 7 WTE consultants on the on-call rota with a minimum of 1 consultant with a designated lead interest in neonatology. Tier 3 consultants should have a Certificate of CCT in paediatrics or Certificate of Eligibility for Specialist Registration (CESR) in paediatrics or an equivalent overseas neonatal or paediatric qualification. They must demonstrate knowledge, skills and CPD appropriate for the level of neonatal care through annual appraisal. Minimum of 1 consultant with a designated lead interest in neonatology, who should have completed a special interest (SPIN) module in Neonatology*. (if this was available during training)
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 declared 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 6 reporting period.
Please access the followings for further information on Standards	BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)
d) Neonatal nursing workforce guidance	
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) 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:

	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.

Technical Guidance for Safety Action 5	
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 further details and definitions: 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?	A supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status. It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity on the labour ward to ensure safety for women, families and staff in the department. The co-ordinator should exercise professional judgement and escalate, if covering for breaks creates a safety risk to other women on labour ward. As long as there is clear evidence that the local escalation policy has been initiated in these circumstances, and this is not a recurrent daily event, Trusts may declare compliance with this standard.

	If the co-ordinator is regularly required to cover for breaks (more than 2-3 times 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.
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.
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.

Technical Guidance for Safety Action 6	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: saving-babies-lives-version-three/ An implementation tool is available for trusts to use if they wish at future.nhs.uk/SavingBabiesLives and includes a technical glossary for all metrics and measures. For any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to MSDS issues for 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 (Element 1); from NNAP Online (Element 5); and from NPID (Element 6). For any other queries, please email nhsr.mis@nhs.net
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. Where MSDS does not capture all process and outcome indicators given in the care bundle, this is indicated in the Implementation Tool.
What percentage performance is required to be compliant for a given intervention?	Where element process and outcome measures are listed in the evidence requirement of the SBLCB V3 a performance threshold is recommended. However, LMNS/ICBs are able to agree local performance thresholds with a provider in view of local circumstances, and the agreed local improvement trajectory.
How do we provide evidence for the interventions that have been implemented?	Trusts will need to verify with their LMNS/ICB that they have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBL e-learning for health modules have all been updated to reflect the changes in version 3. A new module for element 6 has also now been developed and published on the e-learning for health site.

Technical Guidance for Safety Action 7	
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 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.
What does evidence of MNVP engagement look like?	Engagement can include lots of different methods as detailed in the MNVP Guidance under the section *Engagement and listening to families*. Evidence for this includes: • 15 Steps for Maternity report. • MNVP Annual Report. • Engagement reports. • Expenses paid to service users. • List of organisations engaged. • Online surveys and feedback mechanisms. • Analysis of surveys by demographics of respondents.

Technical Guidance for Safety Action 8	
How will the 90% attendance compliance be calculated?	The training requires 90% attendance of relevant staff groups by the end of the 12-month period at: 1. Fetal monitoring training 2. Multi-professional maternity Emergencies training 3. Neonatal Life Support Training
Which maternity staff should be included for 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 and SAS doctors. • 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 Maternity emergencies and multi-professional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants and SAS doctors. • All other obstetric doctors including obstetric trainees (ST1-7), sub speciality trainees, Locally Employed Doctors (LED), foundation year doctors and GP trainees 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 and autonomously practising obstetric anaesthetic doctors. • All other anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) **who contribute to the**

	obstetric anaesthetic on-call rota <u>in any capacity</u>. This updated requirement is supported by the RCoA and OAA. • 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 6 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 6 compliance. At least one emergency scenario/drill should be conducted in a clinical area during the whole MIS reporting period, ensuring attendance from the relevant wider professional team, including theatre staff and neonatal staff. The clinical area can be any area where clinical activity takes place e.g. Delivery Suite, Clinic, A&E, theatre, a ward. This should not be a simulation suite.
Do non-obstetric anaesthetists that contribute to the obstetric rota need to attend obstetric emergency training?	Yes. However, it is recognised that the inclusion of anaesthetic staff who provide only intermittent or on-call coverage to the maternity unit may significantly extend the standards. Therefore, for the inaugural year of this standard, a threshold of 70% achievement is required as the minimum standard for this specific group.
Do non-obstetric anaesthetists need to attend the full day of obstetric emergency training?	It is the gold standard that all staff including non-obstetric anaesthetists that may find themselves responding to an obstetric emergency when on-call attend the full training day together, so that they can benefit from local learning and train alongside their multi-disciplinary colleagues, however it is appreciated that this may be a challenge for this group of staff. Therefore a minimum standard of attendance at half of the full day including obstetric skills drills will be accepted.
Training attendance for rotational clinical staff	It is the gold standard that all staff attend training in the unit that they are currently working in, so that they can benefit from local learning and training alongside their multi-disciplinary colleagues, however it is appreciated that this may be especially challenging for rotational staff. In the following circumstances, evidence from rotating medical trainees having completed their training in another maternity unit will be accepted: • Staff must be on rotation.

	• The training must have taken place in the previous Trust on their rotation during the MIS training reporting 12-month period. • Rotations must be more frequent than every 12 months. This evidence may be a training certificate or correspondence from the previous maternity unit.
Does the multidisciplinary emergency training have to be conducted in the clinical area?	Ideally at least one emergency scenario should be conducted in any clinical area as part of each emergency training day. You should aim to ensure that all staff attending emergency training participate in an emergency scenario that is held in a clinical area, but this will not be measured in year 6 of MIS.
Which staff should be included for Neonatal basic life support?	Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants/SAS doctors or Paediatric consultants/SAS Doctors 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, SAS, LE Doctors and anaesthetic trainees) contributing to the obstetric rota. • 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 dependant on their role within the service. • If nursery nurses work within the service, this should also be recognised in your local training needs analysis.
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 6 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 6 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.
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 LMNS to explore sharing of resources. It is recognised that for smaller hospitals, such as Level 1 units, there may be difficulty in resourcing qualified trainers. These units 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. As a minimum, training should be delivered by someone who is up to date with their NLS training. Please see the RCUK website for the latest guidance regarding NLS GIC training
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined, however a minimum of 90% of paediatric/neonatal medical staff who attend neonatal resuscitations should have a valid resuscitation council NLS certification. Trusts that cannot demonstrate this for MIS year 6 should develop a formal plan demonstrating how they will achieve this for a minimum of 90% of their neonatal and paediatric medical staff who attend neonatal resuscitations by year 7 of MIS and ongoing.
The Core Competencies TNA suggests periods of time for each element of training, e.g. 9 hours for fetal monitoring. Is this a mandated amount of time?	We envisage that the fetal monitoring and obstetric emergencies training will require 1 whole day each. The hours for each element of training can be flexed by the individual Trust in response to their own local learning needs.

Technical Guidance for Safety Action 9	
Where can I find additional resources?	NHS England, Perinatal Quality Surveillance Model PSIRF (Patient Safety Incident Response Framework) Measuring culture in maternity services: Safety Culture Programme for Maternal and neonatal services 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.
Perinatal Quality Surveillance Model	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local governance for sharing intelligence checked, and when needed, updated. • Describe the local governance processes in place to demonstrate how intelligence is shared from the ward to Board. • Formalise how Trust-level intelligence will be shared and escalated with the LMNS/ICB quality group and from there with regional quality groups which will include the Regional Chief Midwife and Lead Obstetrician.
Reporting to Trust Board	
What do we need to include in the dashboard presented to Board each month?	The dashboard should be locally produced, based on a minimum data set. It should include themes identified in line with PSIRF, and actions being taken to support; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. Themes and progress with culture

	improvement plans following local cultural surveys or equivalent should also be included. This may include the SCORE culture survey, NHS staff survey, NHS pulse survey, focus groups or suitable alternative. The dashboard can also include additional measures as agreed by the Trust.
Our Trust Board and / or sub-committee only meet 10 times a year. Is this acceptable?	If the Board or appropriate sub-committee do not meet monthly, it is the expectation that maternity and neonatal quality and safety will be discussed every time the Board or sub-committee meet.
Clarification as to what constitutes a Trust Board, can sub committees be categorised as a Board?	In year 6 the standard has been updated to reflect that an appropriate Trust Board sub-committee, chaired by a Trust Board member, can be delegated to undertake the monthly review of perinatal safety intelligence. If a sub-committee of the Board undertakes this work, an exception report or highlight report must still be provided to the Board and discussion evidence in the Board minutes.
Culture Surveys	
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will have participated in the Perinatal Culture and Leadership Programme. As part of this programme every service completed work to meaningfully understand the culture of their services. This diagnostic was either a SCORE culture survey or an alternative as agreed with the national NHSE team. Diagnostic insights and plans for improvement were to be 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. The expectation is that all maternity and neonatal services will understand how it feels to work in their services, either from the SCORE culture survey, or suitable alternative.
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 survey was 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.
Perinatal Culture and Leadership Programme	
Who is expected to have	Senior perinatal leadership teams from all Trusts that have a maternity and neonatal service in England have undertaken

undertaken the Perinatal Culture and Leadership Quad programme?	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 perinatal leadership team 'Quad' and their work as part of the PCLP, but there is no expectation for them to attend the programme.
Safety Champions	
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
Do both the NED and Executive BSC and all four members of the 'Quad' have to be present at each meeting?	Ideally the meeting would have both Board Safety Champion (BSC's) and at least two members of the Quad present. If this is not always possible, it would be appropriate for either the Executive or NED BSC and at least one member of the quad to be present. However, the expectation is that each professional group is represented throughout the year, and that the nominated member attending brings all four voices to the conversation.
What are the expectations of the NED and Exec Board safety champion in relation to their support for the Perinatal Culture and Leadership Programme (PCLP), culture	As detailed in last year's MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provides an opportunity to share safety intelligence, examples of best practice, identified areas of challenge and need for support. 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:

surveys and ongoing support for the Perinatal Leadership teams? **What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal Leadership teams?**	- Learning from the Perinatal Culture and Leadership Development Programme and how they are using this locally. - How they plan to continue being curious about their local culture. This may be in the form of pulse surveys, or team check ins. - Updates on recent local insight into their team's health, as gathered in the above bullet points. Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, this plan will be fluid and iterative, based on continued conversations with perinatal teams. It is not a plan that can be completed and filed as culture is ever changing and something leaders continually need to be curious about. - Progress with interventions relating to culture improvement work, and any further support required from the Board.
Do the non-executive and executive maternity and neonatal Board safety champion not have to register to the dedicated FutureNHS workspace to access the resources available this year?	We encourage all NED and Exec Board Safety Champions to register on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace. New content and resources are added throughout the year, and we would encourage all BSC's to continue to access the page to benefit from these. You can also reach out to other Board Safety Champions and develop your own community of peer support. However, this will not be a formal requirement in year 6 of the MIS.
We had not continued to undertake feedback sessions with the Board safety champion, what should we do?	Parts a) and b) of the required standard builds on the year four and five requirements of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board level safety champions to raise concerns relating to safety and identify any support required from the Board. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions with staff 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 and four of the maternity

	incentive scheme and the expectation is that this should have been continued.
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 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 continuous 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.
Scorecards	
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here.
Why do we need to review the scorecard quarterly alongside current complaint and incident data?	The scorecard is a quality improvement tool that provides insight into claims in support of clinical governance and quality assurance in your organisation. It provides details of all CNST claims, combined with data from the EN scheme and can provide a full picture of maternity related claims in your organisation. The scorecard provides 10 years of claims experience allowing the impact of clinical effectiveness and safety interventions to be assess over time. It can be reviewed alongside other data sets to provide a fuller picture of safety. It highlights themes occurring in claims which can be addressed through staff education and training. The scorecard provides a number of speciality filtered views allowing quick access to the relevant data for your division/speciality. Where data sharing agreements exist, members may share scorecard data to support learning across partnerships, networks and regions.

	The safety and learning team at NHS Resolution can support you in accessing and using your scorecard, nhsr.safety@nhs.net . A short video on using your scorecard can be found here Videos (resolution.nhs.uk) (Extranet login required). The GIRFT/NHS Resolution Learning from Litigation Claims can be found here Best-practice-in-claims-learning-FINAL.pdf (gettingitrightfirsttime.co.uk) and includes advice on engaging with NHS Resolution Safety and Learning resources, including the scorecard.
Examples have been requested for the scorecards.	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historical 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 historical themes re-emerged. NHS Resolution have developed an example template to share, and this can be accessed via the FutureNHS platform Maternity Incentive Team workspace, or the MIS Team can send a copy out on request. NHS Resolution staff are always happy to talk through this process if it is helpful.

Technical Guidance for Safety Action 10	
Where can I find information on MNSI (previously HSIB)?	Information about MNSI and maternity investigations can be found on the MNSI/ website https://mnsi.org.uk
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 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: (i) when the baby was therapeutically cooled (active cooling only), or (ii) has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following: (aa) hypotonia; (bb) abnormal reflexes including oculomotor or pupillary abnormalities; (cc) absent or weak suck; (dd) clinical seizures Trusts are required to report their qualifying cases to MNSI via the electronic portal. Once 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. * This definition was updated from 1 October 2023. Please see our website for further information, this does not change the cases referred to MNSI.
What is the definition of labour used by MNSI and EN?	The definition of labour used by MNSI and EN 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 <u>from 1 April 2022 going forward</u>	As in year 4 of MIS, in addition to reporting their qualifying cases to MNSI, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once MNSI have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must input the MNSI reference number to confirm the investigation is being undertaken by MNSI (otherwise it is rejected). The Trust must share the MNSI report, along with the MRI report, with the EN team within 30 days of receipt of the final report by uploading the MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the 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 MNSI are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury and have a confirmed reference number. • Where a family have declined a MNSI investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution and advised of this reason for reporting. There is more information here: ENS Reporting Guide - December 2023 (for Member Trusts) - NHS Resolution
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a MNSI investigation where the baby has a normal MRI. • Cases that MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to	If a baby has a clinical or MRI evidence of neurological injury and the case is being investigated by MNSI because of this, then the case should also be reported to NHS Resolution via the Claims Reporting Wizard along with the MNSI reference number (document the MNSI reference in the "any other comments box").

MNSI or NHS Resolution?	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 MNSI maternity team maternityadmins@mnsi.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 MNSI as under investigation. They must also complete the EN Report form and attach this to the Claims Reporting Wizard: EN-Report-Form.pdf
What happens once we have reported a case to NHS Resolution?	On completion of the MNSI investigation, and on receipt of the MNSI report and MRI report, following triage, NHS Resolution will overlay an investigation into legal liability. Where families have declined an 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. 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 MNSI 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 qualifying cases to MNSI as soon as they occur and to NHS Resolution as soon as 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 MNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and 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.
How can we confirm our cases have been reported to NHS Resolution?	We strongly advise making a note of the Claims Management System (CMS) reference number received once the matter is reported, as this will be confirmation that the case has been successfully reported to NHS Resolution.

MIS FAQ	
What do you mean by Trust Board?	Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion.
Why aren't we reporting everything directly to Trust Boards?	Trust Boards have a broad scope of responsibility, covering all aspects of the Trust's governance, strategy, and finances. They provide strategic direction and oversight, while sub-committees such as the Quality Governance Committee takes a more hands-on role in monitoring quality and safety performance reviewing and scrutinising operational detail. It is vital that the most pertinent information that is conveyed to Trust Boards is clearly recognised, and not lost in the operational detail of reporting. A sub-committee's in-depth examination of data, reports, and practices provides the Board with a clear understanding of the Trust's performance on quality and safety, including any immediate priorities or exceptions.
How can I evidence an appropriate sub-committee?	A Board Assurance Framework should highlight the decision-making processes within a Trust and detail those committees with delegated authority from the Board. Individual Terms of Reference from sub-committees should also contain this information. Minutes of sub-committee meetings should demonstrate that the required discussion around MIS standards have taken place, including any output which will be conveyed to the Trust Board. This must be recognised within Trust Board minutes.
What is a Quality Governance Committee, and how does it differ from a Trust Board?	A Quality Governance Committee (QGC) is a committee of the Trust Board responsible for overseeing the Trust's quality and safety governance arrangements. It provides assurance to the Trust Board that the Trust has robust systems in place to identify, assess, and mitigate risks to patient safety. The QGC also reviews the Trust's quality improvement initiatives and provides recommendations to the Trust Board. The information presented to a QGC will be more detailed and specific than the information presented to the Trust Board. They should receive regular updates on the Trust's performance in key quality and safety areas, as well as specific data on individual incidents and concerns. The QGC should also have the opportunity to discuss the Trust's quality improvement plans and provide feedback and recommendations. A QGC is appropriate to review evidence around safety actions, provide additional scrutiny **and then report to the**

	Trust Board, delivering a summary and highlighting any exceptions or particular areas of concern. **It is important to ensure that this process facilitates Trust Board oversight, rather than replaces it.**
Where can I find more information about Board Reporting via Quality Governance Committees?	NHS Providers Board Assurance Toolkit Quality Governance in the NHS
Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice for the Board notification form?	Trust Boards must self-certify the Trust's final MIS declaration 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 CQC 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 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 AO of Clinical Commissioning Group/Integrated Care System before submission.
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

	AO (ICB). Where relevant, an action plan is completed for each action the Trust has not met. **Please send only the Board notification form to NHS Resolution. Do not send your evidence or any narrative related to your submission to NHS Resolution unless requested to do so for the purpose of reverification.** 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 2024 and all Trusts will be notified. 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 3 March 2025, 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 3 March 2025**. If not returned to NHS Resolution by 12 noon on 3 March 2025, NHS Resolution will treat that as a nil response.
Our Trust has queries, who should we contact?	Any queries prior to the 3 March 2025 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 MIS link contacts via the link on the NHS Resolution website.
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	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results.

appeals this year?	The 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 when final results are confirmed and sent to Trusts.
Merging Trusts	Trusts that will be merging during the year six reporting period (April 2024 – January 2025) 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 2024/25 and the reporting of claims and management of claims going forward.

Quarterly PMRT report

Q4|January - March 2024

Title	**Family Care Division Quarterly PMRT Report (Jan-Mar 2024)**
Author	Michael Cocker, Consultant Obstetrician & Perinatal Lead
Executive sponsor	Peter Murphy, Executive Director of Nursing & Midwifery
Summary	This report aims to enable the division to demonstrate actions taken in response to mortality within the division and to share learning from mortality reviews. This report is a mechanism for sharing improvements and changes in practice made as a result of investigations into mortality. The report enables the sharing of good practice across directorates and wider within the organisation where appropriate.
Recommendations	

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
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits, and improvements (safe, efficient, and sustainable care and services) and the organisation's corporate objectives Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe, and effective care through clinical pathways The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact (delete yes or no as appropriate and give reasons if yes)

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

Contents

PMRT process

The PMRT has been designed to support the review of the following perinatal deaths:

- Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g;
- All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g;
- Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

Maternity Incentive Scheme Year 6 criteria

As of the 2nd April 2024 the MIS Year 6 criteria have been published. The criteria relating to safety action 1 (*"Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?"*) have been changed from the previous iteration. The new standards are:

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

Required Standard

a) **Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.

b) **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.

c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 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 and published within six months.

d) **Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.

CNST Safety Action 1 targets (as per MIS year 6 criteria)

Performance against new MIS Year 6 criteria for deadlines due within Q4 (1st Jan

1. Deaths notified to MBRRACE within 7 working days (target 100%)
    a. **100% (n=7) notified within target time**
2. Parents given opportunities to provide feedback or raise questions/concerns (target 95%)
    a. **100% (n=7) of parents had their input sought**
3. A review of the death should be commenced within 2 months (target 95%)
    a. **100% (n=7) had a PMRT review commenced within target time**
4. A multi-disciplinary review should be completed and published by 6 months (target 60%)
    a. **100% (n=9) had a MDT PMRT review report published by 6 months**

PMRT Meeting Grading

Criteria for Care Graded for Antenatal, Intrapartum, Postnatal Care (if applicable)

- Grade A
    - No issues with care identified from birth up to the point the baby died.
- Grade B
    - Care issues identified which would have made no difference to the outcome for the baby.
- Grade C
    - Care issues identified which may have made a difference to the outcome
- Grade D
    - Care issues identified which would have made a difference to the outcome

Grading of care – Stillbirths

	Meeting Month (Q4)			
	January	**February**	**March**	**Total**
Number of cases discussed	**No meeting**	**4**	**0**	**4**
Grading (up to birth of baby)				
A	-	**3**	**0**	**3**
B	-	**1**	**0**	**1**
C	-	**0**	**0**	**0**
D	-	**0**	**0**	**0**
Grading (following death of baby)				
A	-	**4**	**0**	**4**
B	-	**0**	**0**	**0**
C	-	**0**	**0**	**0**
D	-	**0**	**0**	**0**

Grading of care – Neonatal deaths & Late fetal losses

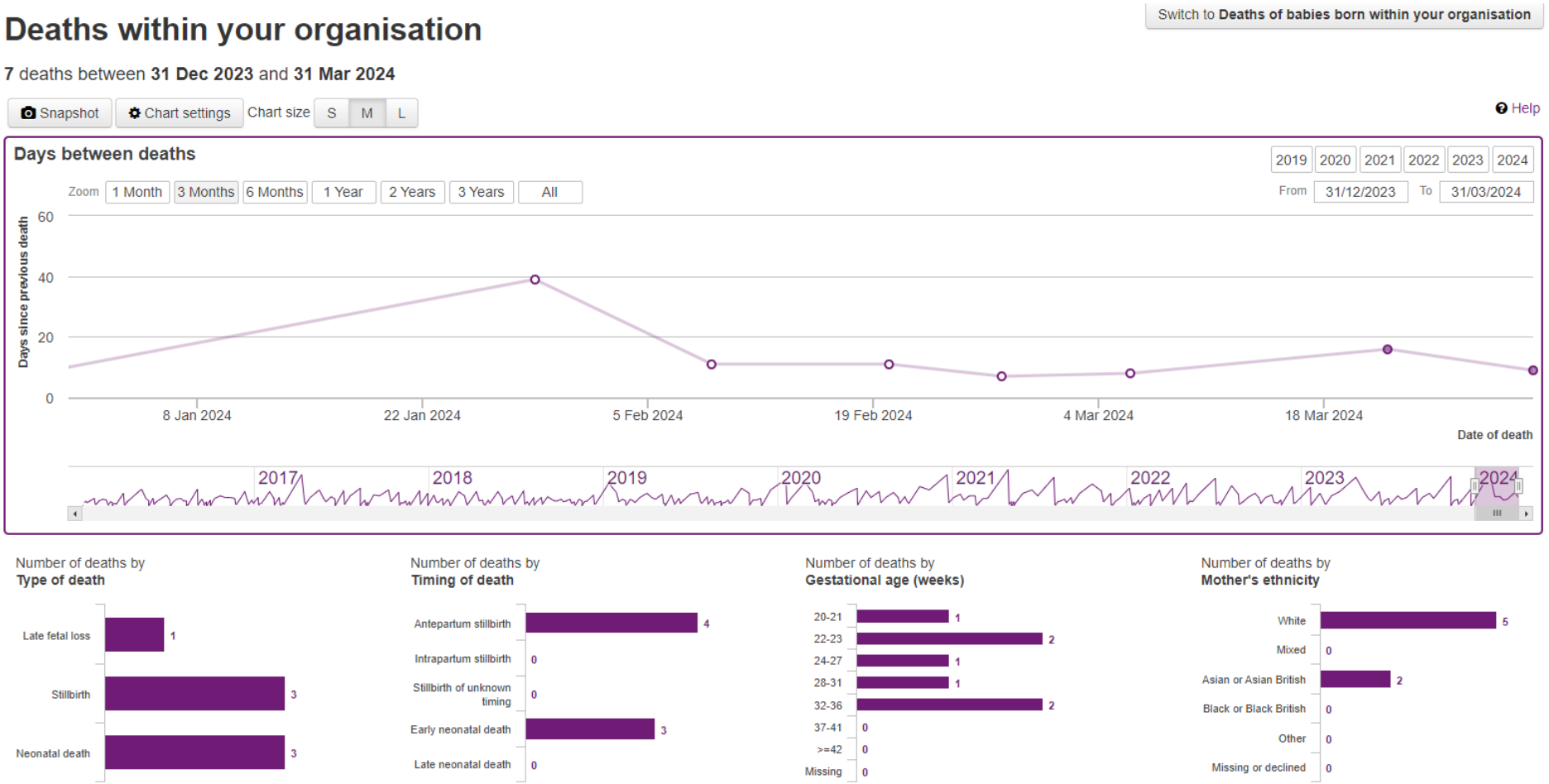
	Meeting Month (Q4)			
	January	February	March	Total
Number of cases discussed	No meeting	1	3	4
Grading (up to birth of baby)				
A	-	1	1	2
B	-	0	2	2
C	-	0	0	0
D	-	0	0	0
Grading (from birth of baby until death)				
A	-	1	3	4
B	-	0	0	0
C	-	0	0	0
D	-	0	0	0
Grading (following death of baby)				
A	-	1	3	4
B	-	0	0	0
C	-	0	0	0
D	-	0	0	0

Clinical summary of new cases eligible for PMRT review occurring during Q4

MBRRACE ID	Case type	Gestation at birth	Date of death	Case summary (brief)
91633	Stillbirth	27+2	29/01/24	Antenatal stillbirth. Chronic hypertension.
91831	Stillbirth	28+2	09/02/24	Type 2 diabetic with poor concordance/control. Known fetal growth restriction. Baby never reached viable weight for delivery.
91981	Neonatal death	23+6	20/02/24	Extremely preterm rupture of membranes and preterm labour.
92144	Late fetal loss	23+2	27/02/24	Twin pregnancy transferred from Lancaster. This twin demised at Lancaster prior to transfer.
92220	Stillbirth	34+5	06/03/24	Low risk pregnancy attended with reduced fetal movements.
92517	Neonatal death	34+3	22/03/24	Multiple abnormalities and fetal hydrops.

