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

11 SEPTEMBER 2024, 12.00

BOARDROOM, FUSION HOUSE

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

OPENING MATTERS				
TB/2024/115	**Chairman's Welcome**	Chairman	v	
TB/2024/116	**Apologies** To note apologies.	Chairman	v	
TB/2024/117	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	
TB/2024/118	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 15 May 2024.	Chairman	d✓	Approval
TB/2024/119	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2024/120	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2024/121	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2024/122	**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/2024/123	**Staff Story (Pendle East District Nurses)** To receive and consider the learning from a patient/Staff story.	Chief Nurse	p	Information/ Assurance
TB/2024/124	**Corporate Risk Register 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/2024/125	**Board Assurance Framework** To receive an update on the annual review of the Board Assurance Framework and risk appetite and approve the revisions based on the Executive Risk Assurance Group, Committees' and the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Executive Director of Service Development and Improvement	d✓	Assurance/ Approval
TB/2024/126	**Patient Safety Incident Response Assurance Report** To receive the paper as a summary update on the incidents reported under the new Patient Safety Incident	Executive Medical Director	d✓	Information/ Assurance

	Response Plan (PSIRP). This report also includes information on maternity specific serious incidents reporting as required by Ockenden recommendations.			
STRATEGIC ISSUES				
TB/2024/127	**Supporting Unpaid Carers in Lancashire and South Cumbria**	Chief Nurse	d✓	Approval
TB/2024/128	**Maternity and Neonatal Services Update** *T Thompson to attend for this item.*	Chief Nurse / Divisional Director of Midwifery and Nursing	d✓	Information/ Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2024/129	**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: **15.15** a) Introduction (Chief Executive) **15.20** b) Safe (Executive Medical Director and Chief Nurse) **15.25** c) Caring (Chief Nurse) **15.30** d) Effective (Executive Medical Director) **15.35** e) Responsive (Chief Operating Officer) **15.40** f) Well-Led (Director of People and Culture and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2024/130	**SPE+ Improvement Practice Update**	Executive Director of Service Development and Improvement	d✓	Information/ Assurance
GOVERNANCE				
TB/2024/131	**Annual Report on Medical Appraisal, Revalidation and Governance**	Executive Medical Director	d✓	Information/ Approval
TB/2024/132	**Emergency Preparedness, Resilience and Response (EPRR) Annual Statement**	Executive Director of Integrated Care, Partnerships and Resilience	d✓	Information/ Assurance
TB/2024/133	**Ratification of Board Sub-Committee Terms of Reference** a) Quality Committee b) Audit Committee	 Committee Chair Committee Chair	 d✓ d✓	 Approval Approval
TB/2024/134	**Triple A Reports from Finance and Performance Committee** To note the matters considered by the Committee in discharging its duties. a) July 2024 b) August 2024	Committee Chair	 d✓ d✓	Information

TB/2024/135	**Triple A Reports from Quality Committee** To note the matters considered by the Committee in discharging its duties. a) August 2024	Committee Chair	d✓	Information
TB/2024/136	**Triple A Report from Audit Committee** To note the matters considered by the Committee in discharging its duties. a) June 2024 b) July 2024	Committee Chair	d✓ d✓	Information
TB/2024/137	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2024/138	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2024/139	**Any Other Business**	Chairman	v	
TB/2024/140	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2024/141	**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/2024/142	**Date and Time of Next Meeting** Wednesday 13 November 2024, 12.30pm, Venue to be Confirmed.	Chairman	v	

TRUST BOARD REPORT **Item** **118**

11 September 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	

Summary: The minutes of the previous Trust Board meeting held on 10 July 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, 13:00, 10 JULY 2024

MINUTES

PRESENT

Mr S Sarwar	Chairman	Chair
Mr M Hodgson	Chief Executive / Accountable Officer	
Mrs P Anderson	Non-Executive Director	
Professor G Baldwin	Non-Executive Director	
Mrs M Brown	Executive Director of Finance	
Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive	
Mr J Husain	Executive Medical Director / Deputy Chief Executive	
Mr P Murphy	Chief Nurse	
Mrs C Randall	Non-Executive Director	
Mr K Rehman	Non-Executive Director	
Mr R Smyth	Non-Executive Director	Present until 13:30

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

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

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary	
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs J Butcher	Staff Guardian	Item: TB/2024/103
Mr M Pugh	Corporate Governance Officer	
Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council	

Miss T Thompson Divisional Director of Midwifery and Nursing Item: TB/2024/099

APOLOGIES

Mrs L Sedgley Non-Executive Director

TB/2024/086 CHAIRMAN'S WELCOME

Mr Sarwar welcomed Directors and members of the public to the meeting.

TB/2024/087 APOLOGIES

Apologies were received as recorded above. Mr Sarwar informed members that Mr Smyth had given prior notice that he would be departing the meeting at 13:30.

TB/2024/088 DECLARATIONS OF INTEREST

The Directors Register of Interests was presented to Directors. No additional declarations of interest were made.

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

TB/2024/089 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 15 May 2024 were approved as a true and accurate record.

TB/2024/090 MATTERS ARISING

There were no matters arising.

TB/2024/091 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. The following updates were provided:

TB2/2024/072: Maternity and Neonatal Services Update – Mr Murphy confirmed that the Trust's Patient Experience Strategy had been revised following the publication of the All-Party Parliamentary Group (APPG) Birth Trauma Report.

RESOLVED: Directors noted the position of the action matrix.

TB/2024/092 CHAIRMAN'S REPORT

Mr Sarwar stated that the pressures facing the Trust were much the same as they had been in previous months, with significant demands in terms of patient numbers and acuity. He stressed that it was important to recognise the high performance that continued to be delivered by colleagues despite this, particularly in relation to the four-hour accident and emergency (A&E) standard and extended his thanks to them on behalf of the Board.

Mr Sarwar went on to provide a summary of his activities to Directors since the previous meeting, advising that he had attended a recent Quality Improvement (QI) Conference hosted by NHS Providers. He added that it had been good to see the activity taking place and that the event had demonstrated how strong the Trust's own QI methodology was. Mr Sarwar informed Directors that he had also attended the NHS 'ConfedExpo' 2024 alongside Mr Hodgson and stated that this had served as a good opportunity to meet with colleagues from across the Lancashire and South Cumbria (LSC) system and the rest of the country. He reported that the primary focus of the event had been on finances, the ongoing demand on healthcare services and workforce planning. Mr Sarwar added that there had been a clear narrative to work with the new Secretary of State for Health and Social Care to positively move forward.

Mr Sarwar confirmed that he continued to attend a range of meetings at system level, including the Provider Collaboration Board Joint Committee (PCBJC) and the System Leadership Oversight Group.

Mr Sarwar informed Directors that he had participated in a range of activities at Trust level. He advised that he had recently attend two Safe, Personal and Effective Care (SPEC) panels with Mr Murphy and stated that they had been a good opportunity to meet staff and gain a better appreciation of how many of them continued go beyond the call of duty.

Mr Sarwar highlighted that he had had the opportunity to chair a recent meeting of the Trust's Inclusion Group and that he had been struck by the passion and energy on display there. He added that the work being done by this group tied into the Trust's ongoing commitment to becoming an intentionally anti-racist organisation and emphasised the importance of ensuring parity across the organisation for both staff and patients alike. Directors noted that Mr Sarwar had also met with colleagues from the Trust's Veterans' Support Service, a service for which it had been recognised nationally, and had recently visited Blackburn College at the invitation of Dr Fazal Dad, formerly one of the Trust's Associate Non-Executive Directors (NEDs). Mr Sarwar commented that it had been good to see the range of work taking place at the college and how much of it was linked to the activities of the Trust. He added that it was the responsibility of the Trust, as a major employer in the area, to continue to provide assistance to the College where it could.

Mr Sarwar concluded his update with a personal observation that there was a significant public health crisis across East Lancashire and that the Trust would have to take great care to maintain a balance between its financial obligations and continuing to deliver high-quality care.

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

TB/2024/093 **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 referred to the recent outcome of the general election and stated that he looked forwarded to working with the new government. He indicated that there was likely to be a renewed focus on constitutional targets, including the four-hour standard, as well as a greater focus on innovation, transformation and efficiency.

Mr Hodgson went on to refer to several other recent events at national level, including the recent cyber-attack on pathology services across London. He noted that this had served as another warning of the dangers of the modern world and advised that the NHS had used it as an opportunity to take stock. Mr Hodgson confirmed that the Board had recently held a development session on information governance and indicated that work was underway to arrange a follow-up session on cyber-security in the near future. He acknowledged that while cyber-security was a constantly evolving subject, much had been learned from the 'WannaCry'

incident several years earlier and highlighted that the additional investments made at that time would hold the Trust in good stead over the coming years.

Mr Hodgson noted that the publication of the findings from the Infected Blood Inquiry had taken place recently and that there had been a range of significant findings, with over 30,000 people in total affected and 3,000 deaths. He stated that the inquiry had made clear that the NHS had failed these people in a multitude of ways.

Mr Hodgson reminded Directors that a significant amount of work had taken place Trust level around Martha's Rule and advised that a dedicated session had taken place around this at the NHS 'ConfedExpo'. He added that as part of this, NHS England (NHSE) had set a target for at least 100 sites to put procedures in place where a second opinion could be easily accessed, and patients and their families could raise concerns more easily. Mr Hodgson highlighted that the Trust had already implemented its own 'Call for Concern' programme and reported that around 20 calls had already been received and responded to.

Mr Hodgson informed Directors that several developments had taken place at a LSC system level, including the most recent meeting of the PCBJC on the 13 June 2024. He indicated that there had been a significant focus on urgent and emergency care (UEC) pressures, finances and transformation programmes, including the One LSC initiative. Mr Hodgson informed Directors that Professor Mike Thomas had recently been ratified for a second term as Chair of the PCBJC and that this would commence on the 17 August 2024.

Mr Hodgson went on to provide a summary of other developments taking place at Trust level. He confirmed that the roundtable exercise with the former Minister of State in the Department for Health and Social Care, Helen Whately, had taken place following her visit to the Trust in May 2024 and that there had been clear recognition of staff efforts and innovation by those present.

Mr Hodgson referred to the previous meeting of the Trust Board that had taken place at Turf Moor stadium in Burnley and commented that it had been good to get out into the community. He confirmed that more activity would be taking place to engage with stakeholders and the Trust's partner organisations over the coming months.

Mr Hodgson informed Directors that a number of changes would be taking place regarding the membership of the Board over the coming months, adding that a recruitment campaign for three additional NEDs and an associate NED had recently gone live. He also referred to the imminent retirement of Mrs Brown and highlighted that she had worked in the NHS for almost

30 years and for the Trust since 2006. Mr Hodgson stated that Mrs Brown's approach had always put the patient first and extended his thanks to her for all that she had done for the NHS, and for the Trust, during her career.

Mr Hodgson reported that there had been a further round of industrial action taken by junior doctor colleagues from the 26 June to the 7 July and, whilst the Trust respected the right for staff to undertake industrial action, he praised Trust staff for rising to the challenge once again with a range of tried and tested techniques. He confirmed that the majority of the Trust's services had remained operational, with only a relatively minor number of theatre procedures needing to be rearranged as a result.

Mr Hodgson informed Directors that the Trust had recently received a bronze award from the North West Black, Asian and Minority Ethnic (BAME) Assembly and that this served as a real barometer of its intent to become an intentionally anti-racist organisation.

Mr Hodgson went on to provide a summary of a range of other highlights taking place at Trust level, including the STAR awards taking place the following day, the recent opening of a new heart centre on the Royal Blackburn Teaching Hospital (RBTH) site and the opening of a new spiritual care centre on the Burnley General Teaching Hospital (BGTH) site.

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 (SPEC) award process. These were: the Burnley Urgent Treatment Centre (BUTC), Rossendale East District Nurses and ward C7.

Directors confirmed that they were content for silver status to be awarded to the areas listed above.

Mr Murphy highlighted that innovation was at the centre of everything being done at the BUTC and that he was aware of several examples of patients who would have waited much longer for treatment without the new models that had been put in place there. He informed Directors that had recently taken the opportunity to visit colleagues at Rossendale East District Nursing Team alongside Mrs Anderson and that a family had also attended to speak on how shared care services were working to manage their relative, with very complex health needs, in their own home. He also praised the leadership being shown on C7 and the adaptability that staff had shown in managing patients and cohorts.

Mr Sarwar extended his own thanks to Mrs Brown for her service to the NHS and to the Trust. He added that it was clear that Mrs Brown was one of the most technically gifted Directors of Finance that the LSC system had ever had, and that her loss would be keenly felt. Mr Sarwar wished Mrs Brown the best in her future endeavours.

Mr Sarwar went on to reiterate that the Trust's anti-racism activity would remain and that it would serve as a real opportunity for colleagues to reflect on what inclusion would need to look like in the organisation. He noted that part of this activity would be a commitment to remove variations and inappropriate behaviours and that it would be the role of the Board as leaders to consider how to challenge this.

Mrs Quinn concurred with Mr Sarwar's comments. She also emphasised that there was a clear and meaningful difference between the Trust's commitment to becoming intentionally anti-racist rather than just not racist. Mrs Quinn informed Directors that there was clear evidence that this kind of work not only improved the experience for colleagues, but also had a clear beneficial impact on patient mortality.

Mrs Atkinson noted as an additional significant development that had occurred regarding the transfer of community services, specifically the transfer of adult services into the Trust and the transfer of Child and Adolescent Mental Health Services (CAMHS) into Lancashire and South Cumbria NHS Foundation Trust and confirmed that this been carried out successfully.

RESOLVED: Directors received the report and noted its contents.

TB/2024/094 PATIENT STORY

Mr Murphy provided a brief introduction to the patient story. He reminded Directors that it was his intention for a balance of more positive and less positive stories to be presented to the Board and that the specific story being presented had more elements of learning than the others recently provided. Mr Murphy added that there were clear lessons around dignity of care, communication and delays that the Trust would need to take on board.

The patient story can be viewed here.

Mr Sarwar thanked Mr Murphy for bringing the story. He agreed that there were clearly several lessons to be learned from the experience of the patient involved and that it was important for the Trust to be able to recognise when it had not got things right and work to address them.

Mr Sarwar observed that there were some cultural issues around consistency of quality of care in the story and that it had made clear how much of a difference even minor gestures could make to the experience of patients and their families. He also pointed out that there some fundamental basics of care that had been missed. Mr Sarwar emphasised the importance of triangulation in the learning from the story to ensure that similar issues were not occurring anywhere else.

Miss Wright stated that she would investigate whether an abridged version of the story presented could be shared at a Teams Brief meeting in the future to raise awareness amongst staff.

Mrs Randall advised that the same story had been presented at the last meeting of the Quality Committee and that similar suggestions had been made there around sharing it more widely with staff across the organisation.

Mr Hodgson extended his apologies to the patient, and their relatives, for their poor experience in the Trust and indicated that he had heard similar feedback from other sources. He agreed that triangulation was important, as there was clearly some variability across the Trust around the processes and structures that were in place to avoid the kind of issues raised in the story.

Mr Sarwar agreed with Mr Hodgson's comments and noted that this was not the first time that the Board had been informed of variations across the Trust. He suggested contacting the family of the patient to determine if they would be interested in attending a separate meeting in person to discuss their experiences with staff.

Mrs Atkinson commented that the story had made for difficult listening. She noted that issues around nutrition and hydration had been raised in the story and confirmed that a raft of collaborative improvement work was taking place across the Trust in this area. Mrs Atkinson explained that a key part of this collaboration work was measurement and ensuring consistency to provide assurance.

Mr McDonald stated that the story emphasised the importance of ward managers and team leaders, as they were often the most senior colleagues that patients would interact with. He added that it would just as important for the Trust to ensure that these colleagues had the time

that they needed to meet with their teams and deliver the standard of care that they would wish to deliver.

Mrs Anderson stated that the story had indicated to her a clear gap in leadership on ward areas and agreed with Mr McDonald's assessment on the importance of ensuring that senior ward colleagues had the capacity to carry out their roles properly.

Professor Baldwin agreed and suggested that it may also be worth considering a more fundamental review of the Trust's organisational structure and leadership at a later date. He added that this was not intended as a criticism of any colleagues, as wards were fundamentally complex areas and had significant and unique challenges to manage on a daily basis.

Mr Murphy confirmed that a shared website with a repository of patient stories was now in place. He also confirmed that active engagement with families continued and included inviting them to monitor the actions taken in response to any concerns that they had raised. Mr Murphy stressed the importance of hearing stories like the one presented, despite how difficult they may be to listen to, as there may otherwise be a risk of the issues raised within them being lost.

Mr Sarwar noted that it was key for the Board was to get assurance around any issues raised in patient stories. He proposed giving consideration to revisiting patient stories a number of months after they were initially presented to Directors, and potentially linking these to walk rounds with Executive colleagues, to ensure that actions had been taken and improvements made.

Mr Murphy agreed that this was a sensible proposal and that updates would be provided six months after patient stories were initially presented going forward. He also confirmed that the website repository of patient stories would be made available to everyone.

Mr Smyth left the meeting at this time.

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

Updates will be provided six months after patient stories are initially presented to the Board regarding any actions taken and/or improvements made.

Miss Wright to investigate if shortened versions of patient stories could be presented at future Teams Brief meetings.

Consideration will be given to inviting patients, or their relatives, to talk about their experiences in person.

TB/2024/095 NURSING PROFESSIONAL JUDGEMENT REVIEW

Mr Murphy referred Directors to the previously circulated report and provided a summary of highlights. He reminded Directors that it was a national requirement for the Trust to carry out professional judgement reviews (PJRs) on a six-monthly basis and that all relevant information relating to the most recent round of reviews, undertaken in November 2023, was included in the report. Mr Murphy confirmed that the results from these had also been previously presented to the Quality Committee.

Mr Murphy highlighted that the Trust had continued to improve on fill rates for registered nurses and support staff. He advised that there was a possibility that the Safer Nursing Care Tool (SNCT) census would indicate that the Trust was overstaffed in some wards and areas but explained that this was due to the nature of the tool itself. Mr Murphy informed Directors that work was taking place to improve the supernumerary status of ward managers and that an improvement case to cover the associated costs was currently in development.
Mr Murphy went on to advise that the Trust had previously had around 280 registered nurse vacancies, and that this was due to be reduced down to zero in September 2024. Directors noted that a substantial amount of work had also taken place around standardisation of agency pay rates and that there had been a subsequent reduction in spend from £14.6m in 2021-22 down to £10.1m in 2023-24. Mr Murphy added that further reductions in agency spend were expected as the number of registered nurse vacancies continued to fall.

Mr Hodgson commented that the report was a good example of the balance being maintained by the Trust around ensuring quality and safety, delivering on performance targets and addressing workforce challenges, whilst also living with its means financially. He acknowledged that the Trust had had to put additional staff into maternity and UEC areas but stressed that colleagues were constantly looking to see how resources could be used more efficiently.

In response to a query from Mr Rehman around staff retention, Mr Murphy stated that it was his firm belief that this would only improve as the numbers of permanent staff in the

organisation continued to increase and that this had already been reflected to some degree in the Trust's A&E department.

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

TB/2024/096 **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 CRR, five of which had been added since the previous meeting, these were:

- **10062** - risk of harm and poor experience for patients with mental health.
- **10065** - pharmacy technical service refurbishment programme.
- **9900** - poor identification, management and prevention of delirium.
- **9895** – patients not receiving timely emergency procedures in theatres.
- **9653** - increased demand with a lack of capacity within ELHT can lead to extreme pressures and delays to patient care.

Mr Husain advised that three other risks had been stepped down from the register, these were:

- **8839** - failure to achieve elective recovery targets.
- **8725** - lack of senior clinical decision making and inconsistent medical cover for CIC services.
- **7008** - failure to comply with 62-day cancer waiting time target.

Mr Husain confirmed that the remaining 14 risks had not shown any movement. Directors noted that the highest scoring risk remained 10082 (failure to meet internal and external financial targets for 2024-25) at 25 and that a number of others remained at 20.

Mr Husain went on to highlight that there had been a reduction in the number of overdue risks of 92% from Q4 2022-23 to Q1 2024-25. He added that reductions of 36%, 35% and 39% had also been seen in the numbers of open risks, moderate or significant risks and risks remaining open for three years or more respectively over the same period.

Mr Hodgson stated that the paper clearly showed that the management of risk in the Trust remained appropriately fluid and not static.

Mr Rehman agreed and stated that there should be clear recognition of the hard work being done by colleagues around risks. He added that it was good to see the trajectory of risks continuing to go down.

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

TB/2024/097 BOARD ASSURANCE FRAMEWORK (BAF)

Mrs Bosnjak-Szekeres referred members to the previously circulated report and explained that it was the first iteration of the BAF being presented following the annual review process carried out with Executive Directors and through Board workshop sessions, the Executive Risk Assurance Group (ERAG) and the various Board sub-committees. She added that the Trust's revised risk appetite statement for 2024-25 had also been included in the report for approval. Mrs Bosnjak-Szekeres pointed out that the development of the BAF remained an ongoing and fluid process, particularly with regard to risk six around the One LSC programme.

Mr Sarwar referred to risk six and requested additional clarification on whether the discussions on risk that had taken place in the closed session of the Trust Board meeting earlier in the day would be reflected in risk six.

Mrs Bosnjak-Szekeres confirmed that this risk would be updated to reflect the comments made earlier.

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

BAF Risk six will be updated to reflect the discussions in the closed session of the July Trust Board meeting.

TB/2024/098 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 highlighted that an Advise, Assure and Alert (AAA) summary had been included in the report and would be included in future iterations going forward. Mr Husain informed members that the Trust had recently 'gone live' with the new national Learning from Patient Safety Events (LfPSE) platform and had uploaded all relevant data within the required deadlines. Directors noted that there had been an increase in the completion of IR2s across nearly all divisions, with all clinical divisions now achieving over 80% compliance. Mr Husain highlighted that all harm levels in the Trust remained below the national average despite the ongoing pressures on its emergency pathways. He reported that there had been no breaches

of Duty of Candour and that Patient Safety Incident investigation (PSII) numbers were reducing, with a total of 24 open as of the meeting. Mr Husain concluded his update by referring Directors to the information provided around Mandatory National Patient Safety Syllabus Training Module compliance. He advised that the Trust had still not managed to reach its self-imposed 95% trajectory target in any of the modules but confirmed that good progress was being made.

Mr Sarwar observed that the training compliance for the level 1b (Boards and Senior Leadership) module currently stood at just over 84%. He urged the need for the 95% threshold to be reached as a priority and requested that this was done by the next meeting.

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

Training compliance with level 1b Patient Safety Training will reach 95% by the next meeting.

TB/2024/099 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson referred to the previously circulated report and provided a summary overview of the Trust's progress against the ten maternity safety actions included in the Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Year Six.

Safety Action 1 - Perinatal Mortality Review Tool (PMRT): Miss Thompson confirmed that the Trust had successfully met all compliance requirements for this action.

Safety Action 2 - Maternity Services Data Set (MSDS): Miss Thompson confirmed that the Trust had successfully met all compliance requirements for this action.

Safety Action 3 - Transitional Care (TC): Miss Thompson confirmed that the Trust had successfully met all compliance requirements for this action. She informed Directors that an in-depth audit had been undertaken around respiratory disease, the main cause of term admissions to the Neonatal Intensive Care Unit (NICU) and that this would form part of the basis of a subsequent improvement project.

Safety Action 4 - Clinical Workforce: Miss Thompson confirmed that an action plan would be produced to address the identified risk around consultant rotas not meeting British Association of Perinatal Medicine (BAPM) standards and that this would be brought to future Board meetings throughout the year.

Safety Action 5 - Midwifery Workforce: Miss Thompson confirmed that an action plan was in place to address the shortfall in the staffing budget against the requirements outlined by Birthrate+. She added that some aspects would also be addressed via the PJR process.

Safety Action 6 - Saving Babies Lives v3 Care Bundle (SBLv3): Miss Thompson confirmed that the Trust was on track to achieve this action, with the Trust currently sitting at 81% overall implementation for the Saving Babies Lives v3 Care Bundle (SBLv3).

Safety Action 7 – Maternity Neonatal Voice Partnership (MNVP) User Feedback: Miss Thompson advised that the Maternity & Neonatal Voice Partnership (MNVP) Workplan 2024-25 would be presented to the Local Maternity and Neonatal System (LMNS) Board later in the month. She also confirmed that the MNVP colleagues continued to attend floor to Board meetings.

Safety Action 8 – Training: Miss Thompson confirmed that work continued to develop an action plan to ensure that a minimum of 90% of neonatal medical staff who attended neonatal resuscitations had a valid Resuscitation Council Newborn Life Support (NLS) certification by Year Seven of the MIS onwards.

Safety Action 9 - Board Assurance: Miss Thompson confirmed that the Trust was compliant against this action.

Safety Action 10 - Maternity and Newborn Safety investigation Programme (MNSI) / NHS Resolution: Miss Thompson confirmed that the Trust was fully compliant against this action.

Miss Thomson confirmed that the findings and recommendations from the APPG Birth Trauma report had been worked into the Trust's Patient Experience Strategy and that this would be monitored through the relevant Safeguarding Committee.

In response to a query from Mr Hodgson on triangulating the staffing requirements set out in the PJR whilst also ensuring the Trust continued to live within its financial means, Mr Husain acknowledged that this would be a challenge and explained that the Trust would need to be very specific with its job and recruitment plans going forward. He also explained that conversations would be needed with the Trust's system partners and that consideration may need to be given to expanding specific services and reducing others on a regional basis.

Mr Murphy added that it would be the responsibility of the LSC Integrated Care Board (ICB) to support the Trust and other organisations in this area over the coming months.

RESOLVED: **Directors received the report and were assured by the activity taking place to deliver safe, personal and effective care in the Trust's maternity and neonatal services.**

TB/2024/100 TRUST PRIORITIES 2024-25

Mrs Atkinson explained that the revised and refreshed Trust Priorities, developed as part of the wider planning process for 2024-25, were being presented to the Board for formal sign-off. She highlighted that one of the Trust's goals as part of its Strategic Framework had been removed (secure COVID recovery) and that the wording of two others had been slightly revised. Mrs Atkinson informed Directors that there were a total of eight key delivery and improvement priorities and that extra work had taken place to ensure that there was a robust measurement framework underpinning them. She added that this would be reflected in the Trust's revised Integrated Performance Report once it was ready for presentation to the Board. Mrs Atkinson requested confirmation from Directors that they were content to formally approve the updates made to the Trust's Strategic Framework, to sign off the key delivery prioirities and strategic plans and to note that future updates would be provided on a regular basis going forward.

RESOLVED: **Directors received the report and noted its contents.**
Directors confirmed that they were content to approve the updates the Trust' Strategic Framework and the key delivery and improvement priorities for 2024-25.

TB/2024/101 RESPONSE TO EDENFIELD REPORT

Mr Murphy referred Directors to the previously circulated report and clarified that it provided a summary of the Trust's response to the Independent Review of Greater Manchester Mental Health NHS Foundation Trust following the discovery of abuse, humiliation and bullying of patients at the Edenfield Centre in Prestwich. He informed Directors that a total of 10 recommendations had been made and explained that although some directly related to mental health services, many others were transferrable and applicable to other services. Mr Murphy confirmed that a comprehensive action plan had been drawn up and would be monitored at the monthly meetings of the Trust Wide Quality Group (TWQG).

Mr Rehman noted that the importance of freedom to speak up (FTSU) had been made clear in the recommendations from the independent review and that it would be vital for the Trust to ensure that this was woven into its action plan.

Mr Murphy agreed and pledged to ensure that the action plan reflected this.

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

The action developed in response to the Independent Review of Greater Manchester Mental Health NHS Foundation Trust will be updated to reflect the recommendations around freedom to speak up.

TB/2024/102 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Mr Hodgson referred to the previously circulated report and confirmed that it covered the period up to the end of May 2024. He stated that the report was generally positive but that some areas clearly reflected the impact from ongoing industrial action. Mr Hodgson reiterated that the Trust continued to perform well in relation to the four-hour A&E standard but acknowledged that this concealed a multitude of other issues.

b) Safe

Mr Husain referred Directors to the Safe section of the report. He highlighted that there had been a single reported case of Methicillin-Resistant Staphylococcus Aureus (MRSA) which had been determined to have been Community Onset Hospital Acquired (COHA).

In response to a query from Mr Rehman regarding the maternal death mentioned in the report, Mr Husain explained that this had been due to a very unfortunate and rare complication with the patient in question and had not been related to staffing levels or industrial action in any way. He added that any maternity deaths that occurred in the Trust were investigated in detail by the Maternity and Newborn Safety Investigations (MNSI) programme and that the Trust's own assessment of the incident had not picked up any issues with the care provided to the patient. Mr Husain also confirmed that the relatives of the patient had been involved in the duty of candour process that had taken place immediately after they had passed, and that additional support was being provided to them by the Trust's bereavement service.

Mr Murphy informed Directors that there had been a rise in stillbirth rates through May and confirmed that this had been reported via the Strategic Executive Information System (StEIS).

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 advised that action plans were in place to address any patient experience issues raised through the Friends and Family Test (FFT) in A&E areas.

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

d) Effective

Mr Husain explained that the data issues referred to at the previous meeting regarding the accuracy of mortality data were still ongoing and that as a result the Trust still could not be certain that its Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) metrics were accurate. He stated that some assurance could be gained from the Trust's crude mortality rate, as this had continued to fall and remained below the North West and national averages.

Mr Husain reported that the backlog in coding was still in place and confirmed that work was ongoing to address this. He added that the removal of Same Day Emergency Care (SDEC) datasets referred to at the previous meeting was also still having an impact and that this had been recognised by NHSE.

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

e) Responsive

Mrs Gilligan reported the Trust's performance against the four-hour A&E standard at 78% at the end of March 2024, 80% for May and just over 81% as of the meeting. She commended the hard work done by colleagues to achieve this but acknowledged that more needed to be done to reduce the high numbers of patients still waiting for 12 hours or more in the emergency department (ED). Mrs Gilligan informed Directors that the opening of a new heart centre on the RBTH site had freed up additional space which had already started to have a positive

impact on ambulance handover times, which had fallen to just over 22 minutes in July against an average of over 31 minutes.

Mrs Gilligan went on to provide a summary of the Trust's cancer performance and confirmed that it had improved significantly over recent months. She highlighted that the Trust had achieved its trajectory targets for the faster diagnosis standard, the 31-day standard and had come in just under its trajectory for the 62-day standard in both April and May 2024.

Mrs Gilligan advised that a significant amount of work was taking place to manage and reduce the numbers of 65-week wait patients, with a reduction in the total number of patients needing to be seen before the end of September from 5,600 to 3,278 over the previous month.

Mrs Gilligan concluded by confirming that the Trust continued to perform well with regard to theatre utilisation and was currently ranked as seventh best in the country for this. She extended her thanks to clinical and operational colleagues for their ongoing work in this area.

Responding to concerns expressed by Mr Rehman regarding the potential impact of strike action on the work taking place to improve corridor care and on winter pressures, Mrs Gilligan explained that the Trust had tried and tested methods of managing industrial action. She acknowledged that potential industrial action from GPs was more worrying, as it would likely not be as regimented as that taken by junior doctor colleagues but stated that she was fully confident that Trust staff would take all actions to make the necessary preparations. Mrs Gilligan confirmed that more information would be provided at the next meeting. on the work taking place around the Trust's winter plan for 2024-25.

Mr Razaq left the meeting at this time.

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.**

An update on the Trust's winter plan for 2024-25 will be included in the wider UEC update at the next meeting.

f) Well-led

Mrs Quinn referred to the discussions earlier in the meeting regarding the work done around recruitment and vacancy rates and emphasised that this, when combined with other work done across the system to reduce agency rate cards, had made a significant positive impact. She

highlighted that there had been significant improvements in job planning and a steady improvement in appraisal rates. Directors noted that organisational development colleagues were considering if any other measures could be implemented to make the appraisal process easier for staff to complete.

Mrs Quinn went on to provide a summary of core skills and mandatory training compliance and pointed out that a number of areas were currently showing as red. She noted that the Safeguarding Adults Level 3 training module currently had the lowest compliance at 78% but explained that this was due to it only being introduced in late 2023. Mrs Quinn confirmed that this as being micromanaged through the Trust's Department of Education, Research and Innovation (DERI).

In response to a query from Mr Sarwar regarding consultant job planning, Mrs Quinn explained that it was important for this to be done on a regular basis to ensure that they accurately reflected the work that colleagues were carrying out.

Mr Rehman informed Directors that the matter of job planning had been an issue considered by the Audit Committee for some time.

Mrs Brown informed Directors that the Trust's annual plan and budget for 2024-25 that had been approved by the Board at its last meeting had subsequently been rejected by NHSE and that negotiations were still ongoing around further revisions required. She indicated that there was potential for the Trust's deficit position to be reduced to £21.9m but stressed that this was still a draft position. Mrs Brown confirmed that any revised plans would be presented to the Finance and Performance Committee and to the Board for formal sign-off.