MBRRACE Real time data

1st January – 31st March



Note – 1 of the 7 deaths reported to MBRRACE is not eligible for PMRT due to be a non-viable gestation (<22+0 weeks gestation)

PMRT Action Tracker (as of 31st March 2024 – completed actions excluded)

ISSUE	AGREED ACTION	PROGRESS	ACTION UPDATE *To go down another line in the same cell, hold Alt&Enter	LEAD	PMRT CASE NUMBER	IR1 number	DEADLINE	STATUS *When entering new row, drag cell down from bottom left corner of cell to continue the formula
Aspirin not prescribed despite being high risk	Audit of aspirin use in ANC over 3 month period.	Ongoing - no issues	Action detected on sweep 27/06/23. Email to Helen Collier to ask to action (request junior doctor perform audit). **Defer until August when staffing better and allocate to new junior at this time.**	Helen Collier	83300 & 87657		01/06/2024	Not due
care of women presenting in pre-term labour and the management of birth at the extremes of viability not given in line with current guidelines	Schedule of regular MDT skills drills in place on birth suite – management of extreme pre-term labour and birth to be included in this	Ongoing - no issues	Email to CBS band 7s and training team to get update	CBS Band 7 and Matron	86399	eIR1252045 EA	01/06/2024	Not due
Previous section notes not reviewed at first appointment. K2 Athena access patchy.	Ascertain whether read-only access to K2 Athena is possible from a generic log-in to aid the reviewing old CS notes	Ongoing - no issues	Awaiting plan regarding access to records and legacy access. Being managed through FCDOG.	M Cocker	86010		01/10/2023	Overdue
Cerner-to-BadgerNet interface not working well. Appointments not showing correctly	Known issue - currently being monitored via FC-DOG. To link this risk into that.	Ongoing - no issues	Ongoing problem - logged with system support and fixes being looked at.	M Cocker	88273		01/08/2024	Not due
Potential for delayed or missed care when referrals rejected (ie. to Placenta Clinic, FMU, PPTB, anaesthetics etc)	Create Referral SOP to standardise procedures for rejected referrals.	Not Started	Ensure to link in with anaesthetics.	M Cocker	88101		01/08/2024	Not due

Cord incorrectly placed in formalin rendering it useless for genetic testing	Feedback to bereavement team adn include guideance in bereavement resources folder on intranet.	Ongoing - no issues	Email sent regarding this to N Cross 03/04/24	Nikki Cross	88101		01/04/2024	Overdue
Unclear if mother received reduced fetal movements guidance due to poor use of interpreters	Upload RFM information in languages as per Tommy's website	Ongoing - no issues	Email to update sent 03/04/24	S Davies/A Lumsden	88824		01/03/2024	Overdue
Poor documentation and transfer of patient following birth in Urgent Care at BGH	Develop education and training package for ED teams	Ongoing - no issues	Email to update sent 03/04/24	L Sellars	89334		01/03/2024	Overdue
Breaking of bad news felt to be of poor quality by parents	Create teaching materials for dissemination to junior doctors.	Ongoing - no issues		M Cocker	89723		01/06/2024	Not due

Healthier Pennine Lancashire

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Transitional care (TC) Audit January-March 2024

ELHT Maternity/ Neonatology

CNST year 5 (Safety Action 3/Quarter 4)

Savi Sivashankar/Rebecca Fennell/Helen Oates

Safe | Personal | Effective

January 2024
Number of term and late preterm admissions(numbers)

Term admissions 24

Preterm admissions 12

Term admissions causes (numbers)

- **Resp disease – 12**
- **HIE suspected/confirmed – 0**
- **Jaundice - 2**
- **Hypoglycaemia - 2**
- **Monitoring – 2 (1x acidosis + poor adaptation, 1x TOF)**
- **Cong anomaly - 1**
- **Sepsis suspected - 1**
- **Readmission for transfer – 0**
- **Social - 1**
- **Other- (specify) – 3 (2x other cardio/respiratory issue, 1x weight loss 16% in community)**

Term - SCBU days that could have been delivered on TC

- SCBU days on NICU-total 54
- could have been on TC- 1
- Reason-not clear; was ready I day before but was transferred the next day

Late preterm babies - causes of admission (numbers)

- Resp disease – 7
- Hypoglycaemia - 2
- Jaundice – 0
- Absent end diastolic flow - 0
- Prematurity – 2
- Other (specify) - 1x continuing care from Stepping Hill

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

- Preterm days of SCBU on NICU – total 27 days
- Total days could have been on TC – 1 day

Reason

- -on NGT feeds

Number of days TC activity higher than 12

8 days

Minimum TC babies = 4

Maximum TC babies = 15

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	

February 2024
Number of term and late preterm admissions(numbers)

Term admissions 32

Preterm admissions 16

Term admissions causes (numbers)

- **Resp disease – 17**
- **HIE suspected/confirmed – 1**
- **Jaundice – 3**
- **Hypoglycaemia – 1**
- **Monitoring – 1 (polycythaemia)**
- **Cong anomaly – 1**
- **Sepsis suspected – 1 (re-admission from Alder Hey)**
- **Readmission for transfer – 0**
- **Social - 0**

- Other- (specify) – 7 – cardiovascular disease x1, other cardio/respiratory issue x1, for specific investigation (HIV pos mum) x1, failed oximetry testing x1, IUGR/SGA x1, bilious vomiting x1, poor feeding/weight loss (admitted from home) x1

Term - SCBU days that could have been delivered on TC

- SCBU days on NICU- 47 days in total
- could have been on TC- 0

Late preterm babies- causes of admission(numbers)

- Resp disease – 6
- Hypoglycaemia - 3
- Jaundice – 0
- Absent end diastolic flow - 0
- Prematurity – 5
- Other (specify) – infection x1, polycythaemia/jaundice x1

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

- Preterm days of SCBU on NICU – 34 days total
- Total days could have been on TC – 1 day

Reason – NG feeds-waiting to have some bottles

Number of days TC activity higher than 12

6 days

Minimum TC babies = 7 babies

Maximum TC babies = 16 babies

Conclusion

- Only 1 day on TC could have been saved if NGT feeds (frequent) can be facilitated on TC
- TC activity was high on 6 days out of 29-20% of the time

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	

March 2024
Number of term and late preterm admissions(numbers)

Term admissions 20

Preterm admissions 11

Term admissions causes(numbers)

- Resp disease – 7 (inc 1x transfer from Lancaster)
- HIE suspected/confirmed – 2
- Jaundice – 2
- Hypoglycaemia – 0
- Monitoring – 4
- Cong anomaly – 0
- Sepsis suspected – 1
- Readmission for transfer – 0
- Social - 0
- Other- (specify) – 4 = 1x other cardio/respiratory issue, 1x NAS, 2x cardiovascular disease

Term - SCBU days that could have been delivered on TC

- SCBU days on NICU-total 34 days
- 1 day could have been on TC-total Reason
- Extra day of monitoring

Late preterm babies- causes of admission(numbers)

- Resp disease – 4 (inc. 1 x admitted from Bolton due to unit capacity)
- Hypoglycaemia - 2
- Prematurity – 1
- Jaundice – 0
- Absent end diastolic flow - 0
- Other (specify) – 4 = 1x GIT disease (born January – transferred to Manchester Jan, and readmitted from Manchester in March) 1x metabolic disease, 2x transfer in continuing care/infection suspected)

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

- Preterm days of SCBU on NICU – total 30 days
- Total days could have been on TC - 0

Number of days TC activity higher than 12

7 days

Minimum TC babies = 3

Maximum TC babies = 19

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	

Floor to Board
Maternity & Neonatal

April 4, 2024
10:00
FCD Divisional Seminar Room

Group Members: Peter Murphy | Khalil Rehman | ~~Dr Savi Sivashankar~~ | ~~Mr. Martin Maher |~~ Tracy Thompson | Ruth Dawson | Charlotte Aspden | Sophie Counsell | Katie Rodwell | Anne Goodwin

Line through indicates apologies for this meeting.

DISCUSSIONS

Item: **Ongoing Actions**

Action	Comments	Outcome
Confirm when the central review of medical job planning will be undertaken in Neonatology. PM	**SS update April 2024** 'Job plan meeting for sign off will be in April. Discussions re: dedicated time for PSR reviews/PSR meetings/CNST targets will be discussed. 2 gaps in consultant rota-ongoing with no success in recruitment-interview held on 21/3/24. Jobs will go out for advert again with modification.' R Dawson added the governance meetings have been more structured and IR1s are being delt with. Alex Brooks-Moizer is attending the ATAIN meetings. Action to remain as per above vacancies.	Ongoing
Invite our MNVP A Goodwin to our floor to board meetings. TT	Anne's attendance at relevant meetings is mandated in Y6 CNST, attending Floor to Board will meet this ask. 15/02/2024 TT to arrange a 1:1 with the MNVP to discuss quarterly attendance at floor to board meetings. PM stated that MNVP chair should have an open invite to the floor to board meeting to ensure inclusivity.	Complete
Provide an update on the timeframes for reviewing the consultant PA's and the plan to release consultant to be able to attend relevant PMRT meetings. RD/SS	SS update April 2024 - 'Consultant attendance at PMRT is not an area of concern. Regular attendance is happening. PMRT monies 1PA from ODN-awaiting meeting with ODN re: plan for this-mainly for external PMRT attendance.'	Complete
Add a risk to the risk register regarding the staffing levels needed to be able to launch our CoC teams. TT/CC	TT update April 2024: this will be included in existing risk [9259] currently scoring 9 to be reviewed. T Thompson advised the risk score has been reduced due receiving monies to relaunch our CoC teams and apart from midwifery vacancies due to maternity leave we are fully staffed. The maternity recruitment and retention lead, Rachel Thorpe is now in post and will be focusing on holding exit interviews to provide data on why staff are leaving the trust. A workforce and recruitment meeting has been set up with Rachel Thorpe as the chair and the workforce PWR	Complete

	dashboard will be presented at QSB and can also be brought to this meeting. P Murphy advised the trust will also be receiving monies that will be specifically for maternity, further information will follow.	
TT to summarise the requirements for neonatal housekeeping staff in an email to P Murphy to raise with the chief nurse of the ISC. TT/PM	TT update April 2024 - Risk assessment to present [Risk ID]: TT completed with R Dawson & K Sansby 04/05/24 Benchmark the risk against other trusts and raise at next weeks 2:1 meeting with P Murphy and J Pemberton. TT	Ongoing
C Cowman to bring an update on our position regarding the use of Citrix to this meeting. CC	Will be addressed at the next meeting with IT colleagues.	Complete
Present the 2023 Maternity CQC survey and action plan at the next Floor to Board meeting. TT/CC/SC	As per agenda	Complete
New actions from this meeting noted below, see notes below for further context		
Members of the Floor to board meeting to ensure a deputy attends the meeting if apologies are given. ALL		New action
Bring the agenda item – 'Safety issue: medical workforce staffing for maternity and difficulties with securing locums/ICB rate card' to the next meeting or email Jawad Husain cc P Murphy to escalate the issue. MM		New action
Email P Murphy with the BR+ business case details to ensure this is added to the agenda for review next meeting. CA/PM		New action
Contact BR+ to arrange the review as per CNST year 6 and provide an update at the next floor to board. CA		New action
Reinstate 1:1 meetings between A Goodwin and T Thompson. TT/AG		New action
Email Dan Hallen cc P Murphy to invite him to the next floor to board meeting to discuss the maternity IT risks. CA		New action

Item: **Mat Neo National Programmes (3 Yr plan/ CNST/ Ockenden) – Key Updates Only**

Conclusions:

- **Maternity CQC Survey Presentation and action plan**
  S Counsell shared the CQC survey results presentation and the draft action plan. P Murphy asked if we could see a breakdown by area, however S Counsell advised this data isn't collected in the survey and has fed this back to IQVIA.
  A Goodwin noted these results should be shared at the MNVP meeting for co production.
  P Murphy suggested completing a deep dive into the survey data alongside our local service user feedback and link to L2 and L4 complaints. S Counsell advised this should be completed as part of the Patient Experience and lessons learnt meeting as the operational meeting triangulating our service user feedback with incidents, FFTs, and complaints, which would then be taken to the MNVP meeting for a co production discussion.
  A Goodwin asked to be invited into the patient experience meeting as the MNVP or a maternity champion could attend, however T Thompson advised this meeting is temporary and will discuss this outside of Floor to Board.

T Thompson stated any updates to the CQC action plan will continue to be monitored through this meeting and once the draft action plan is complete this will be shared at the MNVP meeting to gain feedback and service user support with the actions.

K Rehman requested assurance from the dashboard to underpin the CQC data with equity data. S Counsell advised the maternity dashboard is currently being created by I Wilkinson and ethnicity data will be included.

- **CNST final confirmation for Y5**
  S Counsell advised we have received the final confirmation stating we passed CNST year 5 from MIS with information regarding receiving the funds to follow at the end of April.

- **CNST Y5 and Y6 comparison -** CNST Y5 X Y6 - Key changes.xlsx (sharepoint.com)
  S Counsell advised CNST Year 6 was published on the 2nd April 2024 through the NHS futures portal. The differences from years 5 to 6 have been outlined in the document shared within the agenda for review outside of this meeting. T Thompson advised the quad will meet to review the workstreams and leads for the coming CNST year.
  C Aspden highlighted the business case for BR+ is still awaiting review at panel.
  Action: Email P Murphy with the BR+ business case details to ensure this is added to the agenda for review at the next meeting. C Aspden/P Murphy.
  S Counsell highlighted SA5 now states our BR+ review must be undertaken within the last 3 years meaning we will need to start the review process this year to have BR+ completed in 2025.
  Action: Contact BR+ to arrange the review as per CNST year 6 and provide an update at the next floor to board. C Aspden.

Item: **Perinatal Culture Updates**

Conclusions:

- **SCORE survey Improvement plan – Action plan attached to view updates - Improvement plan link**
  T Thompson advised the three themes from the SCORE survey were discussed with colleagues at the maternity and neonatology away day highlighting the theme around communication. A Goodwin asked if maternal medicine colleagues are involved in the survey. T Thompson clarified maternal medicine were included and added the Maternal Medicine Lead Midwife has now been appointed.

- Northwest Safety Summit Presentation Dr A Sur
  S Counsell shared the presentation Dr A Sur presented at the Northwest Safety summit with the maternity champions. P Murphy suggested this presentation should be taken to the People and Culture meeting. S Counsell explained the purpose of the perinatal working group and how the meeting brings maternity and neonatology together to focus on service optimisation and improvements. H Oates and A Lumsden as digital nurse and midwife are asked to review the optimization data and flag any data issues at the meeting for assurance.

Item: **Safety Intelligence, Examples of Best Practice, Identify Challenges**

- **PQSM Minimum Data Set** – For information only.
  T Thompson gave an update on the 2 maternity red flags for induction of labour presented at the last Trust Board meeting as upon further reflection of the IR1's and staffing levels the red flags need to be retracted due to professional judgement. P Murphy advised T Thompson to state the above in the report for the next meeting.
  P Murphy suggested completing a deep dive into the data from the last few months on practice and modes of birth for 3rd/4th degree tears to understand the impact this has had on the women.
  S Counsell informed K Sansby and I Wilkinson are working towards building the count and rates into a dashboard to allow the data to be analysed, this will be shared at floor to board once available.
  S Counsell will feedback back to K Sansby regarding performing a deep dive into any data highlighted red on the PQSM report for assurance.

- **Safety issue**: medical workforce staffing for maternity and difficulties with securing locums/ICB rate card
  Due to apologies P Murphy advised this can be brought to the next meeting or M Maher can email Jawad Husain cc P Murphy to escalate the issue. Action: M Maher

Item: **Maternity & Neonatology Risks (scoring 15 and above)**

Conclusions:

- **Neonatal Housekeeper/BC and risk assessment**
  R Dawson explained we require 2 WTE neonatal housekeepers 7 days a week to comply with current guidance and we are currently 1.8 WTE staff short.
  Action: T Thompson/R Dawson to benchmark the risk against other trusts and raise at next week's 2:1 meeting with P Murphy and J Pemberton. TT
  P Murphy advised the organization must lose 390 staff due to the NHS financial position therefore staff head count is being reviewed very closely.

- **Diabetes Risk (marked down to 12)**
  C Aspden gave an update on the diabetes clinic since reviewing the service at the end of last year. Capacity has been increased on the Blackburn site; there is an AM clinic for preexisting diabetes and in the PM a dedicated clinic for gestational diabetes. Work is ongoing to embed the pathway into the service.
  A Goodwin offered to visit the clinic to gain service user feedback once it has been fully embedded in the next 3 months. T Thompson advised it might be useful for A Goodwin to visit the Burnley clinic since the schedule increase has been in place longer at this site.

- **C-section Risk Update**
  C Aspden advised the elective sections working group is ongoing with a new RAG rating to standarised assessment of complexity and a scheduling meeting being implemented as lead by S Loveridge. This aims to manage the increased demand for c sections. Work is ongoing with SAS colleagues on the staffing model as although we have been utilizing some gynaecology theatre lists as short-term mitigation this is not a robust plan long-term.
  A Goodwin asked what work is being done around the demand for c sections from the service users perspective, S Counsell advised S Loveridge is auditing c sections under 39 weeks which will give data on indication for c-section including maternal choice. This will also be aligned to the choice and personalization workstream.
  T Thompson will discuss the themes around induction, c sections and women anxious about reduced fetal movements outside of the meeting to explore what is driving the upstream demand.
  Action: Reinstate 1:1 meeting between A Goodwin and T Thompson. TT/AG

- **Mat Neo IT Issues**
  9954 – (12) Community Connectivity for Community midwives
  9867 - (9) Unable to share effectively safeguarding information about newborn babies attending ED and Paediatrics
  New Risk – Access to historical CTG's and clinical information through the K2 legacy system
  10000 - (12) Server Migration & Decommissioning Programme - Risk of Failure or Data Breach
  10045 - (15) Inability to provide complete patient records from Badgernet of an adequate standard to meet Legal and Coronial requirements

  C Aspden gave an update that we have now received a response from IT on the risks listed above however P Murphy suggested inviting Dan Hallen or a deputy to the next meeting to provide the reassurance needed to the safety champions.
  A Goodwin asked if there is a risk around the Badgernotes system not being fit for purpose as there is a regional risk raised on the same. C Aspden confirmed there are several risks related to Badger notes; however, these do not meet the risk score for escalation to safety champions.
  Action: Email Dan Hallen cc P Murphy to invite him to the next floor to board meeting to discuss the maternity IT risks. C Aspden

Item: **NAPF Exceptions**

Conclusions:

- No exceptions to report

Item: Maternity & Neonatal Dashboards – Exceptions

Conclusions:

- No exceptions to report

Other Information

Observers:

None

Resources:

Floor to Board Meeting SharePoint
CNST SharePoint

Special notes:

QUALITY COMMITTEE REPORT **Item**

24th April 2024 **Purpose** Approval
Assurance
Information

Title	**Floor to Board report for Maternity &Neonatology services**
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 to the recommendations set out in the independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford (Ockenden Report, 2022), by Dr Bill Kirkup on maternity and neonatal services in East Kent (Reading the Signals Report, 2022), and 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 is to reflect the four themes within the three-year plan as the structure for Floor to Board reports presented at ELHT Quality Committee, further informing staff teams and service users with a mirrored approach. 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. Standardised communication with all colleagues and service users working towards the shared goals and ambitions of the 3-year delivery plan is an essential part of the perinatal 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. To Improve equity for mothers and babies
3. To Work with service users to improve care.

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

This update follows the previous context and detail given within the February 2024 Quality Committee report. The full results as analysed by IQVIA can be viewed in appendix 2.

The Patient Experience and Lessons Learned group now been established within Maternity and Neonatology by the Quality Governance Lead as a forum for triangulation of key service experience data and information. Such as Friends & Family Test (FFT) themes, complaint's themes, NAPF (Nursing Assessment Performance Framework), safety, support and share visits, Executive and health watch walkarounds, themes from the CQC survey and MNVP (Maternity and Neonatal Voice Partnerships) coproduction feedback scheduled as part of CNST safety action 7. The group and triangulation exercise allow for the services to identify key concerns apparent across the service feedback channels and thematically analyse to inform improvements required. Such themes and improvement ideas are then discussed with the Maternity and Neonatal Voice Partnership (MNVP) for cross-reference to feedback themes through their channels (such as MNVP focus groups, use of social media etc) and for co-production of improvements. The quarterly MNVP meeting chaired by MNVP lead and facilitated by Healthwatch is the key forum for this.

The current update of the actions and improvements informed by the Maternity CQC survey, and above-described process of triangulation, is as below. This has been discussed via the Floor to Board Safety Champions Meeting on the 4th of April – ELHT MNVP Lead was in attendance. As evident, this is a live document with continuous review and update as all actions and improvements are appropriately discussed and progressed.

CQC Maternity Survey Action/ Improvement Plan

Survey - Area of concern	Survey - Related survey question/s	IQVIA Recommendation	Local Action	Triangulation	Action owner / lead	Date for review at Maternity PEG	Status	Update
1. Care while pregnant	B08 'During your antenatal check-ups, were you given enough time to ask questions during your pregnancy	1a. Review the scheduling of antenatal appointment to ensure that adequate time is given	Undertake a piece of work to understand the implications of extending the appts to 30 mins. **Considerations needs to be discussed at senior level:** Staffing models, location & estate needs + cost implications **KS to liaise with LB, TT, CA to lead of this from senior level.**	**FFT** - results are also raising issue with time in appointments/ women feel rushed. **IR1s** - theme of time constraints causing issues. **MNVP** - Feedback theme of appointment timings - specific to diabetic clinic. **MNSI** - Staff raising time implications through MNSI interviews	Director of Midwifery/ Deputy Director of Midwifery/ Directorate Manager	16/05/2024	Ongoing - no issues	▪ 28 week & sweep appointments double appt times in place. ▪ Midwives have autonomy to double individual appointments where required however this impacts wider appointments and this would require standardising. ▪ Willow & Blossom COC teams have a 30 minute appt slot template - these teams have seen benefits of this. ▪ Diabetic clinics - themes of feedback around waiting and running over prevelant for this clinic
			IR1s to be raised for each clinic running late. **Type:** Patient/ Staff **Category:** Problem with appointments/ admissions **Sub-category:** Error in management of appointment/ delay in clinic API to pull report of a month for next PEG meeting	N/A as above	Birth Centre Leads/ Matron Q&S Facilitator	16/05/2024	Ongoing - no issues	Team agreed at April 2024 to re-circulate communications regarding IR1s for clinics running late.
	B17 'Thinking about your antenatal care, were you treated with dignity and respect?'	1b. Review privacy and confidentiality advice with staff as a possible way to address concerns	Liaise with IQVIA to further understand the recommendation made in order to agree beneficial improvement		Q&S Team	16/05/2024	Not started	

2. Labour and Birth	C12 "Were you left alone by a midwife or doctor at a time that worried you?"	2a. Review the question breakdowns to see which stage of labour women felt they were left alone.	Identify from results breakdown at what time women feel they are being left alone and to what extent		Transformation Team	15/04/2024	Complete	During early labour - 12% During later labour - 7% During birth - 2% Shortly after birth - 9% Didn't feel left alone - 76%
			Results indicate main feedback on this to be around 'early labour.' IOL - Link into IOL workstream and ongoing patient experience survey specific to this pathway. Bring survey results to this group once complete.		Consultant Midwife/ Matron/ Transformation Lead	16/05/2024	Ongoing - no issues	
			Results indicate main feedback on this to be around 'early labour.' Latent Labour (spontaneous): Review current information for patients around latent labour to review if this is being given right place/ right time.		Transformation Team	16/05/2024	Not started	
			Review of complaints to assess any feedback around 'feeling left alone' Review 3 months data Jan-Mar 2022		Q&S Facilitator	16/05/2024	Not started	This will be manual process as no category to chose in Datix currently
			Liaise with MNVP to assess if 'feeling left alone' is being reported throug this route		Q&S Lead	16/05/2024	Not started	K Sansby and S Counsell met with Anne Goodwin 18th April to liaise regarding this ask. Anne will collate feedback from the community relating specifically to this through existing engagement sessions and by facilitating focus group ensuring feedback across a range of demographics
			Action TBD dependant on above deeper dives: PEG group discussed ideas: Challenge, coaching conversations, reminding staff, team meetings, walk rounds, documentation if leaving room, communication to women, add to weekly wisdom > 1-1 care in labour.			TBC	Not started	
	C14 "During labour and birth, were you able to get a member of staff to help you when you needed it?"	2b. Consider why some women say they were unable to get help from staff during labour if they needed attention.	Liaise with MNVP to collate some local more detailed feedback on the kind of help women feel they need, how they are asking for help, from whom etc? to identify co-production.		Q&S Lead/ Transformation Team	16/05/2024	Ongoing - no issues	K Sansby and S Counsell met with Anne Goodwin 18th April to liaise regarding this ask. Anne will collate feedback from the community relating specifically to this through existing engagement sessions and by facilitating focus group ensuring feedback across a range of demographics
3. Care in hospital after birth	D05 "Thinking about care you received in hospital after the birth of your baby, were you treated with kindness and understanding?"	3a. Remind staff that kindness and compassion is a key part of delivering high quality postnatal care	Recruitment & Retention Lead to discuss FFT/ Survey theme with staff for understanding of context - what is causing pressure/ tension for the staff? - Conduct engagement meetings with staff - kindness, compasssion, professional, caring. Use of SCORE culture survey results to cross-reference to.	FFT Theme	Recruitment & Retention Lead	16/05/2024	Ongoing - no issues	Working group set up to discuss and undertake piece of work exploring why staff might not be kind or compassionate, identify any issues or barriers and staff wellbeing.
			Liaise with MNVP to identify Birth Stories specific to care postnatally		Q&S Lead/ Transformation Team	TBC	Not started	K Sansby and S Counsell met with Anne Goodwin 18th April to liaise regarding this ask. Anne will collate feedback from the community relating specifically to this through existing engagement sessions and by facilitating focus group ensuring feedback across a range of demographics
			Review any current issues with visiting previously identified e.g. partners respect for the ward (use of equipment/ not dressed appropriately) and if this is an ongoing issue / how this affects staff. **Review IR1, complaint, FFTs for themes - 3 month Jan-Mar 2022 X 3 month Jan-Mar 2024** ** Review if this is specific to PNW or apparent in any other areas?*	IR1 Review - Aggression towards staff due to visiting Complaints Review - Visiting themes FFT Review - Visiting Themes	Q&S Facilitator	16/05/2024	Ongoing - no issues	
			Liaise with Well Team for specific support on PNW i.e. coaching conversations, Well Away Day, Leaders Well Being Afternoons etc.		PNW ward manager and matron / Recruitment & Retention Lead	16/05/2024	Not started	
	D08 "Thinking about your stay in hospital, how clean was the hospital or ward you was in?"	3b. Review the compliance of cleaners and provide clear expectations of cleaning requirements	Review Mini-NAPF results & monthly domestic audit relating to cleaning to identify any specific areas of concern and back to this group escalate to group. Feedback with assurance if no issues seen.		All ward managers	16/05/2024	Ongoing - no issues	**Noted issues with receiving domestic audit reports - Matrons to support ward manager to raise any issues with this.**
4. Feeding your baby	E02 "Were your decisions around feeding respected?"	4a. Ensure that all women are given full support and consistent advice about feeding their baby	Action TBD:				Not started	Maternity and NICU both meet UNICEF Baby Friendly Initiative requirements
5. Care at home	F05 "Would you have liked to have seen or spoken to a midwife more often?" *Breakdown of results to hear 'did not mother want to see/speak to a midwife more often after birth at home, 1-2-1 midwife often and felt it was the right amount*	5a. Look at frequency of visits and ensure mothers are directed to mental health support should they need it	Finalise Digital Video re. mental health and wellbeing to be given to women at discharge and available once at home to signpost to mental health when needed		Transformation Team	June meeting	Ongoing - no issues	Video has been filmed in February 2024. Currently being edited by professional company.

2.2 Care that is personalised – Consultant Midwife and LMNS Workstream Update

A focus on care that is personalised is a key objective of the 3-year plan. The consultant midwife is leading on this Key objective also aligned within the 2024/25 NHS planning guidance. This includes membership within the LMNS Choice & Personalised Care Workstream which brings together consultant midwives and relevant clinical leads across the system with aims to standardise the deliverables of the national asks and further strengthen system wide learning.

A presentation has been collated to give a full overview of the choice and personalised care agenda, local progress, barriers or escalations and trajectory of the project. (Appendix 3)

This also relates to asks within Theme 4 of the 3 Year Plan, which focusses on the use of digital systems including the ability for service users to view the information they need to make informed decisions on their care.

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 Maternity Workforce Programme

This programme has been in place since July 2022, introduced as a Direct Support Offer from NHS England with the overall aim 'to grow midwifery establishment, support providers to reduce band five and six midwifery vacancies (where regional support allows), and to ensure the development of a sustainable midwifery recruitment pipeline with all providers.

Locally the programme has been led by the Recruitment and Retention Lead Midwife post which was implemented also in July 2022. National non recurrent funding has been allocated to all trusts for this post. An overview of the original ten objectives is as below, several are complete, the ongoing actions in the main are in relation to assessing the impact and sustainability period.

Objective	Status	Notes (Bold indicates action ongoing)
1. Employ a retention lead for midwifery workforce	Complete	☑ Recruitment & Retention Lead currently in post: Rachel Thorpe
2. To introduce and implement a staff engagement strategy	Ongoing	☑ Relaunch of SCORE culture survey supported – 44% response rate. Results being analysed and improvements driven via Quadrumvirate. ☑ Spotlight awards commenced **– sustainability and impact to be reviewed.** ☑ Psychological safety survey piloted on Postnatal Ward **- sustainability and impact to be reviewed.** ☑ Ensure exit interview process is being followed and survey results analysed for improvements routinely **– to be further reviewed.**
3. Review PWR data collection monthly with ELHT workforce analyst, with reporting processes within the trust to ensure we are providing accurate data	Ongoing	☑ PWR data webinar video circulated to relevant staff to gain understanding of PWR – **review if any new staff need to access this.** ☑ Initial roundtable meeting taken place with key colleagues to understand PWR process and challenges. Routine meetings diarised to review data prior to submission and identify any anomalies **– Review is data submissions are taking place as BAU or if routine meeting needs to be re-diarised.**
4. Launch and implement the full Professional Midwifery Advocate (PMA) programme	Complete	☑ Relaunch of the PMA programme in May 2022 - 15 PMA trained. ☑ Team and wider staff dedicated SharePoint sites set-up to support programme. ☑ Monthly PMA meetings implemented to support rostering and attendance. ☑ Ensure ongoing monitoring via a PMA programme action plan – implemented.
5. Improve training and resources for IT and digital skills	Ongoing	☑ Package of E-learning training created and launched by the Digital Midwifery Team. Staff to access by April 2024. **– Review impact and feedback from staff.** ☑ Further identified topics for e-learning packages to be developed e.g. personalised care/ care plans & management plans to be added. **– Link with digital team to ensure this is progressing. Understand further training package requirements.** ☑ **Digital Midwives to continue reviewing possibility of reverse mentoring.**

Objective	Status	Notes
6. Improve systems, processes, and guidance provided to staff within 48hrs following a serious incident by devising, implementing a bespoke Work Based Trauma proforma	Ongoing	☑ SOP implemented with bespoke Work Based Trauma proforma as an aid memoire for staff support following serious incident – **Review if implemented into BAU and impact.**
7. ELHT have a cohort of Maternity Support Workers (MSW) who wish to complete their midwifery training as part of the MSW apprenticeship programme	Ongoing	**Update required from UCLAN.**
8. Consider retired midwifes working in the local immunisation services to cover to vaccine clinics in maternity services	Complete	Option fully explored by previous Recruitment and Retention Lead. Unable to progress due to lack of interest from retired midwifes and vaccination programme for flu and whooping cough undertaken by Public Health.
9. Continue with a rolling recruitment programme with ~~a number of~~ recruitment days to schedule for midwives interested in working in community and midwifery-led care	Ongoing	☑ Recruitment open day was successful implemented in 2023 – look to hold recruitment days twice a year and undertake interviews at the same time. **Review if implemented/ sustained.**
10. Recruitment of two international midwives utilising the International Recruitment Toolkit	Complete	☑ 7 international midwives recruited and onboarding processes complete.

Due to the completion and successful progress of the original agreed objectives, a review of the programme and objectives is underway led by the Recruitment & Retention Lead Midwife and Maternity & Neonatal Project Manager. This allows us to revise the objectives and ensure they reflect the current status and challenges of the service for 2024-2025.

To support this, an in-depth review of the asks regarding workforce from national programmes has been completed including those from the NHS England High Impact Areas for Workforce, Ockenden Full Report recommendation and Maternity & Neonatal 3 Year Delivery Plan.

As a result, the first 3 new objectives proposed as additions to the ELHT Maternity Workforce Programme are with focus on:

- Newly Appointed Leaders
- Targeted support interventions for staff at different career stages: Maternity, Menopause, Retirement
- Support of staff following PSI: Serious Incidents/ Coronial Process
- Bespoke workforce meeting with terms of reference to establish a framework of monitoring
- National and local nominations of awards as a continuum for midwifery and support staff plan to extend to medical teams and non-clinical team members

This programme and the Recruitment and Retention Lead has also linked with in with the Trust CQA (Care Quality Academy) anti-racism framework to ensure that objectives regarding equality in recruitment and progression are a key focus within maternity.

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 Perinatal Quadrumvirate

NHS England states, ‘research shows that the most powerful factor influencing culture is leadership’ and therefore offered the Perinatal Culture and Leadership Programme to support services to understand the current culture, create and implement a collective leadership strategy, to create truly compassionate and inclusive working environments where all colleagues can thrive.

NHS England describes collective leadership as ‘a type of culture where staff at all levels are empowered as individuals, within and between teams to act to improve care within and across health and care organisations and systems – ‘leadership of all, by all and for all’.’

An immediate step taken was to implement the monthly Quadrumvirate meetings, following completion of the National perinatal culture and leadership training, ensuring that leaders from Maternity and Neonatology have a forum for joint-working and decision making.
The Clinical Directors for Obstetrics and Neonatology, Divisional Director of Midwifery and Nursing and the Directorate Manager for Maternity and Neonatology are all core members of this group. Each member is assigned as chair of the meeting on a rotational basis, the April meeting agenda is submitted as appendix 4 as an example of this collaborative working and leadership.

4.2 Shared learning and improving

The maternity and neonatal transformation team in conjunction with the perinatal quadrumvirate host a quarterly newsletter which is circulated to staff in both digital and print formats. This shares key updates, learning and improvements from across the directorates and is formatted to follow the four themes for the 3-year delivery plan. This helps with staff understanding of the overall programme and our local ongoing pieces of work. The most recent iteration is submitted as appendix 5.

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

Objective 12. Making better use of digital technology.

5.1 'Supporting the roll out of electronic patient records to enable women to access their records and interacting with their digital plans and information to support informed decision-making.'

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

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

The national CNST-MIS results have now been published as of the 10th of April 2024 and confirm that ELHT Maternity Services achieved compliance against all 10 safety actions for CNST Year 5. The incentive payments to Trust are due to be issued in May 2024.

7. Recommendations

7.1 The committee is asked to acknowledge this summary paper under the four themes of the three-year plan 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 6)

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 – Mr 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 – Choice & Personalised Care

Choice & Personalised Care - A

Appendix 4 – Perinatal Quadrumvirate Meeting

Quad Agenda.docx

Appendix 5 – Mat Neo Away Day Newsletter

Mat Neo newsletter - 5th edition (2).pdf

Appendix 6 – Floor to Board Minutes

[2] 04.04.2024 - Floor to Board.docx

CNST SA 10 update May 24

Name	Incident	MNSI consent	MNSI DOC letter sent	NHSR leaflet given	Referred to MNSI	Case accepted	Reported to NHSR	Claims Reporting Wizard
Emma Daffern	Cooled baby/ Neonatal death	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Abdullah	Cooled baby	Yes	Yes	Yes	Yes	Awaiting decision	Awaiting decision	Awaiting decision
Bell	Cooled baby	Yes	Yes	Yes	Yes	Awaiting decision	Awaiting decision	Awaiting decision
Rafiq	? HIE	Yes	Yes	Yes	Yes	No	N/A	N/A
Gunton	NND	Yes	Yes	N/A	Yes	No	N/A	N/A
Mani	Maternal Death	Yes	Yes	N/A	Yes	Yes	N/A	N/A
Nutter	Cooled	Yes	Yes	Yes	Yes	No	N/A	N/A
Khan	Cooled	Yes	Yes	Yes	Yes	No	N/A	N/A
Sheen	Maternal death	Yes	No	N/A	Yes	Yes	N/A	N/A
Hussain	Cooled Baby	Yes	Yes	Yes	Yes	No	N/A	N/A
Carr	Cooled Baby	Yes	Yes	Yes	Yes	Awaiting decision	Awaiting decision	Awaiting decision
Arthern	Intrapartum stillbirth	Yes	Yes	N/A	Yes	Awaiting decision	N/A	N/A

Evidence of letters and referrals and acceptance are on Sharepoint;

MNSI rejection and acceptance information CNST year 5

Evidience of MNSI NHSR DOC letters given to families

TRUST BOARD REPORT **Item** **73**

15 May 2024 **Purpose** Approval
Assurance
Information

Title	Communications Activity Report - Q1 2024-25
Executive sponsor	Miss S Wright, Joint Executive Director of Communications
Date Paper Approved by Executive Sponsor	8 May 2024

Summary: This paper outlines proposed activity delivered by the communications team, along with other colleagues, in Q4 and that planned for Q1.

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	-
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:

For Trust Board only: Have accessibility checks been completed? Yes/No

1. SUMMARY

This paper sets out the key activities planned by the communications team for delivery in the next quarter – April to June 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
- Management of social media channels or the website
- Development of the 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 Executive team about upcoming activity. The quarterly report will also include completed activity from the previous quarter.

3. PREVIOUS THREE MONTHS

Key data for January 1 – March 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. We are discouraging teams from setting up new profiles unless there is a clear business need.

elht.nhs.uk website	
Page views	797,000 (10% increase on previous three months)
Visitors to the elht.nhs.uk site	306,000 (12% increase on previous three months)

ELHT Facebook	
Followers	22,242 (up 542 since last quarter)
Total reach (number of people who may have been seen our posts)	663,520
Total engagement (likes, shares and comments)	72,496

ELHT X (formerly known as Twitter)	
Followers	10,700 (up 100)
Total impressions from (number of times our posts may have been viewed)	72,508
Total engagements	675

ELHT LinkedIn	
Followers	9,156 (up 431)
Total impressions	33,780
Total reactions	576

Nextdoor	
Number of posts	11
Number of Members as of 31 March	67,644
Total impressions (number of times our posts may have been viewed)	64,136 (up 27,425 on previous quarter)
Total engagement (reactions, link clicks, shares and comments)	152

Communications activity

The following communications activity was a focus during quarter four of 2023/24. This list does not include the business-as-usual activity noted above or some campaigns which have continued into quarter one of 2024/25 and are therefore referenced in item 4.

MEASLES – With cases of measles increasing across the country, a dedicated hub for information has been set up to support colleagues. It includes details about personal protective equipment, posters to display in receptions, briefings provided by the UK Health Security Agency and other useful information. Bespoke posters have been provided to teams to help protect patients and colleagues and key information has been shared on a regular basis. Communications colleagues have also supported the ELHT measles cell with development of targeted patient facing communications and are part of a multi-agency communications group.

WINTER PRESSURES – A joint winter communications plan co-produced by all Provider Collaborative Board Trusts and the ICB drew to a close at the end of March.

The plan focused on three key areas: prevention, signposting and self-care. Evaluation of the campaign is being carried out at a system-level by the ICB, with the Provider Collaborative Board members coming together to learn from the work ahead of launching a refreshed winter campaign for 2024/25.

COLD WEATHER – As East Lancashire faced amber cold weather and health alerts, information was shared to support colleagues and patients. This included weather warnings about snow to help with journeys to and from work, reminders about business continuity planning and tips about how to stay safe. A number of short animation videos were also created that were used by Trusts across Lancashire and South Cumbria.

RAMADAN AND EID – With a large number of colleagues observing fasting, information was shared about guidance and webinars organised nationally. This aimed to raise awareness of Ramadan and provide advice to managers and colleagues so they could support anyone in their team who was fasting. Following the success of our annual Christmas Cracker campaign, which encourages colleagues to put forward nominations for those who go above and beyond, a similar competition, Shine a Light, was organised to mark Eid focussed on thanking colleagues.

PATIENT FLOW – In addition to the weekly updates in our regular communication channels about the work of community teams, a printed newsletter was created to highlight how these teams were supporting discharge of patients. The special edition newsletter helped target colleagues who are not desk based and who may have missed important updates about the development of community services. The newsletter was distributed to all wards around the Trust to encourage them to refer patients where appropriate.

The Communications team continues to work with other Trusts within Lancashire and South Cumbria as well as Place-based communication leads to share consistent messages to help ease pressures on our emergency and urgent care pathways. This has included creating digital marketing materials, videos, posters and copy that can be used by organisations

across the area as part of a collaborative campaign. This activity is also being supported by the ICB engagement team who arranged of briefings with community groups and volunteers to increase the reach of key messages.

PRESSURES IN ED – A series of videos were created to explain services provided at Urgent Treatment Centres and the Minor Injuries Unit and what patients should expect on attendance. They were shared on the Trust's social media to draw attention to alternative support available for people with non-life threatening health needs to avoid any unnecessary visits to ED. They have so far accumulated 15,000 views on social media channels.

A review of the ELHT website was carried out specifically focussed on information about ED. Pages have been refreshed, with additional helpful information and improved navigation to support patients and visitors to find what they need as easily as possible. This new content is also being repurposed for digital screens within the ED department.

The Communications team continues to work with partner Trusts in Lancashire and South Cumbria, as well as Place-based communication leads, to share consistent messages to support patients during winter. They focus on alternative pathways to ED or provide advice to prevent health conditions deteriorating. This work included creating digital marketing materials, videos, posters and copy that can be used by organisations across Lancashire and South Cumbria as part of a collaborative campaign. The activity is also being supported by the ICB engagement team who arranged a series of briefings with community groups and volunteers to increase the reach of key messages.

MARTHA'S RULE – The Trust has formally registered its expression of interest in being part of the first phase of the implementation of Martha's Rule. This follows the Trust's launch of 'Call for Concern', a focused campaign to provide a single point of contact for anyone to use if they are worried about the deterioration of a patient's condition. Posters including a QR code linking to detailed information on ELHT website, have been distributed throughout the Trust.

YOU'RE NOT OK, LET'S TALK – Trust communications continue to spotlight wellbeing support available to colleagues. It is part of the 'you're not OK' campaign, which launched in November encouraging colleagues to check in on each other and highlighting professional support with their current waiting times. Weekly updates share a wide range of help – from counselling through to financial advice. The campaign branding includes images of colleagues to create a more relatable personal connection.

NATIONAL APPRENTICESHIP WEEK – To mark National Apprenticeship Week, colleagues were asked to share details of apprentices who had made a difference and 86 submissions were received. The recognition campaign organisation by the Communications team was used as an opportunity to highlight the Trust's apprenticeship scheme and encourage further interest. Congratulation certificates are in the process of being distributed and inspiring stories submitted as part of the campaign will be shared to encourage further interest in apprenticeships.

0-19 HEALTHY CHILD PROGRAMME – As the Trust starts to deliver the 0-19 Healthy Child Programme in Blackburn with Darwen, around 100 colleagues are transferring from Lancashire and South Cumbria NHS FT to ELHT. The Communications team has worked closely with the project team to create a suite of messages and updates that can be used to explain the change and provide reassurance. This includes a letter to schools and family hubs and newsletter content for use internally and by partner organisations.

£15,000 CHARITY BID – The hospital charity, ELHT&Me, has been supported with an internal campaign encouraging teams to put forward their cases for charity funding. The money will be used to improve patient experience and to increase awareness of the work of the charity. Colleagues were asked to bid for up to £15,000, with promotion across all the Trust's internal communication channels. It led to over 100 submissions from a diverse range of departments and teams.

MATERNITY VIDEOS – A series of videos have been filmed to support new mums. The Communications team worked with colleagues in Maternity to develop scripts that could help as part of the discharge process, providing a library of helpful guides. The films made possible through a grant from Electricity North West Partnership, are in the editing stage. Work is currently taking place to translate scripts into different languages so subtitles can be added to ensure the films support a wider audience.

CAUSE OF DEATH DOCUMENTARY - The third series of Candour's remarkable Cause of Death documentary for Channel 5 concluded in January. Now in the editing and production phase, a broadcast date is yet to be set. The series will again provide and insightful exploration of coronial investigations explaining how unexplained or suspicious deaths are investigated.

EMERGENCY THEATRES DOCUMENTARY – Filming took place over a three-week period in January of a new documentary series about the Trust's emergency theatres. The programme is the brainchild of Proper Content, commissioned by 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.

Master interview, editing and post production of the series will take place in the next quarter with a broadcast date marked for Autumn.

CLINICAL PORTAL DISCONTINUATION – Communications supported the Clinical Informatics team in raising awareness of the discontinuation of clinical portal in January 2024. The key message was 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. Feedback on the roll out was mostly positive.

DIAGNOSTICS SUPPORT - Rossendale Community Diagnostics Centre (CDC) piloted phlebotomy services for four weeks. Direct mailshots, emails and telephone calls to GP practices and strong social media output using patient case studies formed part of the communications plan to raise awareness**.**

INTRANET – The initial scoping work and draft design of the upcoming SharePoint intranet began in January. By December 2024, we will migrate from an external platform to SharePoint to reduce costs, improve functionality and provide a more personal experience for colleagues.

WEBSITE ACCESSIBILITY – Work to improve accessibility on the public-facing website continued at pace, bringing together a multi-department team of people to support the conversion of all documents hosted on the website. The Communications team organised training to show how to convert documents into accessible web pages. This will also support the corporate governance team in improving accessibility of statutory documents such as board papers and annual reports.

INDUSTRIAL ACTION – The team continued to share appropriate messages agreed at a regional level with audiences both internal and external.

NATIONAL STAFF SURVEY – following the creation of a refreshed awareness campaign in 2023 which saw 45% of colleagues (just under 4,000 people) take the time to complete it, the Communications team shared the results of the survey. This included an all-user email, bulletin content, intranet page and external communications prepared on an 'if asked' basis.

- **AWARENESS DAYS –** The team has continued to support a wide range of awareness days during quarter three, including:
  - Colleague Care Month
  - Islam Month
  - Race Equality
  - Random Acts of Kindness week
  - National Cancer Clinical Nurse Specialist day
  - Ovarian Cancer Awareness Month
  - International Women's day
  -

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 Q1 2024/25

Below is a snapshot of some of the key activity which will be undertaken by ELHT Communications team during quarter one - April to June 2024.

HEART CARE UNIT – As the Cardiac Care Unit and Cardiology Ward prepare to move to a new location at Royal Blackburn Teaching Hospital, a communications plan has been developed to ensure colleagues and key partner organisations are aware of changes. A range of communication channels will be used as this plan is implemented over the next two months, including briefings, photos and video show rounds.

COMMUNITY TRANSFERS – Plans continue to be developed regarding the future delivery of community services. A suite of communications is being prepared to support any changes, which includes internal updates, MP briefings and communications to provide reassurance to service users. The Communication team is part of the overarching project

team and is working alongside communications leads at Lancashire and South Cumbria NHS FT and the Integrated Care Board to ensure consistent messaging.

EMERGENCY CARE VILLAGE – With work due to get underway to develop an Emergency Care Village at Royal Blackburn Teaching Hospital, a communications plan will support any movement of team or department to keep colleagues, patients and visitors informed. The Communications team is part of the project team that has been set up to manage activity over the next year. In Q1, the communications focus will be on the temporary change of location for the Resuscitation team.

SUPPORTING PRESSURES – An evaluation of the multi-agency communications activity carried out during the winter is underway. The campaign focused on helping people use the right service for their health needs, self-care and prevention. Communication leads are now focussed on summer messaging and lessons learned from the winter campaign will help shape the approach.

INDUSTRIAL ACTION – With news that junior doctors have a fresh mandate for industrial action, communication planning will continue to take place as and when any dates are announced. Alongside working with the industrial action Incident Management Team on internal information, messages will be agreed across the Lancashire and South Cumbria system, reminding communities to continue to attend appointments unless advised otherwise and to use health services appropriately.

OUTPATIENTS EPR MPAGE – Ongoing optimisation of the EPR continues this year, including a new 'Mpage' solution which will go live in April 2024. The solution has been designed for clinicians in Outpatients to improve efficiency and save time. Communications are supporting with raising awareness of the improvement and sharing 'you said, we did' messages Trust-wide to provide assurance that feedback is being listened to and actioned.

EPR ONE YEAR ANNIVERSARY – June 2024 marks one year since the EPR went live across the Trust. Communications will support the Data and Digital team to celebrate this pivotal milestone in the Trust's digital transformation journey with colleagues whilst remaining cognisant of the current frustrations.