RESOLVED: **Directors noted the information provided under the Well-Led section of the Integrated Performance Report and received assurance about the activity being taken to improve and maintain performance.**

The revised financial annual plan and budget for 2024-25 will be presented to the Finance and performance Committee and to the Trust Board for formal sign-off at a later date.

TB/2024/103 FREEDOM TO SPEAK UP REPORT

Mrs Butcher referred to the previously circulated report and provided a summary of key highlights to Directors. She reported that a total of 237 concerns had been raised through

2023-24, a rise of 32 from the 2022-23, and that the highest proportion of concerns had been for support through a HR process, followed by a perceived lack of support from managers and perceived inappropriate attitudes and behaviours. Mrs Butcher advised that the compliance rate for level 3 FTSU training remained low at 34.2% and confirmed that an action plan was in place to improve this.

Mr Rehman referred to the Trust's recent bronze award from the North West BAME Assembly and suggested that it would be useful to have more anti-racism elements and information included in future reports. He added that it would also be helpful for more information to be provided on the diversity of the FTSU Ambassadors across the Trust.

In response to a request for further clarification from Mrs Hatch on the consequences of the rejection of the recent business cases to further develop the FTSU service, Mrs Butcher indicated that this would directly affect her, and her colleagues', ability to share cases and learning with staff.

Mrs Quinn observed that Mr Rehman's queries linked to an important point around how confident staff from different backgrounds felt to raise concerns through the FTSU service, as there was evidence that they did not feel comfortable doing so. She confirmed that this would be linked to the Trust's anti-racism work and that the Associate Director of Organisational Development, Emma Dawkins, was currently considering how to engage key individuals to determine how this could be addressed.

Mrs Butcher went on to raise serious concerns around recent difficulties that she had witnessed in staff feeling able to raise issues around racism. She explained that even though 25% of the Trust's FTSU Ambassadors were from BAME backgrounds, they had also reported that no concerns were being raised to them and that this was leading to concerns that colleagues may be experiencing racially motivated discrimination and choosing to remain silent. Mrs Butcher added that this was compounded by there being a lack of any relevant case studies with positive outcomes to share and that this made it difficult to demonstrate the Trust's stated zero-tolerance approach to any discriminatory behaviour.

Mr Sarwar thanked Mrs Butcher for her candour and offered apologies on behalf of the Board. He stated that the Trust's zero tolerance approach to discriminatory behaviour was self-

explanatory and that this needed to be clearly publicised. Mr Sarwar stated that he understood the reluctance of BAME colleagues to come forward but stressed that more thought was needed as to what could be done to change this. He added that it would be equally important for staff stories of this nature to be presented to the Board in the future, as this would help to give confidence to staff that Directors were willing to listen and take action.

Mrs Butcher indicated that some of the stories she had heard from staff and their experiences had been upsetting to listen to in many ways and that some had chosen to leave the Trust rather than stay and continue to work with other staff members who had contributed to their distress.

Mrs Quinn stated that she shared Mrs Butcher's frustrations in this area. She pointed out that any colleagues of colour raising concerns around discriminatory conduct not only had to face such treatment in the first place but were then expected to justify why they felt the way that they did and then potentially have to suffer a lack of action being taken. Mrs Quinn stressed that the Trust would need to start making a difference for these staff as a priority.

Mr Sarwar reminded Directors that an equality, diversity and inclusion (EDI) focused Board development session was taking place later in the week and this would be the ideal venue to have a more detailed discussion on the issues raised. He added that it was important to be mindful that although outcomes may be unsatisfactory to those raising complaints, this did not always mean that the wrong action had been taken. Mr Sarwar noted that the Trust would need to work on its responses to the challenges faced by staff, and that doing so via the People and Culture Committee would help it develop a more structured approach.

RESOLVED: **Directors received the report and noted its content.**
Additional information on the anti-racism and diversity elements relating to the freedom to speak up service will be included in future reports.

TB/2024/104 **STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS AND ANNUAL REVIEW**

Mrs Bosnjak-Szekeres clarified that approval was being sought from Directors for the Trust's revised Standing Orders and Standing Financial Instructions (SFIs). She indicated that further

changes to the SFIs were expected from colleagues working in the Lancashire Procurement Cluster (LPC) and that these would be circulated to the Board after the meeting for ratification.

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

Any further updates made to the Trust's Standing Financial Instructions by procurement colleagues will be circulated to Directors after the meeting for approval.

TB/2024/105 **TRIPLE A REPORT FROM FINANCE AND PERFORMANCE COMMITTEE**

The report was presented to the Board for information.

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

TB/2024/106 **TRIPLE A REPORT FROM QUALITY COMMITTEE**

The report was presented to the Board for information.

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

TB/2024/107 **TRIPLE A REPORT FROM PEOPLE AND CULTURE COMMITTEE**

The report was presented to the Board for information.

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

TB/2024/108 **TRIPLE A REPORT FROM AUDIT COMMITTEE**

The report was presented to the Board for information.

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

TB/2024/109 **TRIPLE A REPORT FROM TRUST CHARITABLE FUNDS COMMITTEE**

The report was presented to the Board for information.

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

TB/2024/110 **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/2024/111 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2024/112 OPEN FORUM

Mrs Bosnjak-Szekeres confirmed that no questions had been submitted by members of the public prior to the meeting.

TB/2024/113 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 the meeting had been a productive one, with the report on the Trust's response to the Independent Review of Greater Manchester Mental Health NHS Foundation Trust clearly demonstrating the open and constructive culture at the heart of the organisation.

Mr Sarwar observed that there had been a significant focus on the activity taking place in the Trust and that he felt this was appropriate. He commented that the Trust was clearly doing the right thing in many areas but acknowledged that there were behavioural and cultural issues that required additional attention.

RESOLVED: Directors noted the feedback provided.

TB/2024/114 DATE AND TIME OF NEXT MEETING

Mr Sarwar informed Directors that the next Trust Board meeting would be taking place on Wednesday, 11 September 2024 at 13:00.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **120**

11 September 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	

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:

(120) Action Matrix

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2023/040: Maternity and Neonatal Service Update	A full business case regarding the additional funding required to satisfy the Birth Rate+ nursing and midwifery staffing recommendations will be developed and presented to the Board for approval at a later date.	Chief Nurse/ Head of Midwifery	Q1 2024-25	Update: The business case will be presented at a future meeting once it has progressed through the appropriate business case process.
TB/2024/066: Corporate Risk Register and Risk Performance Report	Discussions to take place regarding the addition of RIDDOR incidents to the Trust's internal audit plan for 2024-25.	Audit Committee	October 2024	Update: This proposal will be discussed in detail at the October meeting of the Audit Committee.
TB/2024/094: Patient Story	Updates will be provided six months after patient stories are initially presented to the Board regarding any actions taken and/or improvements made. Miss Wright to investigate if shortened versions of patient stories could be presented at future Teams Brief meetings.	Chief Nurse Executive Director of Communications and Engagement	Ongoing	Update: a paper will be presented to the Board capturing the feedback from previous patient stories at the required intervals. Update: where possible shortened versions of patient storied will be shared with staff via the team brief channel.

Item Number	Action	Assigned To	Deadline	Status
	Consideration will be given to inviting patients, or their relatives, to talk about their experiences in person.	Chief Nurse		Complete: following discussion outside of the Board meeting, it has been agreed that this suggestion would not be practical.
TB/2024/097: Board Assurance Framework (BAF)	BAF Risk six will be updated to reflect the discussions in the closed session of the July Trust Board meeting.	Director of Corporate Governance	September 2024	Complete: The BAF has been updates as per the discussion at the last Board meeting.
TB/2024/098: Patient Safety Incident Response Assurance Report	Training compliance with level 1b Patient Safety Training will reach 95% by the next meeting.	All Board Directors/ Executive Director of People and Culture	September 2024	Update: Compliance for Board members is at 65% with overall compliance, (for Board members and Senior Managers) is 77% (as of 4 September 2024).
TB/2024/101: Response to Edenfield Report	The action plan developed in response to the Independent Review of Greater Manchester Mental Health NHS Foundation Trust will be updated to reflect the recommendations around freedom to speak up.	Chief Nurse	September 2024	Complete: this action has been completed.

Item Number	Action	Assigned To	Deadline	Status
TB/2024/0102: Integrated Performance Report - Responsive	An update on the Trust's winter plan for 2024-25 will be provided at the next meeting. The revised financial annual plan and budget for 2024-25 will be presented to the Finance and performance Committee and to the Trust Board for formal sign-off at a later date.	Executive Director of integrated Care, Partnerships and Resilience. Executive Director of Finance	September 2024 TBC	Complete: Update forms part of Agenda of Trust Board (Part 2) meeting in September 2024 as part of UEC update. Complete: The financial annual plan has been agreed by the Finance and Performance Committee and Board.
TB/2024/103: Freedom to Speak Up Report	Additional information on the anti-racism and diversity elements relating to the freedom to speak up service will be included in future reports.	Staff Guardian	January 2025	Update: This information will be included in future reports to the Board/
TB/2024/104: Standing Orders and Standing Financial Instructions and Annual Review	Any further updates made to the Trust's Standing Financial Instructions by procurement colleagues will be circulated to Directors after the meeting for approval.	Director of Corporate Governance / Company Secretary	July 2024	Complete: A revised version of the SFIs (with additional comments from procurement colleagues) were circulated to the Board on the 11 July for approval.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **122**

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

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

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by:

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

Statement from Amanda Pritchard, NHS Chief Executive

Amanda Pritchard, the Chief Executive of NHS England, issued a statement on 5 August, 2024, in the aftermath of a violent attack and subsequent riots in Southport. She expresses deep gratitude to NHS staff and emergency services for their tireless efforts in caring for the victims and managing the crisis.

Amanda went on to strongly condemn the violence and racism that followed, labelling it as fundamentally un-British and a cause for shame.

Highlighting the core British values of community, resilience, and the vital role of migration in sustaining the NHS, She called on leaders to demonstrate genuine zero tolerance for racism, ensuring that all NHS workers feel valued and supported, especially during difficult times.

A&E departments experiencing busiest ever summer

NHS colleagues in A&E departments across the country navigated their busiest summer on record, with 4.6 million attendances over June and July – a significant increase compared to previous years. The latest figures show that March, May and June, 2024 were the three busiest months ever, underscoring the immense pressure on the system.

Despite these challenges, over 75% of patients were treated within four hours in July, the highest since 2021, though still below the 95% target.

New chief nursing officer for England announced

NHS England has announced that Duncan Burton has been appointed as Chief Nursing Officer for England. A nurse of more than 25 years, Duncan was most recently Deputy Chief Nursing Officer where he led national work on the maternity and neonatal programme, workforce policies and the children and young people's transformation programme.

As Chief Nursing Officer for England, which starts with immediate effect, Duncan will lead the nursing profession as the government's most senior advisor on nursing matters. Dame Ruth May retired from the post following an incredible 40 years of dedication and service to the health service.

IT systems returned to normal

IT systems across the NHS have been restored following a ransomware cyber attack against Synnovis in June and a global IT outage in July.

The ransomware cyber-attack had significant impact on the delivery of services in a number of acute Trusts and primary care services.

The global outage affected EMIS, an appointment and patient record system, which caused disruption in the majority of GP practices.

Synnovis has secured an injunction - a legal mechanism designed to protect employees and patients by limiting the downloading, sharing or misuse of the stolen data. Synnovis can now take legal action against those who attempt to misuse or disseminate the stolen data, including ordering the removal of the stolen data from locations where it is shared.

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 July 2024. A recording of the meeting is available to watch online here: LSC ICB: 17 July Board Meeting.

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

Provider Collaboration Board meeting

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 July's meeting is at the end of this report as *Appendix 2*.

System wide financial management

NHS England (NHSE) recently assessed the Lancashire and South Cumbria Integrated Care System as being at high risk of overspending against its submitted plan and potentially failing to meet the statutory requirement to break even. In response, Julian Kelly, Deputy Chief Executive and Chief Financial Officer, arranged a meeting with all the system's Chief Executives.

After the meeting, Kevin Lavery, Chief Executive of the Lancashire and South Cumbria Integrated Care Board (ICB), issued a letter addressing these financial challenges and urging a more strategic system wide approach to ensure the agreed targets were met.

In the letter, he acknowledged the Trusts commitment to delivering on their plans but highlighted that risk-adjusted forecasts submitted in August revealed significant challenges. Most organisations, except for the North West Ambulance Service, were operating at a deficit, with only high-risk forecasts predicting a move to surplus later in the year.

He respectfully urged Trusts to accelerate their efforts and take immediate action to improve their financial performance. A list of practical actions that other providers had successfully implemented without compromising safety was shared for consideration.

Kevin Lavery acknowledged the hard work already underway and suggested that further steps could help mitigate the current financial risks. He concluded by expressing confidence in the Trusts ability to meet their financial targets while maintaining quality and safety.

In response, Trust's shared their detailed action plans and risk assessments at the end of August for further discussion at upcoming meetings.

Beyond the challenge: moving into delivery - chief executive's state of the system report published

Kevin Lavery, Chief Executive of the Lancashire and South Cumbria Integrated Care Board (ICB), has published his latest state of the system report, titled "Beyond the challenge: moving into delivery", the report follows on from last year's "Turning challenges into opportunities" report. It describes some of the progress in Lancashire and South Cumbria over the past

12 months and explains what has been taking place to tackle the complex challenges within health and care.

The document is intended to complement the ICB's annual report and joint forward plan, by providing a less formal narrative around the work that is taking place across the system.

Orange Button suicide prevention scheme passes 4,000 members

More than 4,000 people are wearing orange buttons in Lancashire and South Cumbria as part of a suicide prevention campaign. The scheme launched in 2020, with button-wearers trained to listen to people who are having thoughts of suicide and signpost them to the relevant services.

Orange Button training is delivered by Lancashire Mind, Every Life Matters and other organisations, and gives people the skills to identify when people around them are showing signs of mental health concerns and be able to support a person before they have further thoughts of harm.

More information about the scheme is available on the Orange Button Community Scheme webpage. The training can be booked for individuals and workplaces by contacting Lancashire Mind.

Improvements to dental access and oral health across Lancashire and South Cumbria

A new programme aimed at improving dental access and oral health across the region has been launched. Led by the NHS Lancashire and South Cumbria Integrated Care Board (ICB), the initiative focuses on helping those with the greatest need access NHS dental services while also promoting better public understanding of oral health care.

The programme will prioritise investment, streamline patient pathways, enhance communication with the public and staff, and support the recruitment and retention of dental professionals. One key step has been guaranteeing funding for the Lancashire and South Cumbria dental helpline. This service offers advice, support, and urgent appointments for those without a regular NHS dentist, accessible via 0300 1234010.

In addition, a new public campaign called 'The A to Z of oral hygiene' has been launched, offering some crucial pieces of advice to people living across Lancashire and South Cumbria on how they can look after their own teeth, minimising the need to seek the help of a dental professional.

4. Local and Trust specific updates

Use of the Trust Seal

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

- On 10 July 2024 the seal was applied to a contract for the sale of freehold land with vacant possession for 57-59 Infirmary Road, Blackburn. The contract was signed by Mr Martin Hodgson, Chief Executive and Mrs Michelle Brown, Executive Director of Finance.

- On 10 July 2024 the seal was applied to a contract for the sale of freehold land with vacant possession for 61 Infirmary Road, Blackburn. The contract was signed by Mr Martin Hodgson, Chief Executive and Mrs Michelle Brown, Executive Director of Finance.

Trust's response to the recent national unrest

The Trust provided a comprehensive response to the shocking incident that took place in Southport on Monday 29 July in Southport which provoked a period of national civil unrest, including racist, anti-Islamic and anti-immigration riots.

This included a personal statement signed by the Chair and CEO to all colleagues and issued externally via Trust channels. It expressed deep condolences to the victims and their families, acknowledging the profound impact of these tragic events.

The statement condemned the violence and unrest that followed, noting that these actions did not reflect the tragedy in Southport and were not supported by those affected. The statement highlighted that East Lancashire had experienced fewer disturbances, a positive outcome attributed to the Trust's strong community connections.

The Trust also recognised in its response that some colleagues and patients were facing increased fear and unpleasant behaviours as tensions rose. They reassured colleagues of the Trust Board's unwavering support and commitment to anti-racism, encouraging colleagues to seek help through internal channels or externally to Lancashire Police.

A special Teams Brief was held and provided reassurance to colleagues and highlighted the support available. The executive team reinforced the Trust's zero-tolerance policy towards racist and Islamophobic behaviour, both online and in-person and emphasised that any reports of such behaviour involving colleagues would be addressed through disciplinary procedures.

Naveed Sharif was invited to speak as special guest. Naveed is Associate Director of Culture and Inclusion at Lancashire and South Cumbria Integrated Care Board and also the Chair of the North West Regional NHSE Staff Race Equality Network, NHSE Staff Race Equality Network Executive and Co-Chair National NHS Muslim Staff Network. He reaffirmed Martin and Kate's messages, encouraged colleagues to make use of the support available and answered questions they posed.

The Trust also held a face to face and a virtual listening room. The events were open to all colleagues and gave the opportunity to share experiences, challenges faced and discuss what support was needed from the Trust. Over a hundred people attended and shared their stories, which for some colleagues was difficult and emotional. Further events are to be arranged.

The Trust made becoming an intentionally anti-racist organisation a strategic priority for 2024/25 and showed this commitment in the Trust's anti-racism statement and accompanying charter for our patients, colleagues, visitors, and partner organisations.

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

The Trust launched an anti-racism campaign on 9 September, which incorporates a fortnight of in-person and on-line events supporting our strategy. Events include career clinics and inclusive recruitment training, a leadership session on psychological safety with Dr Uma Krishnamoorthy and further listening events to provide opportunities for colleagues to discuss and raise their experiences of working at the Trust.

Over the next few months, we'll be rolling out vibrant posters, pop-up banners, and impactful wall art across all our sites, creating visible reminders of our commitment to fostering an inclusive and supportive environment for everyone.

Transfer of Physical and Mental Health Services

After several months of collaborative effort between the Integrated Care Board (ICB), Lancashire and South Cumbria NHS Foundation Trust (LSCft), and East Lancashire Hospitals NHS Trust (ELHT), significant service transfers took place in July. These changes include:

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

Importantly, the healthcare professionals providing these services remain the same, ensuring patients will continue to receive the same high-quality care, in the same locations, from the same teams. The only difference is the change in the service provider's name.

Teams across all three organisations have worked hard over recent months to ensure a smooth transition of services and staff, maintaining stability and continuity of care for patients.

These changes are designed to improve service responsiveness and resilience, making sure the healthcare needs of local communities are met effectively. The aim is to deliver the right care, at the right time, and in the right place for patients consistently across East Lancashire and Blackburn with Darwen.

Intermediate care at Albion Mill

The intermediate care service at Albion Mill, Blackburn, provides high-quality, person-centred, community-based care for individuals needing additional support before returning home. This short-term service offers on-site medical, nursing, and therapy assistance.

On 1 July, a partnership between ELHT, Blackburn with Darwen Borough Council, and primary care established 15 nursing and rehabilitation therapy beds at the facility.

The primary aim is to assess whether this approach can further reduce unnecessary hospital admissions and support timely discharges for those requiring extra care.

If successful, the partnership plans to expand the service to 35 beds in the coming years, allowing more people to benefit from community-based intermediate care and reducing hospital stays.

0-19 universal health service

In April this year, East Lancashire Hospitals NHS Trust (ELHT) and Home-Start Blackburn with Darwen began delivering the Healthy Child Programme on behalf of Blackburn with Darwen Council.

This initiative is part of a national programme for children aged 0-19, designed to provide essential public health services to local families. Key services include:

- Health Visiting Service: Supporting pregnancy, child development, and improving child health outcomes.
- Infant Feeding Service: Assisting new parents with feeding and nutrition.
- Community and Voluntary Support: Offering additional help to families with children up to five years old.
- School Nursing Service: Ensuring continued health support as children grow.

The programme's plans were unveiled at a launch event at Livesey Family Hub, attended by health and social care leaders.

Care Quality Commission's (CQC) Adult Inpatient Survey

The Trust notes the findings of the Care Quality Commission's (CQC) Adult Inpatient Survey recently issued and is committed to using the feedback to enhance patient experience and care.

The 2023 survey gathered responses from over 63,000 NHS patients nationwide. It focused on those who stayed in hospital for at least one night during November 2023 and were 16 or older at the time of their stay.

At ELHT, 1,250 patients were invited to take part, with around 400 responding. The survey explored various aspects of the patient journey, from admission to discharge, including the hospital environment and overall experience.

While our scores are comparable to other Trusts in many areas, they show a decline in overall experience. On a positive note, we received strong feedback on themes of kindness, compassion, and respect for dignity. This speaks to the ongoing dedication of our colleagues who continue to provide care under challenging circumstances, particularly with record numbers of patients coming through urgent and emergency care pathways.

We're determined to use this feedback as an opportunity to improve and make sure we're providing the best care possible.

Annual General Meeting

The Trust's Annual General Meeting is scheduled for Wednesday, 18 September, from 3pm to 4:30pm at Fusion House, Evolution Park, Blackburn, BB1 2FD.

The Annual General Meeting is a chance for patients, carers, colleagues and members of the public to come together to learn more about the Trust's services, achievements and future plans.

Executive Director of Finance, Michelle Brown, will deliver her final annual financial report before retiring at the end of the month.

Places at the event can be confirmed by emailing corporate.governance@elht.nhs.uk.

Improvements and upgrades in Data and Digital

Despite recent challenges, including discharge letter issues, power outages, global IT outages and cyber-attacks, high-quality data and digital services have been consistently delivered across the organisation.

New features have been enabled on Microsoft Teams, allowing colleagues to record and transcribe meetings. These features offered many benefits, including near real-time subtitles, the ability to rewatch meetings, and assistance with notetaking. A policy was introduced alongside this rollout to ensure safe usage, protecting colleagues, patients, and their families.

Preparations also continued for the replacement of Clinicom with a new system called Careview, accessible to colleagues the intranet and the electronic patient records system. Training guides, videos, and support were made available to ensure a smooth transition, as Clinicom was phased out due to being outdated.

Additionally, the Cisco phone systems were successfully upgraded across all sites. Although minor outages occurred during the process, the transition was well-managed, and thanks were extended to all involved.

Increasing our vaccination take up

Ensuring as many colleagues and patients take up appropriate vaccines over the autumn and winter period is a key strand of our plan to keep people healthy, in work and out of hospital.

Delivering this aim is going to require a system wide approach which colleagues with the People and Communications teams are already well on with. ELHT will concentrate on their

influenceable stakeholders – predominantly colleagues and in patients with the usual mobile vaccinators and programme of events and appointments where people can take up both Covid and Flu. The system led by Lancashire and South Cumbria ICB will continue to work with Public Health and PLACE colleagues to support how we influence the wider population on a general scale.

To inform this work, a survey was carried out to try and understand why people didn't take vaccines up, whilst others were keen to have both. Responses suggest colleagues are intending to take it up this year – albeit it's always possible there is a disconnect between what people say and then do.

The results in more detail said:

- Around 50% of colleagues both vaccines in 2023 with a third taking up one or the other from Covid and Flu
- Key reasons people took them was to protect their family and loved ones, to protect their colleagues or because they had previously had flu or Covid and wanted to reduce either getting it or the severity
- Key reasons that people didn't get the jabs were they didn't believe it was beneficial, they were concerned about the side effects or they felt the side effects outweighed the benefits of being vaccinated

From the respondents, 30 people said they would like to help with this year's campaign, so we have got some factual case studies to positively highlight why people got the vaccines as part of a new marketing campaign. This work has been shared across the system and as well as motivational calls to action, the collateral will promote roaming vaccinators and drop-in jab sessions via an appointment system, as well as developing campaign activity such as a vax-a-thon where hundreds of people are vaccinated on the same day or more focused whole team vaccination events. This follows the feedback that 50% of people said by a vaccinator dropping in to their workplace was the best way to get the jab. We will use the data to help us with myth busting as well as bring to the fore the positive reasons for getting the vaccines.

New pilot to support people living with frailty in Burnley

A new pilot set to launch in Burnley West this year aims to alleviate pressure on accident and emergency services and enhance patient care.

Residents in Burnley West will be fast-tracked into the Older Persons Rapid Assessment unit at Royal Blackburn Teaching Hospital through a GP referral. This unit, located in the specialist

frailty area, will assess patients and direct them to appropriate care and support, potentially avoiding long waits in the A&E department and avoiding hospital admissions.

If successful, the pilot will be expanded across Pennine Lancashire. Kate Atkinson, Director of Service Development and Improvement at the Trust, highlighted the importance of early frailty identification and the programme's role in helping individuals remain safe and independent at home. The initiative, involving various community partners, aims to support independent living while helping relieve some of the pressures on hospital services.

Major milestone in aortic aneurysm treatment

The radiology team at Royal Blackburn Teaching Hospital reached a significant milestone by completing their 500th endovascular repair of an aortic aneurysm, a procedure that has significantly improved patient outcomes by reinforcing the aorta and reducing rupture risks.

This landmark achievement underscores the Trust's pioneering role in this life-saving technique, which began in October 1999 with Dr Duncan Gavan, Consultant Interventional Radiologist, performing the first procedure. Dr Gavan also carried out the 500th procedure, marking a full-circle moment in this remarkable journey.

The procedure involves minimal incisions and reduced anaesthetic needs, making it suitable for patients who cannot undergo more invasive surgery. The procedure has evolved from taking over three hours to just 70 minutes, allowing for faster patient recovery and discharge.

This milestone reflects the Trust's commitment to advancing treatments and achieving better quality outcomes for patients.

Bronze medal wins at the British Transplant Games

Catherine Makin, clerical worker at the Trust, won two bronze medals at the 2024 British Transplant Games. Having undergone a double lung transplant in 2020, Catherine excelled in table tennis and the 50m breaststroke competitions.

The British Transplant Games, held in Nottingham this year, are organised by the charity Transplant Sport and welcome transplant recipients and live donors from the UK and Ireland. Catherine, who works in the General Outpatients Department, described the event as both busy and enjoyable and providing an opportunity to honour donors and their families.
Catherine, who has a longstanding passion for swimming and table tennis, has earned a total of seven medals at the Games over the past three years. The Games, which have been celebrated for over 40 years, highlight the importance of organ donation, promote active

lifestyles among transplant recipients, and acknowledge the contributions of donors and their families. The four-day event draws around 1,000 athletes and over 1,700 supporters each summer.

Birth room named in honour of much-loved midwife

A heartfelt ceremony at Burnley General Hospital celebrated the renaming of a room on the Central Birth Suite in honour of the much-loved midwife Marysia Swiatczak.

The newly named Daisy Suite, used for twin and pre-term births, commemorates Marysia's 20 years of dedicated service before her passing last year due to Creutzfeldt-Jakob Disease (CJD).

Chosen for its special connection to Marysia—Daisy being her birth flower and a symbol of love, beauty, and fertility—the Daisy Suite was officially unveiled by Marysia's husband, Joe, and her children, Dominic, Harry, and Alisha. They revealed a plaque in her memory, joined by Chief Nurse Pete Murphy and Head of Midwifery Tracy Thompson.

Marking World Breastfeeding Week

During World Breastfeeding Week 2024, from 1-7 August, the Trust launched an educational roadshow to strengthen breastfeeding support across its paediatric services. Led by Baby Friendly Specialist Midwife Lisa Jenkinson and Paediatric Baby Friendly Initiative Lead Nurse Emma Broadhurst, the initiative aimed to educate staff on the benefits of breastfeeding and ensure they could provide effective support to new mothers.

They visited Royal Blackburn Teaching Hospital's Children's and Paediatric Units, sharing breastfeeding insights and highlighting local infant feeding support groups. Their efforts reflected the Trust's commitment to improving maternal and child health.

Celebrating Playday at ELHT

The Trust's charity, ELHT&Me invited the community to support its Power of Play Appeal in celebration of Playday, a nationwide event emphasising the importance of play in childhood. This year's theme highlighted childhood culture, focusing on play, fun, and friendships.

Play is essential for a child's emotional, social, cognitive, creative, and physical development, and at the Trust, it is recognised as a vital part of a hospital stay. Nina Thornhill, Play Specialist, noted that play helps children feel happier and more resilient during hospital visits, easing their stress and making treatments more manageable.

Thanks to ELHT&Me, a range of activities, including board games, paints, and Xbox games, are available across Royal Blackburn Teaching Hospital, Burnley General Teaching Hospital, Outpatients Departments, and the Assessment Unit.

Cause of Death – Coronial documentary

Series three of the Cause of Death documentary, which highlights the work of HM Coroner and partner agencies, is now being broadcast on Channel 5.

The seven-part series captures compelling stories and provides invaluable insights into the critical processes at both ELHT and Lancashire Teaching Hospitals. With the series now airing, viewers can look forward to another impactful and informative presentation on Channel 5.

Series four is planned to be aired in autumn 2024. A broadcast date is yet to be announced.

ENDS

Emma Cooke
Joint Deputy Director of Communications
23 August 2024

Appendix 2

Provider Collaborative Board – 8 August 2024

The Provider Collaborative Board (PCB) met on 8 August 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, Clinical Programmes, the Elective Recovery Programme and the Pathology Network Board were discussed under Joint Committee Working items.

Current Performance Update – Urgent and Emergency Care

Overall, there had been a pleasing improvement in performance across Lancashire and South Cumbria (LSC).

A&E 4-hour performance in June was 78.4%, the fourth best out of 42 ICBs in England. This is the best LSC performance since February 2023 with some notable improvements from Lancashire Teaching Hospitals (LTH).

At the end of July, LSC general and acute bed occupancy was below 92% for the first time this year. As occupancy has reduced since January, flow has improved and waits of over 12 hours in ED have reduced. While pressures are less than they were in winter, sites have still been hitting OPEL 4 and experiencing many long ED waits and ambulance delays, even in the middle of summer.

The average number of beds occupied by patients with long stays peaked in February this year, a month later than usual, but has reduced since then.

In July across LSC there were an average of 21 pre-day ambulance handover to ED delays of over 60 minutes, almost exactly the same as in June. This was twice as many as in July, but far fewer than in January to March 2024.

Seasonal pressures such as whooping cough and measles remain above expected levels, though those for whooping cough are reducing. The end of June saw a spike in heat and sunstroke consultations, but the mixed weather meant that heat-related consultations were lower to the 26th July.

It would be important to build on these improvements in advance of the winter period as well as full awareness of any impact that actions to address the financial challenges might have on financial performance and flow.

Current Performance Update – Elective Recovery

The forecast month end position for July 2024 is a total of 6 patients waiting over 78-weeks for treatment – three of which are due to patient choice, one due to a complex case and two due to capacity. As at 31 July 2024, LSC is forecasting 10 patients waiting over 78-weeks for treatment at the end of August.

As of 28 July 2024, there were 881 65-week waits – the month end forecast for August is 396. The specialities with the greatest risk by the end of September are orthopaedics (ELHT), gynaecology (BTH) and cardiology (BTH).

The total waiting list size remains stable at 196,322 patients, and there are currently 8,041 patients waiting over 52-weeks, which is a significant decrease of 896 patients since last month's report.

A level of mutual aid from within the system has been offered to both ELT and BTH and is being progressed. A new risk relating to the system's achievement of 65 weeks has materialised since the last report to PCB; this concerning a number of orthodontics referrals from the Fylde Coast that have been 'held' within the dental referral management centre and will shortly be transferred to BTH for treatment.

ELHT and UHMB Trust Boards have now approved the business case to embed extended theatre sessions in their surgical hubs with work now underway to operationalise this development. LTH have concluded their three-month Cost per Case pilot, with BTH and UHMB continuing theirs until the end of August having started the pilot slightly later. Information available to date indicates the pilot is achieving its intended objectives; delivering additional contribution to Trusts, enabling a reduction in the volume of high margin high volume low cost cases being transferred to the independent sector and increasing the throughput in theatre sessions.

NHSE have approved the request to engage the support of Changeology to undertake a new Outpatient Productivity project across all acute Trusts. Engagement with Trusts is due to commence during August with the project to commence in September 2024.

Current Performance Update – Mental Health and Learning Disabilities

Autism waits remain an ongoing challenge and the Chief Nurse for the Integrated Care Board (ICB) continues to bring together work on neuro development and the framework for next year. In the meantime, non-recurrent funding had been agreed with the ICB for 2024/2025 which would help remove some of the longest waiting children from the list within autism services which has been welcomed by the teams and families involved.

During Q1 there had been a reduction in length of stay; a reduction in the numbers of patients waiting for admission; and the reduction of the Out of Area Placements were in line with the target and out of area spot placements had been eradicated.

Clinically ready to discharge patients were now above 90, ten of which were funding disputes between Lancashire County Council and the Integrated Care Board. This was picked up at the recent assurance meeting between LSCFT and the ICB. This was an issue that also carried across into physical health services and needed to be resolved as part of the same discussions between relevant partners.