IMPROVING FIRST IMPRESSIONS – The Communications team is working with Estates and Facilities to improve the patient and visitor journey through the hospital. This work will initially focus on Royal Blackburn Teaching Hospital and will coincide with lifecycle improvement activity on the hospital's corridors, taking the opportunity to improve location of information and noticeboards and the quality of information on display.

STAR AWARDS – Nominations for the 2024 Star Awards opened mid-March. Following feedback from last year's awards, the process and categories have been reviewed to make it easier for people to find an appropriate category and enter the awards. Nominations close mid-April and following a judging process, a virtual celebration event will be held in July to highlight the fantastic people and teams who work at the Trust.

ACTIVE HOSPITAL – The Communications team will be supporting a new project that aims to get patients moving more to support recovery. The Active Hospital campaign will provide advice and information to colleagues, patients and visitors using a variety of mediums. Scoping is currently being carried out to assess key objectives and activities in order to finalise communication requirements.

COMMUNITY PATHWAYS – As part of ongoing activity to promote the work of community services and aid patient discharge and flow, a video is being developed to highlight different

pathways. This will be used to raise awareness among colleagues of the support available. It will be supplemented with additional visual and written content that will be linked to the video, making use of all communication channels within the Trust.

OPENING OF SPIRITUAL CARE CENTRE – The new facility is set to formally open in May with a special event being organised by the Spiritual Care team with support from Communications.

ANTI-RACISM – The Communications team will be working with the Trust's Equality, Diversity and Inclusion lead to create an anti-racism movement as part of an ongoing commitment to tackling racism. The movement will encourage people to better inform themselves on anti-racist behaviours and practices. It will build on zero tolerance of abuse and violence of any kind – including hate incidents, such as racism, disablism, homophobia or any discrimination experienced by colleagues from patients or the public.

STAKEHOLDER EVENT – The Trust will be holding it's next virtual stakeholder event on 14 May. This has been rescheduled to take place after the local elections to abide by the NHS's pre-election guidance. Lead by the Chair, Shazad Sarwar, Executive Directors will provide an overview of our performance, details of our improvement activity and other key information.

INTRANET – The next step in the project is to identify the existing SharePoint sites and intranet pages and remove any redundant information. During the next quarter, we aim to start the build of the intranet and to begin engagement with clinical and non-clinical colleagues.

NHS PARLIAMENTARY AWARDS – Information is being collated for this year's Parliamentary Awards. This will be sent to local MPs to encourage them to put forward entries spotlighting ELHT, ahead of the deadline for submission in April.

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 International Day of Midwives, International Nurses Day, Dying Matters Week and Bowel Cancer Awareness Month. 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
08/05/2024

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** 75

15 May 2024 **Purpose** Assurance

Title	Integrated Performance Report
Report Author	Mr D Hallen, Director - Data and Digital
Executive sponsor	Mrs S Gilligan, Chief Operating Officer

Summary: This paper presents the corporate performance data at March 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	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:

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 76% improvement trajectory and threshold in March at 78.81%.
- Performance against the ELHT four hour standard was 77.96% in March.
- No patients waited over 78 weeks.
- The number of RTT pathways over 65 weeks has reduced to 191, and is below the trajectory.
- The Cancer 28 day faster diagnosis standard was above target in February at 83.2%.
- Friends & family scores remain above threshold for inpatients, outpatients, and community, and was above threshold for maternity in March.
- The overall Trust performance from the range of patient experience surveys was above the threshold of 90% for 4 of the 4 competencies.
- The Trust turnover rate continues to show a significant reduction on pre-covid levels at 6.1%.
- The Trust vacancy rate is below threshold at 4.5%.

Areas of Challenge

- There were 5 Steis reportable incidents in March. None of these were never events.
- There were 16 healthcare associated clostridium difficile infections identified in March, bringing the year total to 101 vs the annual trajectory of 53.
- There were 9 post 2 day E.coli bacteraemia identified in March, bringing the year total to 134 vs the annual trajectory of 129.
- There were 0 P.aeruginosa bacteraemia identified in March, bringing the year total to 15 vs the annual trajectory of 7.
- There were 7 Klebsiellas detected in March, bringing the year total to 49 vs the annual trajectory of 41.
- There are some issues impacting the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). This includes: coding backlog, removal of SDEC data and data quality in the submission. As a result, neither metric is currently considered a robust measure of mortality.
- There was 1 stillbirth in March.

- There were 1192 breaches of the 12 hour trolley wait standard (47 mental health and 1145 physical health).
- There were a total of 3047 ambulance attends with 1259 ambulance handovers > 30 minutes and 388 > 60 minutes.
- Friends & family scores in A&E are below threshold.
- Performance against the cancer 62 day standard remains below the 85% threshold in February at 70.4%.
- Performance against the cancer 31 day standard remains below the 96% threshold in February at 94.1%.
- The 6wk diagnostic target was not met at 7.7% in March.
- In March, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 73,174, which is above the trajectory.
- In March, there were 3,792 breaches of the RTT >52 weeks standard, which is above the trajectory.
- In March, there were 8 breaches of on the day operations cancelled and not rebooked within 28 days.
- Sickness rates are above threshold at 5.6%
- Compliance against the Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 16%.
- The Trust is reporting a deficit of £15.4m for the 2023-24 financial year, a movement of £0.8m in the month, in line with the position forecast last 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	Mar-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		
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	12		
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	4		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	53	101		
M124	E-Coli (HOHA)	n/a	3		
M124.ii	E-Coli (COHA)	n/a	6		
M124.iv	E-Coli cumulative from April (HOHA & COHA)	129	134		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	0		
M155.ii	P. aeruginosa bacteraemia (COHA)	n/a	0		
M155.3	P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)	7	15		
M157	Klebsiella species bacteraemia (HOHA)	n/a	3		
M157.ii	Klebsiella species bacteraemia (COHA)	n/a	4		
M157.3	Klebsiella species bacteraemia cumulative from April (HOHA& COHA)	41	49		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	1		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	38.9		
M69	Serious Incidents (Steis)	No Threshold Set	5		
M70	Central Alerting System (CAS) Alerts - non compliance	0	1		
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	26%		
C40	Maternity Friends and Family - % who would recommend	90%	94%		
C42	A&E Friends and Family - % who would recommend	90%	72%		
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%	93%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	97%		
C15	Complaints – rate per 1000 contacts	0.40	0.14		
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	N/A	N/A		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at May-23)	N/A	N/A		
M74	Hospital Standardised Mortality Ratio - Weekday (as at May-23)	N/A	N/A		
M75	Hospital Standardised Mortality Ratio - Weekend (as at May-23)	N/A	N/A		
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%	78.0%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	76.0%	78.8%		
M62	12 hour trolley waits in A&E	0	1192		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	1259		
M84	Handovers > 60 mins (Arrival to handover)	0	388		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	43.3%		
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set	56.5%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total		73174		
C37.4	Referral to Treatment (RTT) 65 Weeks (Ongoing)	628	191		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	2082	3792		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	5.0%	7.7%		
C50.1	62d General Standard 85%	85.0%	70.4%		
C50.2	31d General treatment standard 96%	96.0%	94.1%		
C50.3	28d General FDS 75%	75.0%	83.2%		
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	8		
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%	6.1%		
M78	Trust level total sickness rate	4.5%	5.6%		
M79	Total Trust vacancy rate	5.0%	4.5%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	77.0%		
M80.35	Appraisal (Consultant)	90.0%	92.0%		
M80.4	Appraisal (Other Medical)	90.0%	99.0%		
M80.2	Safeguarding Children	90.0%	95.0%		
M80.21	Information Governance Toolkit Compliance	95.0%	94.0%		
F8	Temporary costs as % of total paybill	4%			
F9	Overtime as % of total paybill	0%			
F1	Cumulative variance to planned financial performance (deficit) (£m)	£0.0	-£14.8		
F2	WRP achieved YTD - variance to plan (£m)	£0.0	-£12.3		
F3	Liquidity days	-25.8	-17.6		
F4	Capital spend v plan	85.0%	100%		
F18a	Capital service capacity	0.6	0.4		
F19a	Income & Expenditure margin	-3.5%	-2.0%		
F21d	Agency spend as a proportion of total pay bill (£m)	3.7%	3.4%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	91.2%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	97.3%		
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.

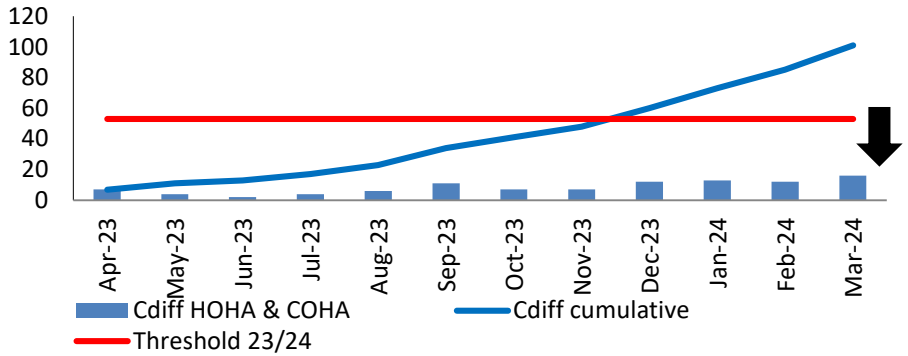
KEY

SPC Control Limits

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

SAFE

C Difficile (HOHA &



From April 2024 there will be a change in reporting of hospital acquired HCAI data. Where a patient has been admitted directly after attendance to A&E it is requested the decision to admit date is entered as the admission date rather than the inpatient admission date.

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

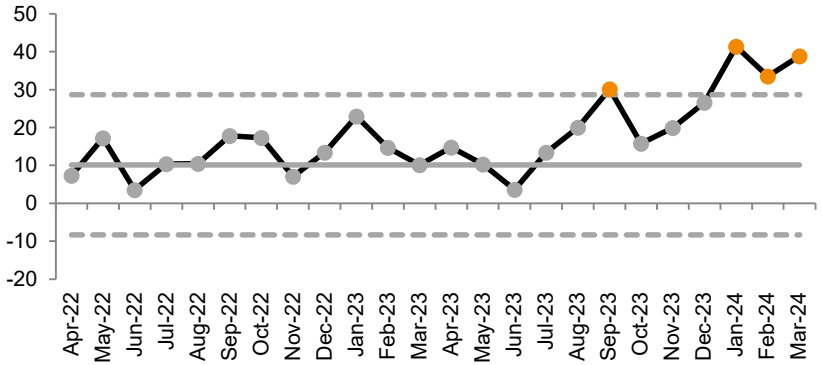
The Clostridium difficile objective for 2023/24 is to have no more than 53 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)'. The figure for cases reported in 2023/24 was 101.

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 16 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in March; 12 HOHA and 4 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 March.

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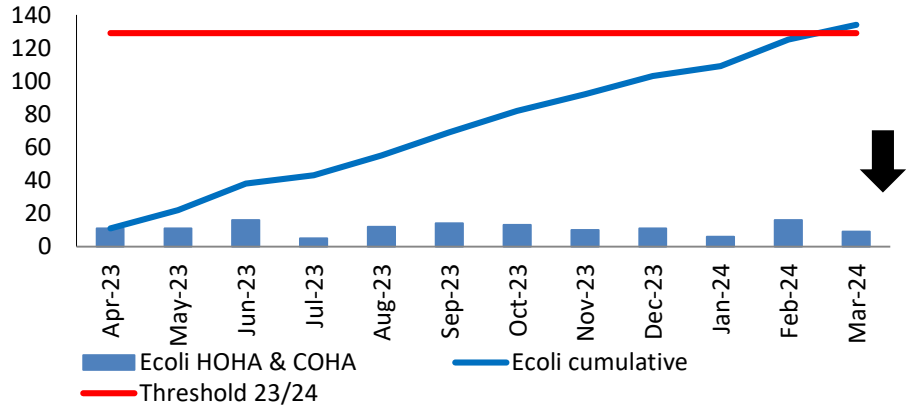
E. Coli (HOHA & COHA)

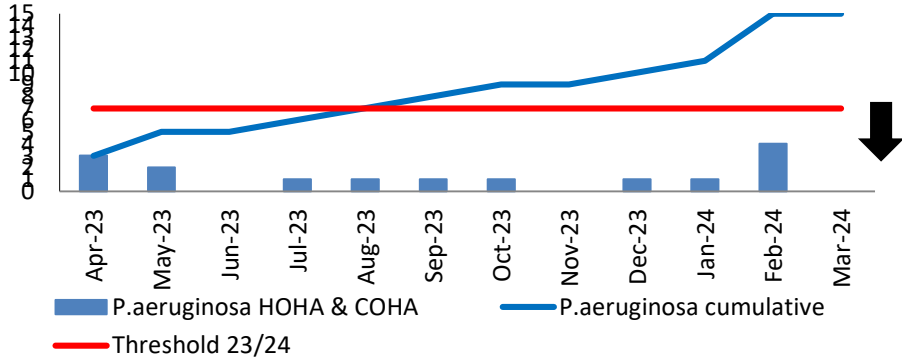


The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

The 23-24 trajectory for reduction of E.coli is 129 HOHA & COHA. The total for 2023-24 was 134.

There were 9 reportable cases of E.coli bacteraemia identified in March; 3 HOHA and 6 COHA.

P.aeruginosa

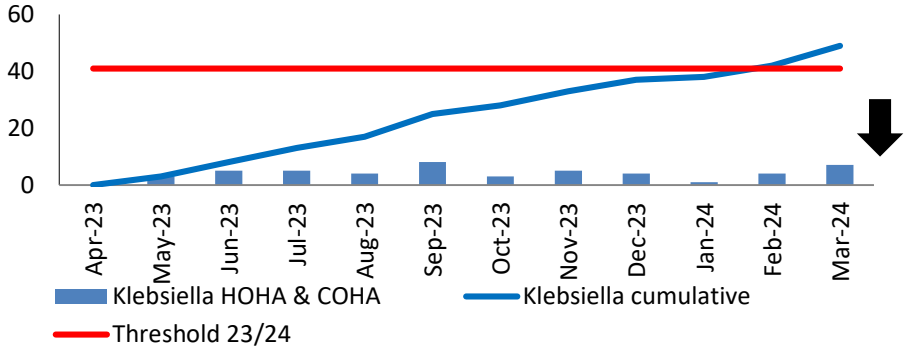


From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England.

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

There were no reportable case of Pseudomonas identified in March. This brings the year total to 15 vs the annual trajectory of 7.

Klebsiella



There were 7 reportable cases of Klebsiella identified in March; 3 HOHA and 4 COHA. This brings the year total to 49 vs the annual trajectory of 41.

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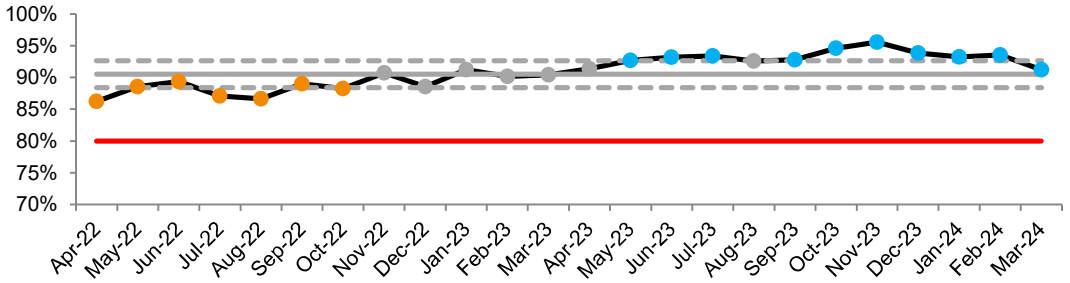
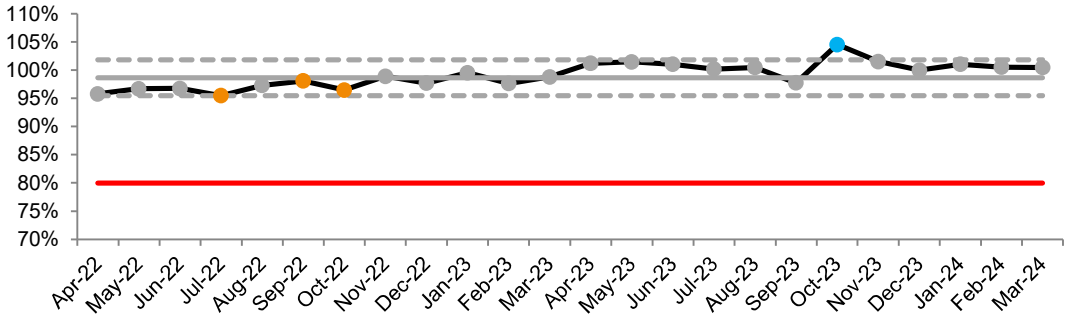
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



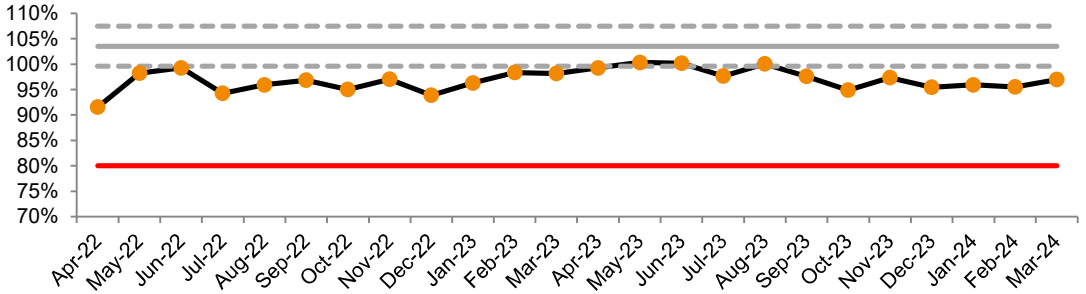
The average fill rate for registered nurses/ midwives during the day is showing improving variation when compared to the pre covid levels. Based on current variation it will consistently be above threshold.

Registered Nurses/ Midwives - Night



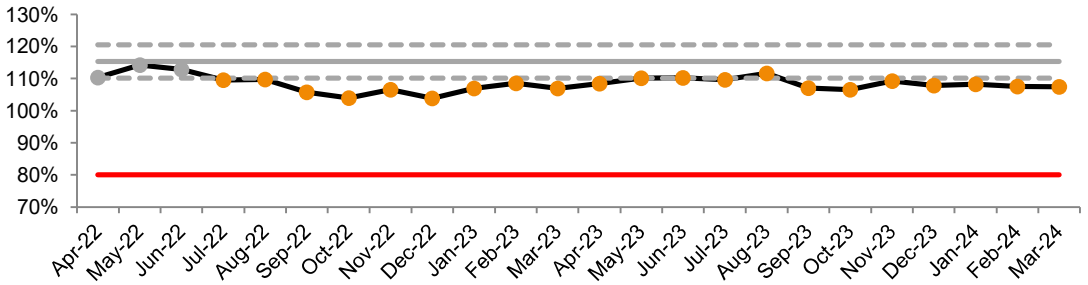
The average fill rate for registered nurses/ midwives at night is showing normal variation when compared to pre-covid levels. Based on current variation it will consistently be above threshold.

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 pre covid levels, however based on current variation will consistently be above the threshold.

SAFE

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 March

	Day Average Fill Rate %		Night Average Fill Rate %	
Hospital site	**Registered nurses / midwives (%)**	**Care staff (%)**	**Registered nurses / midwives (%)**	**Care staff (%)**
Royal Blackburn	90.2	94.0	101.3	108.2
Burnley General	95.6	98.6	97.6	106.9
Clitheroe Community	84.5	117.7	98.9	100.0
Pendle Community	92.9	116.0	100.0	104.5
Total	**91.2**	**97.0**	**100.5**	**107.5**

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
Mar-24	91.2%	97.0%	100.5%	107.5%	30,877	8.23	0	2	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 (%)
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
Feb-24	93.5%	95.5%	100.5%	107.6%	29,830	8.04	1	2	1	1
Mar-24	91.2%	97.0%	100.5%	107.5%	30,877	8.23	0	2	0	1

SAFE

There were 41 wards included in the review.
During March <80% fill rate:

< 80% Care staff		
Day	NICU	59.70%
Day	Critical care	75.40%
Night	NICU	48.40%

NICU – NICU HCA funded establishment does not cover all shifts. Safely staffed for acuity.
Critical Care – HCA sickness, safely staffed for the acuity.

National Red Flags

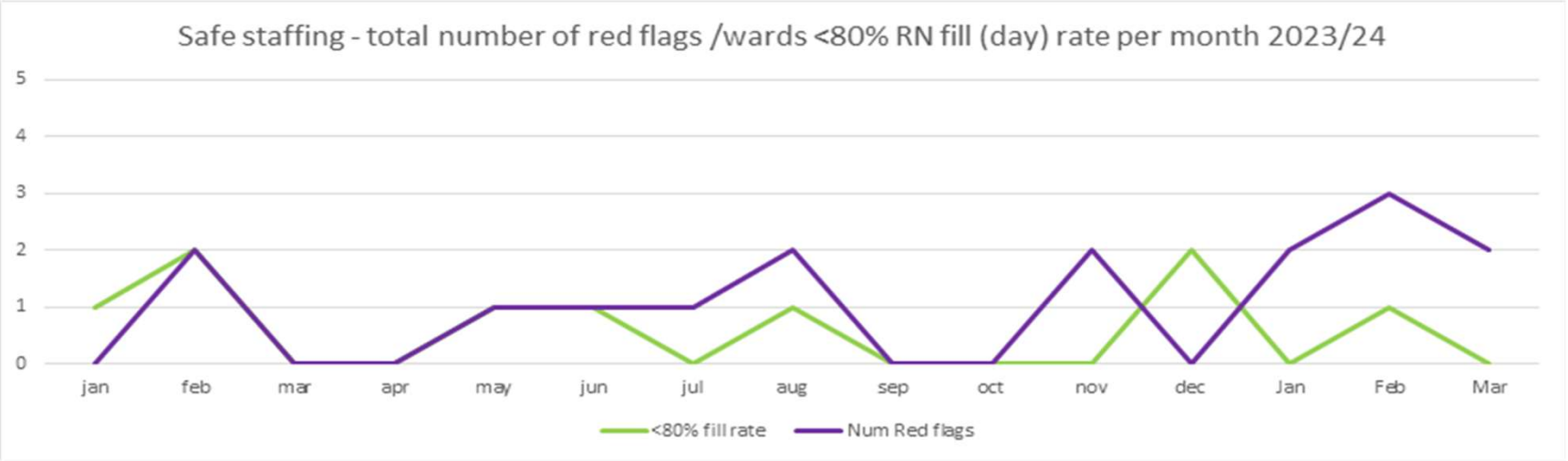
1 national nursing red flags reported in March.
1 midwifery red flags reported in March.

CIC
19 - Staffing shortfall due to last minute sickness on one shift. Delays and omissions in regular checks and medication administrations escalated to the matron. No harm to patients.

FC
Antenatal – Due to high activity and high acuity there was a delay of two or more hours to start the beginning of the induction process.MDT risk assessment deemed safer to delay. No harm or impact to patient / baby.

SAFE

The graph below demonstrates the number red flags and wards < 80% per month trend.



Family Care

Maternity (Midwife to Birth Ratio)

Month	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Staffed to full Establishment	01:27	01:27	01:26	01:26	01:26	01:26	01:26	01:26	01:27	01:26
Excluding mat leave	01:27	01:27	01:26	01:26	01:26	01:26	01:26	01:27	01:26	01:27
Maternity leave	3.40	3.40	3.04	3.04	3.04	5.04	4.40	6.40	6.40	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	21.58	17.50	20.74	19.14	22.26	16.12	15.60	24.36	24.19	23.16
Midwifery vacancies (Maternity VRS) -11wte	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	10 wte backfill for Maternity leave incl	12 wte backfill for Maternity leave incl

SAFE

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.

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

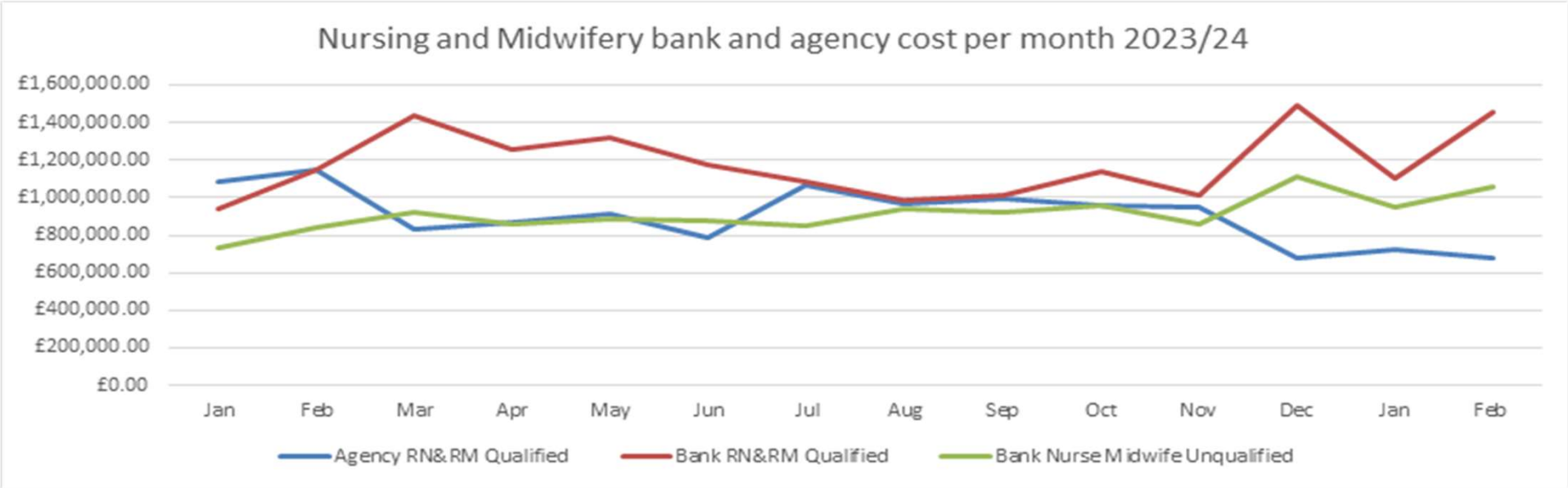
International Nursing Recruitment – agreed to temporarily pause the recruitment of International Nurses until April 2024. This is largely due to an evidenced reduction in appropriate band 5 nursing vacancies.
20 in April; 18 in May; 20 in June; 20 in July; 20 in August; 20 in September; 16 in October; 16 in November; 11 in December; 8 in January; Paused – 5 due in May, 5 due in July.

HCA Recruitment / Retention - ESR data 97.15 band 2 WTE HCA vacancies. Direct recruitment to from bank to substantive posts is underway and for the remaining vacancies a central HCA recruitment event is being planned.

Professional Judgement – formal professional judgement paper to Trust Board.

Trainee Nurse Associate - 24/25 numbers to be agreed and confirmed.

Nursing Bank and Agency Spend



March bank and agency spend not available at the time of the report.

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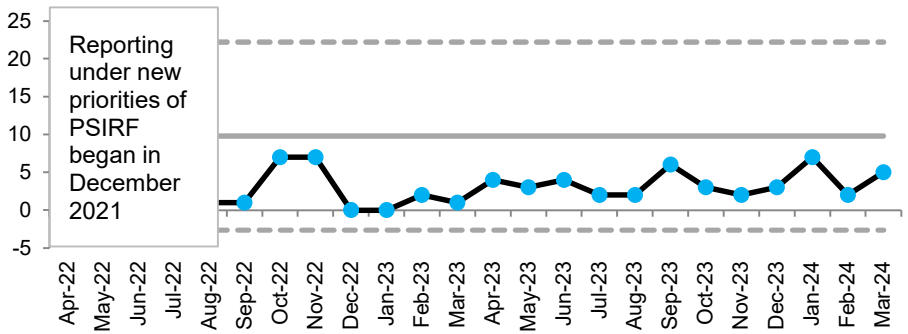
Serious Incidents



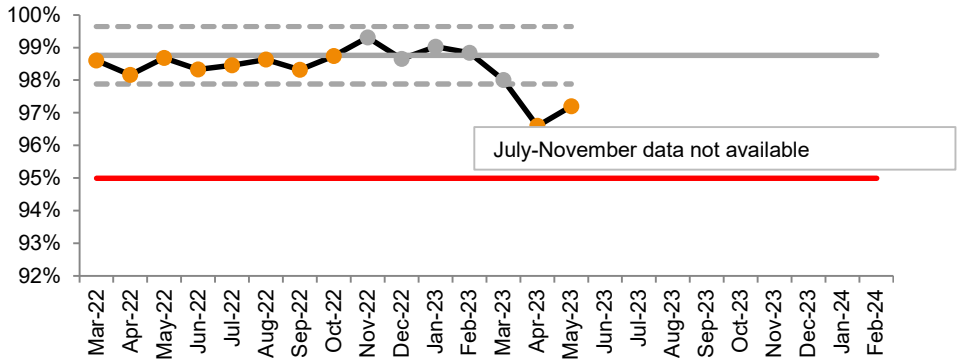
There were no never events reported in March.

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

PSIRF Category	No. Incidents
National priority - death of a person with learning disability	1
National priority - incident resulting in death	2
National priority - maternal death	1
Local priority - anti-coagulant medication errors	1

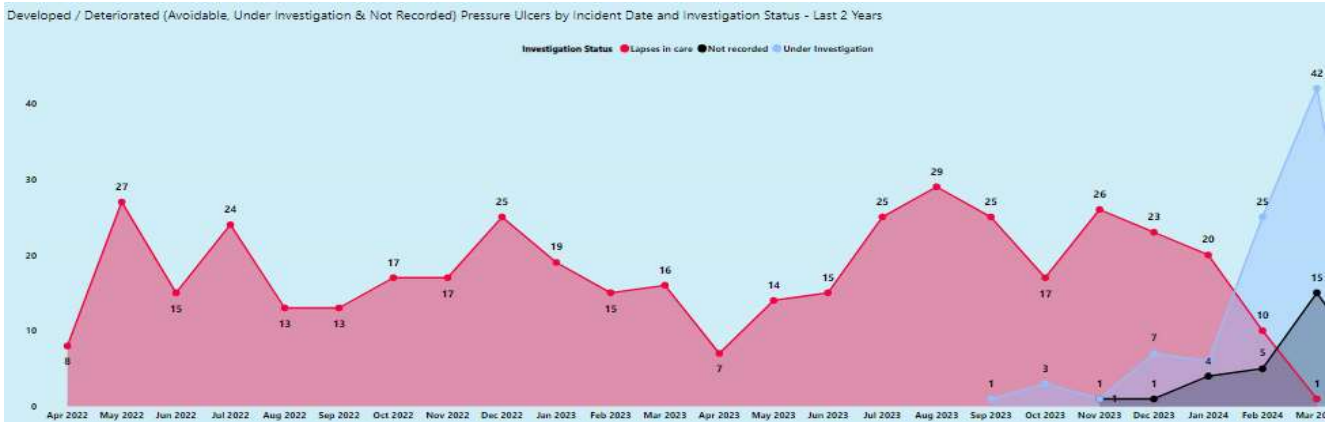
VTE assessment



Venous Thromboembolism (VTE) assessment trend - data not available for July-February.

Pressure Ulcers

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



	Total Number of Incidents developed under ELHT Care		
		2022-2023	1.4.2023 – 31.3.2024
		717	907
Category of Pressure Ulcer	Total Number of Lapses in Care		
	2021-2022	2022-2023	1.4.2023 – 29.02.2024
2	44	73	61
3	14	6	6
4	3	9	14
Unstageable	25	33	28
DTI	53	92	106
TOTAL	**139**	**213 (29%)**	**210 (23%)**

210 lapses in care have been confirmed from the 1 April 2023, which is currently an improved position from 2022-2023. There has been a 20% increase in the number of incidents reported during 2023-2024 which is reflective of the increase complexity and acuity of the patients under the care of ELHT and unpresented attendances and waits in ED.

The main areas of concern which are being addressed by the Pressure Ulcer Steering Group include the need for risk assessments being undertaken in line with Trust Policy, prevention measures being instigated more timely and improved documentation.

Compliance with relevant mandatory e-learning continues to improve; 84.10% for the pressure ulcer module and 93.70% for the moisture associated damage module.

From the 1st April 2024 changes were made to the Datix system removing the option of DTI and Unstageable pressure sores therefore aligning ELHT to the National Wound Care Strategy recommendations.

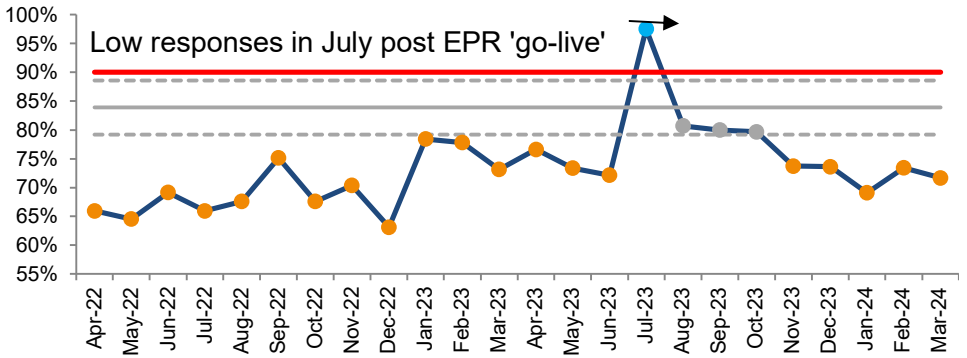
Community Services have started to use the recommended Purpose T Risk Assessment tool replacing the Waterlow Risk Assessment tool which will be evaluated in June 2024 prior to Trust wide roll out. It is hoped that this will improve the identification of patients at risk of pressure damage earlier and ensure that prevention measures are put in place in a more timely manner.

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.

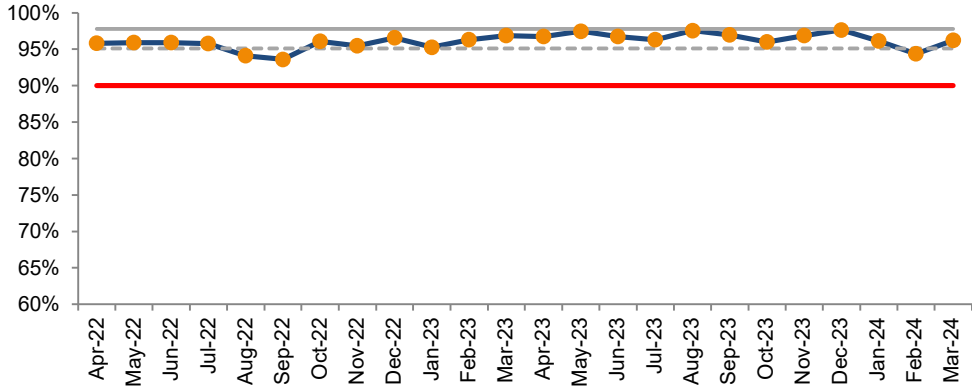
Baseline period for SPC comparison is Apr 18 - Mar 20

Friends & Family A&E



A&E scores are below threshold in March. 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.

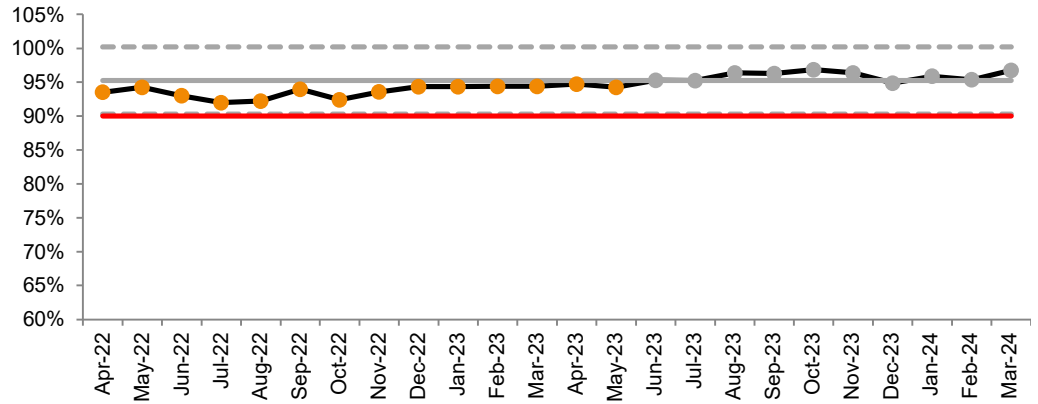
Friends & Family Inpatient



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

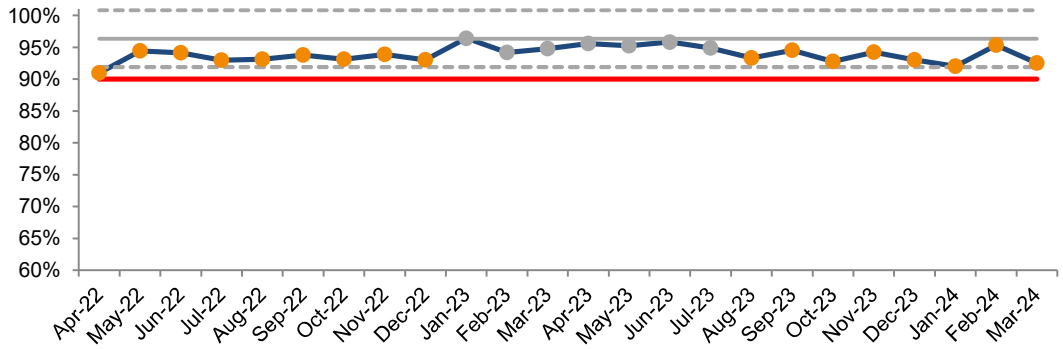
Friends & Family Outpatients



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.

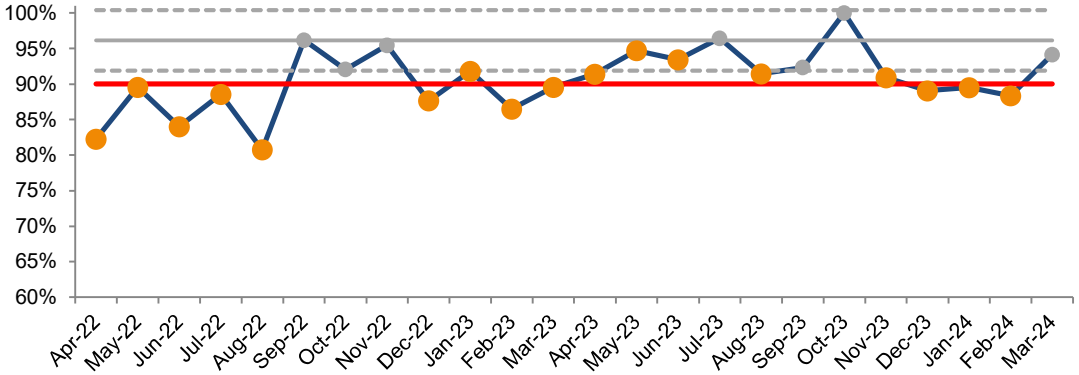
Friends & Family Community



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

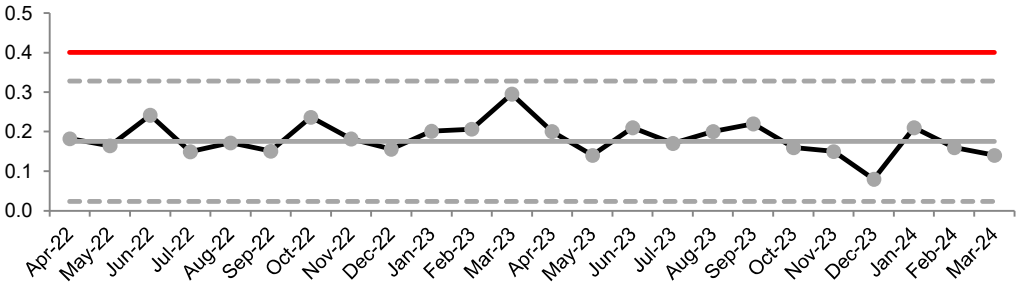


Maternity scores are above target this month and show normal variation when compared to the pre-covid levels.

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

CARING

Complaints per 1000 contacts



The Trust opened 19 new formal complaints in March.

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 March the number of complaints received was 0.14 Per 1,000 patient contacts.

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

Patient Experience

		Dignity	Information	Involvement	Quality	Overall
Type	**Division**	Average Score	Average Score	Average Score	Average Score	Average Score
Antenatal	Family Care	100.00	-	100.00	100.00	100.00
Community	Community and Intermediate Care Services	94.87	91.63	91.73	95.35	93.12
Community	Diagnostic and Clinical Support	100.00	99.60	98.57	100.00	99.59
Community	Family Care	100.00	-	-	93.75	95.00
Community	Surgery	96.30	96.64	-	-	96.55
Delivery	Family Care	100.00	-	100.00	100.00	100.00
Inpatients	Community and Intermediate Care Services	88.01	81.10	86.38	88.17	85.79
Inpatients	Diagnostic and Clinical Support	100.00	94.38	94.71	98.03	97.05
Inpatients	Family Care	98.79	98.53	96.65	97.28	97.72
Inpatients	Medicine and Emergency Care	91.20	85.45	88.22	93.50	89.52
Inpatients	Surgery	95.65	87.22	91.48	92.98	91.85
OPD	Diagnostic and Clinical Support	97.22	96.14	99.33	96.53	96.93
OPD	Family Care	98.68	98.03	94.44	86.08	94.11
OPD	Medicine and Emergency Care	98.99	94.26	99.48	98.09	97.31
OPD	Surgery	100.00	100.00	100.00	100.00	100.00
Postnatal	Family Care	100.00	100.00	100.00	100.00	100.00
SDCU	Family Care	97.22	98.00	95.59	98.21	97.00
	Total	**95.38**	**91.89**	**92.19**	**94.53**	**93.34**

The table demonstrates divisional performance from the range of patient experience surveys in March 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 all 4 of the competencies.

Divisions are encouraged to review survey feedback to identify areas for improvement.

SHMI Published Trend

EFFECTIVE

HSMR

There are some issues impacting the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR), including:
- Backlog in coding
- Removal of Same day emergency care (SDEC) from Admitted Patient Care (APC) dataset
- Data quality issues with SUS submission impacting spell counts

A bulk submission of SUS data will be made in April which should improve data quality. However, the large backlog in clinical coding and the removal of SDEC will continue to impact mortality figures.

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.

Structured Judgement Review Summary

Stage 1	Month of Death																				
	pre Oct 17	Oct 17 - Mar 18	Apr 18 Mar 19	Apr 19 Mar	Apr 20 - Mar 21	Apr 21 - Mar	Apr 22- Mar 23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	TOTAL
Deaths requiring SJR (Stage 1)	46	212	250	262	214	163	231	24	13	15	9	21	15	13	14	10	9	11	8	162
Allocated for review	46	212	250	262	214	163	231	24	13	15	9	20	11	5	5	3	3	1	3	112
SJR Complete	46	212	250	262	214	162	230	5	13	15	6	14	9	4	4	3	2	1	1	77
1 - Very Poor Care	1	1	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	1
2 - Poor Care	8	19	22	34	35	22	41	1	1	2	2	3	1	1	1	0	0	0	1	13
3 - Adequate Care	14	68	70	70	65	49	75	1	4	2	4	2	2	1	1	1	1	0	0	19
4 - Good Care	20	106	133	129	103	78	106	1	7	11	0	9	5	2	1	2	1	1	0	40
5 - Excellent Care	3	18	25	29	10	12	7	1	1	0	0	0	1	0	1	0	0	0	0	4
Stage 2																				
Deaths requiring SJR (Stage 2	9	20	22	34	36	23	42	6	1	2	2	3	1	1	1	0	0	0	1	18
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Allocated for review	6	18	21	30	35	22	42	6	1	2	2	3	1	1	1	0	0	0	1	18
SJR-2 Complete	6	18	21	30	35	22	41	4	1	2	1	2	1	1	1	0	0	0	0	13
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
2 - Poor Care	3	6	7	13	13	10	20	3	0	1	0	2	0	0	1	0	0	0	0	7
3 - Adequate Care	2	10	13	13	21	10	16	0	0	1	1	0	0	1	0	0	0	0	0	3
4 - Good Care	0	1	0	2	1	1	4	1	1	0	0	0	1	0	0	0	0	0	0	3
5 - Excellent Care	0	0	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	Apr 20 - Mar 21	Apr 21 - Mar	Apr 22- Mar 23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
stage 1 requiring allocation	0	0	0	0	0	0	0	0	0	0	0	1	4	8	9	7	6	10	5	50
stage 1 requiring completion	0	0	0	0	0	1	1	19	0	0	3	6	2	1	1	0	1	0	2	35
Stage 1 Backlog	0	0	0	0	0	1	1	19	0	0	3	7	6	9	10	7	7	10	7	85
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	1	5
Stage 2 Backlog	0	0	0	0	0	0	10	2	0	0	1	1	0	0	0	0	0	0	1	5

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

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

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

Learning Disability Mortality Reviews

3 deaths reported to LeDeR in March.

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.

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

Data complete up to Q3 (Q4 for CCG3)

5 incentivised schemes are meeting upper target scores, CCG3 has achieved the CQUIN for 2023-24, a final report is being collated for shared learning

4 Specialist Service Schemes currently meeting upper target scores:

- CCG9 Hep C – NHSE have confirmed all services will meet target due to data issues with national reporting – ELHT are well above this target
- CCG8 National Vascular Registry (NVR) data – figures impacted by submission / data completeness, Vascular team focusing on submission of all data required for CQUIN by Q4 end
- CCG10 on track
- CCG11 to report in Q4

6 Non-incentivised schemes, 2 meeting targets, 4 not meeting lower target scores:

- CCG1, Flu vaccination for Front Line Staff – 34%, looking at region – BTH 57%, LTH 34% and UHMB 49% - national average 42%
- CCG4 improvement in Q3 – actions linked to overall ELHT Cancer action plan this has been shared with the ICB
- CCG12 Pressure Ulcers slight dip in performance 1% in Q3, action plan in place for improvement

CCG14 MUST compliance– improvement in Q3 by 20%, action plan in place for improvement

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.

Table 2: 2023-24 CQUIN Schemes (Relevant to ELHT)

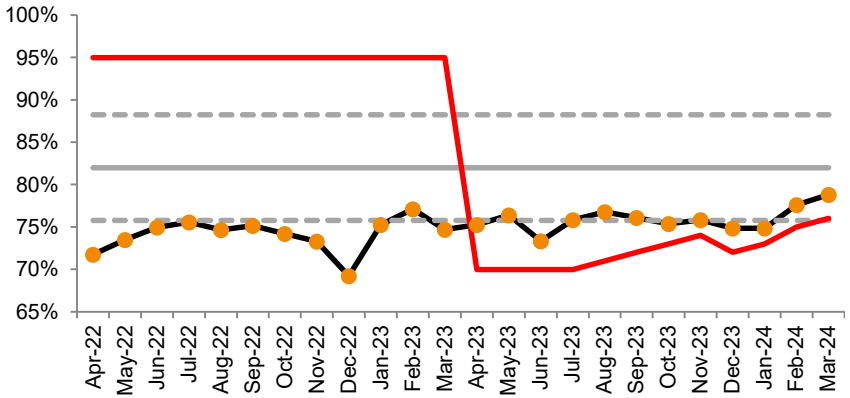
Ref:	Title of Scheme	Indicator	Lead/s	CQUIN Value	Period Calculation	Min (%)	Max (%)	Percentage Compliance (%)				Scheme performance (%)	Travel
								Q1	Q2	Q3	Q4		
CCG1	Staff Flu Vaccinations	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact	S Brewer	NA	All Quarters Quarterly average %	75	80			34*		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	82		88	▲
*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	28	23.75	▼
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	19.9		13.6	▲
*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	87		71	▲
*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	15.6		13.2	▲

*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	94			91.3	▲
**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	Mrs J Buxton L Taylor	NA	All Quarters Quarterly average %	45	65	92	63	50			71	▼
**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			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	45			46	▲
*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	▲

- **Incentivised Schemes in Green, **Specialist Service Schemes in Blue*
- *Yellow Highlight for CCG1 – Data includes figures for Sept to January 2024 published via Gov.co.uk: seasonal-influenza-and-covid-19-vaccine-uptake-in-frontline-healthcare-workers-monthly-data-2023-to-2024*
- *CCG8 Data based on submitted data for Q1 to Q3, Vascular Services focus to ensure all eligible cases are submitted before Q4 data submission close*
- *CCG9 NHSE are assuming achievement of the CQUIN for 2023-24 due to issues with extracting data from Blueteq and incorporating this into reporting*

RESPONSIVE

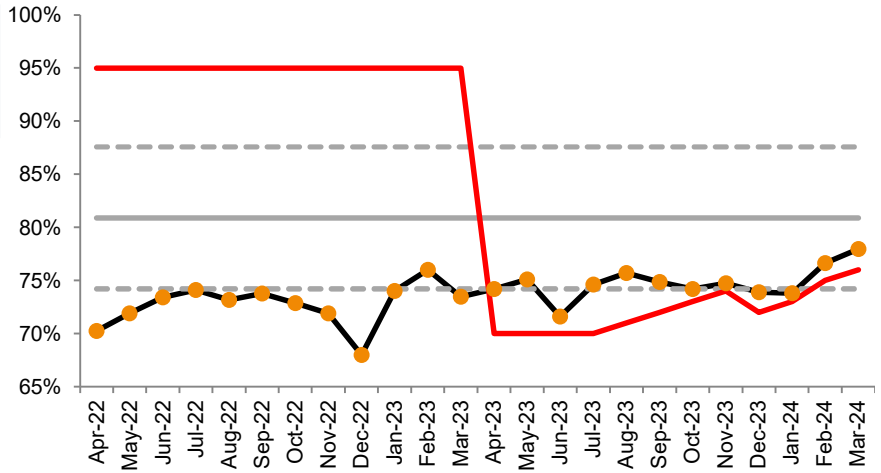
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 78.81% in March, which is above the 76% threshold and above the improvement trajectory (76%).