Cancer Services

Performance for the ICB is delivering the 75% standard in April 2024, and this is above national and regional performance, placing us the 19th ICB out of 42 nationally. Performance against the 31-day first treatment standard is also above national average but is not showing any sustained improvement due to issues with surgical capacity within the system. The 62-day combined referral to a first treatment performance is in line with national averages, although this is well below the 85% standard.

Patients waiting over 62 days for cancer treatment in L&SC increased in June 2024, and a focus in 2024/25 will be on total backlog as national measure, monitoring GP and screening referrals and consultant upgrades. In regard to early cancer diagnosis, there is a national target for 75% of cancers being detected at stage 1 or 2 by 2028, and we are behind target at both an LSC and national level. Our best performing areas in 2023/24 are Breast and Gynaelogical, and those behind include Prostate, Pancreatic and Upper GI. Actions being taken to improve this include detailed communications support to target barriers to prevention including symptom knowledge,

implementing 16 funded projects with a focus on health inequalities, and progressing the development of new Cancer Champion roles working across PCN's.

One LSC – final ratification of SCA and programme update

There had been positive progress within month on the programme with three of the Trusts having formally approved the Shared Collaboration Agreement (SCA). LCSFT were due to sign on 20th August. ELTH were taking some additional legal advice with regard to their position as hosts but also intended to sign within the month. **(Please note that at the time of issuing this update all five Trusts have signed the SCA**).

Throughout July thoughts, comments and questions were received from both the PCB Joint Committee and all Trust Boards. All matters raised that necessitated changes and improvements to the documentation have now been responded to and required updates made. The Corporate Governance Leads/ Company Secretaries from all Trusts had worked very closely with the Programme Team to ensure that changes proposed by individual Trusts did not alter what colleagues are trying to achieve collectively or conflict with the desires of others.

The 'green light' to enact the SCA will come following due diligence once the Supply and Business Transfer Agreements come to all Boards for approval – work is underway on these and they were now expected to be ready to be presented to Boards in the first week of October.

The staff side grievance was still outstanding and ACAS are supporting a process aimed at resolving this. In addition, meetings were taking place to agree an engagement and partnership model with Staff Side.

Staff engagement and feedback from Roadshow session 1 at all Trusts has been positive and more sessions were in the pipeline to keep staff in the loop.

A key element of the programme was now a thorough review of barriers and risks for the first day of operation once the transfer had formally taken place.

The work on One LSC is a critical element of system recovery plans and is subject to review by the Recovery and Transformation Board. PCB agreed in April 2024 that the approval from individual boards would precede consideration by PCB of final approval.

Clinical Transformation

The Strasys workshop three had recently taken place with a proposal on population need and patient segmentation activity for a network clinical model. This highlighted how services can be delivered in a more cost effective and coherent way. Work was ongoing to ensure that the final product from Strasys met the needs of the system.

Work is going on at pace with regard to stroke, gastro and vascular and ongoing conversations were taking place around the use of improvement methodology.

Pathology Network Board Update

An update was provided for information on the development of the business case for a potential consolidated facility. Given the current challenges faced by the pathology service, achieving clinical sustainability and cost savings is imperative, which requires an urgent decision on the best course of action.

The complexity of the business case was noted and the Pathology Service team were therefore asked to focus on the 10 key national pathology priorities for more benefits in year and the presenters provided an overview of these alongside other standardisation and harmonisation work that was taking place.

The ICB outlined their intention to get more involved from a commissioning perspective to generate better cost saving in the short term.

It was acknowledged that network procurement work is due to commence in September which will introduce further, but not in year, savings.

ICB Update

The ICB Chair updated on the need to further strengthen vacancy control processes with further scrutiny from NHSE and PA Consulting.

The ICB were engaging with acute trusts on a contract review across the system with a meeting to take place in early September to review how things can be done differently to make savings in 24/25 and 25/26.

External support had been commissioned to do a review of the community services commission work for 25/26.

NHSE are going to be having their Board meeting in Blackpool on 3rd October with visits to facilities on 4th October. The intention was to have a marketplace to showcase great things happening across Lancashire and South Cumbria (i.e. ULCan's medical apprenticeship scheme).

Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	17 July 2024
Title of paper	Report of the Chief Executive
Presented by	Kevin Lavery, Chief Executive Officer, Integrated Care Board
Author	Kirsty Hollis, Associate Director and Business Support to the Chief Executive
Agenda item	5
Confidential	No

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

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

Implications

	Yes	**No**	**N/A**	**Comments**
Associated risks			x	*Highlight any risks and where they are included in the report*
Are associated risks detailed on the ICB Risk Register?			x	
Financial Implications			x	

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

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

Conflicts of interest associated with this report

Not applicable.

Impact assessments

	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	

Equality impact assessment completed			x	
Data privacy impact assessment completed			x	

Report authorised by:	Kevin Lavery, Chief Executive Officer

Integrated Care Board – 17 July 2024

Report of the Chief Executive

1.0 Introduction

1.1 At the time of writing this report, we have just had the results of the general election and the country as a whole is on the cusp of change. We now know we have a new government, there will be a new ministerial team and that is likely to mean change for the NHS.

1.2 The American author H. Jackson Brown Jr. is quoted as saying "When you can't change the direction of the wind – adjust your sails". As both an organisation and a system, we need to be prepared to be doing just that, although how much adjustment will be required will become clearer over the coming weeks.

1.3 We have recently signed off our operational and financial plans for 2024/2025 with NHS England. Whilst I do not anticipate that the outcome of the election will change that deal significantly, I do think there will be a desire for us to be even bolder and go further, faster, smarter, cheaper.

1.4 It is incumbent on us to be on the front foot if that comes and to continue to deliver our plan at pace. We all know that any period of change can lead to a slowing down of progress and we do not have the time to allow that to happen. We have to put our patients first and foremost to do what is best for them whilst supporting our workforce through continued uncertain times and delivering on the plans we have made for recovery and transformation.

1.5 Until we are instructed to do differently, we need to continue to follow last instruction and deliver our plans. However, we should also look for the opportunities that may come and need to be prepared to seize them and work them to our best advantage.

2.0 Annual Report and Accounts

2.1 Our Board met in an extra-ordinary public meeting on 19th June 2024 to consider the organisation's annual report and accounts for the twelve-month period to 31 March 2024. The outcome of that meeting was to adopt both the annual report and accounts and approve for signature.

2.2 I am able to report that both the annual report and accounts were submitted to NHS England ahead of the deadline of 29 June 2024 and that both were done

with a clean external audit report. This is reflection of hard work not just at year end but throughout the whole year.

2.3 We cannot underestimate the amount of preparation and work that goes into producing both the annual report and accounts and whilst it would seem that this is focussed on the finance team, it does in fact touch on every corner of our organisation with input from many people and I must therefore extend my thanks to all those involved. A true reflection of great teamwork.

2.4 Our annual reports and accounts are now available on our website at LSC Integrated Care Board :: LSC ICB Annual Reports. We are a learning organisation and the board reflected on the improvement in the standard of particularly our annual report over the previous years. We will again be holding a lessons learnt event to reflect on what went well and how we can continue to improve for future years.

3.0 2023/2024 End of Year Assurance Process

3.1 Since my last report, we have met with NHS England regional colleagues for our formal 2023/2024 End of Year Assurance meeting.

3.2 NHS England set the agenda and the key lines of enquiry for the meeting. This included delivery of statutory duties, and performance against the key standards. The discussion during the meeting focussed on our reflections of 2023/24, what we are most proud of and what we could have done differently followed by an outlook to 2024/25, our focus, challenges and what we are most excited about.

3.3 As always, we gave a good account of ourselves and the excellent work that our teams do across all aspects of our work agenda. We are yet to receive the formal outcome from that meeting, but once we do, it will be shared with the Board for information.

3.4 This meeting was the last that we had with Richard Barker as North West Regional Director for NHS England before he retired at the end of June. Since the inception of the ICB, Richard has always been supportive of the work that we do here in Lancashire and South Cumbria, and I would like to offer my thanks to Richard for his support and on behalf of the Board wish him a very happy retirement.

4.0 NHS Adult Community Physical Health Services and Child and Adolescent Mental Health Services transactions.

4.1 On 01 July 2024, following many months of hard work, the following transactions to transfer services and staff were enacted between Lancashire

and South Cumbria NHS Foundation Trust (LSCFT) and East Lancashire Teaching Hospitals NHS Trust (ELHT):

- The transfer of NHS adult community physical health services in Blackburn with Darwen from LSCFT to ELHT – including the transfer of existing colleagues.
- The transfer of 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.

4.2 Well done to everybody who has been involved in this complex process, meeting the challenging deadlines whilst adhering to regulatory and legal requirements, resulting in the smooth transition of services and staff to their respective new organisations.

5.0 2024 State of the System Report

5.1 Following feedback from non-executive members on an earlier draft of the report, I have now published my chief executive's state of our system report, titled "Beyond the challenge: moving into delivery". The report follows on from last year's "Turning challenges into opportunities" report and gives an update on our progress over the past 12 months and explains what we have been doing to tackle the not insignificant challenges we continue to face. The document is intended to complement the annual report and joint forward plan, by providing a less formal narrative around the work that is taking place across the system and give my honest reflections of where we still need to achieve more. The report is available on the ICB website using the above link.

6.0 Supporting our Staff

6.1 Following the results of our last PULSE survey and the themes which were emerging we have been holding a series of Big Conversations to try to understand at a deeper level some of the concerns that were raised and the opportunity for improvement.

6.2 Our staff have really embraced the opportunity to share their experiences and thoughts on how we might improve our organisational culture. These sessions have been held within teams and cross organisation with smaller break out groups to allow all participants to contribute. We also made use of an anonymous feedback tool to ensure that those who did not feel as comfortable speaking within a group could share their experiences, views and thoughts.

6.3 The output from all these sessions will be collated and developed into an action plan for us to take forward and hopefully enable our staff to see that we do take their concerns very seriously and will act upon their feedback.

6.4 Led by our Health and Wellbeing team and champions, we have also continued with our many varied activities to support individuals and groups of people within our organisation. These are publicised weekly and continue to be well attended.

7.0 Integrated Care Partnership (ICP) workshop

7.1 At the start of June, I attended a workshop for our ICP with colleagues from across partner organisations including local authorities, VCFSE, hospices, Healthwatch, Universities and councillors. It was a very productive session where we looked at creating more innovative, action and learning based ways of working to focus on a small number of priorities that we can only do together as a health and care partnership.

7.2 Through the partnership, I think we can have an impact on issues which are beyond the NHS and really tackle programmes for our communities and have a focus on reducing inequalities. We can only achieve this by working as equal partners and in collaboration rather than our silo organisations which was agreed by all participants.

8.0 Veteran Friendly Accreditation

8.1 The 6 June marked the 80th anniversary of the Normandy Landings. This was a very poignant day for many and the ICB was represented at a commemoration ceremony held at Blackburn Cathedral.

8.2 Our commitment to supporting our armed forces, veterans and their families is strong and I am delighted to be able to report that Lancashire and South Cumbria is the first ICB in the north west to reach the target of having at least one practice per Primary Care Network (PCN) receiving veteran friendly accreditation, which supports the aim of delivering the best possible care and treatment for patients who have served in the armed forces.

9.0 Farewells and Welcomes

9.1 The end of June saw two much valued colleagues leave our organisation for pastures new.

9.2 Lee Radford, Interim People Director has left to take up the role of People Director with NHS Derby and Derbyshire ICB.

9.3 On 30 June 2024, Dr Geoff Jolliffe came to the end of his appointment as Primary Care Partner member of our Board. He chose not to express an interest in a further tenure in order to prepare for his new role as the High Sherriff of Cumbria in 2025.

9.4 Both Mr Radford and Dr Jolliffe made significant contributions to our organisation and system for which they have our heartfelt thanks and best wishes for their new roles and exciting challenges.

9.5 Following an expressions of interest process, we welcome Dr Julie Colclough from Cartmel Medical Practice, Grange-over-Sands as our new Primary Care Partner Member. Dr Colclough will be attending her first meeting today and we look forward to her contribution during the period of her appointment.

9.6 Later in the year, Angie Ridgwell will be leaving Lancashire County Council and is therefore standing down as the Board's Local Authority Partner Member. Today will be her last ICB Board meeting. Ms Ridgwell will be replaced by Denise Park, Chief Executive of Blackburn with Darwen Borough Council. Ms Park will join us at future meetings. We thank Ms Rigdwell for her contribution to our Board and look forward to Ms Park joining us.

9.7 Finally, Abdul Razaq has stood down as a regular participant of the board representing the Directors of Public Health of our partner local authorities. In his stead, we welcome Sakthi Karunanithi, Director of Public Health for Lancashire County Council. We welcome Dr Karunanithi to his first meeting today and extend our thanks to Dr Razaq for his contributions to our Board.

9.8 With the new local authority appointments to our Board, we have been able to maintain representation from all four of our partner local authorities.

Kevin Lavery

08 July 2024

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **124**

11 September 2024 | **Purpose** | Approval / Assurance / Information

Title	Corporate Risk Register Report
Report Author	Mr J Houlihan, Assistant Director of Health, Safety and Risk
Executive sponsor	Mr J Husain, Executive Medical Director
Date paper approved by Executive sponsor	3 September 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 may be 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 2024-25 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 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. 6 (As Host of One LSC): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services. (As Partner of One LSC): One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.
Related to key risks identified on the Corporate Risk Register	Risk ID: Risk Descriptor As described
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

Previously considered by:

For Trust Board only: 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 twenty risks. One risk has been newly approved. There has been no movement or change in risk scores.
   b) Highest areas of risk relate to financial sustainability, digital systems and storage of data, the management of medical devices, insufficient capacity to meet demand and sub optimisation of the electronic patient record system.
   c) Quality improvements continue to be made regarding the management of risks held on the risk register resulting in challenging key performance indicator targets introduced being met or exceeded.

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 (HSE) and Care Quality Commission (CQC) 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 twenty risks. One risk has been newly approved. There has been no movement or change in risk scores.
   b) Highest areas of risk relate to financial sustainability, digital systems and storage of data, the management of medical devices, insufficient capacity to meet demand and sub optimisation of the electronic patient record system.
   c) A breakdown of risks by risk type shows eleven (55%) are clinical management risks, three (15%) are data and digital risks, two (10%) are finance risks, two (10%) are health and safety risks, one (5%) is a medical devices risk and one (5%) is a patient safety risk.

d) A breakdown of risks by division shows eleven (55%) are Trust wide, four (20%) are corporate, two (10%) are within diagnostic and clinical services, two (10%) are within surgical and anaesthetic services and one (5%) is within medicines and emergency care services.

e) A summary and detail of risks held on the CRR 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 682 risks in Q4 2034-24 to 639 in Q2 2024-25, a decrease of 6%.

b) Risks identified as being significant or moderate have increased from 215 risks in Q4 2023-24 to 232 in Q2 2024-25, an increase of 8%.

c) Risks remaining open over 3 years old are down from 400 risks in Q4 2023-24 to 353 in Q2 2024-25, a decrease of 12%.

d) Overdue risks have increased from 107 in Q4 2023-24 to 143 in Q2 2024-25, an increase of 34%.

e) 13% of tolerated risks have currently surpassed their review date.

f) Highest numbers of risks held relate to clinical management i.e. medical, nursing or operational (40%) followed by health and safety (18%).

g) A breakdown of clinical management risks shows the highest risk sub types relate to capacity and demand (22%) followed by assessment / diagnosis (9%), standards of care (9%) and treatment or procedure (9%).

h) A breakdown of health and safety risks shows the highest risk sub types relate to buildings and infrastructure (30%) followed by security management (14%) and equipment management (non-clinical) (10%).

i) Highest numbers of risks are held within DCS (27%) followed by SAS (23%).

j) Highest numbers of directorate risks are held within radiology (11%) followed by trust wide risks (10%), pathology (10%) and estates and facilities (8%).

Mitigations for risks and timelines

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

a) There have been a number of challenges presented which have significantly impacted on and detracted away from continued focus and commitment to improving assurances of internal risk management systems, controls, culture and performance. These include:

i. External and internal drivers e.g. industrial action.
ii. Financial pressures.
iii. Changes in organisational strategic direction.
iv. Major organisational system and process change e.g. introduction of e-PR
v. Changes to strategic and operational frameworks (clinical and corporate)
vi. Changes to governance and assurance systems.
vii. Increasing service demands and competing priorities.
viii. Resources and staffing limitations.
ix. Workforce transformation.
x. Staffing levels and pressures.
xi. Past, historical risk management cultural norms and performance.

b) The decision not to implement a new total quality management system (Radar) has significantly impacted on advancing internal systems and controls for risk management through system design and of the need to respond, readapt and realign the approach to risk management.

c) Delays in upgrading Datix servers, competing organisational priorities and work projects, in particular, of Data and Digital and the Datix Manager in supporting system improvements due to implementation of the electronic patient record (e-PR) and of ensuring organisational compliance with national learning from patient safety event (LfPSE) requirements has further limited progression.

d) In addition, matters to advance internal systems and controls for risk management, through development and review of risk management strategy and framework, has been further compounded due to increasing work activity and organisational review of governance and assurance systems.

e) Despite these challenges, a significant amount of work has been undertaken prior to publication of the audit that focused on improvement work to avoid duplication, improve standardisation and the quality and quantity of risks held on the risk register. This is clearly demonstrable within reports and as part of introducing challenging set key performance indicator (KPI) targets which continue to be met or exceeded.

f) A comprehensive risk identification and classification exercise has been completed that strengthens strategic and operational risks and supports the movement towards a more integrated approach to risk management, with further work required to reflect these changes within the risk management strategy and framework.

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

h) The Risk Management Framework (RMF), process of escalation and use of the consequence scoring criteria to assess and score risks continues to be reaffirmed.

i) A comprehensive risk identification and classification exercise has been completed to help drive improvements regarding the management of risks. These include, but are not limited to:

   i. The identification of strategic and organisational risks measured against strategy, legislation, set standards and practice.

   ii. An extensive list of new risk type and risk sub type categories that provide a better risk management framework model i.e. clinical management (nursing, medical and operational), data and digital, emergency planning, finance, governance, health and safety, human resources, infection prevention and control, medical devices, medicines management, patient safety and external risks.

j) An organisation wide review of Committees and or Groups, together with system improvements to the Datix risk management module are being finalised that will strengthen governance, management and control of risks.

   i. A nominated lead specialism or subject matter expert to manage risks within their areas of responsibility and control.

   ii. The mapping of risk types and sub types to nominated Committees or Groups to strengthen risk management governance whose duties are to oversee and seek assurances of risks being suitably managed.

k) A number of controls have been implemented to address concerns and drive improvements regards a steady rise in numbers of risks held on the risk register across divisions scoring fifteen or above not on the CRR. These include:

   i. The continued reaffirmation of the RMF and process of escalation.

   ii. Improved scrutiny and challenge of risk scores, controls and assurances and their validity against catastrophic, severe/major and moderate consequence scoring criteria.

   iii. More detailed assurance requirements within divisional reporting.

   iv. Specific inclusion and monitoring of risk management KPI metrics.

   v. More intensive focus and scrutiny by the Risk Assurance Meeting (RAM) and Executive Risk Assurance Group (ERAG).

vi. Addressing the challenges of risk handlers or leads being unable to present risks due to conflicting priorities and urgent work activity.

l) The implementation of the above controls is having the desired outcome, resulting in a reduction in risks scoring fifteen or above not held on the CRR.

m) The effectiveness of Divisional Quality and Safety Board (DQSB) meetings in scrutinising risks before their presentation at the RAM is being undertaken. First meetings have been held within the Q1 2024-25 period with DCS, who hold the highest numbers of divisional risks, and Estates and Facilities, who hold the highest numbers of corporate risks. In addition, the use of deputy management meetings in reviewing risks and KPI metrics will further help mitigate controls.

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

o) A review of risk profiles to improve the quality of risks has been completed with manual handling, medical devices and security management lead specialisms.

p) A targeted review of all live and tolerated risks, whereby the current risk score has met its target score and continues to be well managed, and of their subsequent closure has been completed.

q) Work to support the data and digital service to improve the quality of risks held, in particular, regarding information governance and electronic patient record risks has been completed.

r) Assisting services in addressing the three hundred and thirty eight 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 RMF 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 BAF, 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, whilst remaining diverse in nature, are measured more intensively in an effort to proactively influence, promote and drive a more positive risk management and safety 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, however, much further significant and challenging work identified by the audit is still required to deeply embed the management and ownership of risks, improve governance and performance monitoring, increase levels of education, training and competency and remove past historical risk management cultural norms and performance.

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 RMF and compliance with the process regarding escalation of risks remains a key area of focus. This is heavily impacting on the quality of risks held on the risk register.

Next Actions

12. A summary of key focused activity.
    a) System improvements to the Datix risk management module are to be made, with further enhancements planned that will include:

i. the review of RL Datix system upgrade and capabilities.
ii. profiling and mapping of new risk type and sub type categories.
iii. review of approval statuses.
iv. inclusion of nominated committees and or groups.
v. linking of risks, in particular, those scoring 15+ on the corporate risk register to the board assurance framework.
vi. creation of a mandatory actions required to be taken section.
vii. limiting access to the risk register to improve ownership, accountability and responsibility for the identification, assessment, management, control and review of risks and prevent the risk register for being inappropriately used.
viii. the removal of the 'other' risk type category as this does not add any value to the risk management process
ix. use of mandatory fields and minimum characters to avoid sections of risks being left blank.

b) A number of measures have been put in place to improve the risk management competencies of managers and key staff. Work to address risk management and risk assessment training, and its inclusion as part of the competency framework of managers, remains very challenging due to limited capacity and resource. The submission of a formal training evaluation report outlining health and safety competency and training needs, including risk management and risk 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.

c) A detailed and extensive consultation process has been completed with lead specialisms and subject matter experts. It is expected open risks held on the risk register will significantly decrease as more focused attention is given to the utilisation of lead specialists and or subject matter experts in managing risks within their own areas of responsibility and control, leaving clinical services to focus more on their local operational risks. This will take place as part of system improvements made to the Datix risk management module.

d) A complete overhaul of the risk management strategy and framework, as detailed within the action plan, remains a key area of focus, with a more longer term plan to

integrate health and safety and risk management strategic frameworks to form a single, more integrated and unified approach.

e) The use of KPI and target criteria is to remain a key focus within the financial year.

How the decision will be communicated internally and externally

13. Decisions regarding the review and approval of risks and the validity of risk scores are made via DQSB 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 the RAM, Trust Wide Quality Governance (TWQG) and ERAG meetings.

15. A senior executive lead is nominated by the ERAG to monitor and review risks approved onto the CRR and ensure they are being managed and mitigated in accordance with the RMF.

Appendices

Summary of the CRR

Detailed CRR

Mr J Houlihan, Assistant Director of Health, Safety and Risk

03 September 2024

Summary of the Corporate Risk Register

	ID	Type	Division	Title	Likelihood Score	Consequence Score	Risk Score	Exec Lead	Effectiveness of Controls	Risk Movement	Committee / Group
1	10082	Financial (BAF 5)	Trust wide	Failure to meet internal and external financial targets for 2024-25	5	5	**25**	M Brown	Limited	◁▷	Finance and Performance Committee
2	10086	Clinical (BAF 2)	Trust wide	Lack of adequate online storage for images may result in missed or delayed diagnosis	5	4	**20**	M Brown	Inadequate	◁▷	Data and Digital Senate
3	9545	Clinical (BAF 2)	SAS	Potential interruption to surgical procedures due to equipment failure	5	4	**20**	M Brown	Limited	◁▷	Medical Devices Steering Group / Capital Planning
4	9336	Clinical (BAF 2 & 3)	MEC	Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care	5	4	**20**	J Husain	Limited	◁▷	MEC DQSB via ED Governance Meeting
5	8126	Data & Digital (BAF 2)	Corporate	Poor records management due to sub optimal implementation of new e-PR system	5	4	**20**	J Husain	Adequate	◁▷	Data and Digital Senate
6	9746	Financial (BAF 5)	Corporate	Inadequate funding model for research, development and innovation	4	4	**16**	K Quinn	Limited	◁▷	People and Culture Committee / Finance and Performance Committee
7	8941	Clinical (BAF 2)	DCS	Increased reporting times in histology due to increased activity outstripping resource	4	4	**16**	J Husain	Limited	◁▷	Elective Productivity and Improvement Group
8	8061	Clinical (BAF 2 & 3)	Trust wide	Patients experiencing delays past their intended clinical review date may experience deterioration	4	4	**16**	S Gilligan	Limited	◁▷	Divisional DMB / Clinical Effectiveness / Elective Productivity and Improvement Group
9	8033	Clinical (BAF 2)	Trust wide	Increased requirement for nutrition and hydration intervention in patients resulting in delays	4	4	**16**	P Murphy	Limited	◁▷	Nutrition and Hydration Streeting Group
10	7165	Health & Safety (BAF 2)	Corporate	Failure to comply with RIDDOR	4	4	**16**	T McDonald	Limited	◁▷	Health and Safety Committee / TWQG Part B
11	6190	Clinical (BAF 3)	Trust wide	Insufficient capacity to accommodate patients in clinic within timescales	4	4	**16**	S Gilligan	Limited	◁▷	Elective Productivity and Improvement Group
12	10065	Clinical (BAF 2)	DCS	Pharmacy Technical Service refurbishment programme	3	5	**15**	J Husain	Inadequate	◁▷	TWQG Part B / Quality Committee
13	10062	Clinical (BAF 2)	Trust wide	Risk of harm and poor experience for patients with mental health concerns	3	5	**15**	P Murphy	Inadequate	◁▷	TWQG Part A / Quality Committee
14	9900	NICE (BAF 2)	Trust wide	Poor identification, management and prevention of delirium	5	3	**15**	J Husain	Limited	◁▷	TWQG Part b WQG Part B / Quality Committee
15	9895	Clinical (BAF 3)	SAS	Patients not receiving timely emergency procedures in theatres	5	3	15	J Husain	Limited	◁▷	TWQG Part A / Quality Committee
16	9851	Data & Digital (BAF 2)	Trust wide	Lack of standardisation of clinical documentation processes and recording in Cerner	5	3	15	P Murphy	Limited	◁▷	Data and Digital Senate
17	9653	Clinical (BAF 2 & 3)	Trust wide	Increased demand with a lack of capacity within ELHT can lead to extreme pressures and delays to patient care	5	3	15	P Murphy	Adequate	◁▷	Elective Productivity and Improvement Group
18	9301	Health & Safety (BAF 2)	Trust wide	Risk of avoidable patient falls with harm	3	5	15	P Murphy	Limited	△	Falls Strategy Group / TWQG Part A
19	8808	Health & Safety (BAF 2)	Corporate	Breaches to fire stopping and compartmentalisation at BGH	3	5	15	T McDonald	Adequate	◁▷	Fire Safety Committee / TWQG Part B
20	4932	Clinical (BAF 2)	Trust wide	Patients who lack capacity to consent to hospital placements may be being unlawfully detained	5	3	15	P Murphy	Limited	◁▷	Safeguarding Committee / TWQG Part A

Corporate Risk Register Detailed Information

No	ID	Title				
1	10082	**Failure to meet internal and external financial targets for 2024-25**				
Lead		Risk Lead: Charlotte Henson Exec Lead: Michelle Brown	**Current score**	**25**	**Score Movement**	⇔
Description		There is a risk that the failure to meet the Trust financial plan and obligations together with the failure to meet the wider Lancashire and South Cumbria ICB system financial plan is likely to lead to the imposition of special measures and limit the ability of the Trust to invest in the services it provides. The financial risk is made up of insufficient funds to provide the services to the population of East Lancashire, a lack of control on how funds are allocated across partner organisations, a 7.7% efficiency target of £57.8m for the Trust, a level that has never been achieved previously and a Trust and system wide financial deficit that still needs closing.				
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		**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 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.	
Update since the last report		**Update 19/08/2024** **Risk score reviewed. No change in risk score** There is a reporting deficit of £20.4m for the 2024-25 financial year to date (FYTD), £1.3m behind the revised draft plan, with the run rate showing a £32.9m deficit, an adverse variance of £12.5m. The Trust is working to an annual draft planned deficit of £21.9m which includes a £59.7m waste reduction programme. The movement from plan is due to industrial action and a shortfall in funding for consultant pay award on addition to additional ward areas being used, corridor care staffing, pathology and security management costs and additional waiting lists in surgery. There is an increased capital programme of £33.1m for this financial year, £0.1m behind planned capital spend, with cash balance standing at £2.8m, an increase of £0.5m compared to the previous month. The position is supported by £18.2m of Provider Revenue Support Public Dividend Capital (PRC). The Trust has met 3 out of 4 Better Payment Practice Code (BPPC) to pay 95% of invoices on time for the FYTD but is below target for non NHS invoices by volume at 90.6%. FYTD spend on agency staff represented 2.2% of total pay against the ceiling set by NHSE for 2024-25 of 3.1%. The Waste Reduction Programme for the financial year is £59.7m, of which, £6.3m has been delivered recurrently this FYTD in line with the plan. **Next Review Date 18/09/2024**		**Date last reviewed**	**19/08/2024**	
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
					25	25		
				8-week score projection	**25**			
				Current issues	System wide external influences			

No	ID	Title
2	10086	**Lack of adequate online storage for images may result in missed or delayed diagnosis**

Lead		Current score	20	Score Movement	⇔
	Risk Lead: Dan Hallen Exec Lead: Michelle Brown				

Description

There is a risk that 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 or digital storage solution can be found.

The ultrasound machines currently used have no option for storage and transfer of images currently being stored on scanning machines that have very limited memory availability. Once storage limits have reached, capacity and images cannot be offloaded and machines will stop functioning which may result in loss of images and the potential of patients having missed or delayed diagnosis of life saving cardiac abnormalities and pulmonary pathologies impacting on the management of care, patient safety and increased medicolegal implications if the risk is not suitably managed or controlled.

Controls and Assurances in place

Controls

1. The existing service contract has been extended.
2. Current ultrasound images stored on scanning machines and McKesson software installed on NICU computers.
3. Image transfer via desktop, through the PACS system, out of hours and via MS teams which have prevented transfer of a baby and safe overview of images.
4. Patient transfer to other Hospitals for echocardiology review.
5. Set standards on provision of an ultrasound service issued by the Royal College of Radiologists include key areas essential for delivery of high quality, effective ultrasound imaging services and examinations that services are expected to review and follow.
6. Organisational policy and procedural controls in place for the lifecycle management of medical devices.

Assurances

1. Imaging incidents closely reviewed and monitored and linked to the management of risk.
2. Cerner e-PR has an imaging module, cloud storage and PAS patient list connection that capture, store, access and share imaging data and multimedia across the system providing a holistic patient view.
3. Current capacity levels regularly being monitored. Capacity within Childrens Observation and Admissions Unit is 117.2 GB (99.8% full) with 247.9 MB remaining. Capacity within COPD is approx. 250 GB and NICU is approx.. 800 GB with further capacity checks required.
4. The Technical Diagnostics Team within the Integrated Care Board (ICB) is exploring costs and solutions, 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 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 in place to review and support the management of this risk.
8. Medical Devices Management Group meetings in place to provide assurances of compliance regarding the lifecycle management of medical devices.

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. Images transfers to desktop, through PACS and MS teams is ineffective. Attempted input of images onto PACS slows the entire system down, is too big to be sent via image exchange portal and has limited storage availability. Use of MS teams heavily reliant on availability of consultants to attend MS team meetings.
4. Patient transfers to other Hospitals may be unnecessary, unsafe and reliant on bed availability.
5. Limited assurance Royal College of Radiologists standards are being used to benchmark or measure performance or compliance.
6. Additional staff training in system use is required.
7. Development of a virtual private network (VPN) tunnel is under trial and not embedded as clinical management process.
8. 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 being brought in by the ICB to increase storage capacity is awaiting implementation.
10. Limited assurance policy and procedural controls regarding the lifecycle management of medical devices is robust, is being followed or suitably performance managed.

Gaps / weaknesses in assurances

1. Common incident themes 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. Limited evidence of assurance current capacity levels are regularly checked and monitored.
4. Bridgehead solution remains fully dependent on the release of funding and approval by the ICB.
5. Solution offered by Siemens does not help image sharing with other Hospitals and effectiveness of direct image transfers still requires exploration.
6. Effectiveness of the Medical Devices Management Group to support management of this risk.

Update since the last report

Update 03/09/2024
Risk requires review. No change in risk score.
The ICB has ownership of the risk and is working on a digital solution that will better support the reduction in risk scoring.