The trend continues to show an improvement on previous performance and the Trust is on track to deliver the 76% target.

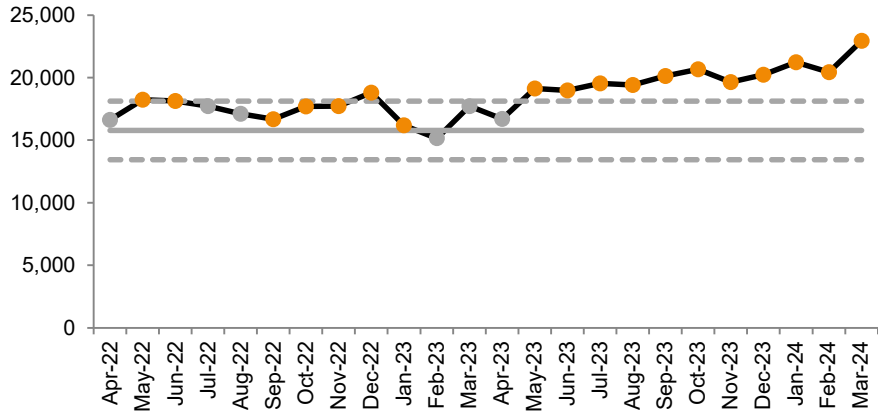
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 77.96% in March.

The national performance was 74.4% in March (All types).

A&E Attendances - Trust

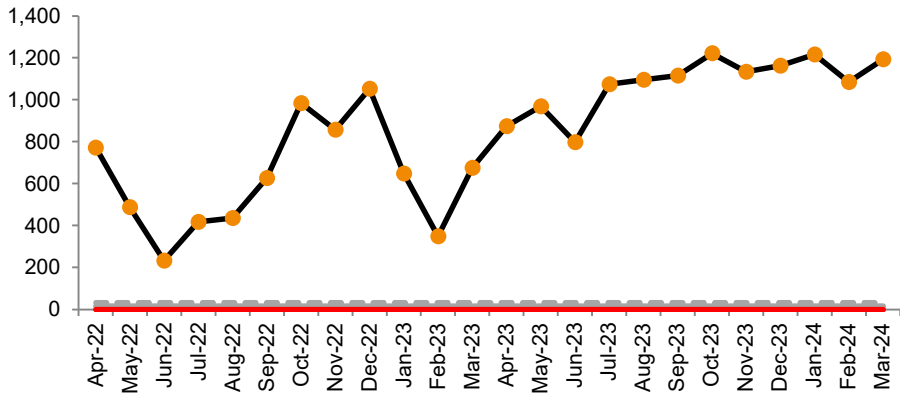


The number of attendances during March was 22,952, which is above the nornal range when compared to the pre-covid baseline.

Following NHSE guidance, the attendance count has been amended in June 23, to include patients who are appointed following inital assessment, which was previously excluded from the count.

RESPONSIVE

12 Hr Trolley Waits

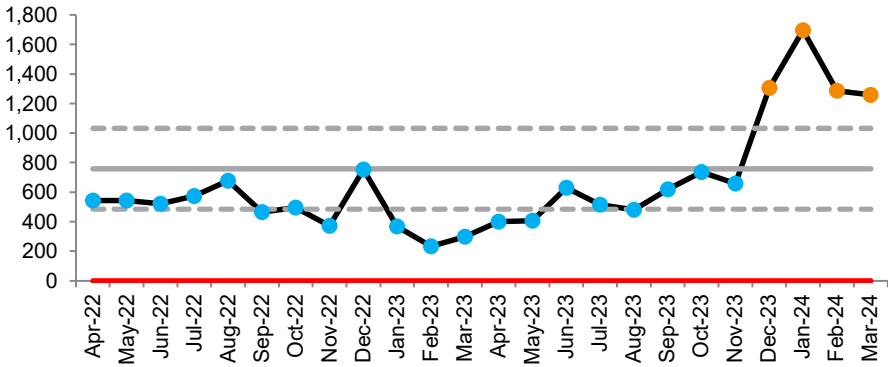


There were 1192 reported breaches of the 12 hour trolley wait standard from decision to admit during March, which is higher than the normal range. 47 were mental health and 1145 were physical health.

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	47	1145
Average Wait from Decision to Admit	44hr 24min	26hr 58 min
Longest Wait from Decision to Admit	120hr 57min	86hr 34 min

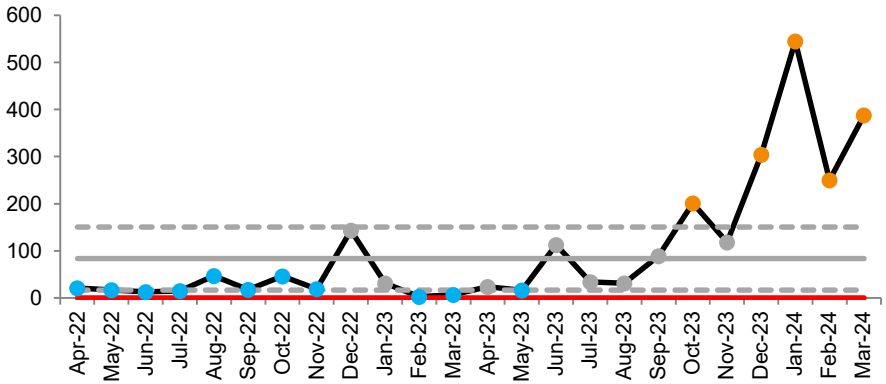
Ambulance Handovers - >30Minutes



There were 1259 ambulance handovers > 30 minutes in March. 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 3047 ambulance attends with 1259 ambulance handovers > 30 minutes and 388 > 60 minutes.

Ambulance Handovers - >60 Minutes



It is no longer possible to split between ED delays and HAS compliance due to the HALO system. Work is ongoing with NWAS to identify a method for reporting this.

The average handover time was 44 minutes in March.

The longest handover in March was reported by NWAS as 10hr 22 minutes. We are working with NWAS to reduce longer waits due to cohorting since the introduction of the HALO system.

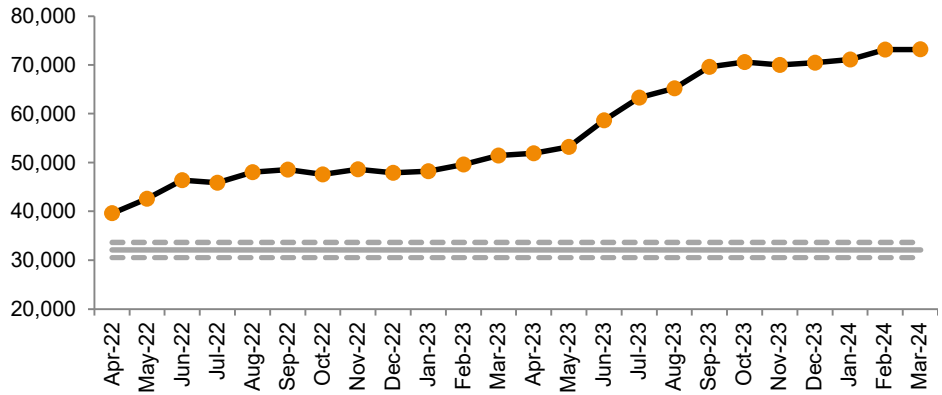
RESPONSIVE

At the end of March, there were 73,174 ongoing pathways, which has increased on last month and is above pre-COVID levels.

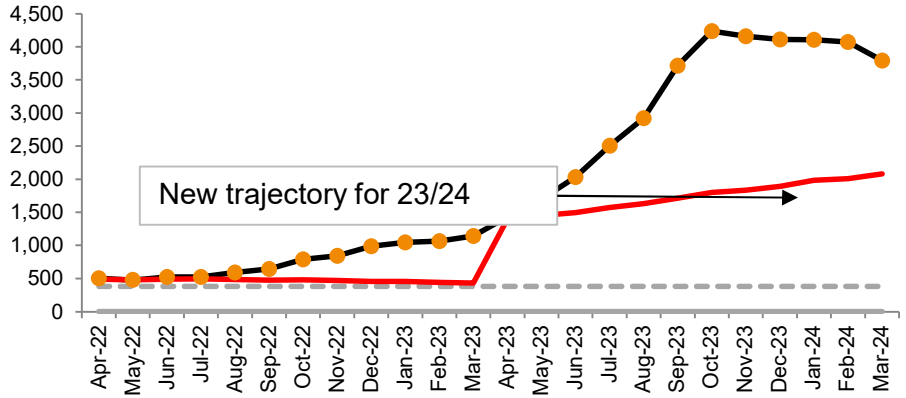
There were 3792 patients waiting over 52 weeks at the end of March which has reduced on last month but is above trajectory.
There were 191 patients waiting over 65 weeks at the end of March which has reduced on last month and is below trajectory.
We are aware of a number of data quality issues impacting on performance post EPR go live, which the Trust is working on to resolve.
There were 0 patients waiting over 78 weeks

Trajectory
Actual

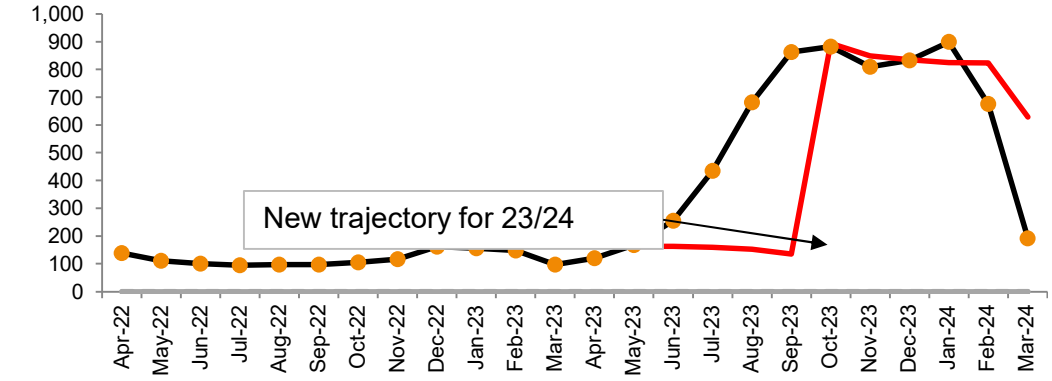
Referral to Treatment (RTT) Total Ongoing



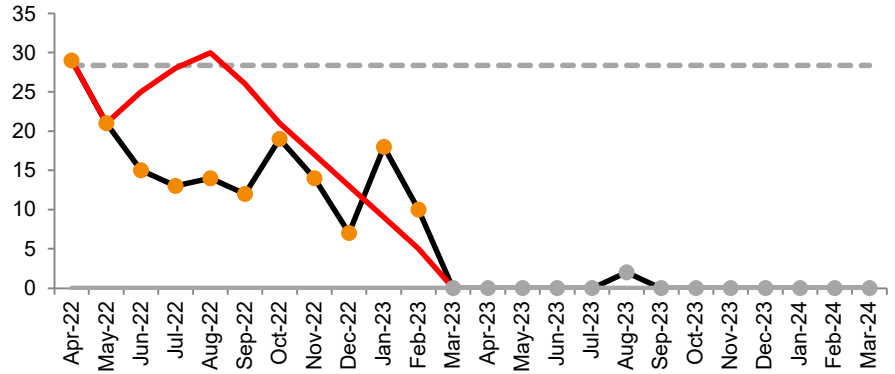
RTT Total Over 52 wks



RTT Total Over 65 wks



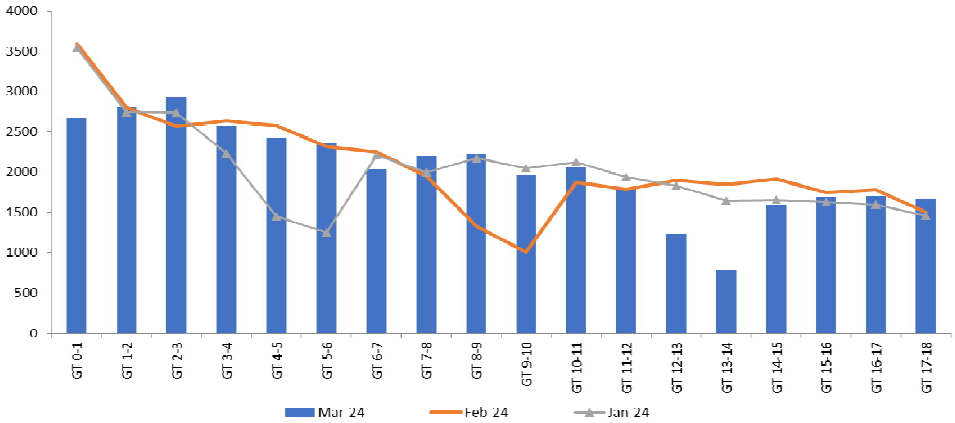
RTT Total Over 78 wks



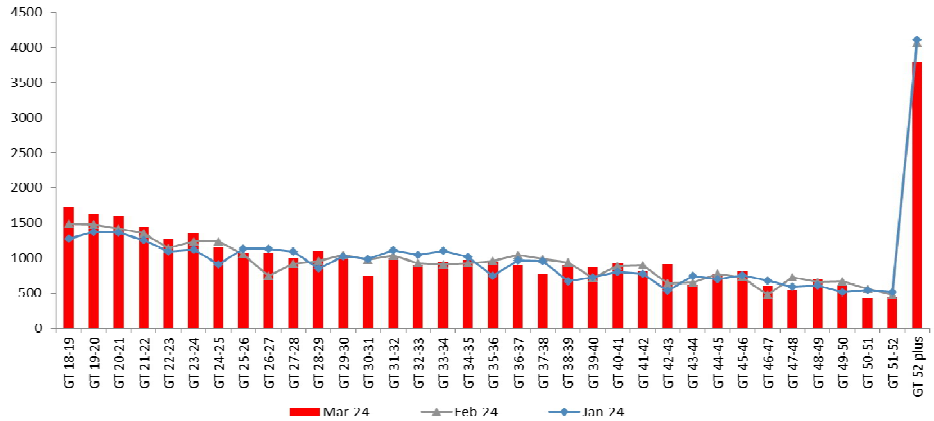
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

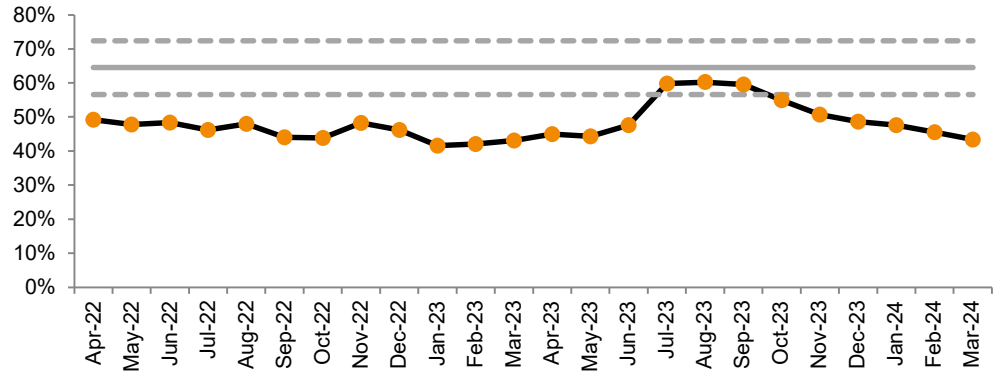


RTT Over 18 weeks

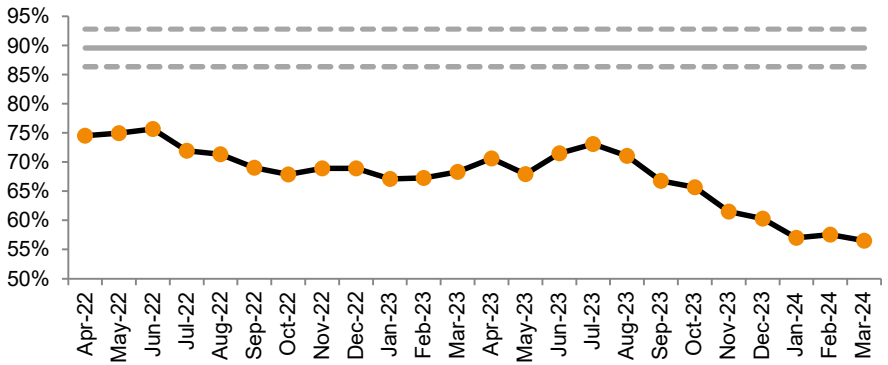


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted



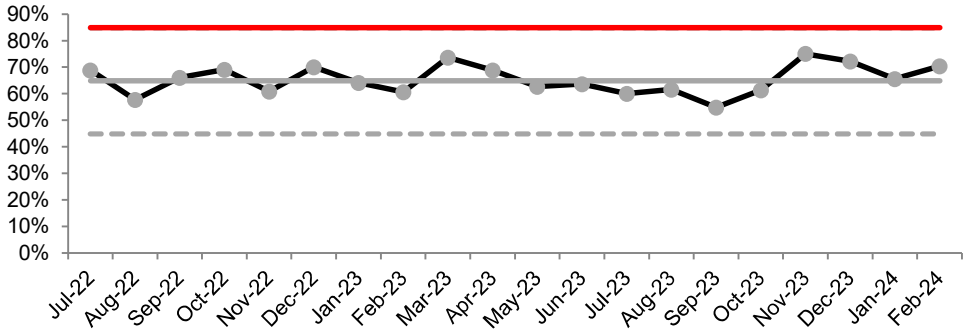
RTT Non-Admitted



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

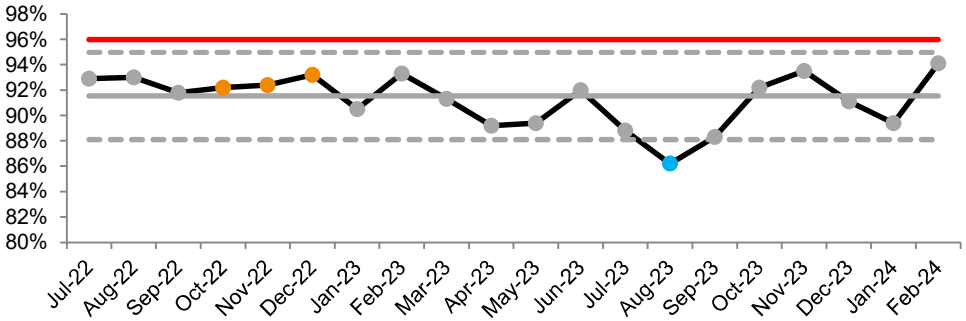


The 62 day standard was not acheived in February at 70.4%, below the 85% threshold.

National performance February - 63.9%

Based on current variation the measure is not capable of hitting the target routinely.

Cancer 31 day general treatment

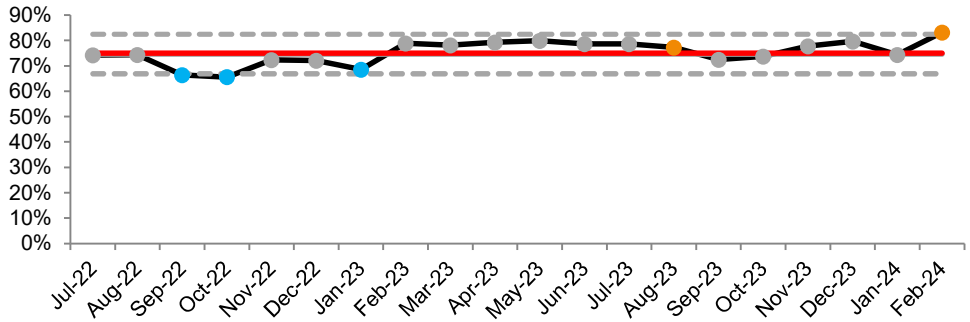


The 31 day standard was not achieved in February at 94.1%, below the 96% threshold.

National performance February - 91.1%

Based on current variation the measure is not capable of hitting the target routinely.

28 day general FDS

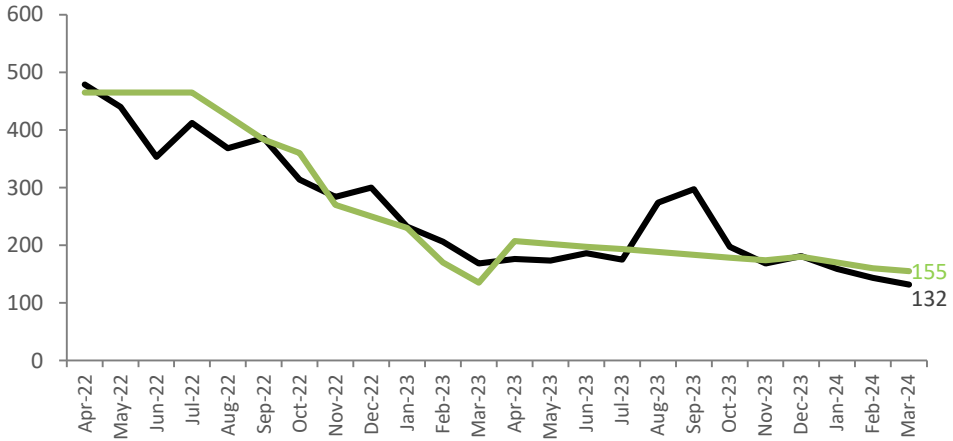


The 28 day FDS standard was achieved in February at 83.2%, above the 75% threshold.

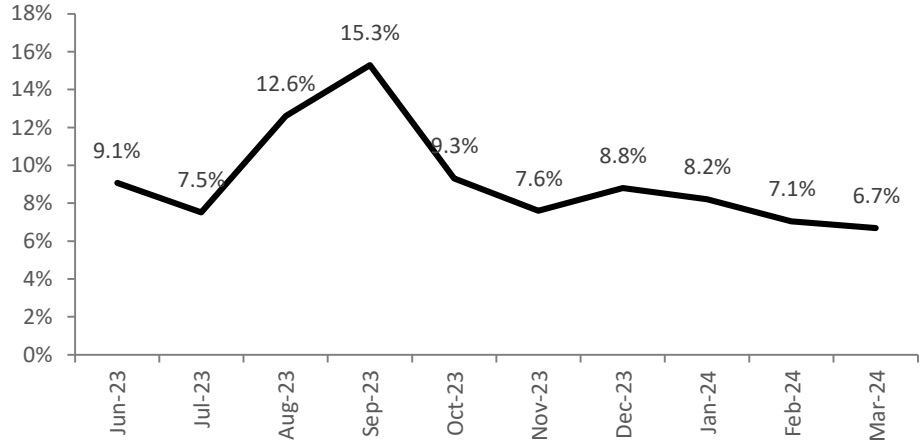
National performance February - 78.1%

RESPONSIVE

Cancer >62 day vs trajectory



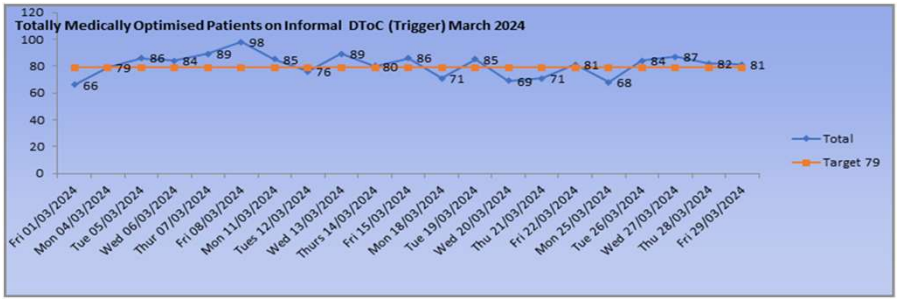
Cancer % Waiting >62days (Urgent GP Referral)



At the end of March the number of patients >62 days was 132 vs 155 trajectory. This was 6.7% of the total wait list.

RESPONSIVE

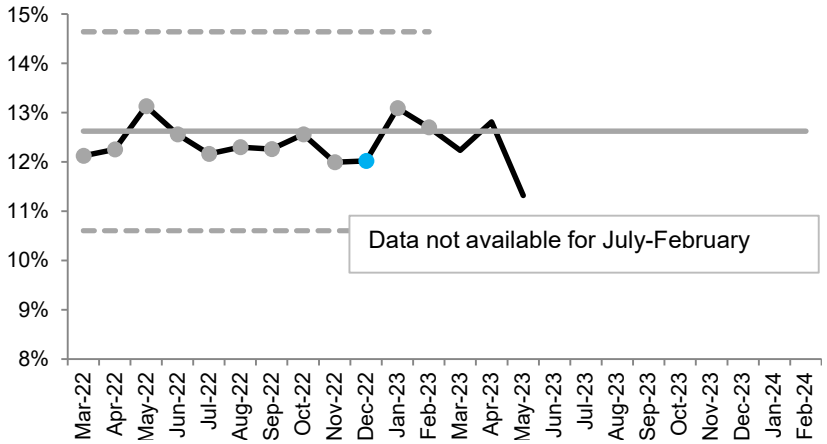
Delayed Discharges



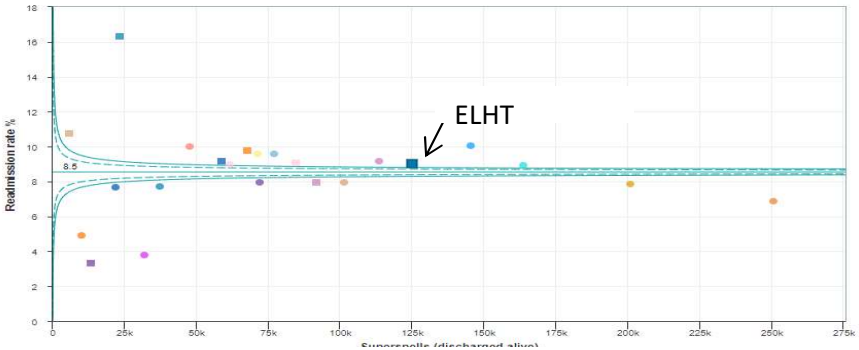
We continue to discharge patients using the rapid discharge principles set out in the Hospital discharge and community support: policy and operating model government guidance, utilising pathways 0-3. Pathways are being used to ensure patients have a discharge plan identified from admission, with pathway 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. There are data quality issues with missing spells in the current HES dataset which means more recent data is not available.

Emergency Readmissions

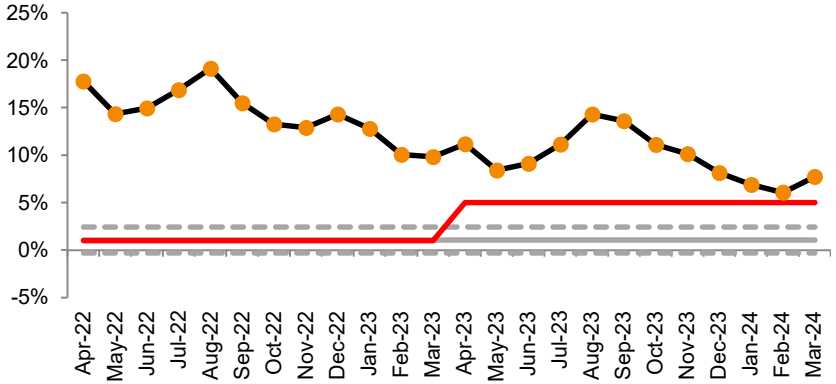


Readmissions within 30 days vs North West - Dr Foster
June 2022 - May 2023



Data not available for emergency readmission.

Diagnostic Waits



In March, 7.7% 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 20.8% in February.

RESPONSIVE

Average length of stay benchmarking

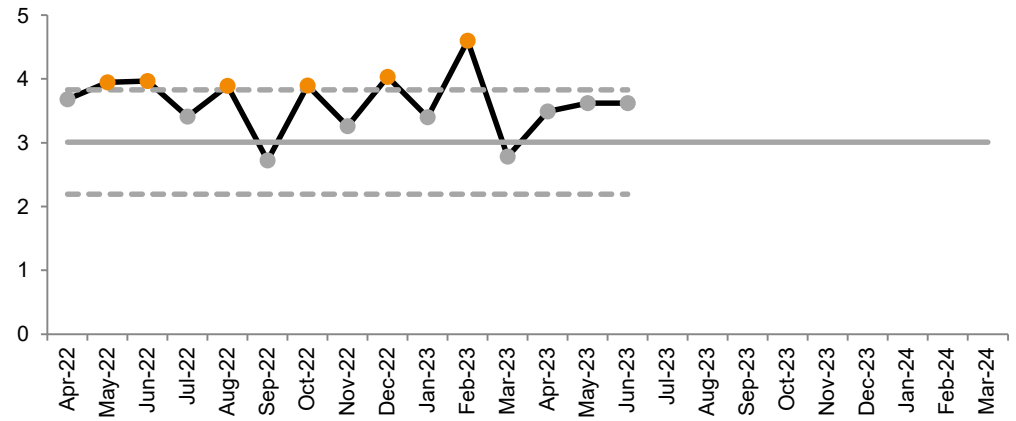
Dr Foster Benchmarking June 22 - May 23

	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

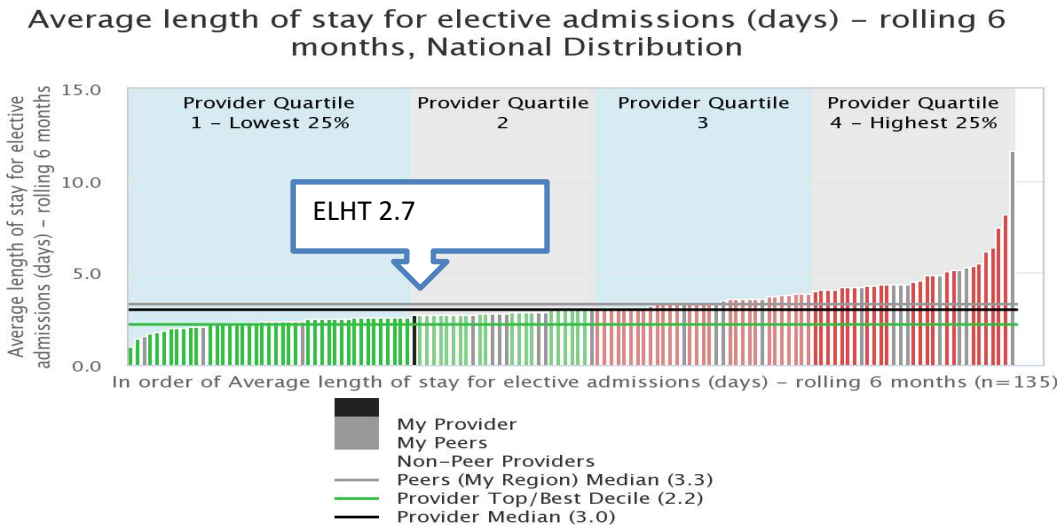
There are data quality issues with missing spells in the current HES dataset which means more recent data is not reliable for the metrics below.

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

Average length of stay - elective



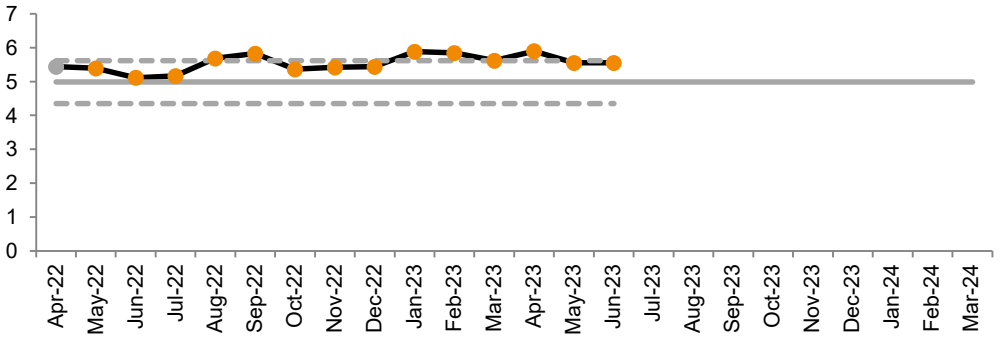
The Trust elective average length of stay is not available between July-March.



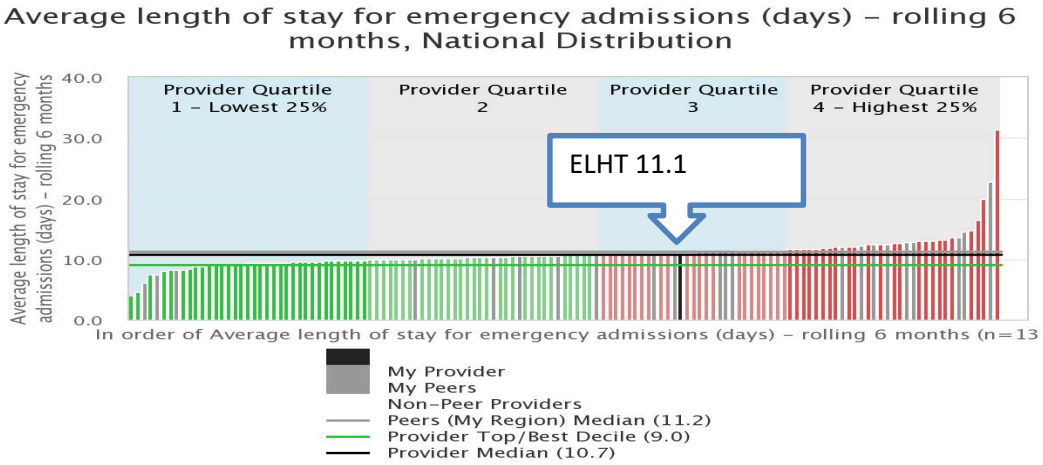
Data up to June 23 from the model health system shows ELHT in the second quartile for elective length of stay. Excludes day case.

RESPONSIVE

Average length of stay - non elective

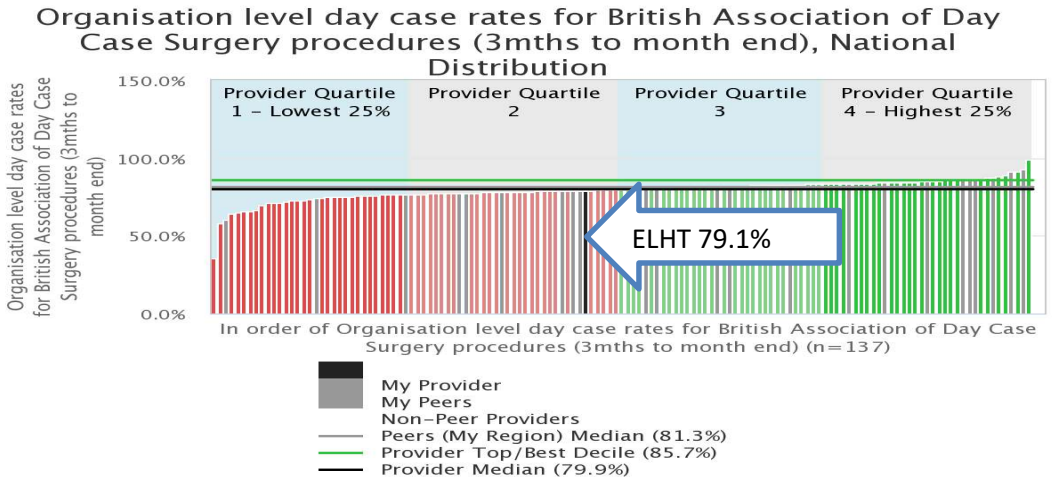


The Trust non-elective average length of stay is not available between July-March.



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.

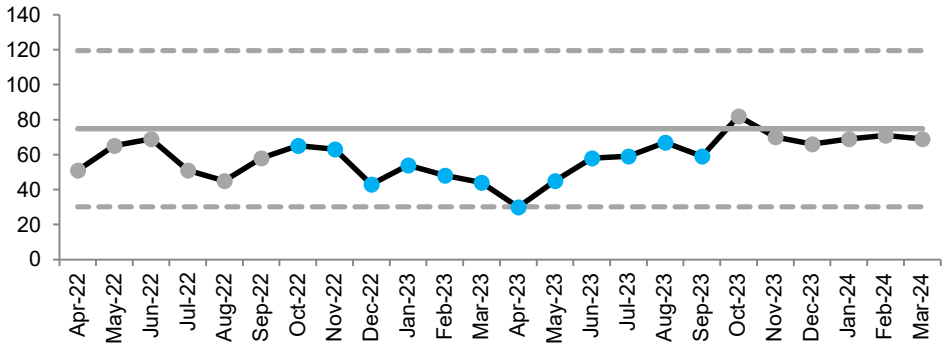
Daycase Rate



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

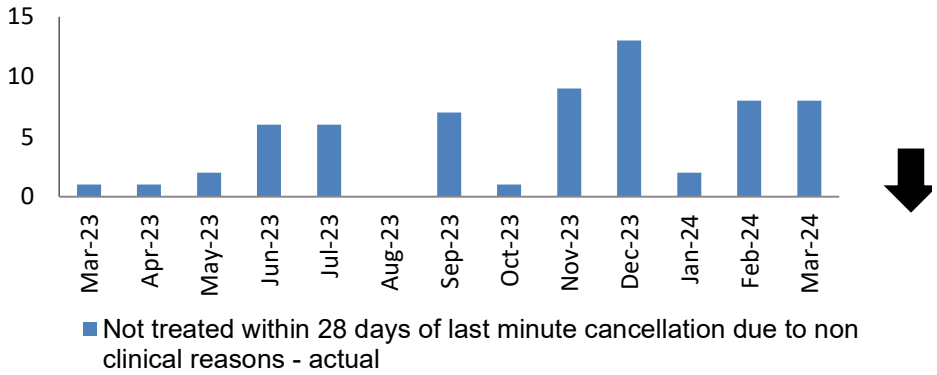
Operations cancelled on day



There were 69 operations cancelled on the day of operation - non clinical reasons, in March.

The trend is similar to pre-covid levels.

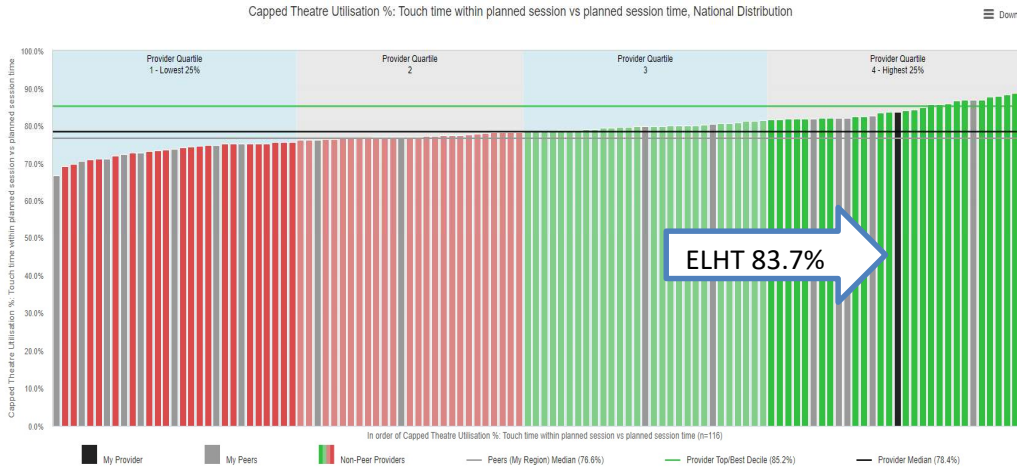
Operations cancelled on day - breaches of 28 day



There were 8 ‘on the day’ cancelled operations not rebooked within 28 days in March.

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.

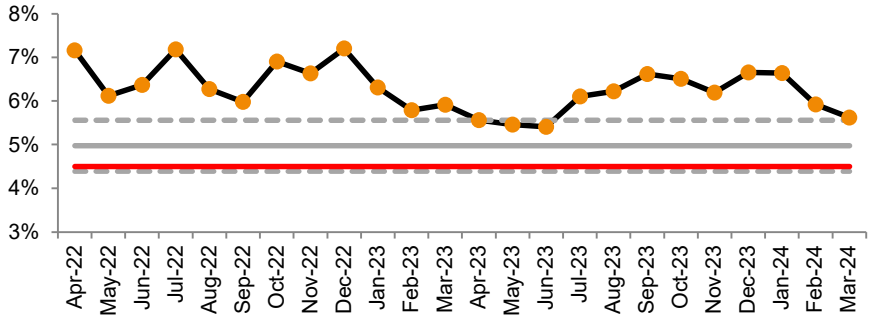
Theatre Utilisation



Data taken from 'The model hospital' shows capped theatre utilisation at 83.7% for the latest period. This is in the fourth quartile nationally, with 4 being the highest and 1 the lowest.

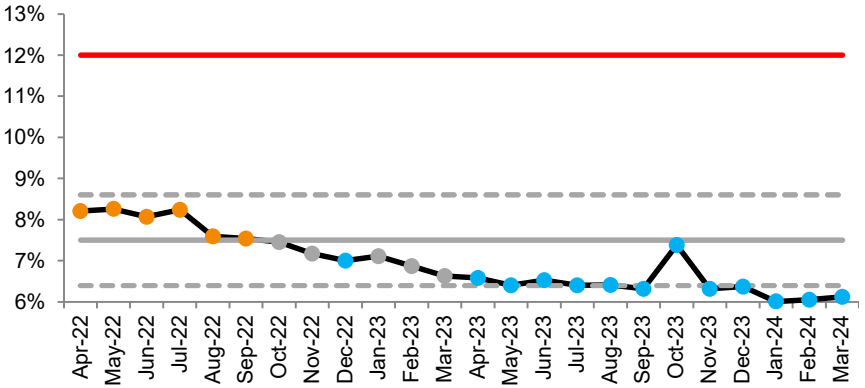
WELL LED

Sickness



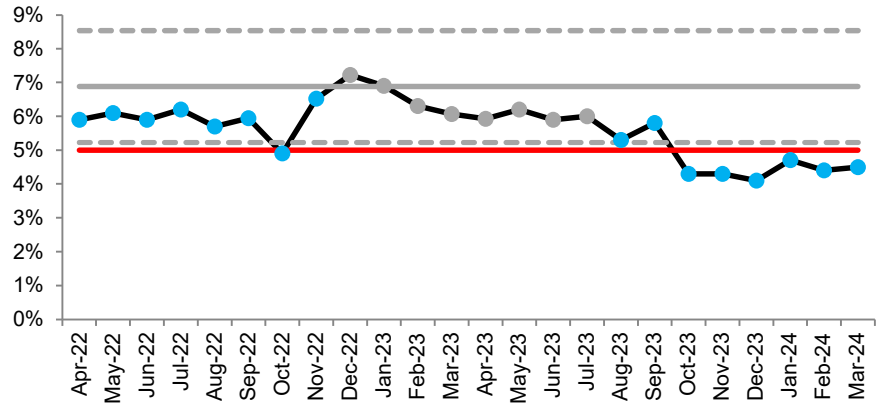
The sickness absence rate was 5.6% for March which is above the threshold of 4.5%. The trend is significantly higher than the pre covid baseline and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 6.1% in March 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



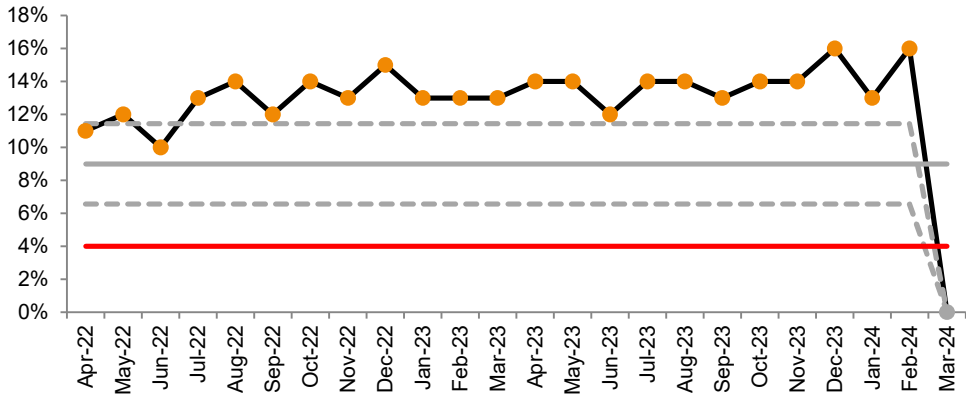
The vacancy rate is 4.5% for March which is below the 5% threshold.

The trend is showing improvement but based on current variation this indicator is not capable of hitting the target routinely.

A detailed action plan has been developed and a quarterly progress update will be provided to the Trust Board.

WELL LED

Temporary costs and overtime as % total pay bill



In March 2024, £6.9 million was spent on temporary staff, consisting of £1.3 million on agency staff and £5.6 million on bank staff.

WTE staff worked (10,203 WTE) was 159 WTE more than is funded substantively (10,044 WTE).

Pay costs are £3.3m more than budgeted establishment in March 2024, excluding £19.9m of centrally funded pension costs.

At the end of March 24 there were 440 vacancies.

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

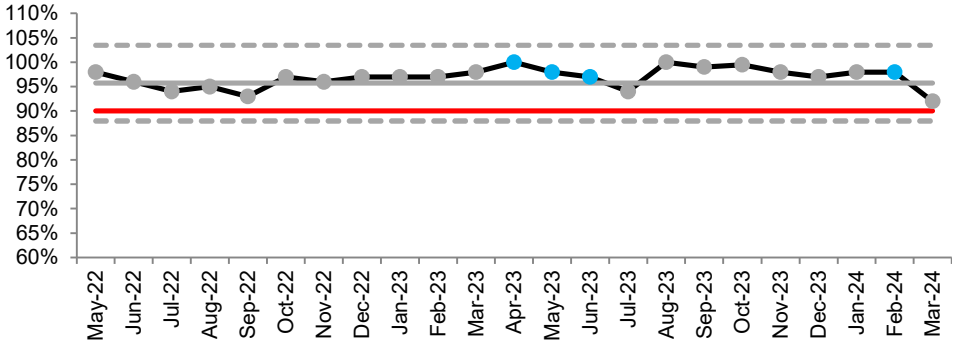
Job Plans

Stage	Consultants	Non consultant grades
Awaiting Signatures	190	42
Complete	19	2
Due Soon	20	11
In Progress	137	38
No Current Job Plan	21	10
Not Started	2	1
Referred Back	4	0
Uploaded	6	1
Total	399	105

As at March 2024, the table shows the numbers in each stage of the job planning process.

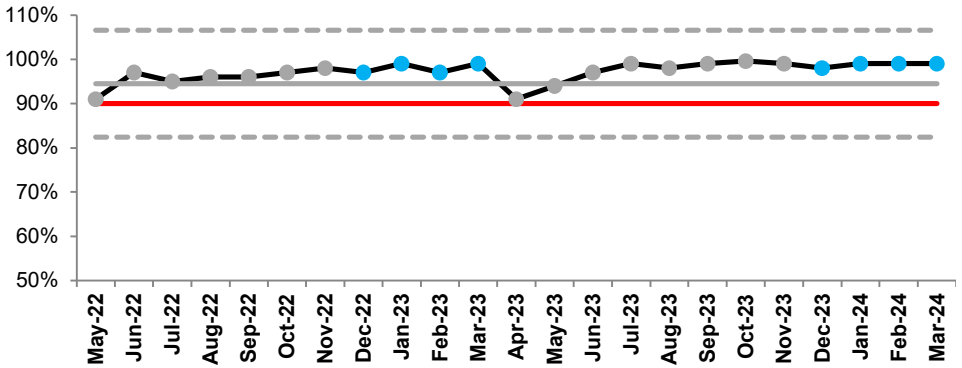
WELL LED

Appraisals, Consultant



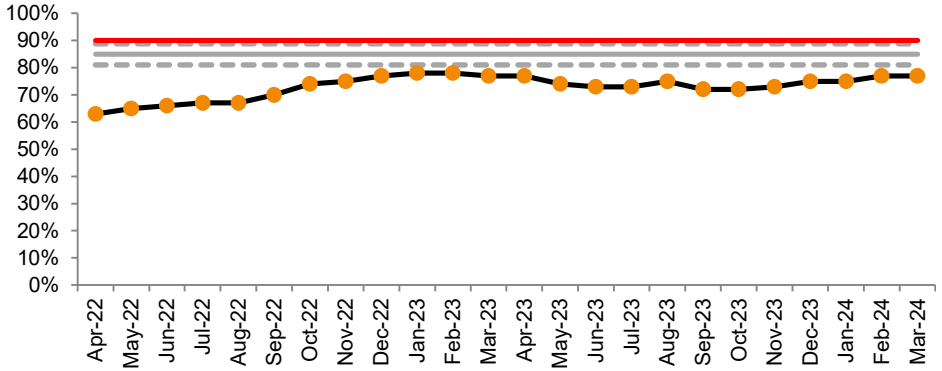
The appraisal rates for consultants and career grade doctors are reported for April - March 24 and reflect the number of reviews completed that were due in this period.

Appraisals, Other Medical



They both continue to be above target with 92% (consultant) and 99% (other medical) completed that were due in the period. 100% of all appraisals due for 23-24 were due in this period.