Next Review Date 02/10/2024

Date last reviewed	**03/09/2024**			
Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
	20	20		
8-week score projection	12			
Current issues	System wide external influences			

No	ID	Title				
3	9545	**Potential interruption to surgical procedures due to equipment failure**				
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**			
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		**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	
Update since the last report		**Update 01/08/2024** **Risk score reviewed. No change in risk score** Contracts have now been signed for implementation in Sept-24 with dates for equipment delivery awaiting confirmation. **Next Review Date 01/09/2024**	**Date last reviewed**	**01/08/2024**		
			Risk by quarter 2024-25	**Q1**: 20	**Q2**: 20	**Q3**:	**Q4**:
			8-week score projection	12		
			Current issues	Management of Medical Devices		

No	ID	Title				
4	9336	**Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care**				
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. Ambulance handover and triage escalation processes to reduce delays 2. Operational Pressure Escalation Level triggers and actions completed for ED and Acute Medical Units. 3. Established 111 / GP direct bookings to Urgent Care Centre. 4. 111 pathways from GP / North West Ambulance Service (NWAS) directly to Ambulatory Emergency Care Unit. 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.		

Update since the last report	**Update 21/08/2024.** **Risk reviewed. No change in risk score** Emergency Department Footprint Plan and Value Engineering Assessment in place. A second Nursing Assessment and Performance Framework (NAPF) Assessment has been completed which has resulted in an amber rating score, demonstrating improvements are being made. A review of the risk score will be based upon demonstrable evidence being presented of a prolonged period of sustained improvement. **Next Review Date 21/09/2024**	**Date last reviewed**	**21/08/2024**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			20	**20**		
		8 week score projection	**20**			
		Current Issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
5	8126	**Poor records management due to sub optimal implementation of new e-PR system**

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

Description	A lack of continuous optimisation and investment may lead to frustration and create disillusionment, leading to poor usage and productivity, unsafe workarounds, substandard data and ineffective clinical decision making.		
Controls and Assurances in place	**Controls** General - significant resource in place to support improvement opportunities and deliverables - dedicated senior consultant identified by Cerner to undertake work to review issues identified and support further development and actions required - recruitment of e-PR champions, super users and floor walkers to support system implementation - development of e-PR SharePoint one stop shop site of readily available resources e.g. workflow sheets, 'hot sheets' outlining brief instruction on how to complete tasks on Cerner and FAQ's covering general, clinical, administrative, IT, pharmacy and discharge processes Clinical management - improvement plan in place with identified learning outcomes spread across the Trust - initial focus on outpatient areas i.e. head and neck, cardiology, urology, fracture clinical, gynaecology, respiratory and dermatology - completion of project to identify all policies, procedures and guidance affected by system implementation - prescribing is structured and follows a digital process with appropriate auditing capabilities - replacement of ICE with Order Entry Catalogue and Order Entry Form to place requests and ordering of all surgical procedures and medications Communication - regular updates using a variety of trust wide communication systems, digital and social media platforms - use of roadshows and walkabouts to raise awareness and demonstrate system use - issue of role specific posters, flyers and key contacts - use of displays across inpatient and staff areas Education, training and competency - registration process and extensive roll out of end user training and support - development and issue of staff handbooks - library of quick reference guides developed and available on SharePoint and e-Coach and organised by job role describing how to use particular tools or complete set workflows e.g. admission, transfer, discharge, prescribing etc. - 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	**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, 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

	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 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 - e-PR programme included as standing agenda item at Executive and Senior Leadership Group meetings		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

	- progress on those key control issues identified undertaken at weekly Cerner incident management team meetings - monitoring and performance management of incidents reported through DATIX and IT helpdesk following system go live - learning from themes and trends converted into videos or quick reference guides and uploaded onto e-Coach - operational teams monitoring and reviewing clinical pathways - escalations, monitoring and performance discussed at ICB assurance meetings - governance arrangements to be reviewed in Jan-24 - ongoing assessment of staff feedback, incidents and problems raised through operational teams are assessed to look at change requests and training requirements Digital - completion of build work and excessive technical testing - all critical systems directly and indirectly managed by data and digital - 24/7 systems support in place - significant amount of business intelligence system data quality and usage reporting - consistent monitoring of clinical management systems and support via IT helpdesk - service desk e-PR tickets are continuously monitored - robust process in place for change requests Patient and staff safety - no patient or staff harm at present Task based - evaluation of issues undertaken by multi-disciplinary teams e.g. digital, clinical operational teams, learning and development, improvement hub, system support and leadership etc. through in person and observations utilising SPE+ improvement methodology		

Update since the last report	**Update 03/09/2024** **Risk requires review. No change in risk score.** The data and digital senate group is overviewing the management of this risk and will focus on system based issues, clinical management issues, education and training issues, governance related issues and behavioural and competency based issues to take account of data submission and its impact on income, activity, mortality etc along with clinical informatics team supporting operational teams to daily monitor and action issues regarding discharge. **Next Review Date 02/10/2024**	**Date last reviewed**	**03/09/2024**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			20	**20**		
		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. 4 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 28/08/2024** **Risk reviewed. No change in risk score.** Income recovery work progressing at pace with a dedicated team set up and seconded to the role of recovering historical income. Staff shortages means the work is expected to be completed by Sept-24 **Next Review Date 25/09/2024**	**Date last reviewed**	**28/08/2024**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			16	16		
		8-week score projection	**16**			
		Current issues	System wide external influences			

No	ID	Title				
7	8941	**Increased reporting time in histology due to increased activity outstripping resource**				
Lead		Risk Lead: Dayle Squires / Victoria Bateman Exec Lead: J Husain	**Current score**	**16**	**Score Movement**	⟺

Description	Increased reporting times in histology due to increased workload and reduced staffing numbers can lead to the mismanagement of patient care with long term effects, the non-compliance with national standards with significant risk to patients, poor patient experience if results are delayed, multiple complaints, low performance rating i.e. NHSE cancer performance, uncertain delivery of key objectives or service due to lack of staff and low staff morale	**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 the issue of overtime and use of locum staff. 3. Failure of medical devices and equipment is adding to delays. 4. Volume of work marked urgent has increased by c.45%. 5. Gaps in recruitment of junior doctor posts remain. **Gaps / weaknesses in assurances** 1. Unexpected cancers found after waiting in backlog. 2. Surges in incidents regarding histology reporting times. 3. Poor monitoring and escalation of issues and meetings often stood down. 4. Some breaches fall outside the control of the Trust e.g. patients breaching targets due to complexity of pathways, comorbidities and patient choice.
Controls and Assurances in place	**Controls** 1. A 5 year workforce plan is in place to support recruitment and retention. 2. A locum consultant pathologist and biomedical scientist in post covering long term sickness and maternity. 3. Triaging of cases to prioritise cancer cases. 4. Breast workload referred to neighbouring NHS Trusts across Lancashire and South Cumbria. 5. Colposcopy screening cases referred to external provider. 6. Routine cases sent to external reporting services. 7. Additional dissection bench created to increase capacity. 8. Overtime being offered to existing staff to cover gaps and increase capacity. **Assurances** 1. Consultant staff supporting with dissection. 2. Work being triaged based on clinical urgency given the information provided upon the request form. 3. Weekly cancer performance meetings attended by the histology/performance manager. 4. Escalation process for priority cases is well established.		
Update since the last report	**Update 05/07/2024** **Risk requires review. 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 05/08/2024**	**Date last reviewed**	**05/07/2024**

	Q1	Q2	Q3	Q4
Risk by quarter 2024-25	16	16		
8 week score projection	12			
Current issues	System pressures			

No	ID	Title				
8	8061	**Patients experiencing delays past their intended clinical review date may experience deterioration**				
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.	**Gaps and Potential actions to further mitigate risk**			
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 / 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 05/08/2024** **Risk reviewed. No change in risk score** No change in risk score due to continuing increase in the volume of patients and time constraints due to competing waiting list demands **Next Review Date 04/09/2024**	**Date last reviewed**	**05/08/2024**		
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				16	**16**		
			8 week score projection	**16**			
			Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
9	8033	**Increased requirement for nutrition and hydration intervention in patients resulting in delays**				
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 30/08/2024** **Risk requires review. No change in risk score.** Risk score to be reviewed once system and resource improvements are embedded. **Next Review Date 30/09/2024**		**Date last reviewed**	**30/08/2024**	
				Risk by quarter 2024-25	**Q1**: 16	**Q2**: 16	**Q3**:	**Q4**:
				8 week score projection	**12**	
				Current issues	Recovery and restoration pressures, recruitment and retention	

No	ID	Title				
10	7165	**Failure to comply with RIDDOR**				
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				
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 marginally improving and remains challenging from 12% in 2021/22 to 53% in 2022/23 to 56% in 2023/24.	**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. 6,529 were reviewed or investigated in 2021/22, 6,713 in 2022/23 and 6,725 in 2023/24. 4. Numbers of RIDDOR reportable incidents have increased by 50% in 2023/24 compared to previous financial year.		
Update since the last report		**Update 16/08/2024** **Risk reviewed. No change in risk score.** A new process has been developed to improve RIDDOR performance and compliance which has been formally approved by the Senior Management Team. This requires the cooperation and involvement of corporate and clinical divisions and subject matter experts in relation to identifying potential RIDDOR reporting incidents which will be supported by detailed guidance and further delivery of RIDDOR awareness training. **Next Review Date 13/09/2024**	**Date last reviewed**		**16/08/2024**		
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				16	**16**		
			8 week score projection	**16**			
			Current issues	Systems, capacity and workforce pressures			

No	ID	Title				
11	6190	**Insufficient capacity to accommodate patients in clinic within timescales**				
Lead		Risk Lead: Michelle Montague 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 very large holding lists of overdue patients, in some cases, there is significant delay and increased risk to patients. The demand far outweighs capacity and waiting lists have increased significantly over the past few years. All patients are risk stratified (red, amber, green rated) but still cannot be seen within timescales with an added risk those patients identified as amber could become red over time.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Clinical management policy and procedural controls for managing patient lists requires full review in line with implementation of Cerner Millennium 2. Relaunch of Outpatient Transformation Group to take place, with all services looking at project streams with the support of improvement managers. 3. Insufficient workforce and resource to provide capacity or carry out validation of all waiting lists. 4. Limited outpatient space to provide required clinics. 5. Increasing service demand and improved medical advancements are resulting in increased appointments and complexity of cases. **Gaps / weakness in assurance** 1. Limited funding to recruit additional staff and equipment to be able to increase activity e.g. medical, nursing, administration 2. Challenges in extending outpatient estates capacity. 3. Possibility of meetings being stood down due to operational pressures 4. Increasing staff burnout and wellbeing due to constant pressures.
Controls and Assurances in place		**Controls** 1. Action plan and ongoing service improvements identified to reduce demand. 2. Expanded non-medical roles e.g. orthoptists, optometrists, specialised nurses etc. 3. Use of clinical virtual pathways where appropriate 4. Additional capacity sessions offered to clinicians when opportunity arises 5. Operational management team in place including administrative support for waiting list validation to micromanage full utilisation of clinics to ensure capacity is maximised **Assurances** 1. Weekly divisional and performance meetings held to discuss current position 2. Weekly operational meetings held with Chief Operating Officer to challenge outpatient activity and recovery. 3. Bi weekly CORE meeting to discuss Cerner related issues 4. Regular monitoring of waiting lists at directorate level and escalated to division 5. Incident reporting and review.			
Update since the last report		**Update 20/06/2024** **Risk requires review. No change in risk score.** The holding list remains a concern with numbers of patients awaiting review of appointments unable to be accommodated. **Next Review Date 19/07/2024**		**Date last reviewed**	**20/06/2024**	
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
					16	**16**		
				8 week score projection	**16**			
				Current Issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
12	10065	**Pharmacy Technical Service refurbishment programme**				
Lead		Risk Lead: Michelle Randall Exec Lead: Jawad Husain	**Current score**	**15**	**Score Movement**	⟺

Description	The aseptic units are not being maintained to external standards and there is a risk the air handling units, specialist equipment such as pharmaceutical isolators and HEPA filters in both units will fail due to planned and reactive failure in the maintenance and replacement schedule and a number of potential issues: ▪ Temperature fluctuations may lead to environmental breaches. ▪ Product degradation may lead to contaminated products being administered to patients. ▪ Delays in chemotherapy service provision when equipment fails may hinder cancer recovery plans and breaches in cancer targets. ▪ An increased higher risk of dispensing and reconstitution of high risk products in clinical areas if incorrect stock is used or staff exposure to products that may cause health issues. ▪ A reduced ability to support clinical trials of investigational medicinal products requiring aseptic preparation. ▪ Outsourcing is not possible for supporting research and development where aseptic preparation is required due to air handling unit or equipment failure. ▪ The clinical trials team are based in the aseptic unit and if the unit closes, clinical trials dispensing will cease and research will stop which may impacts on commercial viability, reputational damage.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Failure to comply with health technical memorandum guidance and quality assurance standards. 2. Dispersed oil testing and pressure differential failure in clean rooms visible on magnahelic gauges, interlocking doors not working. 3. A chemotherapy port has exceeded its life span with no plans in place regarding lifecycle management. 4. Contract with JLA (formerly Atlas) now expired, reports not being sent through, so having to review maintenance contract which is more expensive. 5. Difficult to manage all reports being recorded on the unit. 6. No environmental control in the old outpatient dispensary so not suitable for storing clinical trials unless upgrade works carried out. 7. Delays of up to forty four weeks ordering isolators adds to existing financial pressures and work programme constraints. 8. Growth restriction of aseptic unit with at least one pharmaceutical isolator not operational in last two years. 9. CIVA service has been stopped. 10. Outsourcing of parenteral nutrition service due to failing equipment. 11. Increased waste due to shelf life of outsourced products. **Gaps / weaknesses in assurances** 1. Lack of national pharma support to provide aseptic service provision is putting a strain on services and workforce. 2. Multiple shut downs of the units have occurred in the last two years. 3. PFI agreed to upgrade aseptic unit but awaiting dates for lifecycle works to commence. 4. There has been a 15% increase in aseptic service provision in last two years with capacity and demand intensive. 5. Chemo and clinical trial demand growing and exceeding capacity of unit. 6. Review of capacity data highlighting workforce issues. 7. Environmental monitoring results have a two week response time causing delays in picking up any breaches. 8. Limitations in mutual aid due to age and condition of units across NHS organisations in the LSC area. 9. Workforce issues are leading to increased psychosocial risks. 10. Difficult to assess safety of MABs when in phase 2 of development, as COSHH data not available.
Controls and Assurances in place	**Controls** 1. Auditing of aseptic units being undertaken by external service providers via the Interactive Quality Assurance of Aseptic Preparation Service Quality Management System. 2. Staff preparations using aseptic none touch technique to reduce contamination risk 3. Old outpatient dispensary identified to be able to store clinical trials 4. Risk assessment of monoclonal antibodies designed to look at new products being accepted on the formulary. **Assurances** 1. The aseptic team is reviewing the system for any environmental breaches on a monthly basis via pharmacy quality meetings. 2. Quality exception report excursions are being investigation and error rate reviews undertaken 3. Monthly meetings taking place and urgent response service plans sent through from clean room specialist company. 4. Regular environmental testing undertaken of the unit and the workforce. 5. Transformation plans for aseptic unit in place, with an integrated care systems working group looking at long term service provision. 6. A north west pharmaceutical quality assurance regional audit is undertaken every 18 months. 7. Outsourcing of products is undertaken where possible to meet service demand. 8. Non aseptic medicine trials and other alternatives being explored to prepare aseptic products in clinical areas.		
Update since the last report	**Update 28/08/2024** **Risk Reviewed. No change in risk score.** Awaiting isolator parts. Equipment not fully operational. Estates and PFI meeting held in Jul-24 and provisional date for shut down set for 30 Sep-24 **Next review date 27/09/2024**		

Date last reviewed	**28/08/2024**			
Risk by quarter 2024/25	**Q1**	**Q2**	**Q3**	**Q4**
	15	**15**		
8-week score projection	**15**			
Current issues	Systems, capacity and workforce pressures			

No	ID	Title
13	10062	**Risk of significant harm and poor experience for patients attending with mental health concerns**

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

Description	The Trust is registered with the Care Quality Commission for the assessment and treatment of patients on the emergency care pathway who are subject to sections 136, 5,2 or 5.4 of the Mental Health Act. Patients are being admitted onto hospital wards who, whilst their acute physical health needs are being met, can present a risk in relation to their mental health needs when awaiting a more formal mental health assessment, a suitable mental health bed or transfer to other more suitable clinical pathways outside of the Trust and lead to patients not receiving coordinated care against standards, poor patient experience in the absence of specialist care and a deterioration in mental health condition.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Shared care protocols not formalised. 2. Informal arrangements not present when enhanced care lead is not on duty. 3. Risk assessments only provided for patients with medical recommendations in place and often provide limited information. 4. Infrequent availability of resource to address escalated patients via gold command due to bed availability. 5. Lack of clarity regarding the provision of support once ELCAS leaves the Trust. 6. Access to specialist advice for child mental health concerns only available from ELCAS until Jul-24. 7. Access to specialist advice for adult mental health concerns can only be accessed externally from LSCFT. 8. Lack of ability for specialised care plans to be written by mental health nurses to support patients within general adult acute ward environments 9. Limited control of other patients witnessing distress and deterioration in mental health conditions within ward environments. 10. Staffing levels not able to manage associated risk when gaps are not covered by specialist teams. 11. Acute staff often manage mental health risks without adequate training placing themselves and patients at risk 12. Incomplete or unsuitable environmental and clinical risk management processes 13. Lack of formal agreed shared care model results in inconsistent levels of support and gaps in provision. **Gaps / weaknesses in assurances** 1. Assurance processes not embedded or visible against jointly agreed standards. 2. No specialist input from mental health nurses to ensure appropriate actions are being taken. 3. The mental health liaison meeting is not linked to formal governance arrangements. 4. Compliance against s.136 pathway requirements not visibly reported across the Trust. 5. The LSCFT multi agency oversight group is not linked into formal governance arrangements 6. No access to specialist internal support for adult mental health concerns. 7. No access for staff to undertaken mental health training to support patients and families. 8. Requirements from treat as one documentation are outstanding 9. No formal oversight of ligature risk assessments
Controls and Assurances in place	**Controls** 1. Shared care protocol in place with Lancashire and South Cumbria NHS Foundation Trust (LSCFT). 2. Escalation of mental health patients via gold command. 3. Easy access to ELCAS / RAIS teams to provide flexible support for children. 4. Multi agency s.136 pathways in place. **Assurances** 1. Enhanced care lead nurse informally monitors and escalates gaps in completed risk assessments to the mental health liaison team based in the emergency department. 2. The mental health liaison meeting reports to the emergency department divisional management board meetings and facilitates joint working between the emergency department and mental health liaison team. 3. A new mental health interface meeting has been set up to provide assurances against established measures. 4. LSCFT multi agency oversight group monitors patient mental health activity and is chaired by the Integrated Care Board. 5. Incidents of harm involving patients with mental health or learning disabilities reported in Datix.		
Update since the last report	**Update 23/07/2024** **Risk Reviewed. No change in risk score.** A review of incident reports shows 17 self-harm incidents all of low or minor harm. A review of treat as one actions have assigned leads. A regular review of incidents is taking place to understand causation and address issues. A mental health nurse post is currently being advertised. Due to annual leave and interface meeting next review date is to take week commencing 23 Sept-24. **Next review date 23/09/2024**	**Date last reviewed**	**23/07/2024**
		Risk by quarter 2024/25	Q1: 15 · Q2: 15 · Q3: · Q4:
		8-week score projection	**15**
		Current issues	System wide influences

No	ID	Title				
14	9900	**Poor identification, management and prevention of delirium**				
Lead		Risk Lead: Will Fielding Exec Lead: Jawad Husain	**Current score**	**15**	**Score Movement**	⇔
Description		National Institute of Clinical Excellence (NICE) guidance relating to the identification, assessment, management and prevention of delirium in acute hospital settings is partially and or not being met				
Controls and Assurances in place		**Controls** 1. A paper based delirium bundle and assessment is in place for clinical teams investigating and managing delirium. 2. A delirium awareness training module is available to staff with rapid tranquilisation training in support. 3. Available guidance on agitated delirium in elderly persons. 4. Patients with suspected delirium can be referred to relevant specialist nursing teams for support and review where required. **Assurances** 1. Delirium reports and updates produced and shared at dementia strategy meetings and the patient experience group. 2. Diagnostic data has identified a downward trend in delirium diagnosis since the introduction of the electronic patient record system. 3. A dementia champion documentation audit is being piloted monthly that includes seeking assurances of the effectiveness of delirium assessments. 4. A share point site has been created for signposting and resource identification. 5. A change request for the identification, management and prevention of delirium workflow has been approved with work underway to produce a single assessment question to identify delirium (SQID). 6. A training programme is in place to deliver delirium awareness key points training with training delivered to c.`40 staff members between Jan-24 to May-24. 7. A nationally accredited delirium awareness e-learning module has been added to the learning hub.	**Gaps and Potential actions to further mitigate risk**		**Gaps / weaknesses in controls** 1. Existing digital clinical assessment does not fully identify delirium or populate a problem list. 2. Existing paper based delirium bundle does not utilise the 4AT delirium assessment and is not being routinely used in practice. 3. Compliance with dementia audits and outcomes requires stronger divisional support. 4. The training module for delirium is not a mandatory training requirement and does not fully mitigate the risks associated with delirium. 5. Published guidance and recommendations (agitated delirium in elderly) are not always followed. **Gaps / weaknesses in assurances** 1. Poor compliance with pilot assurance measures. 2. No reported compliance of delirium assessments for clinical areas captured. 3. No digital pathway for delirium management available. 4. A revised care plan for the prevention and management delirium is to be integrated into Cerner e-PR. 5. Work to create an investigation prompt for clinicians as part of the delirium diagnostic work flow and to assist clinical judgement underway.
Update since the last report		**Update 20/06/2024** **Risk requires review. No change in risk score.** The initial results from a national audit of dementia has identified limited assurances regarding the effectiveness of delirium assessments on patients that require them with the delirium pathway significantly reducing effectiveness. Change of risk handler currently taking place **Next review date 19/07/2024**	**Date last reviewed**		**20/06/2024**	
			Risk by quarter 2024/25		**Q1**: 15 / **Q2**: 15 / **Q3**: / **Q4**:	
			8-week score projection		**15**	
			Current issues		System wide influences	

No	ID	Title
15	9895	**Patients not receiving timely emergency procedures in theatres**

Lead	Risk Lead: Nicola Tingle Exec Lead: Jawad Husain	Current score	15	Score Movement	⇔

Description	There is a risk that increasing demand on the emergency theatre due to increased hospital acuity may lead to delays in patients not receiving timely emergency procedures.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. No systematic approach in alerting and reviewing patients once listed. 2. No alert system when emergency patients have breached NCEPOD categorisation and not had timely emergency procedure. 3. Standing down of elective theatres or opening second theatres not always possible due to capacity and clinical priorities of elective patients. 4. Financial impact of cancellations on day of elective patients. 5. No bed capacity for surgical patients. 6. Not all cases are appropriately listed due to MDT requirements, times unknown, case complexity etc. which impacts on oversight at scheduling. 7. Known complex overruns are not always staffed requiring emergency staff to cover. 8. Regular overrun of elective theatres requires staff to relieve others who have to go home. Only six theatre staff available resulting in stopping of theatre six. 9. Limited assurance policy and procedural controls are effective or are being followed. 10. Reliance on voluntary staffing of capacity lists. **Gaps / weaknesses in assurances** 1. Potential for inappropriate categorisation when booking emergency patients. 2. Failure to discuss patient safety and risk at theatre triad and at divisional and directorate meetings. 3. Incident reports not always completed or capture severity of harm as unknown if there is a delay to surgery or disease progression. 4. Issues not highlighted if coordinator is not on duty. 5. Actions from meetings may not be enacted upon 6. Failure to manage capacity list due to lack of resource.
Controls and Assurances in place	**Controls** 1. All patients listed in accordance with NCEPOD guidance and time to theatre. 2. Patients reviewed by medical team to ensure they remain appropriately categorised and have not deteriorated. 3. Standing down of elective theatre based on clinical urgency and prioritisation. 4. Escalation standard operating procedure in place for patient flow. 5. Scheduling to ensure elective theatres are run in accordance with session time. 6. Senior theatre coordination and duty anaesthetist ensure efficient running of all operating theatres to prevent overrun. 7. Policy arrangements in place for ensuring elective procedures are booked in a timely manner to facilitate correct staffing for the elective capacity. 8. Additional second theatre at weekends to cover capacity. **Assurances** 1. Daily review of acuity of emergency list and capacity to assess availability of opening a second emergency theatre where required. 2. Theatre triad, directorate meetings held to discuss patient safety and risk at divisional and theatre directorate level. 3. Monitoring and review of incidents. 4. Emergency coordinator highlights capacity issues to duty anaesthetist and theatre operational manager. 5. Scheduling and oversight meetings in place for elective lists 6. Business case being made for additional theatre sessions.		
Update since the last report	**Update 07/08/2024** **Risk reviewed. No change in risk score** High emergency activity and continued use of additional capacity sessions to ease impact. Date report on NCEPOD breaches being worked on by SAS informatics. **Next review date 09/09/2024**	**Date last reviewed**	07/08/2024

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

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

No	ID	Title				
16	9851	**Lack of standardisation of clinical documentation process and recording in Cerner**				
Lead		Risk Lead: Clare Owen Exec Lead: Pete Murphy	**Current score**	**16**	**Score Movement**	⟺

Description	The introduction of Cerner e-PR system has created changes in documentation processes. There are numerous ways to navigate the system and document information in Cerner. As a result there is a lack of standardisation in documentation. 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 when documenting in Cerner could result in the omission of documentation, evidence of care, duplication or contradictory information relating to the provision of care and potential that processes no longer align to clinical management policies, standard operating procedures and national guidance, with elements of documentation captured in existing audits no longer available to view.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Staff unaware of variation of processes in Cerner at go live so all processes need review and agreement to standardise. 2. Compliance audit reporting for some elements may not be possible or align to Cerner. 3. Unable to set up compliance reports until agreement of standardised process. 4. No electronic document management system or guidance on scanning in place. **Gaps / weakness in assurance** 1. Due to the volume of change requests and system analyst capacity, the alignment of system builds, audit and policy review is taking time to work through and prioritise. 2. Availability of lead experts to review system and advise and update policies is a timely process. 3. Limited assurance of monitoring scanning activity. 4. Limited capacity of reporting team to work on clinical reporting due to pressure for business as usual reports and resolving data quality issues for operational reporting.
Controls and Assurances in place	**Controls** 1. Appointment of a Chief Nursing Information Officer (CNIO) now in post. 2. New Integration Architect has been recruited to assist and upskill system analysts to execute change requests. 3. Head of Nursing leading review of the effectiveness of clinical management policy and procedural controls, risk assessment processes and care plans. 4. Library of quick reference guides on step by step instructions on common processes available via e-coach. 5. Training videos available on OLI, YouTube and the Learning Hub. 6. Review of clinical documentation included as part of Nursing Assessment and Performance Framework (NAPF). 7. Standardisation of clinical information and records management now obtained and can be audited. **Assurance** 1. Key processes lacking in standardisation are being identified. 2. Assurances provided by policy authors of the effectiveness of policy, procedural and risk assessment controls being aligned to Cerner. 3. Escalation process for Cerner related issues in place. 4. Engagement groups with staff and subject leads in progress to understand the issues. 5. A clinical records management group has been established to monitor and receive assurance of compliance. 6. Nursing risk assessments now available via systems reporting portal with other reports awaiting development. 7. Mini NAPF and audits of clinical areas undertaken by matrons with outcomes shared and enacted upon. 8. 93% of staff have received training on Cerner e-PR before 'go-live' date and all new staff complete training on commencement of employment. 9. Ongoing updates, including changes or handy tips, issued via trust wide approved communication systems. 10. Creation of One LSC model allows for pooling of resources across the region that will help address capacity.		
Update since the last report	**Update 05/08/2024** **Risk reviewed. No change in risk score** Number of recent incidents in relation to poor completion of fluid balance and food charts shows gaps in assurances and highlights further training is required **Next Review Date 02/09/2024**	**Date last reviewed**	05/08/2024

Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	15	15		

8 week score projection	15
Current Issues	System wide influences

No	ID	Title
17	9653	**Increased demand with a lack of capacity within ELHT can lead to extreme pressure**

Lead		Current score	16	Score Movement	⟺
	Risk Lead: Jane Dean Exec Lead: Pete Murphy				

Description

Extra bed capacity is achieved by use of escalation beds in areas that have been risk assessed. Since January 2024 a standard operating procedure has been developed that introduced an extra trolley on each ward where there is inability to offload ambulances and patients are nursed on hospital corridors.

There is an increased risk extreme escalation to increase capacity within hospital environments will result in patient and staff physical and or mental harm as well as increasing privacy and dignity issues, hospital acquired infection, complaints, poor patient experience and reputational damage.

Controls and Assurances in place

Controls

1. Each ward has an individual risk assessment in place for the area in which the escalation bed space is to be opened and is reviewed as required.
2. Patients assessed by senior nurse on duty to ensure most appropriate patient is identified to be cared for in escalation bed.
3. Portable nurse call systems in place for additional bed to enable patients to alert staff when required.
4. Temporary storage made available as required.
5. Patient medications are stored within ward medication trolleys.
6. Patients placed onto the escalation bed are to be self-caring and able to stand to aid transfer to bathroom where possible.
7. Patients requiring electrical equipment or oxygen therapy are not to be allocated bed space.
8. Emergency equipment available if unexpected deterioration is experienced.
9. All staff to ensure adherence to infection prevention control policy and procedural controls.
10. A standard operating procedure in place to support and strengthen decision making of patient selection and placement when using escalation bed and trolleys.

Assurance

1. When escalation trolley is in use, the ward risk assessment is reviewed each day.
2. Assessment is signed by appropriate staff to confirm required needs are being met each time the area is opened.
3. A signature sheet is kept with the ward assessment and compliance of its use audited as required.
4. Extra equipment in use to support bed space e.g. patient call alarm, bedside table and crate for any belongings are being managed as per policy and procedural controls.
5. When equipment is not in use, it is the wards responsibility to ensure the electronic patient buzzer is kept on charge at the nurses station and checked twice daily as part of safety huddles.
6. Use of extreme escalation trolleys is monitored, incidents are reviewed, linked to the risk and investigated as appropriate, with lessons learned shared with staff.
7. The Electronic Patient Tracking System is updated to ensure the correct ward area is used at all times of extreme escalation.
8. Quarterly review of risk assessments are undertaken by the health and safety team via use of audits and incident review.
9. Monthly meeting are set up to review any incident reports received to identify any ongoing themes or increased risk.

Gaps and Potential actions to further mitigate risk

Gaps / weaknesses in controls

1. Lack of space around bed area affecting personal care and impacting on patent and staff safety.
2. Reduced access to electrical power sockets, oxygen and suction, overhead lighting and trailing wires and cables have increased slips, trips and fall hazards.
3. Reduced space where escalation bed is positioned has increased risk of patient falls due to compromised observation of patients and additional equipment in the area and is impacting on safer handling of patients and infection prevention and control adherence.
4. Privacy and dignity may be compromised due to privacy screens not allowing the same privacy as the curtains.
5. Poor patient experience leading to increased patient and relatives concerns being raised and potential risk of increased formal complaints and potential reputational damage.
6. Reduced space around bed/trolley for staff to safely deliver care. Lack of amenities for patients to enable them to be independent with some aspects of care e.g. no bedside table to provide access to personal belongings and diet and fluids within their reach.
7. Potential staff harm due to inability to safely handle patients and increased equipment in area
8. Increased nurse anxieties due to managing medical staff's expectations.
9. Staff morale and wellbeing may be reduced due to increased workload and managing patients and visitors expectations.
10. Due to the number of nursing vacancies and high agency or bank usage, there may be times, in particular, overnight, when the ward team are very junior and may be under already significant pressures leading to heightened stress and anxiety.

Gaps / weakness in assurance

1. Reduced space between bed spaces not adhering to national guidance and potential to increase risk of hospital associated infections.
2. Capacity and demand cannot be predicted.
3. Patients refusing to move to the trolleys if they are in bed.
4. Inability to find suitable patients to go onto the trolleys due to acuity or dependency.

Update since the last report

Update 03/09/2024
Risk reviewed. No change in risk score.
Awaiting approval to open additional beds which will reduce the likelihood of risk and subsequent risk score.

Next Review Date 03/10/2024

Date last reviewed	03/09/2024			
Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
	15	15		
8 week score projection	15			
Current Issues	System wide influences			

No	ID	Title
18	9301	**Risk of avoidable patient falls with harm**

Lead	Risk Lead: Alison Duerden Exec Lead: Pete Murphy	**Current score**	**15**	**Score Movement**	⇧

Description

Failure to prevent patient slips trips and falls resulting in avoidable harm due to lack of compliance / assurance with Local and National policies / procedures

Controls and Assurances in place

Controls

1. Patient falls included as part of the Trust's Patient Safety Incident Response Framework as a local priority for learning
2. 5 investigations completed on falls leading to #NOF and themed to identify safety improvements
3. Completion of investigations for all inpatient falls resulting in moderate or above harm in line with the ELHT Patient Safety Incident Response Framework
4. Falls investigation reports are carried out by appropriately trained nurses from the clinical areas which are reviewed through the DSIRG process for Patient Safety Response investigations at Divisional level and by PSIRI for STEIS reportable incidents monthly
5. Enhanced care scoring tool in place with appropriate SOP (SOP004 Levels of enhanced care) enhanced care e-learning accessible on the learning hub, enhanced care lead nurse in post and developing a digital solution for staff to undertake a patients enhanced care score (this is currently a paper process)
6. Multifactorial patient falls risk assessments in place monitored through monthly ward audits for assurance (following the implementation of ePR) it was evident that a change request was urgently required as the information from the falls risk assessment was not being correctly pulled through to request a multi-factorial falls risk assessment which potentially led to lack of risk assessment compliance at patient level - this change request has now been actioned and issue resolved)
7. Falls strategy group meets monthly and represented by all divisions
8. Divisional falls action plans monitored through the falls steering group and uploaded to the risk quarterly. themes and trends following falls investigations are shared for learning across all divisions at the falls strategy group
9. Yellow ID badge introduced to identify staff undertaking enhanced care for patients at high risk of falls
10. Cohort bays are identified through appropriate "C" logo on doors entering the bay to increase staff awareness
11. Patients at risk of falls are identified daily at ward safety huddles
12. Enhanced care lead is recruiting a team of 30 enhanced care support workers who will support the most vulnerable patients in our care with appropriate supervision, interaction and observation
13. Falls checklist now aligned with PSIRF

Assurances

1. Good monitoring tools in place across the wards and also links into Trust meetings at all levels (Directorate, Divisional sharing of incidents and lessons learned)
2. FALLS SUMMIT action plan approved
3. FALLS SUMMIT workshop day planned with the falls strategy group to use a start stop continue approach to share and spread falls prevention strategies Trust wide

Gaps and Potential actions to further mitigate risk

Gaps / weaknesses in controls

1. Lack of consistency / compliance with local assurance tools including enhanced care scoring tool and patient risk assessments
2. Lack of consistency in approach following a fall with harm on a ward (currently bespoke input to ward area to assure patient safety for all patients on the ward which is dependent on initial review findings
3. Falls checklist to be built directly into DATIX to reflect other checklists, i.e. pressure ulcers
4. No trust wide falls action plan as patients coming to harm following a fall are reported through DATIX and investigated through divisional processes. This information is presented through a divisional quarterly report which are specific to their areas and provide assurance of actions, themes. trends and wider learning
5. Inconsistencies with staffing in relation to increased level of observation requirements for patients in our care and in accordance with the enhanced care policy
6. Inconsistencies with staff training in relation to understanding and delivery of enhanced levels of patient observation as per SOP004 (Levels of Enhanced care)
7. Inconsistencies in documentation on e-PR for falls prevention and management (change requests made Dec 23)

Gaps / weaknesses in assurances

1. Increase in fracture neck of femurs as in-patient past 6/12 - 11 since Jan 23 any avoidable harm will be captured through the Falls Checklists completed and presented at divisional DSIRG meetings - learning shared at monthly Falls strategy group meeting and assurance through Divisional quarterly reports uploaded to ACTIONS within this risk
2. Increase in number of falls with avoidable harm to inpatients which have potentially contributed to the patient's death
3. Due to increase in falls contributing to patient death which has not seen previously the risk has been re-scored at 15 (understand that a consequence score should not change however death had not been seen previously so not scored as such but now this is evident this is felt to be a more accurate reflection of the risk
4. Due to this change it is felt that the falls collaborative work undertaken in 2015 should be revisited and reviewed in line with current practice and changes since COVID

Update since the last report

New Risk
Next Review Date 01/09/2024

Date last reviewed	02/08/2024			
Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
		15		
8 week score projection	**15**			
Current issues	System wide influences			

No	ID	Title
19	8808	**Breaches to fire stopping and compartmentalisation at BGH**

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. 3. 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. 4. Not all locations within occupied areas have an updated fire safety risk assessment. 5. 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. **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.
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. 6. External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place. 7. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England. 8. Independent consultant employed to review and oversee project.		

Update since the last report	**Update 23/08/2024** **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 20/09/2024**	**Date last reviewed**	23/08/2024			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			15	15		
		8 week score projection	15			
		Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
20	4932	**Patients who lack capacity to consent to hospital placements 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**			
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 local authority acting as the Supervisory Body. 6. Ability to extend urgent authorisations for all patients up to 14 days in total. **Assurances** 1. The Supervisory Body is aware of the risk. 2. Policy and procedural arrangements being adhered to by wards along with applications continually made in a timely manner. 3. Quarterly review undertaken by Internal Safeguarding Board. 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. Patients not known to suffer any adverse consequence or delays in treatment.		**Gaps / weaknesses in controls** 1. The inability of the Supervisory Body to process assessments in line with set statutory provision. 2. As a result the Trust is unable to extend urgent authorisations beyond the maximum time permitted of 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. Limited assurance received from Supervisory Body it is advancing meeting the challenge in addressing resource requirements for the assessment of patients as part of statutory provision		
Update since the last report		**Update 29/07/2024** **Risk reviewed. No change in risk score.** Approval status changed to a tolerated risk. The mitigation of this risk is the responsibility of the Local Authority as the Trust cannot control the fact the Supervisory Body does not have the resource to meet the requirements for the assessment of patients. **Next review date 29/08/2024**	**Date last reviewed**	**29/07/2024**		
			Risk by quarter 2024/25	**Q1**	**Q2**	**Q3**	**Q4**
				15	**15**		
			8-week score projection	**15**			
			Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

11 September 2024

Item	**125**
Purpose	Information Action Monitoring

Title	Board Assurance Framework (BAF)
Report Author	Miss K Ingham, Corporate Governance Manager
Executive sponsor	Mrs K Atkinson, Executive Director of Service Development and Improvement

Summary: The Executive Directors and their deputies have reviewed and revised the BAF during the course of August 2024. In addition, the Finance and Performance Committee and People and Culture Committee have received the risks relevant to the Committee at their most recent meetings in September 2024 and agreed to recommend the BAF risks within their remit to the Board for ratification.

Due to the timings of the Committees it has not been possible for the Quality Committee to review the BAF formally, therefore the members have received the BAF via email for comments and approval.

The cover report sets out an overview of the changes made to the document, including updates on actions and the addition of assurances where actions have been completed. The timelines for some of the actions have been revised and explanations are provided in the detailed BAF sheets and changes are highlighted in green on the individual BAF risk sheets.

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

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

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

Report linkages

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

Impact

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

Previously considered by:

(125) Board Assurance Framework

Executive Directors, August 2024

Executive Risk Assurance Group (ERAG), 29 August 2024

Finance and Performance Committee, 2 September2024

Quality Committee, via email

People and Culture Committee, 2 September 2024

Introduction

1. The Executive Directors and their deputies with BAF risks assigned to them have met with the Corporate Governance Manager to review and revise the individual risks.
2. This document sets out an overview of the changes that have been made to the BAF since the Board meeting that took place in July 2024 including any updates to the actions, assurances and controls.
3. The full BAF is presented to the Finance and Performance Committee, Quality Committee and People and Culture Committee. However, the Committees are only asked to discuss the risk scores, mitigations and actions for the risks that are within their remits as follows:
   a) **Finance & Performance Committee:** BAF 1, BAF 3, BAF 5 and BAF 6.
   b) **Quality Committee**: BAF 2 and BAF 6.
   c) **People and Culture Committee**: BAF 4 and BAF 6.
4. For ease of reference, we have produced the following heat map of the BAF risks for 2024-25 below.

2024-25		LIKELIHOOD				
		Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
CONSEQUENCE	Catastrophic 5					BAF 5
	Major 4				BAF 1 BAF 2 BAF 3 BAF 4	BAF 6
	Moderate 3					
	Minor 2					
	Negligible 1					

Risk 1: (Risk Score 16 (C4 x L4) - The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.

5. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
6. There have been no updates to the controls or assurances section of the risk.
7. With regard to the actions section of this risk, there have been a number of updates, including two new actions (actions 4b and 4c), the details of which are included in the detailed BAF sheet. Now that the planning processes for the year are concluded there is a change in emphasis on implementation of actions to support benefits realisation.

Risk 2: (Risk Score 16 (C4 x L4) - The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.

8. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
9. There has been one new addition to the controls section and three additions to the assurances section of the risk, which are highlighted in green in the detailed BAF sheet.
10. With regard to the actions section of the risk, there have been updates provided to the progress section for actions 1, 2, 4 and 5. In addition, action 3 has been revised in greater detail to ensure that it adequately reflects the current requirements.

Risk 3: (Risk Score 20 (C4 x L5) - A risk to our ability to deliver the National access standards as set out in the 2024-25 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.

11. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
12. There has been one update to the controls section of the risk, which is highlighted in green on the detailed BAF sheet.
13. There have been updates to all of the actions. In addition actions 4, 7 and 8 have been marked as completed and will move to the assurances section of the BAF at the next

review. Action number 9 has had a revised date for completion of the action, and an update on progress against this action will be updated as part of the Board discussions at its meeting on 11 September 2024.

Risk 4: (Risk Score 16 (C4 x L4) The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.

14. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
15. There have been no amendments to the controls and assurances sections of the risk.
16. There have been updates to all of the actions, with the exception of action 1. The details of which are highlighted in green in the detailed BAF sheet.

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

17. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
18. There have been a number of updates to the controls section of the BAF risk and two new controls have been added which can be seen in the detailed BAF sheet.
19. There have also been two new sources of assurance added to the BAF sheet and can be seen highlighted in green.
20. There have been updates to all actions, with actions 1, 2 and 3 being marked as complete and will therefore be moved to the sources of assurances section at the next review.
21. Two further actions have been included, one relating to the system wide financial plan for 20234-25 and the second relating to the lack of a signed contract for 2024-25. Further details of these actions can be found in the detailed BAF sheet.

BAF 6: (Risk Score 20 (C4 x L5) (As Host): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services.
BAF 6: (Risk Score 20 (C4 x L5) (As Partner): One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.

22. The current risk scores remain unchanged for this risk, as do the tolerated and target risk ratings.
23. There has been one addition to the controls section, which relates to the setting out of the hosting obligations and risk share through the partnership arrangements, further details can be found in the highlighted section on the detailed BAF risk.
24. There have been updates provided to the progress section for actions 1, 2,3 and 4. The due date for action 6 has been revised in line with the proposed change to the transfer date for One LSC.

Recommendation

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

BAF Risk 1 – Integrated Care / Partnerships / System Working

Risk Description: The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.

Executive Director Lead: Chief Executive / Executive Director of Service Development and Improvement

Strategy: ELHT Strategic framework (Partnership Working)

Links to Key Delivery Programmes: Care Closer to Home/Place-based Partnerships, Provider Collaborative

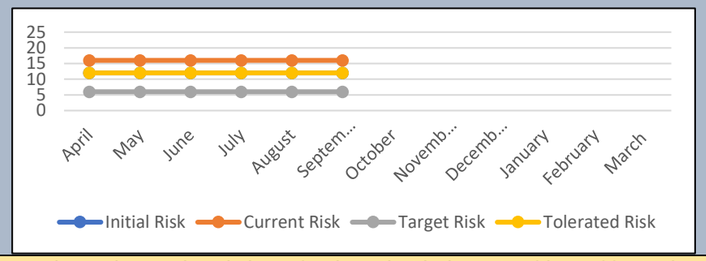
Date of last review: Board Strategy Session, 6 June 2024

Lead Committee: Finance and Performance Committee

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

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

Current Risk Rating:	**C4 x L4 = 16**
Initial Risk Rating:	C4 x L3 = 12
Tolerated Risk	C4 x L3 = 12
Target Risk Rating:	C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

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

- The ICB has worked with partners to develop a Joint Forward Plan which continues to be reviewed and developed to reflect system strategy development and a refreshed system clinical strategy is in development
- The ICB continues to develop its commissioning approach and has formalised commissioning intentions for 2024/25 alongside a commissioning delivery plan
- The System Recovery and Transformation Programme and Board and System Leadership Oversight Group has refocussed for 2024/25 around delivery of key priority programmes and Financial Recovery
- The system Programme Management Office continues to develop to support delivery and monitoring of benefits realisation of system-wide programmes.
- ELHT has strong representation at all levels of system working and oversight groups. This is inclusive of Executive, senior clinical and operational representation at ICS working groups for key programmes, tactical co-ordination groups and planning groups to ensure alignment of plans.

Provider Collaborative Board (PCB):

- The PCB drives key programmes of work on both Clinical Services and Central Service redesign which feed into PCB Governance Structures and the system Recovery and Transformation Board.
- A Joint Committee has been formed to enable effective decision making for specified Programmes.
- ELHT plays a key role in the PCB including Chief Executive and Chair at PCB Provider Collaborative Board, lead Director Senior Responsible Officer (SRO) roles, representation at all other functional Director co-ordination groups and senior clinical and operational staff represented at clinical and non-clinical programme and working groups.
- The Clinical Services Programme Board, chaired by ELHT Chief Executive, oversees a programme of work focussed on clinical services configuration including fragile services.
- Central Services Programme Board oversees potential savings and other benefits of Central Services programmes opportunities with ELHT as the host of One LSC (refer to separate BAF risk 6).

Place-Based Partnership (PBP):

- Blackburn with Darwen Place and Lancashire Place including East Lancashire priorities are now agreed with place based delivery structures continuing to develop and be reflected in system commissioning intentions.
- Place + key forums in place to support delivery where needed across East Lancashire and Blackburn with Darwen e.g. Urgent and Emergency Care Delivery Board

ELHT:

- ELHT Strategic framework has been developed to ensure clear alignment of organisational aims to wider system aims.
- Key organisational strategies have been refreshed/developed to clearly outline ELHT priorities for development as a partner in the wider system.
- Strategy deployment framework/process will support development and delivery of organisational plans aligned to wider system, supported by Accountability Framework to monitor delivery.
- 11 Key Delivery and Improvement Programmes, with associated programme board and working groups, have been identified to ensure delivery against organisational aims and objectives and aligned to wider system programmes.
- In 2024/25 8 key improvement priorities have been agreed aligned to these programmes with clear fit to system priorities

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

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

- ICS/PCB/PBP Updates are a standing agenda item at Executive meeting and Senior Leadership Group.
- PCB Programme Update reports to the PCB Joint Committee.
- Weekly monitoring of Key Delivery and Improvement Programmes via Executive Improvement Wall
- Trust Improvement Register monitored at Divisional Transformation Boards and Clinical Effectiveness Committees.
- Organisational plans for operational planning established and agreed via Trust and System planning processes.
- Accountability Framework implemented from January 2023 including weekly Improvement Wall updates as part of the weekly Executive Team meetings, Senior Leadership Group and quarterly Divisional Performance meetings.

Specialist support, policy and procedure setting, oversight responsibility:

- Standing agenda item at Trust Board where approvals will be established, and permissions are provided by the Board to let Executives progress the generation of ideas and options with external stakeholders.
- Board Chief Executive Officers (CEO) report including updates on system developments and engagement.
- System delivery plans are reflected in updates on Trust Key Delivery and Improvement Programmes. ELHT Key Delivery and Improvement Programmes established with relevant Programme Boards in place which feed into Trust sub-committees to report progress and give assurance.
- Strategic dashboards developed to enable monitoring of key Trust strategies at relevant Trust sub-committees with reporting to Trust Board twice a year.

Independent challenge on levels of assurance, risk and control:

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

BAF Risk 1 – Integrated Care / Partnerships / System Working

• ELHT Improvement Practice (Improving Safe, Personal and Effective Care (SPE+), developed to support delivery and build capacity for Improvement. Detailed Improvement Practice Development Plan (2022-25) in place with 1 year delivery plans generated each year to support embedding of improvement across the organisation.	

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	System strategies will continue to be developed and aligned as they are agreed.	Work with system partners to finalise system strategies and ensure full alignment with commissioning intentions and delivery plans.	Director of Service Development and Improvement with SRO leads	Sept 2024	Clinical strategy development work underway across the system. Clinical strategy workshops ongoing from which next steps and timescales to be determined. ICB Commissioning intentions developed and supporting delivery framework in development. Initial scoping of place priorities to Trust priorities complete and to remain under review Review of alignment of system, place and trust priorities undertaken as part of Trust planning process and being reviewed through Trust Sub-Committees. With the exception of clinical strategy development work all actions complete and focus is now on delivery of benefits for 202425 and 20265/26 (refer to actions 3, 4 and BAF risk 6 on OneLSC).	G
2.	System (LSC, PCB, Place) delivery structures are still maturing to support effective implementation and realisation of benefits	Work with system partners to optimise delivery structures	Executive leads	Sept 2024	SROs supporting further development of delivery programmes through the Recovery and Transformation Programme, Provider Collaborative Board and Place e.g. community services/out of hospital programme. Continuing to align ELHT key delivery and improvement programmes and resources to support delivery and maximise benefits. Initial development of plans and alignment across the system complete. Clear programmes in place which now need to focus on delivery of benefits for 2024/25 and 20205/26 (refer to actions 3, 4 and BAF risk 6 on OneLSC).	G
3.	Clear Clinical Transformation Programme development and delivery plans	Agreement of clear timescales for delivery of key priority programmes and benefits	Chief Executive and lead SROs	April 2025	Clinical strategy work to inform a roadmap to delivery of priority programmes over next 5 years and long-term plan linked to New Hospital Programme Work progressing on fragile service specialty priorities with clear programmes established. Work underway to accelerate programmes of work on fragile services and focus on delivery of benefits for 2024/25 and 2025/26.	A
4a.	Benefits for community services/out of hospital priorities not yet fully realised.	Complete the transfer of BwD Community Services to ELHT	Executive Director of Integrated Care, Partnerships and Resilience	July 2024	Community services transfer business case completed and agreed by all parties Mobilisation workstreams completed and facilitated a successful transfer on 1st July Continue to monitor transfer during early weeks to address any early implementation issues. Mobilisation actions complete and monitoring as part of business as usual.	B
4b.	Benefits for community services/out of hospital priorities not yet fully realised.	Work with Place + partners to further develop community services in line with the Community Transformation Programme to maximise benefits to support patients to receive care in their own home where possible.	Executive Director of Integrated Care, Partnerships and Resilience	April 2025	Co-production and co-delivery with place partners of service development and transformation including enablement hub, UEC pathways, End of Life, Care Home improvements, Integrated Neighbourhood Tean development and Acute Respiratory Infection (ARI) hub mobilisation.	G
4c	Lack of clarity and understanding of decision-making mechanisms between Place and Trust footprint resulting in disconnect and/or micro-management by Place(s)	Lead Trust Executive for Place Partnerships, Robust Divisional Leadership Structure via Community and Intermediate Care Division (CIC) and engagement in Place based structures.	Executive Director of Integrated Care, Partnerships and Resilience	April 2025	Lead Trust Executive is Executive Director of Integrated Care, Partnerships and Resilience with regular meetings wit Place Leads. CIC Divisional Leadership mirrors Clinical Divisional triumvirate structure. Representation on Place Partnership structures with delivery on Place Plus basis where appropriate (e.g. UECDB). Monitoring of strategies and impact of Place strategies to ensure appropriate linkages to Trust Strategic Framework and footprint.	A
5.	Trust planning process will continue to mature to support floor to board connections of goals and priorities alongside wider system alignment	Ongoing review and improvement of planning processes at organisational and system level	Director of Service Development and Improvement	April 2025	All Trust strategy plans 2024/25 signed off via sub-committees with reporting mechanisms throughout 2024/25 agreed. Ongoing alignment of place with place and system partners. Ongoing work with Divisions to support connection of Trust goals to teams and individual objectives.	G
6.	Ongoing development of SPE+ improvement Practice to support delivery of key improvement priorities and to build improvement capability across the organisation/system	Ongoing review and development of SPE+ Improvement Practice at organisational and system level to build capability and support delivery and refresh of SPE+ Practice Plan/Strategy in line with NHS Impact	Director of Service Development and Improvement	April 2025	'Year of Improvement' launched to develop SPE+ training offer to reach 3000 staff in 2024/25 – second improvement week complete which is informing changing to communication strategy for SPE+ improvement. Third improvement week will focus on roll out of daily management/production boards to support waste reduction programme.	G

BAF Risk 1 – Integrated Care / Partnerships / System Working

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Improvement hub team capacity identified to support key improvement priorities for 2024/25, increased monitoring in place to support realisation of benefits for 2024/25. Scoping of work to refresh Trust SPE+ Practice Plan/Strategy commenced to align to the new NHS Impact framework and ongoing engagement with NHS Impact. Continue to review the offer from NHS Impact to align organisational and national improvement priorities.	
7.	Trust Accountability Framework can mature further to support and assure delivery of Trust priorities and realisation of benefits.	Review effectiveness of Trust Accountability Framework and further improve to support delivery	Director of Service Development and Improvement	Sept 2024	Review commenced of Accountability Framework including effectiveness of Divisional Quarterly Performance meetings, measurement and reporting framework Review of Integrated Performance Report (IPR) underway and to be published in September. Plans in place to update and sign off updated Accountability Framework by end September, Board Development Workshop on revised IPR, review of quarterly performance meetings complete. Review of Improvement Walls underway to refresh for 2024/25 priorities Improvement Walls being rolled out to operational areas e.g. ED, pathology	G

BAF Risk 2 – Quality and Safety

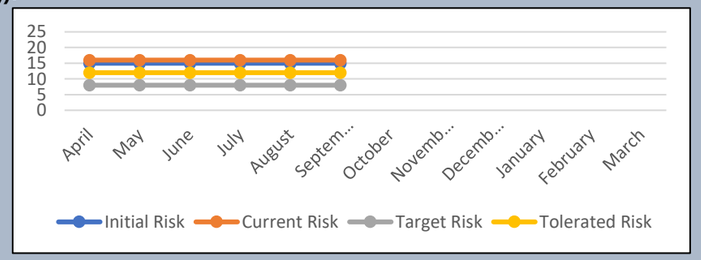
Risk Description: The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.		**Executive Director Lead:** Executive Medical Director and Chief Nurse	
Strategy: Quality Strategy	**Links to Key Delivery Programmes:** Quality and Safety Improvement Priorities	**Date of last review:** Chief Nurse, 22.08.2024 Medical Director,	**Lead Committee:** Quality Committee

Links to Corporate Risk Register:

Risk ID	Risk Descriptor	Risk Rating
10086	Lack of adequate online storage for images may result in missed or delayed diagnosis	**20**
9545	Potential interruption to surgical procedures due to equipment failure	**20**
9336	Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care	**20**
8126	Poor records management due to sub optimal implementation of new e-PR system	**20**
8941	Increased reporting times in histology due to increased activity outstripping resource	**16**
8061	Patients experiencing delays past their intended clinical review date may experience deterioration	**16**
8033	Increased requirement for nutrition and hydration intervention in patients resulting in delays	**16**
7165	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	**16**
6190	Insufficient capacity to accommodate patients in clinic within timescales	**16**
9851	Lack of standardisation of clinical documentation processes and recording in Cerner	**15**
8808	Breaches to fire stopping and compartmentalisation in walls and fire door surrounds – Burnley General Teaching Hospital.	**15**
4932	Patients who lack capacity to consent to placements in hospital may be unlawfully detained	**15**

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

Current Risk Rating: C4 x L4 = 16
Initial Risk Rating: C5 x L3 = 15
Tolerated Risk C4 x L3 = 12
Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Minimal

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

Strategy and Planning:

- The Quality Strategy contains 14 core priorities which are routinely reported and monitored through the Quality Committee. These will be reviewed and updated annually through workshops with key partners.
- The Quality Strategy priorities for 2024/25 have been confirmed, with associated KPIs. Progress against the 2024/25 priorities is reviewed by the Executive team a minimum of quarterly via a presentation and update of the Executive Improvement Wall.
- The Patient Safety Incident Reporting Plan identified 5 priorities for investigation during 2022-24, the investigations now complete are moving to thematic review for organisational learning, led by the Improvement team. New priorities for 2024-25 have been agreed following engagement with key stakeholders, including the PPP and Healthwatch. following presentation at the Trusts Quality Committee and at the ICB Quality Committee. in November 2023
- Learning from the first year of implementing PSIRF has acknowledged priorities for 2022-23 were implemented over 18 months and therefore the 23-24 priorities are anticipated to cover until mid-2025.

Floor to Board Reporting and escalation (Risk and Quality):

- The Trust has an established quality assurance process supported through a formal Committee Structure. This provides the golden thread enabling reporting and escalation between the Divisions and the Board.
- The Trust Board, Quality Committee, Finance and Performance Committee, People and Culture Committee and Audit Committee all receive reports on risk/quality as part of their annual workplan, or as escalation where indicated.

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

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

- Monitoring against Model Hospital, Getting it Right First Time (GIRFT), National Institute for Health and Care Excellence (NICE) guidelines, Internal and Clinical Audits (local and national), specialist commissioning, CQC insight data (monthly)
- Quality Walkrounds including Executive and Non-Executives (not sure that these are if you look at the activity)
- Establishment of 3s visits to all areas of the Trust, to listen to both staff and patients/carers, receive feedback and take action.
- Nursing Assessment Performance Framework (NAPF) Process ongoing and reports to Quality Committee
- Safe, Personal, Effective Care (SPEC) process and the ratings of green/silver/gold wards/areas (mapped to the CQC Key Lines of Enquiry).
- Co-ordination of GIRFT through Audit and Effectiveness Team to identify Trust wide efficiency and effectiveness gains and reported to the Quality Committee regularly.
- Direct patient referrals into Same Day Emergency Care (SDEC) pathways to help bypass urgent care and ED.
- Admission avoidance through the use of Intensive Home Support Service (IHSS) in ED.
- Acute Care Team supporting resus in ED.
- Acute medical physician in-reach into A&E from 8.30am to 8.30pm
- Patient champions in A&E
- Use of 24/7 ambulatory care on an intermittent basis to assist acute care (staffing dependent).
- Work is being undertaken with colleagues in primary care regarding patient pathways.
- Medical Examiners review the care provided to patients who have died in the Trust and can make recommendations or seek further action dependent upon their findings.

BAF Risk 2 – Quality and Safety

- Escalation required outside of standard Committee processes is enabled through a weekly Senior Leadership Group, chaired by the Chief Executive or other Executive member to enable timely decision making and trust wide focus where required.
- All Divisions (including Estates and Facilities) have Quality and Safety meetings which coordinate Directorate assurance reports and escalation. Divisional reports are escalated to the Quality Committee through standard reporting and/or as patient/staff safety escalation points.
- Statutory requirements are monitored specifically through Trust Wide assurance meetings including, but not limited to Mortality Steering Group, Patient Safety Group, Patient Experience Group, Clinical Effectiveness Committee, Infection Prevention and Control Steering Group, Safeguarding Board, Medicines Management Committee, Blood Transfusion Committee, Organ Donation Committee, Health and Safety Committee, all of which report to the Trust's Quality Committee, which is a sub-committee of the Board.
- The Professional Standards Group and Employee Relations Case Review Group monitor professional/staff behaviours and all referrals to professional bodies.
- The Risk Assurance Meeting coordinates and monitors all risks reported as potentially scoring 15 or above and escalates to the Executive Risk Assurance Group (ERAG) before inclusion onto the Corporate Risk Register.
- The Patient Safety Incident Response Plan, Patient Experience Framework, Risk Management Framework and Clinical Effectiveness Framework co-ordinate the operational implementation of the priorities which are reported and monitored through respective assurance groups, and exceptions reported to Quality Committee.
- Implementation of the Extreme Escalation Policy which replaces beds with trolleys in clinical spaces to assist the transfer of patients from ED into AMU/more appropriate environment. This in turn assists the capacity within the ED to see and treat other patients. Every morning at 8am, there is exec lead clinical safety meeting with A&E, divisions and flow team to manage and monitor patient admissions and flow.
- Due to ongoing industrial action and sustained and increased unscheduled attendance and admission, twice a day IMT meetings have been stood up along with daily meeting with Place based partners and stakeholders. These meetings will be managed according to the OPEL level declared by the organisation
- A&E Delivery Board lead by an Executive Director ensures processes are in place to help co-ordinate the care of patients between community, primary care, NWAS and ELHT.
- A&E improvement board, developed with weekly executive review
- Quarterly Divisional performance meetings where all elements of quality and performance are discussed.
- The EPR Programme Board will run until the end of February 2024 and will be replaced by a new Digital and Data Board.
- The Patient Safety Incident Response Framework implementation was reviewed through a workshop with Non-Executives present in November. This confirmed learning from the first 12 months and a core focus on continuing to improve systems and culture during 2023-24.

- Clinical Harms Review commenced from mid-December 2022 for patients waiting 52 weeks for treatment. It is being rolled over to specialties to assist in the management and prioritisation of waiting lists.
- Complex Case meeting weekly to monitor and allocate for investigation any patient/staff safety incidents identified.
- Monthly complaints and inquest drop-in sessions with each Division to monitor performance and highlight risk
- Mobilisation of 24/7 IHSS service complementing the 24/7 Intermediate Care Allocation Team (ICAT) service Monday to Friday between 8am – 4pm for the ED front door team.
- New PSIRP priorities have now been identified and included in the update Patient Safety Incident Response Plan due to be approved at Quality Committee on 1st November.
- New model for patient safety culture reflecting the Insight/Involve/Improve model – integrating patient and staff safety data (in line with the National Patient Safety Strategy) has been agreed in principle with the Quality and Safety team.
- Patient safety specialists are working with Deputy Director of HR to integrate staff safety metrics alongside patient safety.
- Patient Safety Summit held in June 2023 following a number of Never Events and focused on receiving staff feedback on ELHT safety culture and psychological safety of staff. Learning from this is being rolled out in partnership with the Quality and Safety Team.
- New Clinical Lead for Retention, Resilience and Experience commenced in post on 1 August 2023 with a focus on nursing and AHP workforce.
- Work is being undertaken with ward managers and team leaders to review and learn from observations of patient care to improve patient care, outcomes and experience.
- Quality Wall walkrounds have commenced (reviews of the quality KPI's in ED)
- Triple S visits which are informal
- An ED Improvement Wall has commenced with weekly attendance from front line clinical leaders, divisional leaders and Trust Executives.
- A new Patient Experience Strategy has been approved by the Board of Directors and will launch in September 2024.