Appraisals Agenda for Change (AFC) Staff



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

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

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

WELL LED

Core Skills Training % Compliance

	Frequency	Target	Compliance at end March
Basic Life Support	2 years	90%	88
Conflict Resolution Training L1	3 years	90%	97
Equality, Diversity and Human Rights	3 years	90%	96
Fire Safety L1	2 years	95%	95
Health, Safety and Welfare L1	3 years	90%	97
Infection Prevention L1	3 years	90%	98
Infection Prevention L2	1 year	90%	91
Information Governance	1 year	95%	94
Preventing Radicalisation Level 1	3 years	90%	96
Preventing Radicalisation Level 3 †	3 years	90%	93
Safeguarding Adults L1	3 years	90%	96
Safeguarding Adults L2	3 years	90%	96
Safeguarding Adults L3*	3 years	90%	76
Safeguarding Children L1	3 years	90%	95
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%	95
Safer Handling Level 2 (Patient Handling)	3 years	95%	87

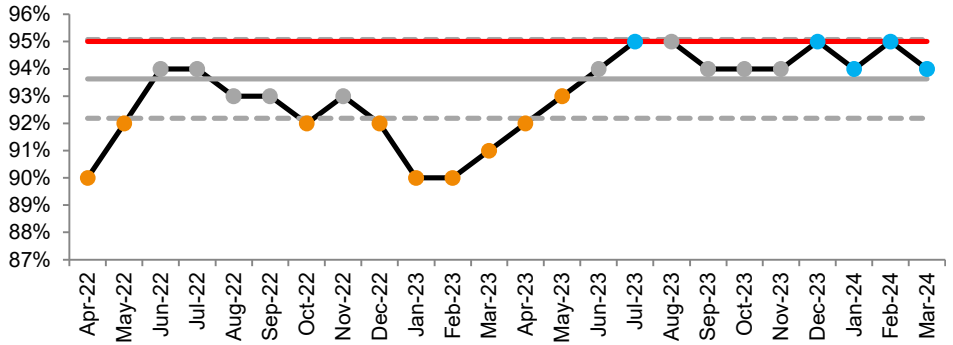
The core skills framework consists of eleven mandatory training subjects, with 19 modules in total. Training is via a suite of e-learning modules and knowledge assessments on the learning hub.

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

5 of the 19 modules are below threshold in March. 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

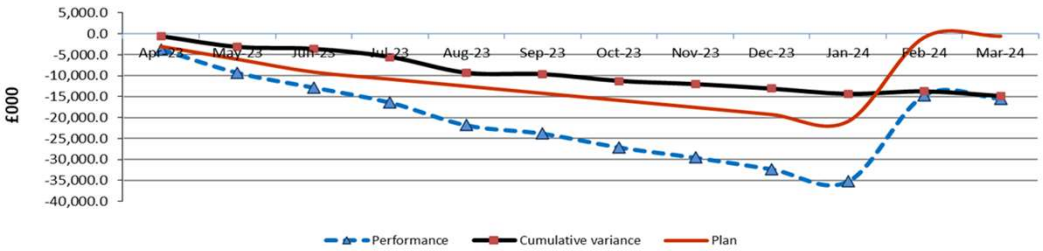


Information governance toolkit compliance is 94% in March which is just below the 95% threshold. The trend is now above pre-covid baseline, however remains at risk of not meeting the target.

WELL LED

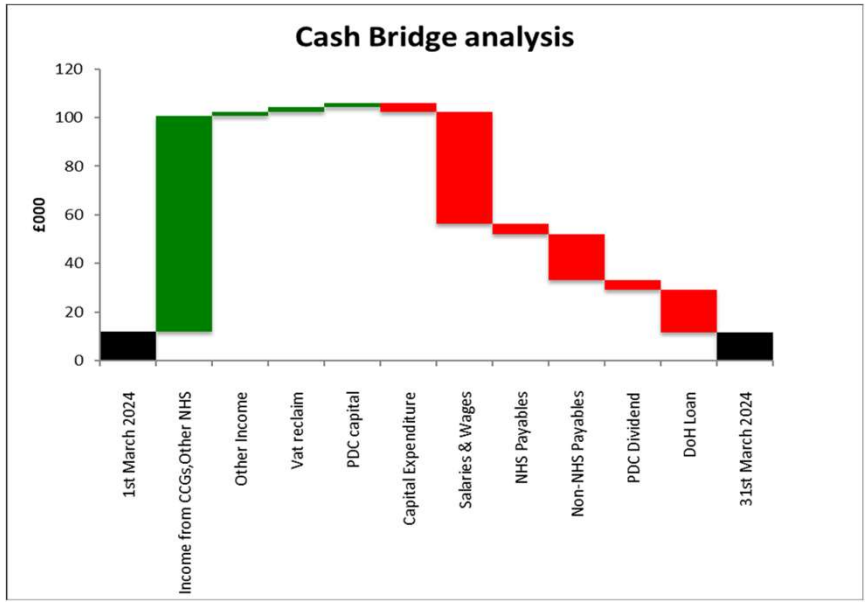
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



The Trust is reporting an outturn breakeven duty deficit of £15.4m for the 2023-24 financial year, £14.8m behind plan.

Cash



The Trust's cash balance is £11.6 million as at 31st March 2024.

The Trust is reporting a deficit of £15.4m for the 2023-24 financial year, a movement of £0.8m in the month, in line with the position forecast last month.

The Trust underspent against its £34.3m capital allocation for 2023-24 by less than £0.1m with £13.2m of capital expenditure funded from Public Dividend Capital.

The cash balance on 31st March was £11.6m, a reduction of £0.4m compared to the previous month. This position is supported by £18.1m of Provider Revenue Support PDC following the repayment of £17.6m in March, made possible by the additional £23.7m allocation from the ICB reported last month.

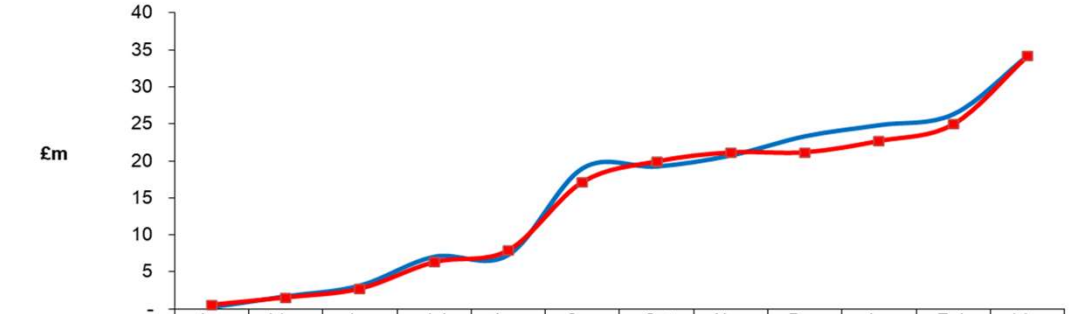
The Trust expects to meet three of the four Better Payment Practice Code (BPPC) targets year to date to pay 95% of invoices on time for the financial year to date based on draft figures.

The Waste Reduction Programme achievement for the 2023-24 financial year is £42.3m, of which £23.5m is recurrent. The full year effect of recurrent schemes is £24.8m

WELL LED

Capital expenditure

Capital expenditure profile



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	0.25	1.74	3.19	7.09	7.34	19.03	19.28	20.77	23.37	24.86	26.36	34.26
Actual	0.54	1.54	2.72	6.31	7.90	17.12	19.91	21.13	21.15	22.67	24.97	34.20

The outturn position for the capital programme was £34.2m, within £0.1m of the Trust's capital allocation.

Waste reduction programme

WRP schemes analysis

Division	23/24 Target	23/24 Achieved	Recurrent	Non- Recurrent	Recurrent FYE
	£000s	£000s	£000s	£000s	£000s
Trust Wide Schemes	36,191	36,733	17,930	18,803	18,646
Medicine & Emergency Care	1,294	969	969		1,294
Community & Intermediate Care	410	354	354		411
Surgical & Anaes Services	1,338	841	841		849
Family Care	809	658	658		658
Primary Care	30	10	10		10
Diagnostic & Clinical Support	1,058	1,058	1,058		1,058
Estates & Facilities	606	1,103	1,103		1,103
Corporate Services	404	414	414		609
Education, Research & Innov'N	140	140	140		140
Total	**42,280**	**42,280**	**23,477**	**18,803**	**24,777**
System Gap	12,338	0	0	0	0
	54,618	42,280	23,477	18,803	24,777

Schemes to the value of £42.3 million have been transacted in the 2023-24 financial year, with a full year effect of £24.8m of recurrent

TRUST BOARD REPORT **Item** **76**

15 May 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 28 March 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 and VSMs.
- the specific total reward / 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.
- To receive and consider the Chief Executive's annual report on Executive performance and appraisals.

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 **Item** **77a**

15 May 2024 **Purpose** Assurance
Information

Title	Triple A Report from Finance and Performance Committee
Report Author	Mrs L Sedgley, Non-Executive Director
Date Paper Approved by Executive Sponsor	2 May 2024

Summary: This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 25 March 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related Trust Goal

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

Related to key risks identified on Board Assurance Framework

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

Related to key risks identified on Corporate Risk Register	10082 - Failure to meet internal & external financial targets for 2024-25
Related to recommendations from audit reports	Assurance Framework Key Financial Controls Risk Management Core Controls
Related to Key Delivery Programmes	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:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	Finance and Performance Committee
Date of Meeting:	25 March 2024
Committee Chair:	Mrs L Sedgley
Attendance:	Quorate
Key Items Discussed:	Planning Update Finance Reporting Improvement Update Integrated Performance Report Community Services Transfer including Albion Mill Contract over £1,000,000 Estates Strategy Update

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter

- The Committee noted the significant pressures within the 24/25 plan due to the non-recurrent savings from 23/24 being carried forward into 24/25 and adding to the Waste Reduction Programme (WRP) for 24/25.
- The Committee heard that the income for 24/25 had been reduced by £5m within the revised plan to help address the Integrated Care System (ICS) deficit for 24/25. This is additional to any adjustments that will come through from the review of the block contracts that the Trust has with the ICS for services.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee received an update on the Trust's Estate strategy and noted that it is linking into the ICS estate strategy. Work is ongoing to review the utilisation of all community and leased premises as part of a review of service configuration. This

work will help to ensure that the Trust receives best value from its estate and leased premises.

- The Committee were pleased to receive assurance on the ongoing improvement projects across the Trust especially with the Emergency Department department which recently received an amber grade (improving from Red) on its recent Nursing Assessment Performance Framework (NAPF) review. This is really encouraging given the significant pressures the teams working in the department are continuing to deal with.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee received a paper on the effects of the Industrial action by Junior doctors and consultants detailed both the financial cost and the effect on patient activity.
- The Committee heard about the continuing effect of high demand for emergency care together with the increasing acuity of patients presenting through the Emergency Department.
- The Committee were pleased to note that despite the numerous challenges faced throughout 23/24 that the Trust had achieved a number of key performance indicators, however the Committee acknowledged that due to the high levels of demand for services, patients were at times having very long waits for treatment.

TRUST BOARD REPORT	**Item**	**77b**
15 May 2024	**Purpose**	Assurance Information

Title	Triple A Report from Finance and Performance Committee
Report Author	Mrs L Sedgley, Non-Executive Director
Date Paper Approved by Executive Sponsor	2 May 2024

Summary: This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 29 April 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the content of the report.

Report linkages

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

Related to key risks identified on Corporate Risk Register	10082 - Failure to meet internal & external financial targets for 2024-25
Related to recommendations from audit reports	Assurance Framework Key Financial Controls Risk Management Core Controls
Related to Key Delivery Programmes	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:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	Finance and Performance Committee
Date of Meeting:	29 April 2024
Committee Chair:	Mrs L Sedgley
Attendance:	Quorate
Key Items Discussed:	Planning Update Finance Reporting Budget for 2024/25 Improvement Update Integrated Performance Report Community Services Transfer including Albion Mill Contract over £1,000,000 Pathology Business Case Corporate Risk Register Board Assurance Framework

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter

- The Committee approved the financial plan for 24/25 and alerts the Board of the significant challenges in achieving the Waste reduction Programme (WRP) programme of £57.8m or 5.1% of expenditure in order to achieve the planned deficit of £30.3m
- The Committee approved the annual budget for 24/25.
- The Committee noted that managing the cash position in 24/25 will be challenging and noted the mechanisms to obtain interim Public Dividend Capital (PDC) revenue support and the governance that will sit around such applications.
- The Committee was alerted to the reduction of Whole Time Equivalent (WTE) in the forecast for 24/25 of 600 WTE and discussed the implications of this and the need for a clear communication strategy both internally and externally to manage this. We

also discussed the need to manage the expectations of regional and national colleagues who will be scrutinising this throughout the year.

- The Committee noted that due to the remeasurement of the Public Finance Initiative (PFI) Liability under IFRS16, the change has had a negative impact on our cumulative break-even position, reducing our surplus from £29m down to £4m. It has been escalated to the centre that a change in an accounting standard should not have a detrimental impact on an organisation. Further updates to be provided.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee heard that the executive team have carrying out the quarterly performance reviews with the divisions and we discussed that the outcomes of those reviews will be reported through the committee for 24/25
- The monthly improvement update featured the work on the Outpatients transformation programme which is one of the Trust's key improvement programmes for 24/25. The report also featured the work being carried out improve the Cerner programme for outpatients which has had to be significantly strengthened to make it fit for purpose and support clinicians in the outpatient setting.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee received the year end position reports and were pleased to note that given all the significant challenges experienced in 23/24 of the strikes and increased demand through the Emergency Department of very acute patients, that the Trust:
    - Met the agreed forecast outturn position of £15.4m deficit.
    - Met the Capital departmental expenditure limit (CDEL) and External Financing Limit (EFL) positions for 23/24
    - Met 3 out of the 4 Better Payment Practice (BPP) targets.
    - The agency spend for 23/24 was below the ceiling cap of 3.7%

- The Committee received the Integrated Performance report to March 2024 and were pleased to note that the Trust hit all the trajectories on performance that we had committed to. And that the Trust had achieved a number of the national performance targets despite the challenges noted above. The committee also noted the improvement work being carried out over a number areas with the aim to improve access, reduce waiting times and enhance patient safety and experience whilst improving Value for Money for the public funding received.
- The Committee approved the pathology business case and were pleased to note the engagement of the Pathology team with the improvement team to build the solutions to the issues faced by the department and develop the case to address them.

TRUST BOARD REPORT **Item** **77a**

15 May 2024 **Purpose** Assurance
Information

Title	Triple A Report from the Quality Committee
Report Author	Mrs T Anderson, Non-Executive Director
Date Paper Approved by Committee Chair	2 May 2024

Summary: This report sets out the summary of the items discussed at the Quality Committee meeting held on 27 March 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people
Related to key risks identified on Board Assurance Framework	2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
Related to key risks identified on Corporate Risk Register	N/A
Related to recommendations from audit reports	N/A.
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access.

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	Quality Committee
Date of Meeting:	27 March 2024
Committee Chair:	Trish Anderson
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update Mental Health Pressures in the Emergency Department Pressure Ulcer Update Lancashire Diabetic Eye Screening Programme Quality Assurance Recommendations Progress Report Patient Safety Incident Response Framework Report Quarterly Report on safe Working Hours: Doctors and Dentists in Training Nursing Assessment and Performance Framework Update Patient Participation Panel Update Sustainability and Improvement Plan Introduction Harms Reduction Programme Closure Report Summary

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The Committee received a verbal update on the Urgent and Emergency Care pressures facing the Trust with attendances continuing to increase. The Committee noted the range of support projects put in place to try to ease pressures.
- The Committee was alerted to the significant rise of Mental Health pressures presenting in the Emergency Department and was advised of ongoing system wide work in this area,
- The Committee received the Quarterly report on Safe Working Hours for Doctors and Dentists in training. The report flagged up the issue of vacant shifts with over 11,000 needing to be filled in a 4 month period.
- The Committee received a Patient Safety Incident Response Framework Report (PSIRF). A significant rise in the increase in the number of medical incidents was noted in March with no harm caused. Assurance has been requested from the Trust Medicines Optimisation Group.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee received an update on progress with the 10 recommendations made in relation to the Lancashire Diabetic Eye Service screening programme following an external Quality Review in March 2023. 5 of the recommendations are now closed and the remaining 5 will be closed imminently.
- The Committee received a report on the closure of the Trust Harms Reduction Programme which covered 12 areas of work. The programmes will now be embedded into strengthened governance arrangements.
- The Integrated Performance Report was received and noted by members.
- Minutes from the Safeguarding Committee, Patient Experience Group and Mortality Steering Group were received and noted.
- The Committee was updated on progress made in the management of pressure ulcers which remain an area of concern as they are the 3rd highest category of reported incidents. A list of actions planned over the coming six-month period were shared and an additional ED pressure ulcer plan has been in place for 6 months.
- The Committee received the Integrated Performance Report. It was reported that 8 cases of measles had been confirmed in the Trust some of which had been in contact with other patients in the ED. Significant efforts had been made to trace potential contacts through the Trust IPC team with 3 further cases identified.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee were updated on the progress made in the management of pressure ulcers which remain an area of concern as they are the 3rd highest category of reported incidents. A list of actions planned over the coming 6-month period were shared and an additional ED pressure ulcer plan has been in place for 6 months.

- The Committee was advised about work being undertaken on the Nursing, Assessment and Performance Framework which covers 72 separate areas. Plans are being put in place to change the SPEC review process.
- The Committee was pleased to receive a report from the Patient Participation Panel who have identified 4 key areas for improvement as part of a focused Quality Improvement Plan.
- The Committee was advised of plans to introduce new requirements on the Trust on a number of core quality and performance metrics as part of a Sustainability and Improvement plan. The plan will be integrated into the Trusts assurance mechanisms.
- The Committee were informed of plans for the closure of the Harms Reduction Programme. A detailed review of the 12 programmes has taken place and they will be embedded into the strengthened governance arrangements in the Trust.
- The Committee were advised that there may be a potential Inspection by CQC later this year.
- Committee members received minutes from Safeguarding Committee, Patient Experience Group , and Mortality Steering Group.

TRUST BOARD REPORT **Item** **77b**

15 May 2024 **Purpose** Assurance
Information

Title	Triple A Report from Quality Committee
Report Author	Mrs C Randall, Non-Executive Director
Date Paper Approved by Committee Chair	2 May 2024

Summary: This report sets out the summary of the items discussed at the Quality Committee meeting held on 24 April 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people
Related to key risks identified on Board Assurance Framework	2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
Related to key risks identified on Corporate Risk Register	N/A
Related to recommendations from audit reports	N/A
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access.

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	Quality Committee
Date of Meeting:	24 April 2024
Committee Chair:	Catherine Randall
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update National Hip Fracture Database National Joint Registry Professional Judgement Review Floor to Board Report for Maternity and Neonatology Services Patient Experience, Engagement and Involvement Strategy 2024-27 Corporate Risk Register Report Draft Quality Account 2023-24

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

Patient story

Nicholas' story - more to be done in the Trust to improve the experience for patients with learning disabilities. Repository of lived stories to be build up going forward to be accessed by staff on Trust intranet. More work going to be done to utilise library of patient stories and thread the learning from them throughout the Trust.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

Maternity update

Updates on the work taking place in relation to the four high-level themes from the Maternity and Neonatology 3-year delivery plan.

Slide deck also provided to update members on 3-year plan to empower staff to ensure that all women are offered personalised care and support plans as part of their care.

National Hip Fracture Database National Joint Registry

Slide deck provided to members – highlights included 15 continuous years of quality improvement for patients with hip fractures. ELHT has been consistently ranked at either first or second with regard to attracting best practice tariffs. Drops were seen around best practice tariffs during the COVID-19 pandemic and summary was provided around the measures being taken to improve this.

National Joint Registry – collections information on hip, knee, ankle, elbow and shoulder joint replacement surgery and monitor the performance of joint replacement implants. Larges orthopaedic registry in the world. A summary of reported procedure numbers at both RBTH and BGTH were provided to members.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

Professional Judgement Review findings – agenda item for May Trust Board.

Delegated authority going to be requested for Quality Account approval.

TRUST BOARD REPORT **Item** **79**

15 May 2024 **Purpose** Assurance
Information

Title	Triple A Report from the People and Culture Committee
Report Author	Mrs T Anderson, Non-Executive Director
Date Paper Approved by Committee Chair	3 May 2024

Summary: This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 4 March 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: (advise the Board/Committee of a suggestion or proposal as to the best course of action/what they are asked to do/decision they are being asked to make).

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.

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	N/A
Related to recommendations from audit reports	N/A.
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	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name:	People and Culture Committee
Date of Meeting:	3 May 2024
Committee Chair:	Trish Anderson
Attendance:	Quorate
Key Items Discussed:	Intentionally Becoming an Anti-Racist Organisation National Staff Survey Summary Report 2023 Flu Vaccination Plan Quarterly Workforce Report Corporate Risk Register Report Board Assurance Framework Review of People and Culture Committee Workplan

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The Committee received a detailed report on the National Staff survey. The Trust deemed to be above average in 7 areas of the 9 main themes and below average in 2 largely around sense of belonging. Divisional leaders will be involved in developing co-produced action plans.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee received the Quarterly Workforce Report. Highlights included successful recruitment of 170 International nurses, significant work on staff retention, and the launch of a bespoke Mary Seacole Leadership Programme. The Trust is also on track to achieve its target of 3.7% of spend for agency cover. A 'Colleague Care ' month was held in January 2024.
- The Committee received The Corporate Risk Register report. Members were advised that there had been no movement in 15 out of 19 risks on the register since

the previous month. Work is ongoing with risk ID8725 (Lack of senior clinical decision making and inconsistent medical cover for CIC services) and is likely to reduce.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee received the Board Assurance Framework and was advised that the annual review process would begin shortly to review and revise the objectives.
- The Committee was informed that a Committee workplan would be circulated for ratification at the next meeting.
- The Committee received minutes from the Educational Operational Delivery Board and the Joint Negotiating and Consultative Committee.

TRUST BOARD REPORT	**Item**	**79**
15 May 2024	**Purpose**	Approval Assurance Information

Title	Triple A Report from Audit Committee
Report Author	Mr K Rehman, Chair of Audit Committee
Date Paper Approved by Executive Sponsor	7 May 2024

Summary: This report sets out the summary of the items discussed at the Audit Committee meeting held on 22 January 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

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

Related to key risks identified on Corporate Risk Register	N/A
Related to recommendations from audit reports	N/A
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	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed? Yes/No

Committee Name: **Audit Committee**

Date of Meeting: **22 Jan 24**

Committee Chair: **Khalil Rehman**

Attendance: Quorate

Key Items Discussed:

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter

- The board should be aware that progress regarding completing consultant job planning is well behind plan. This issue has been on-going since 2016. However, the committee noted the hard work and efforts of the deputy Managing Director to complete the implementation. In particular it recognised the impact of industrial action. The committee suggested that senior executives review the situation and lend their support to manage the challenging issues in this area.
- Internal audit is impacted by a large number of reports due in Q4. Head of internal audit opinion currently amber but committee assured that trajectory is towards green.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The committee noted the assurances and progress on tackling medical sickness.
- Assurances and explanations received pertaining to the HFMA financial sustainability checklist and risks mitigations around Urgent & Emergency Care Pressures.
- Updates on the internal and external audits.

- Good discussion around the Corporate Risk Register and in particular to boost training and support as we remain with the current Datix system and no longer migrating to RADAR.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- Nothing material to advise

TRUST BOARD REPORT **Item** **81**

15 May 2024 **Purpose** Information

Title	Trust Board (Closed Session) Summary Report
Report Author	Miss K Ingham, Corporate Governance Manager
Executive sponsor	Mr S Sarwar, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 13 March 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: **13 March 2024**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 10 January 2024 were approved as a true and accurate record.

The minutes of the Extraordinary Trust Board held on 14 February 2024 were also approved as a Trust and accurate record.

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) National Planning Guidance 2024-25
c) Blackburn with Darwen Community Services Transaction and Albion Mill
d) Electronic Patient Record Progress Update
e) National Staff Survey Results
f) Financial Recovery Plan Update and Revenue Support Application
g) Central Services Update, including Governance Processes
h) Mutually Agreed Resignation Scheme
i) Pathology Collaboration Update and Trust Pathology Improvement Work Update
j) Industrial Action Update
k) Fire Remediation Programme Update: Burnley General Teaching Hospital
l) Fire Remediation Programme Update: Royal Blackburn Teaching Hospital

ITEMS RECEIVED FOR INFORMATION

None.

TRUST BOARD REPORT	**Item**	**82**
15 May 2024	**Purpose**	Information

Title	Remuneration Committee Summary Report
Executive sponsor	Professor G Baldwin, Non-Executive Director

Summary: The list of matters discussed at the Remuneration Committee meetings held on 13 March 28 March 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: **13 March 2024**

Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 13 March 2024, the following matters were discussed in private:

a) Arrangements for Interim Director of People and Culture

Meeting: **Remuneration Committee**

Date of Meeting: **28 March 2024**

Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 28 March 2024, the following matters were discussed in private:

a) Secondment of Executive Director of Integrated Care, Partnerships and Resilience
b) Remuneration Committee Terms of Reference