Specialist support, policy and procedure setting, oversight responsibility:

- Integrated Care Board (ICB) have confirmed their contract requirements in relation to Quality reporting. Internal systems have been updated to ensure timely data and exception submission. First submission completed at the end of Q2. The Trust has continued to strengthen reporting against the updated Quality contract requirements and is proposing updates to the Quality metrics contained within the IPR to further strengthen internal assurance and visibility of these metrics
- ICB Improvement and Assurance meetings (IAG), monthly executive to executive assurance meetings
- ICB has split the assurance and safety functions with new leadership and focus.
- Monthly Quality Review Meetings with ICB Quality Team continue.
- Maternity and Newborn Safety Investigations (MNSI) (formerly Health Safety Incident Board) reports – review deaths and Health and Safety incidents.
- Engagement meetings with Care Quality Commission (CQC) in place monitoring performance against the CQC standards. The Trust is preparing for its next Well-Led review, via Task and Finish Group working.
- Patient Safety Incident Response Framework (PSIRF) supported through regular contact with NHS England Implementation Team. The Trust is supporting the adoption of PSIRF across the system as an active member of the implementation group.
- Early adoption of Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards supported through regular contact with PHSO Local Safeguarding Children's Board (LSCB)/Safeguarding Adults Board (SAB) reporting on Care Act and Children Act Standards.
- Arctic Willow winter specific EPRR exercise undertaken to ensure the NHS is adequately prepared for the winter period.
- Regular Updates on ICB EPRR.
- Regular meeting with Specialist Commissioner for tertiary services (Vascular, HPB, Neonates)

Independent challenge on levels of assurance, risk and control:

- Annual organisational appraisal report.
- CQC inspections and preparation/evidence gathering ongoing. Internal assurance processes evidencing performance against CQC Quality Standards have been aligned to the updated regulatory framework.
- The Internal Audit Plan for 2023-24 has being developed by the Mersey Internal Audit Agency (MIAA) in conjunction with Trust colleagues and improvement actions plan reporting to Audit Committee.
- Regular Engagement meetings with General Medical Council (GMC). Coroner reviews of care provided through Inquest Processes.
- Public Participation Panel (PPP) involvement in improvement activities and walk rounds.
- PHSO complaints monitoring and external reports. Elective Care Recovery Board which includes regional and ICS level representation and scrutiny.
- Quarterly Guardian of Safe Working report (GOSW) for junior doctors provided to the Quality Committee.
- JAG accreditation in Endoscopy
- Regular GIRFT assessment and bench marking
- Annual organ transplant report to NHSE

BAF Risk 2 – Quality and Safety

	• Patient Safety Walkrounds • Board sign-off for SPEC recommendations • Review of MHUAC with Stakeholders • ICB Quality reviews of services

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Fragility and availability of the medical workforce Health and Wellbeing of the Workforce	As part of WRP work has commenced to identify opportunities to reduce agency spend on medics. To strengthen the Patient Safety Culture in line with the Workforce Plan and a Just Culture Approach.	Executive Medical Director/ /Executive Director of People and Culture	Quarterly reviews with projected completion in Q4.	Long term This has been partially achieved and the Governance Assurance structure review completed. Job Planning Scrutiny Committee now embedded and focusing on productivity and VFM, recognising the need to increase effectiveness of Medical workforce in support of individual medics achieving their job plans. PCB and ICB are working closely in addressing the fragile services identified across LSC. Compassionate Conversations approach introduced as part of leadership training module to support psychological safety whilst learning from mistakes. This is now embedded as part of leadership training. Domestic Abuse and Sexual Violence workshop attended by Deputy Chief Nurse and Executive Director of People and Culture in October 2023, with a Trust meeting now in the calendar to commence the resultant work. Completed and support now also available to staff. Nursing professional judgment review process completed was presented to the Quality Committee in February and to the Trust Board in July 2024. This is now complete reported to Board and approved in July 2024. Medics have now started the introduction of the process of professional judgement. Strengthening of job planning scrutiny panel with support provided to CDs by medical staffing team in job planning. Nurse vacancies have now significantly reduced with an anticipation of zero vacancies in Q3.	A
2.	Functionality of ePR causing issues with data quality, performance and effecting users capability to maximise the potential of the electronic system. Provision of histopathology within the Trust (medical and healthcare scientists) No longer just histopathology, its wider pathology department given the current IA/workforce discussions	Work is taking place across providers via mutual aid and exploration of outsourcing and open recruitment. Improvement work within Cell Pathology has initiated to identify internal efficiency opportunities. Continued effort to appoint into Biomedical Scientist (BMS) and Medical Laboratory Assistant (MLA) vacancies in the department. Action plan in place detailing short- and medium-term actions whilst improvement work is taking place. Datix system to ensure best use of resource within current contract. June 2024. (NRLS being phased out). Agree and implement a training plan for all users as a compulsory module.	Executive Medical Director	Review Q3	The Trust's cell pathology lab in May 2024 confirmed with NHSE that NRLS will be deactivated nationally significant backlog of samples at various stages of the process from 30 June 2024 and the reception to report. This has been escalated to the Executive Team and there is a risk on the risk register. From April 24 consultant vacancies in Histopathology have now all been filled. There are BMS and MLA vacancies which have impacted on the lab's productivity and throughput. From April 24 the improvement team are supporting within the lab to identify opportunities for efficiency. An action plan is in place to outline the work taking place in the lab to increase capacity and reduce the backlog which includes the use of temporary staffing and exploring alternative workforce options.	R

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
		Cerner implementation has identified additional system updates and requirements improvements to Datix to ensure effectiveness. There is a need for relevant clinical document formats to be standardised and uploaded to Cerner eLancs team best use of resource needed to manage data cleansing and accuracy issues to enable timely reporting and performance monitoring and acting on change and service requests from staff/departments. Within current contract Update the Datix incident management module to ensure compliance with NHS England National Learning from Patient Safety Events (LfPSE) system requirements which is replacing the NHS England National Reporting and Learning System (NRLS) which is being phased out end Jun-24	Executive Medical Director	Q4 Delay in implementation due to lack of resource /25	Informatics has confirmed that a plan is in place to ensure that Datix is updated to meet the requirements of the new ongoing limited mutual aid from Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB). The Trust continues to use external providers to support with the backlog. The matter has been escalated to the national reporting system (LFPSE) to meet deadline. The Datix Manager has been requested to provide a roll out plan for the required training to implement LFPSE, inform an improvement case to clarify additional resource required to enable staff to continue report and manage incidents. LFPSE now implemented. Trust has been reporting live from 25 June 2024. Executive team have agreed the formation of a Task and Finish group to address the operational matters identified as a part of business-as-usual activity whilst Data and Digital Board and Senate continue to have strategic oversight of the T and F group. Work being completed on policies and procedures in respect of scanning and recording documents within the ePR CRMOG is overseeing the review and the decision not to implement RADAR has delayed full implementation and has resulted in the continuation of Datix until such time as an ICS wide solution has been agreed, procured and implemented which has impacted on the inability of the Trust to meet the initial deadline of reporting using the national LfPSE system in Sept-23. Whilst access to the NRLS system can still be utilised that enables national reporting, this is scheduled to be decommissioned at the end of Jun-24. A temporary post in support of implementing RADAR ended in Dec-23 and a business case continues to be developed by the Datix Manager and Deputy Medical Director to support longer term improvements in system analysis and learning from quality metrics and in line with the national patient safety strategy. An upgrade to the Datix server to accommodate LfPSE requirements has been completed following financial approval, with support provided by the supplier (Datix). There is a risk if data migration cannot be achieved and supported by the Data and Digital team before the date of decommission that this will result in the failure to meet national target and resulting manual uploading of incidents and associated hidden costs. This work activity has been prioritised by the Datix Manager. A risk has been placed on the risk register (Datix ID 9786 lack of coordinated centralised end to end management of procedural documentation and clinical records) which is due for presentation at the Risk Assurance Meeting in Jun-24 and is linked to DATIX ID 9851 lack of standardisation of clinical documentation into processes and recording in Cerner and reporting to Data and Digital Committee monthly. Improvement team supporting outpatients/activity data capture e-PR currently held on the Corporate Risk Register A review of the board assurance framework and system improvements to the risk management module of Datix is currently taking place to capture data and digital / infrastructure risks Issues with ePR and Data Quality continue to be escalated and are being managed through the Data and Digital Senate/Board.	A

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
3.	Management of Deprivation of Liberty Safeguards processes.	Continuous programme of audit Trust wide and implementation of action plan including: • Strengthened MCA/DoLS training offer • Development of 'heat map' to identify areas in need of greatest support • Development of 7 minute briefings • Development of a 'myth-busting' animation which will be mandatory for all level 3 staff • Strengthened documentation on Cerner • Working with the NAPF team to ensure a consistent approach	Executive Director of Nursing/ Executive Medical Director/ Executive Director of Integrated Care, Partnerships and Resilience	This date has been removed and there is no further date for implementation confirmed.	On trajectory for improved referrals. The number of DoLS applications was 153 in July 27 (increase from 136 in May 24). The number of DoLS are still below the expected number given the size of the organisation. 31 ward/departments audited in Q1. Audit activity feedback is increasing Ward Manger/Matrons knowledge of what is expected to meet the requirements. Formal action to be taken by the Deputy Chief Nurses. Meeting to be held with Divisional Chief Nurses to support in increasing compliance. Revised MCA assessment has gone live within Cerner on 3rd July 24. 7 Minute Briefing for MCA was presented at the Nursing and Midwifery Forum on 25th July. A 7 minute briefing for DoLS is under development and is due to be shared at the Nursing Midwifery Forum on 26th September 24. Awareness raising ongoing. Potential significant workload associated to cover approx. 260 annual applications. An announcement was made on 05.04.2023 that the implementation of LPS would be delayed 'beyond the life of this Parliament'. As a result, all internal and external local and national working groups have been stood down for the immediate future. The Trust will await any update from the new Labour government in relation to if and how this will progress. Lancashire and South Cumbria NHS Foundation Trust (LSCFT) have agreed in principle to formalise support of Mental Health (MH) registration through the management of psychiatric medication, oversight of MH care plans, management of MH Act paperwork for any Section 5(2)s applied within ELHT and to provide training to staff on MH and Restraint. LSCFT have proposed a formal Service Level Agreement (SLA) at cost. SLA is in the process of being signed. Individual patient MH risk assessment and MH strategy shared by LTHT, currently being adapted for adoption at ELHT.	G
4.	Financial Constraints	Constraints in finances will result in lack of investment into workforce, development of service, capital investment and revenue. This has the potential to negatively impact on quality and safety.	Executive Director of Finance / all Executive Directors	March 2025	Organisational focus on improvement methodology to improve productivity and efficiencies. Waste reduction programme with Execs leading as SRO for various workstream – chaired by the CEO. Consolidation of previously approved schemes and QIA for ongoing projects and the ones which have been deferred for a later date. Ongoing work through PCB on clinical strategy and services. Recruitment and retention campaign being undertaken as well as work to improve recruitment from overseas. This has now been reviewed and stopped as registered nurse vacancies recruited to with a trajectory that assures sufficient registered nurse supply New arrangements: better care, better value meetings now in place, with SLG members meeting twice per week (chaired by Clinical Executive Director) and once per week with Executive Team members (chaired by CEO).	A
5	Lack of capacity to manage increased activity across the Trust	Bed remodelling for managing increased activity Work with Place based partners in improving patient pathways	Executive Director of Finance / Executive Medical Director / Executive Chief Nurse / Chief Operating Officer	Quarterly review August 2024 – on track	Established relationships through interface meetings with Place based leadership. Clinical Lead with responsibility for GIRFT and Model Hospital working with Q and S team. Ongoing work with our East Lancs team, coders and the Mortality Steering Group (with deep dives into outliers).	B

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
		Implement GIRFT and Model Hospital best practice approaches to care Complete ongoing work on clinical harms review management Data submission to national teams on activity, mortality, coding, audit to ensure that accurate and validated assumptions on income, HSMR/SHMI and activity. Quality of information added to the system remains an issue. Training is taking place with clinical/admin colleagues Coding and quality and affects mortality indicators too.			Working with divisions on ensuring that that we capture activity levels. Working with national teams. Bed remodelling exercise about to complete. Improvement Case being developed to open permanent clinical accommodation to reduce corridor care. Further capital work planned to increase ED footprint Improvement case being developed to increase senior medical presence in UEC.	

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

Risk Descriptor: A risk to our ability to deliver the National access standards as set out in the 2024-25 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.

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

Strategy: Clinical Strategy & Operational Strategy

Links to Key Delivery Programmes: Elective and Emergency Pathway Improvement

Date of last review: Deputy Director Review: 09.08.2024
Executive Director Review: 27.08.2024

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register

Risk ID	Risk Descriptor	Risk Rating
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**20**
8126	Poor records management due to sub optimal implementation of new e-PR system	**20**
8941	Increased reporting times in histology due to increased activity outstripping resource	**16**
8061	Management of harm from the holding list	**16**
6190	Insufficient capacity to accommodate patients in clinic within timescales	**16**
9895	Patients not receiving timely emergency procedures in theatre	**15**
9851	Lack of standardisation of clinical documentation processes and recording in Cerner	**15**
9653	Increased demand with a lack of capacity within ELHT can lead to extreme pressures and delays to patient care	**15**

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

Current Risk Rating: **C4 x L5 = 20**
Initial Risk Rating: C4 x L5 = 20
Tolerable Risk Rating: C4 x L4 = 16
Target Risk Rating: C4 x L3 = 12

Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Moderate

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

Overall planning and delivery processes:

- Trust clinical strategy developed covering a 5-year period to support ongoing delivery and development of elective and emergency care services.
- Development of systems and processes to support reduction in risk to Health Equity supported by a plan to address health inequalities at place level.
- Development of system and processes to assess and reduce risk of clinical harm potential for patients on both the elective waiting lists and emergency care pathways ensuring safe, personal and effective care.
- Annual business planning and review of progress against delivery in place. This includes performance trajectories for all emergency and elective performance standards.
- A joint place delivery and improvement plan (via the Urgent and Emergency Care Delivery Board (UECDB)) for urgent and emergency care (UEC) in place. Further work around primary care access needs to be confirmed from place leads/ICB, work is being carried out around priority wards and integrated neighbourhood care. Updated the plan on a page for UECDB and this is based on three pillars; a) making it easier to access the right care b) increasing urgent and emergency care capacity c) improving discharge and expanding care outside of hospitals.
- Robust planning arrangements in place for planned strike, winter and bank holidays to ensure appropriate capacity planning in response to the demand forecast.

Operational Management processes:

- Active implementation and monitoring of elective improvement plans for 2024/25, diagnostic clearance plans and OP booking to ensure effective support for delivering the overall plan.
- Monthly Emergency Care Improvement Programme (ECIP) meetings have been refreshed and is now called the Emergency Care Improvement Group (ECIG) with a revised membership are being refocused to support UEC improvements.

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

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

- The Trust achieved agreed trajectories against all performance standards.
- A trajectory is in place to eliminate 65 weeks waits by September 2024 in line with planning guidance.
- Clear trajectories for other key targets for Referral to treatment times, 4-hour UEC target, Cancer, Diagnostics and activity levels in place and monitored via reporting to weekly operational team meeting, executive team meeting, senior leadership group.
- Site meetings 7 days a week ensuring timely escalation of delays (potential and actual) with corrective actions.
- Mobilisation of 24/7 IHSS service complementing the 24/7 ICAT service and Monday to Friday between 8am – 4pm for the ED front door team.
- Established a Trust Health and Equalities Committee chaired by the Chief Nurse feeding to the Quality Committee and People and Culture Committee

Specialist support, policy and procedure setting, oversight responsibility:

-
- Executive meet all with all divisions every morning (Monday – Friday) at 8.00am to support delivery manage risks and address any issues.
- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital.
- Cancer Alliance support on focussed areas requiring improvement.
- Lancashire and South Cumbria oversight and co-ordination via Elective Activity Co-ordination Team, Elective Care Recovery Group, Lancashire and South Cumbria Chief Operating Officers meetings.
- System level plan monitoring at Pennine Lancashire via UECDB and Integrated Care Board (ICB) level via relevant system forums
- Enhanced escalation policy which is activated when patients have been in the emergency department for an excessive amount of time (12 hours from arrival) in place 24/7supported by surge escalation capacity on the inpatient wards during times of pressure.

Independent challenge on levels of assurance, risk and control:

- Delivery of trajectories are monitored at ICB level through
- The monthly improvement and assurance meeting with the ICB

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

- Robust flow management system and processes in place with flow team and bed meetings for ongoing Situation Reports (SitRep) reporting and agreement of actions over 24/7 period and ongoing plans to strengthen discharge matron and patient flow facilitator role for supporting timely 7-day discharges
- Sustaining ambulance handover improvement and extending this to SDEC areas to spread ambulance handover performance. Monthly SDEC meetings now in place with involvement from NWAS colleagues.
- Data collection to identify target themes and services from the high intensity service users' group to inform the system demand management schemes for UEC. Specific focus around Mental Health pathways with Lancashire and South Cumbria Foundation Trust (LSCFT).
- Refreshed support to continue to strengthen internal ED processes to manage maximum time in department to 12-hours from arrival to discharge. This includes activation of enhanced escalation during surge and work in progress to finalise additional bed capacity on wards (Led by the Chief Nurse).
- Improve Multi-disciplinary Team (MDT) compliance against the agreed ward discharge process based on the best practice discharge bundle and board round effectiveness. A clinically led safe discharge MDT steering group in place.
- Clinical engagement with the required compliance to agreed standards and change plans ensuring ownership for discharge planning on admission.
- Sustaining community response services for both step-up (admission/attendance avoidance) and step down (timely discharge facilitation) care to maximise opportunities for admission avoidance and reduce demand for inpatient beds.
- Manage acute beds No Medical Criteria to Reside (NMC2R) to less than 10% of bed base with a stretch target of 5% of bed base in line with national requirements to maximise acute bed capacity for appropriate acute needs.
- Winter arrangements include the opening of a further escalation ward in December once the fire prevention works is completed and the Heart Centre is in place.

Oversight arrangements:

- Weekly operational meetings to monitor progress against KPIs, chaired by COO /Deputy COO.
- Monthly outpatient improvement group chaired by the Executive Director of Service Development and Improvement plan with Patient and Public Panel representatives.
- Theatre Utilisation Improvement Board in place and aligned with GIRFT requirements, targeting over 85% utilisation.
  Governance processes have been reviewed around theatre utilisation and introduced support and challenge sessions with the Chief Operating Officer and Deputy Medical Director for Performance for any specialties that do not achieve trajectory as intensive support.
  Embedding Elective Productivity and Improvement (EPIG) jointly chaired by Chief Operating Officer/Deputy Chief Operating Officer and Director of Service Development and Improvement to oversee the delivery of all elective care standards.

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Activity 109% of 2019-20 levels not achieved consistently.	The controls and weekly monitoring taking place to work towards the achievement of the 107% of 2019/20 activity.	Chief Operating Officer	March 2025	. Plans are in place to achieve in 2024/25. Q1 for 2024/25 Performance RESTORATION ELHT V's PLAN New Outpatient 107.1% EL/DC 108.2% Outpatients & EL/DC: 107.3%	A
2	Diagnostic clearance to 95% of patients receiving a diagnostic test within 6 weeks of referral by March 2025.	Implementation of Modality level delivery plans.	Chief Operating Officer	March 2025	ICS wide modelling completed, and discussion are ongoing around mutual aid to across the Lancashire and South Cumbria area ensuring patients have equity of access.	A

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

<table>
<tr><th>No.</th><th>Gap in controls and/or assurance</th><th>Action Required</th><th>Exec Lead</th><th>Due Date</th><th>Progress Update</th><th>BRAG</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>The Trust continues to performance better than the national average and a trajectory is in place to meet the 95% standard by March 2025 in the in-line with the planning guidance. Endoscopy remains the biggest pressure area, but recovery plans are in place and monitored by the Chief Operating officer.

April and May – Echocardiogram, performance has deteriorated due to staffing levels due to sickness – recruitment being undertaken to address workforce challenges and improve performance, July performance has seen improvements with performance at 101.50%</td><td></td></tr>
<tr><td>3</td><td>Meeting Cancer Standards
National Ambition for the standards
62 day – 70% by March 2025
31 day – 96%
28 day – 75% (77% by March 2025</td><td>Joint work with the Cancer Alliance on improvement

Continued Tumour site level detail to prevent backlog

Continued transparency of backlog delays at tumour site level for targeted preventative interventions

Refresh of the cancer action plan to focus on delivery of faster diagnostic standard, 31 and 62-day standards.</td><td>Chief Operating Officer</td><td>March 2025</td><td>Achieving trajectory for faster diagnosis standard, and trajectory for 31-day standard and working to get back on trajectory for 62-day standard

Cancer action plan refreshed and updated and monitored through the Cancer Steering Board

Current Performance against the National Ambition<table><tr><td>June Performance (Trust)</td><td>National Ambition by 2025</td></tr><tr><td>62-day standard 70.4%</td><td>70%</td></tr><tr><td>31-day standard 93.7%</td><td>96%</td></tr><tr><td>FDS standard 80.2%</td><td>77%</td></tr></table></td><td>A</td></tr>
<tr><td>4</td><td>Outpatient, Elective and Productivity</td><td>Outpatient Transformation Review to be undertaken.

Review and improve booking processes as part of the Trust QI process ensuring standardisation across all outpatient areas.

Elective Improvement Productivity Group to be established (EPIG)</td><td>Chief Operating Officer</td><td>March 2024</td><td>Review completed and high-level transformation plan has been shared and agreed at Finance and Performance committee.

Next steps will be implementing EPIG to monitor improvements in productivity.

This action is now complete and will move to the sources of assurance section.</td><td>B</td></tr>
<tr><td>5</td><td>Maintain capped theatre utilisation at a minimum of 85%</td><td>Performance oversight and support

Sustain improvements in achieving specialties and intensive support for other specialties</td><td>Chief Operating Officer</td><td>April 2024</td><td>As of week of 28th January the theatre utilisation report has now been built and we are able to obtain and monitor our performance for both capped and uncapped theatre utilisation.

The BI and operational teams continue to monitor for data quality issue and areas requiring improvement

The Division has actions they are undertaking to improve performance for both capped and uncapped theatre utilisation

Performance for Capped Theatre Utilisation was at 86.7% for week ending 11 August 2024.

The Trust is now submitting theatre utilisation data to Model Hospital and performance is back to pre Cerner levels. This is closely monitored by the Chief Operating officer and oversight will be provided by the EPIG.</td><td>G</td></tr>
<tr><td>6</td><td>Continued risk of >78 week RTT breaches and risk of not delivering < 65 week maximum wait by March 2024.</td><td>Demand and capacity at specialty review completed with improvement actions</td><td>Chief Operating Officer</td><td>September 2024</td><td>There are daily meetings with divisional reps on managing all patients at risk of breaching 78 and 65 weeks.</td><td>A</td></tr>
</table>

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
		Consultant and Junior Doctor strikes remain a risk to delivery. Mitigating plans in place focusing on clinical urgency, cancers and long waits as priority groups for any residual activity during this time. Rescheduling managed a working day before the strike to ensure managed displacement of slots.			The new planning guidance has altered the target for managing <65-week maximum wait from March 2024 to September 2024 The Trust has achieved the revised trajectories set for April - 207 against a trajectory of 307 May – 274 against a trajectory of 274 June was 291 against a trajectory of 251 (note impact of IA in June) July 212 against a trajectory of 220 therefore the trajectory was met. Daily monitoring continues as we work towards elimination of 65 weeks waits by September 2024.	
7	Improved ED processes for managing to a maximum of 12-hours total time from arrival to discharge, transfer or admission to ward	Support consistent compliance to agreed internal ED processes to ensure timely senior reviews, decision making and use of alternative pathways including a stronger focus on reducing delays for patients on non-admitted pathways. Support timely access to ward admissions from ED through the improvement in flow principles and the Trust escalation capacity for managing a time limited surge/overcrowding in ED Ensure patients are streamed to alternative pathways and services.	Executive Director of Integrated Care Partnerships and Resilience / Chief Operating Officer	End of March 2025	Extending the footprint within ED by relocating Ambulatory Care and delivering the Urgent Treatment Centre in the Ambulatory Care department and utilising space within the old CCU located beside ED Introduction of a new Acuity Triage d improve the time to triage and support streaming patients into alternative pathways and ambulance handover times is now in place and is having a positive impact. Further work is required on 12-hour total time in department, this is now classed as business as usual and will be removed from the actions section of the BAF. The focus for the 2024-25 year is to eliminate corridor care on the main corridor and AMUB corridor and reduce the number of patients spending 12 hours or more in the department. This is linked to the system wide UEC improvement plan.	B
8	Strengthen ward discharge bundle and clinical ownership for timely discharges	Embed the discharge bundle across all wards with clinical champions to promote best practice. Release the discharge matron colleagues from community bed management functions to enable a dedicated focus on pathway 0 discharges and ward support for preparing pathways 1, 2 and 3 patients for the community teams to case manage.	Executive Medical Director/ Executive Chief Nurse/Executive Director of Integrated Care Partnerships and Resilience	End of March 2024 New deadline set due to the ongoing implementation and learning from Cerner and refocusing on Everyday Matters to support safe and timely patient flow/discharge.	The Discharge care bundle is now commonly referred to as the discharge checklist following the implementation of Cerner millennium in June last year. The learning from a paper-based format moving to electronic was valuable and we now have a greater opportunity to monitor compliance towards the checklist being completed and ensuring the patient received a Safe, Personal and Effective discharge. We have noticed an improvement in compliance since the transition. A ward level discharge dashboard to support and embed improvements Following the implementation of the new EPR Cerner Millenium, a further test for change took place, with the creation of the live ward/organisational level discharge dashboard. A series of adjustments have been made to the electronic scrip, to include good practice around the SAFER principles in particular long length of stay reviews and NMC2R. This will be rolled out trust wide now the test and adapt phase had been successfully completed. A communication and engagement plan has now begun, kick starting at the April Nursing and Midwifery forum. The roll out will take approximately 8 weeks This is complete and will be removed from the actions section at the next review. .	B

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
9	Bed model for medicine suggests a gap of around 100 beds (including the 53 de-escalated beds). This is further exacerbated with the immediate need to create decant wards at BGTH and RBTH sites resulting in a 53-bed reduction from 17th April 23.	Monitor impact of 53 bed reduction. Increased efforts around pathway 0 discharges with the discharge matron team. Continued admission avoidance via ED and SDEC pathways as well as IHSS team. Home including rehab as a default for pathways 2. Increased use of pathway 1. Use of escalation beds and trolleys when required in extreme pressures	Executive Director of Integrated Care Partnerships and Resilience/ Chief Operating Officer	November 2024	Improvement case to support the right sizing of the acute medical bed base has been completed and is scheduled to be taken to the Finance and Performance Committee on 2 September 2024 and the Trust Board on 11 September 2024. This case also addresses the Trust's winter plan for 2024-25	A
10	Ambulance handover times	As part of an LSC collaboration the Trust is working with NWAS colleagues to improve ambulance handover times, admission avoidance and direct streaming to alternative pathways and service	Chief Operating Officer	End of March 2025	As part of the 2024-25 planning, the Trust is committed to improving ambulance handovers within 30 minutes. Working collaboratively with NWAS colleagues on handover times and processes including the improvement of the HAS compliance data There has been an improvement of patients' handovers within 30 minutes and HAS compliance in From April to July with July showing a reduction in > 60 mins handovers Our Service Development and Improvement are working alongside the ED & community team and NWAS representatives on improvement schemes to avoid conveyance, direct to Same Day Emergency Care services and direct into appropriate community services Ongoing evidence to confirm positive results in diverting activity to alternative provision.	G
11	Temporary lack of data, including theatre utilisation data as a result of the implementation of Cerner (this was an expected outcome of the implementation of the system).	As a first step there is a need to rebuild all operational reports to the previous standard, with the second stage of the work to improve upon the quality of reports.	Chief Operating Officer/Chief Nurse	End of Jan 2025	The BI team continue to work internally and with Cerner on on-going data quality issues and monitoring through data quality reports. Issues are managed as identified. There is considerable work ongoing and mitigation in place around the UEC pathways, particularly regarding redefining datasets. An Executive Director led assurance meeting has been established and is chaired by the Chief Nurse to consider improvements within ED. In January a triple A system is being established which will also consider datasets and will be led by the Chief Nurse, Executive Medical Director and Chief Operating Officer. The Trust BI team are now able to pull reports there are still data issues and operational managers with BI senior analysts are working together to establish resource requirements to ensure data within Cerner is accurate and duplications are corrected. This action has been addressed and will move to sources of assurance from the next review.	B

BAF Risk 4 – Culture Workforce Planning & Redesign

Risk Description: The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of its inability to attract and retain staff through our compassionate wellbeing, equality, diversity and inclusion and improvement focused culture.

Executive Director Lead: Executive Director of People and Culture

Strategy: People Plan

Links to Key Delivery Programmes: People Plan Priorities

Date of last review: Director of People and Culture: 27.08.2024

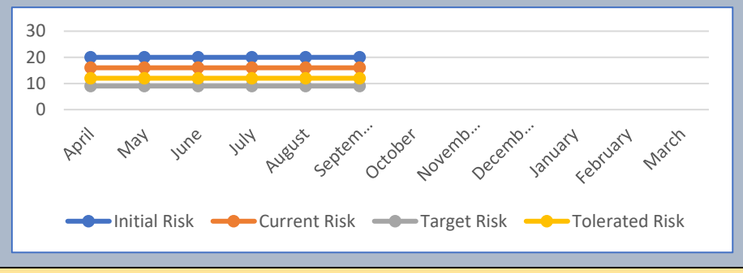
Lead Committee: People and Culture Committee

Links to Corporate Risk Register:

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

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

Current Risk Rating: **C4 x L4 = 16**
Initial Risk Rating: C4 x L5 = 20
Tolerated Risk Rating: C4 x L3 = 12
Target Risk Rating: C3 x L3 = 9



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

- Freedom to Speak Up (FTSU) Guardian and Ambassadors – in line with the national FTSU agenda. They report to the Staff Safety Group, People & Culture Committee and Trust Board.
- Agreed Integrated Care System (ICS), place-based workforce plans and Trust People Plan– The ICS plan stratifies actions to be delivered at organisation, place, and system level. The plan is monitored through the ICB People Board. Operational issues from these forums are picked up through the Executive team and reporting on progress is provided through the quarterly workforce report to the People and Culture Committee.
- The Trust People plan is operationally delivered through the Senior Leadership Group (SLG) and Divisional Management Boards (DMBs) and delivery is accountable through People and Culture Committee (PCC) as part of the Trust workforce report. This also forms part of the workforce section of the Integrated Performance Report (IPR).
- There is an agreed ICB Workforce Strategy that will be managed and delivered through the ICB People Board.
- Health and Wellbeing – a comprehensive health and wellbeing strategy and offering in place and leading the ICS Enhanced Health and Wellbeing and occupational health workstream. This is monitored through the One LSC governance structures. Regular updates are provided to the Board on wellbeing and a NED wellbeing guardian is in post.
- Department of Education, Research, and Innovation (DERI) Strategy clearly articulates the ambition of the Trust to support workforce, research and innovation to make the Trust a more attractive place to work. DERI reporting to the PCC.
- Recruitment – multi-disciplinary recruitment steering group in place, meeting monthly, to review vacancies and recruitment activity. Currently reviewing international nursing plan, with a view to reducing/ceasing as we are nearing zero registered nursing vacancies and have robust pipelines through domestic recruitment and newly qualified. Close work between Divisions, HR and DERI around education opportunities (nursing associates, apprenticeships), as well as centralised, value-based recruitment and development of new Healthcare Assistants. Medical recruitment group also in place and opportunities around medical apprenticeships ongoing – likely to commence September 2025.

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

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

- International Recruitment Plan, along with more traditional recruitment pipelines will achieve the Trust goal of zero Registered Nurse vacancies by the end of Q2, 2024/25. Plans in place beyond this to maintain appropriate numbers/skills of registered professionals through universities, apprenticeships, and domestic recruitment.
- The Trust's Staff Safety Group oversees the day-to-day operational risks and interventions to ensure staff safety matters are addressed.
- Eight Staff Networks, each are supported by an Executive Lead and Non-Executive Champion and reporting through the Inclusion Group:
  - BAME,
  - Women's,
  - Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+),
  - Disability and Wellness,
  - Mental Health
  - Muslim
  - Overseas and International Staff Support
  - Armed Forces Veterans & Families
- The Chief Executive is the Executive Sponsor for the BAME Network and Anti-Racism Framework.
- Anti-Racist Framework and Allyship Framework launched as part of the Festival of Inclusion in 2023 and a working group established to embed during 2024.
- Freedom to Speak-Up (FTSU) – the Trust has FTSU Ambassadors embedded across the organisation to support the FTSU Guardian in enabling staff to raise concerns. The Trust continues to recruit new Ambassadors to increase access and fill gaps caused by turnover, including discussions with our local BMA representative about increasing the number of FTSU Ambassadors within the medical workforce.
- MIAA (internal) audit of the FTSU service in December 2022 gave substantial assurance.
- FTSU included within the Trust's mandatory training programme.

BAF Risk 4 – Culture Workforce Planning & Redesign

• Anti-racism - Project team (Aarushi) established as part of the CQA with support from the improvement team taking forward four themes. BAME network engagement underway on antiracist statement, framework and draft strategy led by Aarushi leads, Campaign support being provided by communications team. Health equity training piloted with ops teams to be rolled out by HE Lead and Inclusion Team with support/ eLearning to be developed by Marmot foundation. Developing an EDI dashboard which will support Trust and Divisional EDI goals. Regular updates to be provided in the overall EDI update paper that will come to the PCC and to Board. Establishment of work programmes is underway including inclusive recruitment, talent management, anti-racism campaign	• Continued expansion of the Team Engagement and Development (TED) Tool across the organisation enabling teams to manage team culture. • The Trust's Behaviour Framework continues to be embedded across the organisation and is now integrated into the recruitment and appraisal processes. • Flexible working manifesto in place to assist staff and managers in exploring opportunities to work flexibly. • The Trust's Leadership Forum has been established since September 2022 and seeks to engage stakeholders across the Trust and system. • The Trusts new SPE+ leadership programme has been launched with the first cohort nearing conclusion. Roll out of the additional leadership modules has been launched, including a focus on wellbeing for leaders and managers. The Core Management Pathway will launch in Q1 2024/25. • Reviewing Divisional workforce metrics and support through Divisional Performance Meetings. • Further alignment of leadership and Organisational Development (OD) activities to the Safe, Personal, Effective Plus (SPE+) Improvement Practice as part of Trust Improvement Continuum has been scoped and built into Improvement Practice Development Plan. • Recruitment and Retention Group have oversight of the vacancies and risks associated with non-medical staffing – overseen by Senior Leadership of the Trust. Significant progress on data quality, looking at vacancy rates, alongside colleague absence and bank/agency usage. • Job planning panels – have established a job planning scrutiny panel who review medical job plans to ensure that they are all compliant with regulatory guidance. • Medical Recruitment and Retention Steering Group • Project M: support for managers launched in January 2024, through the sharing of practical tools and peer support models • Extension of inclusion elements of workforce dashboard being developed, which can be used in divisional performance review meetings and for presentation at People and Culture Committee. • The Trust is part of Cohort 2 of the People Promise Exemplar Project with NHS England, linking with the regional NHSE Team and Systems Retention Lead and taking forward a 30, 60, 90-day programme of improvement linked to the People Promise to improve retention and morale. The People Promise Manager is now in post. • A review of mental health support for colleagues across the Trust has been commissioned through LSCFT. • Leadership programme in place, including specific work to support members of the workforce who have been internationally recruited. • Close working with DERI around career pathways which is linked to values-based recruitment. <u>Specialist support, policy and procedure setting, oversight responsibility:</u> • Executive Director of People and Culture is involved in a national staff experience forum. • Integrated Care System (ICS) Equality, Diversity, and Inclusion (EDI) collaborative is in place to support the development and sharing of best practice. • Two cohorts of our bespoke, local Mary Seacole Programme (commencing November 2023 and March 2024) are underway, with a total of 28 internationally educated nurses being supported to develop their knowledge and skills in leadership and management. • ICS Culture and Belonging Strategic Group established • ICS OD Collaborative established • Trust Chair and NED EDI lead are members of the regional BAME Assembly. • The Trust is participating in developing the ICS Belonging Strategy. • Recruitment, retention, and staff in post data is monitored through IPR and Quarterly Workforce Report to People and Culture Committee. • Human Resources (HR) Directors Group across the ICS inform and monitor delivery of the system level workforce agenda but also direct Trust activity where collaboration has been agreed or where opportunities have been identified. • Executive Director of People and Culture is the health member on the Lancashire LEP Skills Advisory Panel. • Aarushi Project at ELHT becoming intentionally anti-racist is part of the Clinical Quality Academy programmes of improvement and has agreed scope with executive sponsorship from CEO and a Board development session in June 2024. Communication campaign to be launched after the May local elections and Project Team presenting at a range of Trust forums to raise awareness. <u>Independent challenge on levels of assurance, risk, and control:</u> • WRES and Workforce Disability Equality Standard (WDES) standards are monitored nationally and reported to the People and Culture Committee then to the Trust Board on an annual basis. • Workforce Race Equality Standard (WRES) and Workforce Diversity Equality Standard (WDES) action plans with timelines in place. Regular reporting to the People and Culture Committee and the Trust Board on progress. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust staff networks.

BAF Risk 4 – Culture Workforce Planning & Redesign

	• National Staff Survey reports and benchmarks the Trust's performance against other organisations at a national and regional level. • to the Trust works within the national FTSU framework and is accountable to the National Guardian for delivery. • Reporting to the People and Culture Committee, Trust Board and the ICB People Board on a regular basis to provide assurance and address areas of challenge. • Workforce Plan submission – there is an annual workforce plan submission to the national regulator which is triangulated internally with finance and activity data and aligned to our clinical strategy. This is monitored through the Integrated Care Board (ICB). 2024/25 plan submitted 25 April 2024. • Monitored by NHS England and the ICB on our bank and agency spend, with a requirement to report any breaches of NHSE cap – ELHT has remained within the NHSE cap since October 2023 and zero off-framework since August 2023. • Significant reductions in agency usage of registered nurses have seen over 100 agency nurses join our internal staff bank in the last 6 months. • Workforce elements of Annual Internal Audit Plan agreed. • There is a Bank and Agency Oversight Group in place across the PCB to ensure delivery against the Value Stream Analysis (VSA) outputs. • Internal and ICB vacancy control panels provide oversight on recruitment. • Monthly IAG meetings with the ICB which scrutinise the workforce KLOE.

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Reducing the Trust vacancy gap	To achieve zero registered nurse vacancies and improve turnover through recruitment and workforce transformation activity.	Executive Director of People and Culture	End of September 2024	A recruitment and retention group continues to work towards a trajectory to deliver zero vacancies by September 2024. This group is also developing initiatives to assist in retention of staff through greater flexible careers, flexible working, benefits etc. The Trust is working with colleagues across the ICS to deliver a workforce capacity programme aimed at reducing vacancies and securing future workforce pipelines. Specific work is underway to address shortages in specific roles, leading to fragile services such as diagnostics. International recruitment has been a success, delivering on plans and a decision has been taken to reduce the next intake and review future plans, so as not to impact on opportunities for newly qualified nurses, where we have a very strong pipeline.	G
2	Improve Trust retention levels / Develop Retention Strategy	Implementation of targeted plan to deliver the national People Promise of Flexible Working and development of a Trust Retention Strategy.	Executive Director of People and Culture	September 2024	Work on developing the Trust's strategic approach to is ongoing through participation with the People Promise Exemplar programme. Regular updates are taken to the Executive Team (July/August 2024), Staff Sponsor Group and then be presented to People and Culture Committee (September 2024). Following the submission of the PID, the People Promise Manager (PPM) reports through to the national and regional teams and was identified as being an exemplar who has gone further faster than other Trusts, leading to an invitation to present to the national and regional teams. The PPM has developed a suite of 'you said we listened' posters to share back with teams. This includes highlighting improvements to appraisal, new line manager induction and share point site, handbook for line managers and greater support for clinical teams with team based rostering and opportunities for flexible working.	G
3	Risk of staff leaving the NHS due to burnout.	On-going delivery of the ELHT People strategy underpinned by a compassionate and inclusive culture	Executive Director of	A milestone report wo be provided to the	The People & Culture Directorate continue to explore how staff can be further supported during this ongoing period of unprecedented demand.	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
			People and Culture	People and Culture Committee in September/ November 2024	Given the on-going need identified regarding supporting staff with their mental health an external review has been commissioned to review the existing staff mental health pathways and interventions. This work is due for completion by 12 July 2024 Project M – a peer support group for line manager wellbeing was launched in January 2024 by the CEO with 300+ managers engaged with the sessions. The LSC occupational health and wellbeing collaborative programme has been identified as one of the functions to move across to OneLSCc. PCB OH and Wellbeing services are currently scoping a future service specification in readiness for the future model. People Promise Exemplar programme – project initiation includes a pilot project linked to burnout, full project plans to be completed by August 2024. Areas currently being highlighted, and budget being allocated subject to approvals in light of financial challenges. Line manager development in pipeline with people promise induction for new managers commenced on 25 July 2024, with monthly sessions thereafter. Positive feedback and additional questionnaire carried out to inform wider offer. Wellbeing for leaders programme is now available in the Trust (NHS England) and will be revised for cohort 2.	
4	Risk of loss of service due to national industrial action.	Ongoing management of action through Industrial Action Cell.	Executive Director of Integrated Care, Partnerships and Resilience	Ongoing with next update to the Board in September 2024.	The potential impact of any industrial action is monitored through the Industrial Action cell which now meets as/when action is called. A live strike mandate remains in place for Junior Doctors (BMA, HCSA, Unite), but BMA are recommending acceptance of latest offer. Details of 2024/25 now known and will be enacted in October 2024, with backpay to April 2024. Unions are putting the offer to their members, with ballot outcomes in September. Expected to be accepted. Industrial action is a standing item at the People and Culture Committee.	G
5	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients due to the specific impact of racism.	Trust becoming anti-racist. Progress being made through using improvement science, adoption of NW BAME Assembly framework. Programme of transformational culture change to be developed through allyship as a journey of development.	Executive Director of People and Culture	End of March 2025	**Anti-Racism** Project team established with support from the improvement team taking forward four themes and targeting work to within Family Care Division in first instance. CEO as Executive Sponsor. Diagnostic work underway to support the design of a board development session in July with follow up in October Listening events held in response to the violence including racist and anti-Islamic abuse experienced by colleagues. Slippage on the communications strategy and campaign has led to a revised launch date of September. Train the trainer is planned to support the allyship and anti-racism training in September. Full training plan to be developed by October 2024. Too Hot to Handle report – review ongoing by HR, EDI, FTSU and Staff Side in respect of cases at ELHT to ensure we reflect on practices and ensure we learn from these findings, through our existing monthly case review meetings and Professional Standards Group Trust developed divisional EDI dashboards which will support EDI goals by end of August 2024	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Aarushi Project team presenting at different forums within the Trust to raise awareness before the full campaign is launched in July 2024. Regular updates to be provided in the overall EDI update paper that will come to the PCC (July) and to Board. Achievement of Bronze Award. Silver action plan developed. Anti-Racism Summit planning taking place.	
6.	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients due to protected characteristics.	Development of a culture of inclusion and belonging. Ensuring that inclusion is embedded as everyone's business. Person-centred approaches to people practices, through informed and engaged line managers. Processes for reasonable adjustments are improved and embedded. Vibrant staff networks.	Executive Director of People and Culture	End of March 2025	**General** Review of terms of reference for the Inclusion Group ongoing, with a draft produced in June 2024, alongside a 12-month draft workplan, both of which will be tabled in July 2024. The Inclusion Group is now chaired by the Trust Chairman and future agendas are to be co-produced. Group to be developed further with divisional nominations and greater emphasis on data and performance. Agendas to be codesigned with input from the group. **Inclusive recruitment** - A working group has been formed, initial meetings in June 2024, to review attraction, recruitment, selection and progression, through an inclusion lens. The outcome will be a manager toolkit and updated manager training, focussing on quality and inclusion, with changes made to policy based on improvement work. Initial pilot of toolkit to take place in July 2024, finalised toolkit and training by end of November 2024. **DAWN** Following valuable feedback through the People & Culture Committee staff story and a recent presentation to Executives, a working group has been formed to improve how we support colleagues with a disability, including making reasonable adjustments in a timely manner. An initial meeting was held on 25 June 2024to commence a QI.A business case has been developed to support a centralised process, enhance staff experience, support for managers and navigation and recharge from Access to Work. **Mental Health** Review into the provision of MH support for colleagues is underway following the MH staff survey carried out by the network. **Neurodiversity** TAFG in place for 12 months and has recently become a network. Aim is for group to lead the development of a positive culture regarding neurodiversity including a toolkit, training, and support. A hidden disabilities project has launched with greater awareness in key teams like people and culture, awareness for line managers. **LGBTQ+** The Network is aware of the impact of national messages related to gender identity having a negative impact on wellbeing of the community. It will join with system partners to advance LGBTQ+ inclusion and help to develop the allyship framework for the Trust whilst the future of the Rainbow Badge accreditation becomes clearer. **Women's Network** Is supporting the advancement of the Sexual Safety charter in the Trust which is being led by the Head of Safeguarding with support from HR and other teams.	A

BAF Risk 5 – Financial Sustainability

Objective: The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Providing VFM needs to be explicit in the descriptor

Executive Director Lead: Executive Director of Finance

Strategy: Finance Strategy

Links to Key Delivery Programmes: Waste Reduction Programme

Date of last review: Operational Director of Finance, 01.08.2024
Executive Director of Finance, 28.08.2024

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR):

Risk ID	Risk Descriptor	Risk Score
10082	Failure to meet internal and external financial targets for the 2024-25 financial year	25

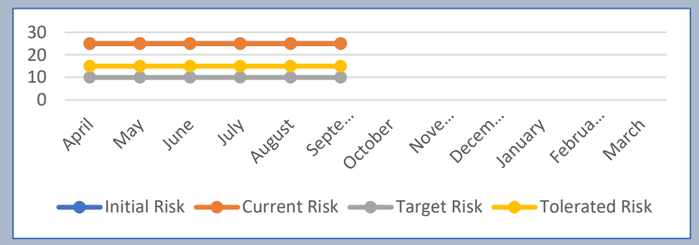
Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: **C5 x L5 = 25**

Initial Risk Rating: C5 x L4 = 25

Tolerated Risk Rating: C5 x L3 = 15

Target Risk Rating: C5 x L2 = 10



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/Moderate

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

Organisation

- Moved to IMT cell Better Care Better Value – senior leaders 3 times per week with targeted finance actions, using improvement methods
- Financial Recovery plan in place including additional Trust level controls, weekly one-hour financial recovery meetings with each Division (Divisional Management Teams alternate weeks), Weekly workforce control meetings, weekly Non pay Control Group and a Fortnightly Pay Control Group
- The Pay Control group is reviewing the oversight and process behind all payments to staff and contractors. The Medium-term financial strategy was presented to the Finance and Performance Committee in October 2023 and Trust Board in November 2023, an updated version has been shared with the Executive team and has been presented to Finance and performance Committee in August and will be shared with the Trust Board in September 2024.
- Draft Financial plan for 2024-25 has been developed via the annual planning process, and signed off at the Trust Board in June 2024
- An early forecast outturn for 2024-25 submitted to ICB and national team (2nd August 2024)
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations. The last review was completed in July 2024
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Waste Reduction Programme (WRP) are reported and scrutinised through the monthly Finance Assurance Board with Executive and cross-Divisional team representation, Capital Planning Board chaired by the Director of Finance, and Finance and Performance Committee, sub-committee of the Board.
- A new Waste Reduction Programme governance structure is in place that is now integrated across the Trust. Supported by dedicated resource by way of the Benefits Realisation Team and the Improvement Team in addition to divisional transformation leads.

System

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

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

- 2023-24 financial targets achieved.
- Trust breakeven duty not breached in 2023-24,
- A good external audit report for 2023-24
- Financial plan and delivery of ongoing performance scrutinised via Finance and Performance Committee with key risks identified
- Corporate Risk Register updated for latest financial risks facing the organisation with action plans in place to mitigate risks which are regularly reviewed and updated
- Divisional, Trust wide and system Waste reduction programmes continuing to be developed, savings not fully identified, QIRAs are completed for all schemes and signed off by the Chief Nurse and Medical Director
- Additional financial controls are in place to reduce spend.
- In-depth review of the additional financial pressures identified in year have been determined. Mitigations etc will be reported through Finance and Performance Committee.
- Financial controls document has been developed and circulated through the Trust. Trust and ICB additional controls currently applied
- ICB level financial governance through System Finance Group and ICB proposals being reviewed by provider governance.

Specialist support, policy and procedure setting, oversight responsibility:

- Benefits realisation team is now integrated within the Trust and is leading the delivery of key projects associated with waste reduction programme and the reporting and progress with all waste reduction schemes at a Key Delivery Programme level and at a divisional level
- Corporate collaboration – full participation in all areas and opportunities identified.

BAF Risk 5 – Financial Sustainability

• System finances monitored through System Finance Group (includes representation of all providers and Integrated Care Board (ICB)) to facilitate understanding and actions associated with the overall system financial position. • One LSC Central services collaborative programme underway with ELHT confirmed as hosts, a planned transfer date of October 2024. The senior Management Team are appointed. • System financial controls implemented from August 2023 and remains in place (All recruitment and non-pay controls/thresholds.	<u>Independent challenge on levels of assurance, risk and control:</u> • Internal and external audit – agreed internal audit plan for 2024-25, clean Head of Internal audit opinion received, clean external audit of annual accounts for 2023-24. Counter fraud workplan for 2024-25 agreed. • One NHS Finance Towards Excellence Accreditation shows that the finance team's processes and procedures are working. It proves that we have developed a culture where staff feel appreciated, and successes are celebrated. ELHT Finance Team are accredited at the highest level (Level 3). High level of qualified staff in department (53%) with a further 35% in training. The 3-year reaccreditation is due in the Autumn of 2024.

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	No signed contract nor agreed financial plan for 2023-24	Continue to develop plans for system, region and national sign off, and documenting all risks of reducing expenditure in line with expectations.	Executive Director of Finance	Financial plan will not be formally agreed. Contract – end March 2024	System plan agreed internally but with significant financial risk. Plans received but not accepted/approved. Financial plan signed off by Trust Board July 2023, with full documentation of risks associated with achievement of said plan. Contract work continuing for the year – not currently signed due to continued work on income plans Work has begun on the LSC system financial plan for the next 3 financial years. There are a number of outstanding queries between the Trust and ICB, the Trusts' contracting team are working to address these No further changes will be applied in the current financial year, the focus is to ensure any queries are resolved for 2024-25 Following the implementation of the ePR the activity data issues are being worked through. The Trust has been informed it is not likely to be monitored against the ERF target in year due to the data issues and will be reviewed in May 2024, giving the Trust more time to work through the issues The 2023-24 Contract was signed with a side letter in May 2024 This action has been completed and will be moved to sources of assurance at the next review	B
2	Fully identified Waste Reduction Programme (WRP) 2023-24/Financial recovery plan. Risk to elective recovery, quality and safety of stretch target financial plans	Continue work with Divisions and central to develop plan for 2023-24. Ensure all schemes have Quality Impact Risk Assessments (QIRA) assessment, and document risks of non-delivery, cost reduction. Ensure Board oversight of all risks. Ensure safety not compromised.	Executive Director of Finance / Executive Directors	End March 2024	£40m is identified and is being worked up. (74% of the cumulative of the WRP and system gap at £54m) Finance Assurance Board is now chaired by the Chief Executive with full Executive Team presence. Divisional Improvement boards are in place. Revised timeline due to the challenging financial situation. This action has been completed and will be moved to sources of assurance at the next review	B
3	Lack of full knowledge of system financial flows recognised in the NHSE review	Work with system CFOs to determine full flows and impact on ELHT	Executive Director of Finance	Q4 2023-24 An update will be provided in September 2024	Remains outstanding – Block contract review underway, part of financial strategy and recovery Work to continue through Provider Finance Groups.	B

BAF Risk 5 – Financial Sustainability

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Work is ongoing to achieve full transparency There is no further update at this time, a further update will be provided at the March Board meeting. A full contract review will take place as part of the 2024-25 review process. With the appointment of a PCB Managing Director in July 2024, we should see an improvement in the governance and oversight	
4	ICB/PCB workplan identification and capacity	Work with system to ensure plan developed and capacity gaps rectified and mitigated	Executive Director of Finance/ Operational Director of Finance	Updates due in September 24	2 system meetings to identify specifics. Joint meeting CFOs/Operational colleagues to take place. Work on the system roadmap to be continued with new PCB finance lead. System transformation programme in place. Benefits realisation currently being defined System Investigation and Intervention process in place. First draft reports out, which identify areas of support required across providers and ICB.	R
5	No agreed System Financial plan for 2024-25 – it is still a draft plan awaiting NHSE confirmation that the £175m deficit financial plan has been accepted	Continue to develop plans for system, region and national sign off, and documenting all risks of reducing expenditure in line with expectations.	Executive Director of Finance	In Progress updates will be provided in September 2024	The System plan has been agreed across the LSC System but not formally accepted by NHSE. The financial plan was signed off by the Trust Board in June 2024 with full documentation on the risks attached to the delivery of such a high-risk plan	A
6	No signed Contract for 2024-25	To work with the ICB to agree the contract disputes	Executive Director of Finance	In Progress updates will be provided in September 2024	A response has been sent to the ICB to document the contractual disputes, to follow it up with a meeting	A

One LSC BAF Risk- ELHT as Host

Risk Descriptor

As Host: Staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services.

As Partner: One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations

Executive Leads: Executive Director of Finance
Executive Director of Service Development and Improvement
Director of Corporate Governance

Strategy: Indirectly links to all and overall Trust strategy.

Links to Key Delivery Programmes: Provider Collaborative

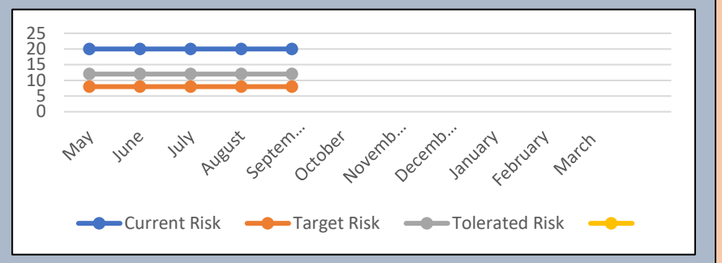
Date of last review: Executive Directors: August/September 2024

Lead Committee:
Finance and Performance Committee
People and Culture Committee

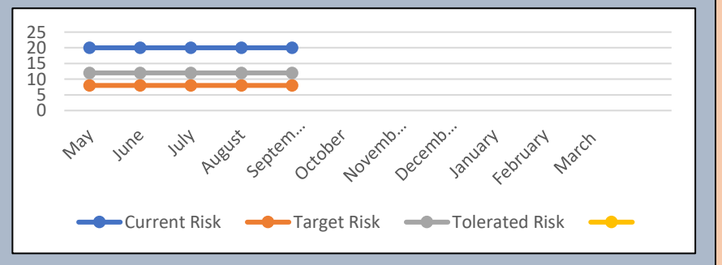
Links to Corporate Risk Register (CRR):

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

As Host
Current Risk Rating: C4 x L5 = 20
Initial Risk Rating: C4 x L5 = 20
Tolerated Risk C4 x L4 = 12
Target Risk Rating: C4 x L2 = 8



As Partner
Current Risk Rating: C4 x L5 = 20
Initial Risk Rating: C4 x L5 = 20
Tolerated Risk C4 x L3 = 12
Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

As Host

	Effective
x	Partially Effective
	Insufficient

As Partner

	Effective
x	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

The LSC Provider partners and ICB have been working together to identify ways of collaborating (refer to BAF risk 1 for details of collaborative working) on the delivery of central services across the area. This had resulted in delegated powers bestowed by the individual Trust Boards to the PCBJC to deliver on the agreed objectives.

The process included identifying a host Trust (ELHT) with a comprehensive programme for the planned transfer in October 2024.

One LSC Managing Director and senior leadership team in place to work together with the Programme Director and report regularly on progress thorough system and provider governance channels.

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

1. Progress being reported into the Recovery and Transformation Board

Provider Collaborative Board (PCB):

1. Provider Collaborative Board Joint Committee (PCBJC) meeting monthly and regular reporting on progress and decisions sought on delegated items as required.
2. Central Services Executive Sub-Committee (CSESC) as a sub-committee of the PCBJC with a remit for the delivery of the collaborative element for central services under the delegated authority for operational matters. Membership made up of 5 provider CEOs or their deputies who are voting Executive Board members of the provider Trusts.
3. Strategic Collaborative Agreement sets out the high level legal, commercial and governance principles of collaboration amongst the partners. Plans in place for approval by the partners Board and ratification by PCBJC in

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

Service delivery and day to day management of risk and control:
Internal group with a defined terms of reference links into the operational governance via ERAG and Executive Team
Formation of the hosting Board will add an additional layer of governance to ensure seamless service delivery and management and mitigation of risks at host and partnership level

Specialist support, policy and procedure setting, oversight responsibility:
Existing PCBJC and CSESC terms of reference form the foundation of policy and procedure for central services collaboration including system oversight
The emerging governance and performance infrastructure for One LSC (to be in place by September 2024) will add an additional layer to the collaboration infrastructure together with the Strategic Collaboration Agreement, business transfer agreement and supply agreement which need to be agreed by the partner Boards before the transfer date can commence.

Independent challenge on levels of assurance, risk and control:
MIAA as internal auditors will audit the governance and management processes of One LSC
ICB as the regulatory body will also provide a scrutiny of the collaborative arrangements for central services.

advance of the transfer date on 1 October 2024. The governance infrastructure sitting below the SCA is being organically developed with the input of the professional groups.

ELHT

ELHT (as partner and host) has put in place and continues to develop the governance infrastructure to ensure that it delivers on its partner and host obligations. The monitoring of the One LSC and other services hosted by ELHT will be through the hosted services Board, the plans for which are to be in place before the transfer date. Regular monitoring of host and partnership activities and assurance about governance and risk management will occur through the ELHT Board and sub-committee structure and operational groups, such as the Executive Team, ERAG and One LSC Planning Group.

1. Trust Board
2. Audit Committee
3. Finance and Performance Committee
4. People and Culture Committee
5. Quality Committee
6. Executive Team
7. Executive Risk Assurance Group
8. Finance Assurance Board
9. One LSC Planning Group
10. Hosting Board (to be formed)

The SCA will set out key hosting obligations and risk share through the partnership arrangements. The due diligence process associated with the completion of key schedules of the SCA (e.g. Business Transfer Agreement) will ensure that the Trust as host is able to fully risk assess its ability to meet Host obligations and standards and work with partners to mitigate these risks accordingly.

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Strategic collaboration agreement, business transfer agreement and supply agreement has not yet been signed off.	Sign off by all partner Boards before the transfer date in October 2024	Executive Director of Finance Director of Corporate Governance (partners for own Trusts)	End September 2024	Various work through the professional groups with external lawyers continue July Board round will receive the latest draft for socialisation for review with sign off planned for August/September for all partners. Further work completed to review the SCA from a host perspective to ensure all risks identified with plan for mitigation agreed which will be monitored through Trust processes.	A
2.	Agreement not yet reached with NHSE on the sign off process to establish One LSC from a partner or host perspective.	Continued liaison with NHSE to build on the positive work in relation to the sign off procedure with the regulator.	Executive Director of Service Development and Improvement Managing Director of One LSC	End September 2024	Positive developments following liaison with NHSE on the process for regulatory sign off. Regular review process in place to support monitoring of sign off requirements and completion of self-certification processes in advance of transfer date which will be co-ordinated via CSEC.	A
3.	The governance infrastructure sitting below the SCA needs to be organically developed with the input of the professional groups. No formal governance structure in place for a number of workstreams at this time and the overall One LSC governance and performance framework which will seamlessly dovetail into the governance processes of the partners organisations	Working through the professional groups and one LSC leadership on a multi-disciplinary approach in finalising the governance infrastructure sitting underneath the SCA. Move from the informal working groups into a more formalised model.	Director of Corporate Governance Managing Director of One LSC Executive Directors for professional groups	End September 2024	A number of regular professional group meetings in place with workgroups undertaken in August for a multi-disciplinary approach to establish the building components of the governance and operational infrastructure before the transfer date. ELHT One LSC Planning Group meeting regularly to oversee due diligence processes from a Host perspective.	A
4.	Establishing the monitoring of the One LSC and other services hosted by ELHT through the Hosted Services Board.	Developing the terms of reference and agreeing them at ELHT level, linking into existing Trust governance processes and socialising with system partners.	Executive Director of Finance Executive Director of Service Development and Improvement Director of Corporate Governance	End September 2024	Work commenced on the Terms of Reference (TORs) and will be taken through the One LSC Planning Group in August with the Hoste3d Services Board to be established September 2024.	A

One LSC BAF Risk- ELHT as Host

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
5.	TUPE transfer and consultation processes and resources are to be determined.	This is dependent on numerous factors, including the resolution of the union grievance.	Executive Director of People and Culture	End September 2024	Progress being made in this area with the professional group leading on advising on the governance for TUPE and constructive engagement with staff. Positive progress with union colleagues with regard to resolving the grievance.	A
6.	Due diligence not yet assessed and will potentially impact the cash position of ELHT as the host.	Commencement of the due diligence with each of the services leads, including asset transfers	Executive Director of Finance Executive Director of People and Culture	Commenced and ongoing to transfer date in October 2024	Plans in place for the due diligence process to commence and be monitored through the One LSC Planning Group and Finance Assurance Board, ERAG and Executive Team. Board level monitoring through Audit Committee and Finance and Performance Committee.	A
7.	Corporate capacity to support the set-up of One LSC is still to be fully scoped and transferred in advance.	Close liaison with Managing Director for One LSC and Directors for confirmation and linking into the One LAS performance and governance framework which is being established.	Executive Directors of all corporate functions	End August 2024/early September 2024	Mapping of processes continues to be undertaken and progress to be monitored through the ELHT One LSC Planning Group.	A
8.	Further work to ensure that the communication plan and co-ordination of it delivers its desired objectives and results in positive and constructive engagement with all stakeholders.	Collaborative working with the One LSC MD, SRO for LSCPCB to ensure that the communication plan is enhanced.	Executive Director of Communications and Engagement Executive Director of People and Culture	End July 2024	Discussions at Executive level and system level on the best approach to communication and staff engagement. Monitoring to take place through the One LSC Planning Group.	A

TRUST BOARD REPORT | **Item** | **126**

11 September 2024 | **Purpose** | Information / Assurance

Title	Patient Safety Incident Response Assurance Report
Report Authors	Mr L Wilkinson, Incident and Policy Manager Mrs J Hardacre, Assistant Director of Patient Safety and Effectiveness
Executive sponsor	Mr J Husain, Executive Medical Director

Summary: The Trust Board is asked to receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP) and the outcome of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel decision-making process on high level investigation reports.

Report linkages

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

Related to key risks identified on Corporate Risk Register	-
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	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: N/A

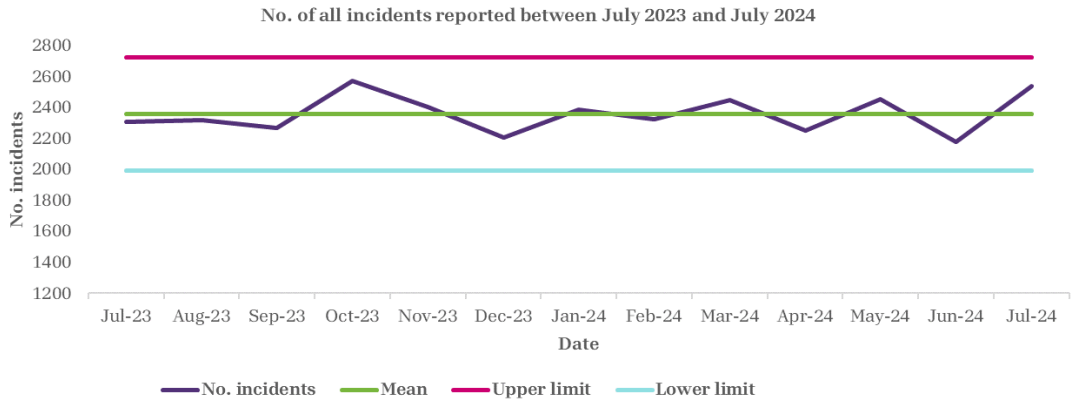
For Trust Board only: Have accessibility checks been completed? Yes/No

Patient Safety Incident Response Framework Report

Reporting Period:		June 2024
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group. The last meeting held was 23rd July 2024 with 23 members in attendance and the meeting was quorate.
1a.	**Alert**	Due to continued long term sickness within the Incident and Policies Team, the team has not been able to review and close incidents at the usual level. The rate has been under target for the last 5 months. Incidents are still being reviewed and investigated and all incidents are triaged when reported so any immediate concerns have and continue to be identified. A total of 3411 incidents were finally approved in June 2024.
1b.	**Advise**	The team successfully achieved the requirement of reviewing and marking over 3000 incidents ready for the final upload to NRLS. The team are now prioritising work on final approvals and have significantly reduced the number of incidents awaiting Final Approval, with 1049 awaiting at the end of June 2024. The team is now consistently keeping the number of incidents awaiting final approval at around 1000, with a goal of reducing this to 500 over the next two months. Incidents resulting in moderate harm have increased in June 2024 and been above the previous year's average for 3 months. This due to the national change in grading of pressure ulcer incidents. Following the transition to LFPSE, there will be an increase in harm reporting for the following reasons: • Reporting of actual impact to patients following an incident regardless of whether the incident contributed to said harm. The contribution can be recorded separately, this will be built into future reporting. • Both physical and psychological impact is now reported essentially meaning we may see a doubling of harm reported in some cases. Once we have enough data, we will be able to report the two harm levels separately. To enable a successful transition to LFPSE several changes were required to the Datix incident reporting form, as result this has affected the data available to form themes and trends this month. The changes have also increased the amount of data available for analysis and therefore it is hoped that it will improve the themes and trends that are captured going forward. Work is underway to adjust the data analysis tools so that reporting can return in the next report.
1c.	**Assure**	The Trust successfully transferred from reporting incidents into the National Reporting Learning System (NRLS) to Learning from Patient Safety Events (LFPSE) on 24th June 2024.

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 Incidents resulting in moderate harm have increased in June 2024 and have been above the previous year's average for 3 months, however this is due to the change in grading of pressure ulcer incidents. It should also be noted that following the transition to LFPSE, there will be an increase in harm reporting for the following reasons:

1.2.1 Reporting of actual impact to patients following an incident regardless of whether the incident contributed to said harm. The contribution can be recorded separately, this will be built into future reporting.

1.2.2 Both physical and psychological (new) impact is now reported, essentially meaning we may will see a doubling of harm reported in some cases. Once we have enough data, we will be able to report the two harm levels (physical and psychological) separately.

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 the Trust has set a target that these should be reviewed and actioned within 30 days of reporting. A KPI of 90% has been set and appendix B provides an overview by division.

3.2 There was a reduction in performance against the KPI in May 2024 with an achievement of 64.95% overall. However, this recovered in June 2024 to 80.35% overall and will continue to be monitored with the divisions.

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 There continues to be a reduction in the number of open PSR investigations in most Divisions, however, there has been an increase in the proportion of those that have been open for more than 90 calendar days.

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

5.1 In June 2024 and July 2024, the Complex Case meeting reviewed 7 new incidents of which all 7 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 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 July 2024, the Trust had 23 open PSII incidents of which 8 were being investigated by MNSI.

5.3 At the end of July 2024 there was 1 PSII which had been open longer than 6 months and 1 MNSI report1.

5.3.1 1 x MNSI report was overdue which are outside of the control of trust.

5.3.2 At the time of writing the 1 PSII was overdue due to several delays caused by family involvement, divisional advisors not responding to PSII requests for information and the need to prioritise 2 investigations for Coroners inquests.

5.4 In June 2024 and July 2024, 8 PSII reports have been approved by PSIRI with learning and closed.

6 PSIRI Panel Approval and Learning from Reports

6.2 During June 2024 3 new reports were reviewed, of the 3 approved by PSIRI Panel there were 3 new PSII reports.

6.2.1 Incident resulting in death (eIR1275594) – The report was approved with no amendments required. The areas identified for improvement identified were:

- The investigation did not identify any contributory factors that caused the incident to occur, across the tools/technology used, the environment the x-rays are reviewed in, any competing priorities, or organisational factors.
- There were already processes in place to ensure that radiographers maintain their competencies, and ensuring diagnostic accuracy is within accepted standards.
- The investigation was not able to identify any safety recommendations in relation to improving systems and processes related to the subtlety of the lesions.
- The investigation was not able to identify any national tools or technology to support staff to identity lung lesions more easily.

6.2.2 Incident resulting in death (eIR1275653) – The report was approved with some minor amendments required. The areas identified for improvements were:

- No safety recommendations were made due to the extensive work on improvement that had already taken place by the Division following an initial review.

6.2.3 Incident resulting in death (eIR1268228/eIR12677889) – The report was approved with some minor amendments required. The areas identified for improvement were:

- Division to ensure all staff are aware that radiology results can be endorsed via ICE and Message Centre within the PowerChart application of Cerner.
- Division to review the assurance process for the management of investigation results in accordance with the changes to the system for the management of these following the implementation of Cerner.

7 Patient Safety Incident Updates

7.1 Patient Safety Incident Response Framework – Training

7.1.1 Two sessions have now been delivered on the updated Introduction to Human Factors Training with positive feedback from staff attending. Further dates are available to all trust staff to book via the learning hub.

7.1.2 Patient Safety team are currently developing Patient Safety Response Investigations training which will be available to book on the learning hub from Oct 2024. This will hopefully support the divisions in improvements to the quality of PSRs and timely completion.

7.1.3 A Patient Safety Workshop on PSR process has been planned for 10th October with the Division to look at other possible ways to improve the process and ensure reports are completed in a timely manner.

7.2 Patient Safety Incident Investigation Safety Improvement Plan Assurance

7.2.1 To improve the monitoring and assurance of safety improvement plans linked to patient safety incident investigations a new Divisional Patient Safety Group Assurance report has been designed which now includes an update on all open PSII safety improvement plans and PSR actions. As well as the divisional template updated, safety improvement plan assurance has been included in the terms of reference for the Patient Safety Group. Divisions are now using the new template to provide assurance at Patient Safety Group bi-monthly.

7.3 Patient Safety Matters Event

7.3.1 The first Quality Governance Forum was held on 9th July with over 30 staff attending from the Trust and our ICB. The event had a key focus on the requirements of:

- Patient Safety Incident Response Framework
- The new Learning from Patient Safety Events national reporting database
- Involving Patients and families in incident investigations (being open and honest)
- How learning is shared

The event was well received, and the team are looking at planning the next one by the end of the year.

7.4 Patient Safety Podcast

7.4.1 The Patient Safety Incident Investigation Team has launched its first podcast to shine a light on the work they do and share important messages. The first episode, which is now live on the Patient Safety Team's SharePoint site, provides an introduction to the team and the Patient Safety Incident Investigation (PSII) process. The Podcasts will be recorded on a regular basis and made available both audio and video formats and will cover a range of patient safety topics.

8 Mandatory National Patient Safety Syllabus Training Modules

8.1 At the end of June 2024, the Trust has achieved 93.9% Level 1a, 84.1% Level 1b and 89.4% Level 2 for National Patient Safety Training since making it mandatory for all staff to complete within the Trust. Several staff have been identified and added to requiring Level 1b which was missed when training first set up this has led to a slight decrease in Level lb. At the present time this is not mandated training by NHS England but is expected for Trust to encourage staff to complete to ensure and health and care services are as safe as possible for patients and service users.

Table 3: Patient Safety Syllabus Training (as of end of June 2024)

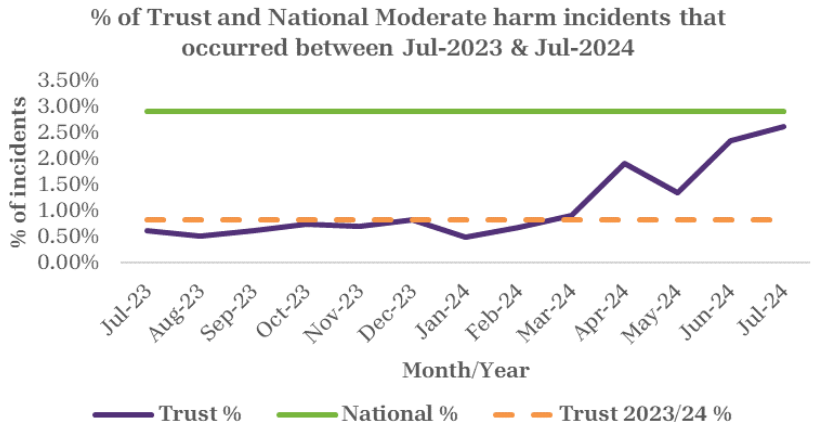
Patient Safety Training Modules	KPI Target	% of staff completed training
Patient Safety Level 1a – all staff	95%	93.90%
Patient Safety Level 1b – Boards and senior leadership	95%	84.10%
Patient Safety Level 2 – Essential to role	95%	89.40%

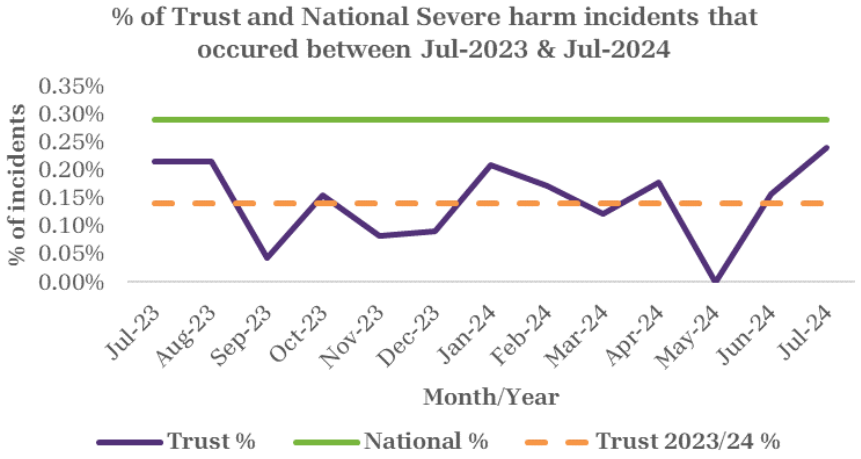
9 Maternity specific serious incident reporting in line with Ockenden recommendations

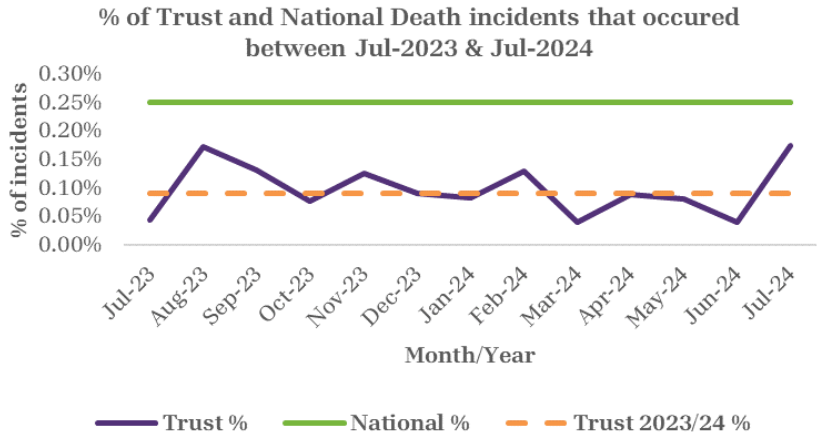
9.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 66 maternity related incidents have been reported on StEIS of which:

- 37 have been closed by the ICB with learning.
- 15 have been agreed for de-escalation from StEIS.
- 10 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 Trust Target 90%	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Trend
CIC	Total IR2 reported	336	368	391	331	306	362	314	410	378	341	315	360	
	(total number investigated) % complete within 30 calendar days	(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%	(300) 87.98%	(281) 89.21%	(323) 89.72%	
DCS	Total IR2 reported	122	141	128	139	174	143	148	138	129	110	112	136	
	(total number investigated) % complete within 30 calendar days	(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%	(85) 77.27%	(93) 83.04%	(91) 66.91%	
FC	Total IR2 reported	238	330	253	252	348	307	245	237	221	284	283	314	
	(total number investigated) % complete within 30 calendar days	(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%	(222) 78.17%	(228) 80.57%	(240) 76.43%	
MEC	Total IR2 reported	796	883	885	877	926	880	947	947	915	992	903	899	
	(total number investigated) % complete within 30 calendar days	(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%	(863) 87.00%	(762) 84.39%	(752) 83.65%	
SAS	Total IR2 reported	386	457	385	391	542	425	346	415	397	434	344	426	
	(total number investigated) % complete within 30 calendar days	(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%	(291) 67.05%	(276) 80.23%	(362) 84.98%	
Corp	Total IR2 reported	40	70	53	78	79	78	69	82	89	83	87	97	
	(total number investigated) % complete within 30 calendar days	(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%	(37) 44.58%	(47) 54.02%	(63) 64.95%	
Trust Total	Total IR2 reported	1918	2249	2095	2068	2375	2195	2069	2229	2129	2244	2044	2232	
	(total number investigated) % complete within 30 calendar days	(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%	(1798) 80.12%	(1687) 82.53%	(1831) 64.95%	

Total number of IR2s open on DATIX over 30 calendar days old						
Division	CIC	DCS	FC	MEC	SAS	Corp
No. open	19	61	81	127	77(26)	282

* 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	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Trend >90
CIC	No. open	41	43	26	47	51	73	47	29	39	55	40	44	
	No. open more than 90 calendar days	5	7	6	7	2	2	7	5	7	5	5	9	
DCS	No. open	8	11	11	17	19	19	19	21	7	9	8	9	
	No. open more than 90 calendar days	1	4	6	9	4	2	3	5	2	1	0	1	
FC	No. open	35	33	27	36	43	43	40	47	40	53	54	51	
	No. open more than 90 calendar days	13	14	15	11	13	12	12	16	9	11	17	14	
MEC	No. open	118	135	157	168	141	105	107	125	94	124	115	88	
	No. open more than 90 calendar days	25	36	39	45	28	12	19	15	16	18	24	25	
SAS	No. open	49	41	49	55	57	71	76	60	56	51	50	31	
	No. open more than 90 calendar days	9	12	11	13	11	21	19	15	16	13	17	17	
Trust	No. open										292	277	223	
	No. open more than 90 calendar days										48	66	66	

Appendix B: KPI Dashboards for PSIIs

PSII reports (including HSIB/PMRT)	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Total / Trend
No. incidents at Complex case	20	21	22	31	25	20	31	32	41	23	3	5	296
No. incidents agreed as PSII including (MNSI was HSIB)	2 (0)	1 (0)	6 (0)	3(2)	0	1(0)	4(1)	3	5	5	2	5	44 (5)
No. over 6 months	6 (2)	10 (2)	10 (2)	8(2)	6(2)	7(4)	5(4)	6(5)	6(4)	5(3)	3(2)	3(3)	
Total No. of PSIIs Open including (MNSI was HSIB)	29 (4)	29 (4)	32 (5)	28(6)	26(6)	24(6)	19(5)	23(6)	23(4)	25(4)	24(4)	27(10)	
No. approved/closed by PSIRI including (MNSI was HSIB)	3 (1)	0	3 (0)	5(0)	2	4	9 (2)	4	5	5	5	3	51 (4)

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **127**

11 September 2024 **Purpose** Approval

Title	Supporting Unpaid Carers in Lancashire and South Cumbria
Report Author	Mrs S Draeger, Regional Carers Lead, NHS England North West
Executive sponsor	Mr P Murphy, Chief Nurse
Date Paper Approved by Executive Sponsor	18 June 2024

Summary: The Lancashire and South Cumbria Integrated Care Strategy 2023 – 2028 commits to improve identification and support to unpaid carers. The Lancashire and South Cumbria Carers Partnership have developed a Carers Charter to deliver the promise made in the Integrated Care Strategy. Supporting carers at hospital discharge is a key element of fulfilling the pledge to carers outlined in the Integrated Care Strategy. This paper recommends a scoping exercise on current practice around carers and hospital discharge for action.

Recommendation: The Trust Board is asked to:

- Support and endorse the implementation of the Lancashire and South Cumbria Carers Charter.
- Improve identification and support to unpaid carer at hospital discharge.
- Consider signing up to the Carers Charter once endorsed.

Report linkages

Related Trust Goal	Deliver safe, high quality care Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
Related to key risks identified on Corporate Risk Register	

Related to recommendations from audit reports	
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

For Trust Board only: Have accessibility checks been completed? N/A

SUPPORTING UNPAID CARERS IN LANCASHIRE AND SOUTH CUMBRIA

Executive Summary

1. Supporting carers addresses health inequalities in access, outcomes and experiences and reduces pressures on the health and care system. The Lancashire and South Cumbria Integrated Care Strategy 2023 – 2028 acknowledges unpaid carers and commits to improve identification and support to carers across the system.
2. The Lancashire and South Cumbria Carers Partnership have developed a Carers Charter to fulfil the promises made to carers in the Integrated Care Strategy. This paper asks to support the implementation of the Carers Charter.
3. Supporting carers at hospital discharge is a key element of fulfilling the pledge to carers outlined in the Integrated Care Strategy. This paper recommends a scoping exercise on current practice around carers and hospital discharge for action.

Supporting Carers in Lancashire and South Cumbria

Introduction

4. Carers Trust define a carer as “anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.”
5. According to the 2021 census there are approximately 175,000 unpaid carers in Lancashire and South Cumbria, whilst Carers UK estimates the true number may be double that.
6. The Lancashire and South Cumbria Integrated Care Strategy 2023-2028 acknowledges that unpaid carers play a vital role in supporting people in the communities. The strategy recognises the needs of carers at all five stages of life and includes commitments to work collaboratively to improve the identification of carers; to enable carers to gain access to the information and support they need; and to develop a carers charter for Lancashire and South Cumbria.
7. Actions to fulfil the promises of the Integrated Care Strategy are outlined in the priorities and workplan of the Lancashire and South Cumbria Carers Partnership Group (Appendix A).

Part 1: The Carers Charter

8. The Lancashire and South Cumbria Integrated Care Strategy 2023 – 2028 outlines: 'We will develop a Carers Charter for Lancashire and South Cumbria, which will set out how we want to improve understanding and appreciation of the role of carers and get better support for carers in the future.'

9. The Lancashire and South Cumbria Carers Partnership has delivered this promise (Appendix B). The Carers Charter provides a framework for organisations across health and social care and promote a consistent approach to carer awareness and support throughout the system. It does not replace any carers charter already in place in organisations or at Place level.

10. The development of the Carers Charter for Lancashire and South Cumbria was carried out in an exemplar model of co-production with carers with lived experience, and a collaborative way of working between health and social care providers, local authorities and Voluntary, Community, Faith and Social Enterprises (VCFSE) (Appendix C).

11. Greater Manchester has had a carers charter in place since 2018 and all 33 organisations in the Greater Manchester Health and Social care partnership have signed up carers-charter-final.pdf (gmintegratedcare.org.uk). Cheshire and Merseyside Integrated Care Partnership (ICP) have published their carers charter on Carers Rights Day 23 November 2023 Cheshire and Merseyside Carers Charter - NHS Cheshire and Merseyside .

12. Once the Carers Charter is approved through the ICP, it will be published on the ICP website along with names of organisations that have signed up to the charter. The pledge will be valid for 2 years.

13. To sign-up to the Carers Charter, organisations will sign the following pledge.

    We will:

    a) Publish the Lancashire and South Cumbria Carers Charter on our website alongside information for carers where to find support
    b) Have a named member of our organisation/team as a champion for carers. (A carers champion is the designated lead for carer support in the organisation and is the contact person for local carer services. In a trust, this is usually someone in the Patient Experience and Engagement team.)
    c) Proactively identify carers and link them to support
    d) Raise carer awareness amongst staff through staff training or covering issues relating to carers at staff meetings
    e) Develop our support offer for working carers employed with us

Part 2: Carers and Hospital Discharge

14. With regards to hospitals, supporting carers through discharge is a key element of fulfilling the pledge to carers outlined in the Integrated Care Strategy 2023-2028.

Recently published national guidance specifies the legal duty for NHS hospital Trusts to involve unpaid carers as soon as feasible when plans for the patient's discharge are being made:

a) Hospital discharge and community support guidance - GOV.UK (www.gov.uk)
b) Discharge from mental health inpatient settings - GOV.UK (www.gov.uk)

15. Through the Accelerating Reform Fund, the Department of Health and Social Care is providing funding to local authorities to support unpaid carers in 2024-2025. In Lancashire and South Cumbria, local authorities decided to work on priority 12: 'Ways to encourage people to recognise themselves as carers and promote access to carers services.' The project description includes hospital discharge as one of the areas for investment.
16. In support of the Accelerating Reform Fund, the local authorities agreed to share good practice examples through the Lancashire and South Cumbria Carers Partnership. As a scoping exercise it is therefore recommended that all acute and mental health Trusts present their current practice around identification and support of unpaid carers at hospital discharge at the Lancashire and South Cumbria Carers Partnership Group.
17. Identification of good practice and gaps around supporting carers at hospital discharge may feed into the current system-wide work on Transfer of Care Hubs as part of the Lancashire and South Cumbria Intermediate Care Programme.

Recommendations

Part 1: The Carers Charter

18. Support the implementation of the Lancashire and South Cumbria Carers Charter.

Part 2: Carers and Hospital Discharge

19. Improve identification and support to unpaid carers at hospital discharge.

Actions

Part 1: The Carers Charter

20. Recommend the Lancashire and South Cumbria Carers Charter to the Integrated Care Partnership for approval.
21. Trusts to consider signing up to the Carers Charter once approved.

Part 2: Carers and Hospital Discharge

22. Scoping exercise for Trusts to share current status of how carers are supported at hospital discharge at the Lancashire and South Cumbria Carers Partnership on 18 April 2024/16 May 2024.

Sigrid Draeger, Regional Carers Lead, NHS England North West, February 2024

Carers Priorities and Workplan (Appendix A)

Carers Priorities and Workplan 2024/2025

Lancashire & South Cumbria Carers Partnership Group
Update February 2024
DRAFT

Overview Carers Priorities and Workstreams

No	Priority	Workstream
1	Strategic Development	A. Establishing the Carers Partnership Group B. Develop governance arrangements within ICS C. L&SC Carers Charter D. Working toward ICS-wide carer's strategy
2	Effective Pathways	A. Hospital Discharge and Virtual Wards B. Timely Assessment process for carers C. Contingency plans for Carers in place (R 11) D. Link in with Integrated Neighbourhood Teams
3	Comms & Engagement	A. Increase awareness of carers and carers support (R 1,3, 5, 9) B. Find out from carers what matters to them/carer survey
4	Data & Intelligence	A. L&SC Carer Services Directory (R 5) B. Improved recording and sharing carers data (R 2) C. Increase identification of hidden carers
5	Support for Carers **Living Well** **Ageing Well**	A. Improve experience of working carers (R 3) **Working Well** B. Identify young carers and link them to support/Engage with Schools **Starting Well** C. Review respite options for unpaid carers (R 4, 8) D. Supporting carers around end-of-life (R 10, 12) **Dying Well** E. Professional Carers Training (R 6) F. Emotional wellbeing support to carers (R 7) G. Supporting carers with mental health and substance misuse H. Supporting Parent carers

Note: These priorities and workstreams have been developed by the Lancashire & South Cumbria Carers Partnership Group
Purple Colour references the ICP Strategy including the stages of life
R Refers to the number of the recommendation in the I Care report Healthwatch South Cumbria 2023

Current workstreams for carers

Past six months Q3/Q4 2023/2024

On 21/09/2023 the L&SC Carers Partnership decided to prioritise the following workstreams over the next 6 months:

- Young carers
- Carers around end-of-life
- Working carers

A dedicated Carers Partnership Meeting for sharing good practice on end-of-life carers was held 19/10/2023, and for young carers on 16/11/2023. With regards to working carers, the regional carers lead has invited Lee Radcliffe to present at the Carers Partnership Group the development of the ICS workforce strategy.

Plans for 2024/2025

In 2024/2025 the Carers Partnership will support the Accelerating Reform Fund with the priority workstreams identified by local authorities across Lancashire and South Cumbria:

- Supporting carers around hospital discharge
- Carers Assessment
- Carer Respite
- Carer Data

In addition, the Carers Partnership will focus on the following workstreams

- Sign-off and implementation of the Carers Charter for Lancashire & South Cumbria
- Embedding reporting and governance for the Carers Partnership Group within the ICB/ICP
- Progress integration of carers agenda into wider ICB workstreams such as dementia, workforce etc.

Note: Please note this overview focuses on system-wide activities. If a workstream is marked as "not yet started" there will in most cases be activities at Place level and individual organisation. For those workstreams, discussions still need to be held about benefits of system-wide activities.

L&SC Carers Priority 1 Strategic Development

Key achievements to date
• The carers agenda is firmly embedded in the **Lancashire & South Cumbria Integrated Care Strategy 2023 – 2028**. The strategy takes a lifecourse approach, and recognises the needs of carers at all stages of life. Furthermore, supporting unpaid carers is acknowledged as a theme that will support delivery of priorities with a specific carers section in the strategy. • Establishment of the **Lancashire & South Cumbria Carers Partnership Group** with key partners including the ICB, Local Authorities, NHS Foundation Trusts, Healthwatch, VCFSE organisations working with carers, and carers with lived experience. The Carers Partnership is a key vehicle for sharing information, learning and good practice and driving forward the ambitions outlined in the Integrated Care Strategy • **Carers Charter for Lancashire & South Cumbria** developed in co-production with carers with lived experience, signed off by the Carers Partnership on 21/09/2024

RAG Score
Not yet started
Progressing
Embedded

Current position	Key deliverables planned in next 6 month	Lead	RAG Score
1A L&SC Carers Partnership Group Established with wide range of stakeholder	Review Terms of Reference (see below)	Sigrid Draeger	
1B Governance arrangement within ICS Terms of Reference agreed by Carer Partnership 21/09/2024. However, governance and reporting awaiting confirmation through ICB/ICP	Reporting of carers agenda into Integrated Care Partnership to be established	Sigrid Draeger Claire Roberts	
1C L&SC Carers Charter Co-produced Carers Charter signed off by Carer Partnership 21/09/2024. ICP layout and formatting for Carers Charter completed. Awaiting ICB/ICP sign-off	• Sign-off carers charter through Provider Collaborative Board/ICB/ICP • Publication on ICP website with contact information for carers • Develop and implement sign-up for organisations across L&SC	Jenna Matthews Sigrid Draeger Claire Roberts	
1D L&SC Carers Strategy Development of Place based carers charter in LCC and BwD shared at Carers Partnership 21/12/2023. Workstream for L&SC Carers Strategy deferred whilst working on L&SC Carers Charter			Deferred

L&SC Carers Priority 2 Effective Pathways

Key achievements to date	RAG Score
• North West Webinars on hospital discharge and carers held on 20/03/2023 and 13/12/2023 sharing good practise • Principals of good discharge agreed by Carers Partnership in 2022 • Cooperation established with Virtual Wards. Virtual Wards model presented to the Carers Partnership. Connections established between local virtual wards teams and local carer organisations	Not yet started Progressing Embedded

Current position	Key deliverables planned in next 6 month	Lead	RAG Score
2A Hospital Discharge/Virtual Wards Supporting carers around hospital discharge as one of the workstreams of the ARF priority for carers	Working with the Provider Collaborative to have all Acute and Mental Health Trusts present current status for hospital discharge and carers at the Carers partnership for scoping	Colin Phipps Sigrid Draeger	
2B Timely assessment process for carers Carers assessment as one of the workstreams of the ARF priority for carers	Best practice on carers assessments to be presented to the Carers Partnership on 15/02/2024 from LCC, Furness carers, and Wigan Council	Colin Phipps Sigrid Draeger	
2C Contingency plans for carers in place			
2D Link with Integrated Neighbourhood Teams Good practice identified in East Lancashire. However, this is not established across the whole system.	?	Claire Roberts	

L&SC Carers Priority 3 Comms & Engagement

Key achievements to date	RAG Score
• North West Toolkit for CHC and Community professionals on identification and support to carers launched in January 2023 • Carers Partnership informed and involved with several carer engagement projects: "I Care" report Healthwatch South Cumbria, ICB project with Lancashire BME network, "A Call from Carers" exploring experiences of carers for people living with dementia and other neurological disorders Healthwatch Lancashire. In addition, comprehensive carers engagement taking place at Place level as part of the development of new carers strategies (LCC and BwD)	Not yet started Progressing Embedded

Current position	Key deliverables planned in next 6 month	Lead	RAG Score
3A Increase awareness of carers and carers support • Carers awareness training delivered through L&SC GP safeguarding forum May 2023, UHMB Community Team Leads August 2023 • Place based awareness training	Embed dementia carer awareness training in GP training on dementia as part of the L&SC dementia action plan	Helena Hounslow Pamela Lee Sigrid Draeger	
3B Find out from carers what matters to them • Recommendations from "I Care" report Healthwatch South Cumbria embedded in Carers Partnership workplan • Results from ICB carers engagement with Lancashire BME network expected spring 2024 • Results from Healthwatch Lancashire engagement with carers for people living with dementia and other neurological disorder expected late spring 2024	Embed new recommendations from carers engagement in carers partnership priorities and workplan as they become available	Project leads	

L&SC Carers Priority 4 Data & Intelligence

Key achievements to date	RAG Score
• Data on young carers identified in the school census submitted for the first time in 2023 and shared with Carers Partnership Group on 16/11/2023 • Data on numbers of carers identified by GPs for the first time available through the national Core Contract service. Analysis commissioned to be shared with the Carers Partnership and local authority carer leads	Not yet started Progressing Embedded

Current position	Key deliverables planned in next 6 month	Lead	RAG Score
4A L&SC Carer Services Directory Digital Co-production invited all carer services to join at Carers Partnership April 2023. However, no public-facing directory developed yet at system or place?			
4B Recording and sharing of carers data First overview comparing numbers of carers through the census 2021, GPs, and local authorities currently being developed as a baseline, and then for further application for progress monitoring for the ARF carers project.	Baseline for numbers of carers to be established for L&SC to be shared with Carers Partnership and beyond.	Stewart Bond Colin Phipps Sigrid Draeger	
4C Increase identification of hidden carers Potential good practice: Mobilise Lancashire, N-Compass, Blackpool Carers Centre			

L&SC Carers Priority 5 Support for Carers

Key achievements to date	RAG Score
• Carers Partnership held dedicated sessions to share good practice and support networking for carer and end of life care on 19/10/2023 and young carers on 16/11/2023	Not yet started Progressing Embedded

Current position	Key deliverables planned in next 6 month	Lead	RAG Score
5A Working Carers Carers Partnership developed recommendations in a working carer subgroup in December 2022	Contacting Lee Radford to present workforce strategy to Carers Partnership for feedback	Sigrid Draeger	
5B Young Carers Dedicated Carers Partnership Meeting for sharing good practice on young carers 16/11/2023		Sigrid Draeger	
5C Review respite options Respite named as one of the workstreams of the ARF priority for carers	Arrange good practice sharing on respite options to support ARF	Colin Phipps Sigrid Draeger	
5D Supporting Carers around end of life care Dedicated Carers Partnership Meeting for sharing good practice on end of life carers 19/10/2023		Sigrid Draeger	
5E Carers Training on caring skills	With regards to dementia carers - embed in action plan for L&SC dementia strategy	Helena Hounslow Pamela Lee Sigrid Draeger	
5F Promote emotional well-being techniques			
5G Supporting carers with mental health and substance misuse			
5H Parent Carers			

Carers Charter (Appendix B)

Lancashire and South Cumbria
Integrated Care Partnership

Lancashire and South Cumbria
Carers Charter

Our commitment to you as a carer

Carers play a vital role in supporting people in our communities. This charter sets out what carers, who are often family and friends, can expect from services across Lancashire and South Cumbria.

Do you help a family member, friend or neighbour who cannot manage without your support? If so, and the care you provide is unpaid, this charter may be for you.

Acknowledge

We will acknowledge you in your caring role, making sure that we understand the help you provide. We will make sure you are listened to, valued and respected throughout your experience with us.

Involve

We will make sure that you are involved and included. We will keep you informed where we can, and explain why if we can't. We want you to tell us how we can improve our services.

Communicate

We will make sure you are listened to and communicate clearly.

Support

We will make sure you know about the services you can access, and make you aware of your rights as a carer including the statutory carers assessment.

SCAN ME SCAN ME SCAN ME SCAN ME

Please note the QR-code is not yet active as the Carers Charter has not been published on the ICP website and awaiting sign-off.

Carers Charter Engagement Process (Appendix C)

Members of the Working Group
Jenna Matthews, LSCFT (lead)
Barry Williams, ELHT (lead)
Alison McCrudden, LTHT
Alyson Mousley, Carer
Chantelle Bennett, ICB
Colin Bowman, N-Compass
Sigrid Draeger, NHS England NW

Draft carers charter shared for feedback

- Public Involvement and Engagement Advisory Committee PIE AC (22 participants)
- Lancashire & South Cumbria Carers Partnership Group (81 participants)
- Provider Collaboration – chairs of Acute and Mental Health Trusts via Mike Thomas, Chair UHMBT
- Directors of Health and Care Integration – South Cumbria, Blackburn with Darwen, Lancashire, Blackpool
- Lancashire County Council commissioning team

Carer groups who provided feedback

- Carers Groups at Carers Link Lancashire
- Carers Forum at LTHT with 12 carers and representatives from Carers UK, Alzheimer's Association, Disability North West, NWAS and the Preston & District carers forum
- Carer Support Carlisle & Eden
    - 2 Carers hub, the first (Coffee Hub) had 14 carers present, the second (Lunch Club) 7 carers
    - 18 staff members read and discussed it at their team meeting.
- Coffee & Chat N-Compass Lancashire with 16 carers in face to face meeting
- Service User and Carer Council members at LSCFT (mix of service users & carers), approx. 40 people

Individuals who provided feedback
Lisa Forster, Healthwatch
Joanne Dalton, Population Health ICB
Louise Taylor, Director of Health and Care Integration Lancashire
Neil Greaves, Director of Comms, ICB
Liz Winkley Riding, Lead Nurse ELHT
Dr. Dani Leslie, Carer Support Carlisle & Eden
Dr. Katie Clarke, GP partner, Burnley West PCN
Paul Jebb, Associate Chief Nurse, LSCFT
Angela Bennett, Carers Link Lancashire
Emma Lawson, Carers Link Lancashire
Dr Vicky Ellarby, Director of Place Development and Integration South Cumbria

TRUST BOARD REPORT **Item** **128**

11 September 2024 **Purpose** Approval
Assurance
Information

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

Summary: The purpose of this report is to provide:
1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Maternity Safety Ambition, specifically relating to the ten CNST (Clinical Negligence Scheme for Trusts) maternity safety actions included in year 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
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	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 2023 (start of the Y6 reporting period) required deadlines have been met above the required % compliance thresholds. See dashboard in report below. ● Q1 PMRT report covering Apr-Jun cases has been included in the report below (**Appendix 2**).
2. Maternity Services Data Set (MSDS)		● July 2024 will be the month reviewed for compliance of this safety action. The scorecard reflecting the compliance for July will be published in October. ● Continued review of the published scorecard monthly. See most recently published monthly dashboard below.
3. Transitional Care (TC)		● Q1 audit Apr-Jun has been completed and is included in the below report (**Appendix 3**). ● The audit identified that the main reason for babies not being discharged from NICU to TC was the mother being discharged home. A review of the readmission of mothers to TC is under review/ although bed capacity in view of the C/S rate primarily reduces this option. ● 2 Quality improvement projects now registered with the central improvement team for adequate thermoregulation of the neonate (Temperature Management) on CBS (Central birth suite) PNW (Postnatal Ward) and the number of Caesarean sections being performed with clinical indication at appropriate gestations.
4. Clinical Workforce		● Audit for employing short- and long-term locums to be completed for submission to November Trust Board. ● Q1 April-July consultant attendance audit assurance is included in the below report (**Appendix 4**). ● Anaesthetic team have provided 1 month rota evidencing compliance to ACSA standards (**Appendix 5**). ● Neonatal Nursing workforce action plan to be continued as submitted to Trust Board during CNST Year 5 reporting period. Updated action plan is included below (**Appendix 6**). ● Report included to evidence Neonatal Medical workforce compliance with BAPM standards (**Appendix 7**).
5. Midwifery Workforce		● Midwifery Safe staffing report January-July 2024 attached (**Appendix 8**). ● 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 establishment 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.

6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 81% overall implementation as per previous LMNS (Local Maternity and Neonatal System) assurance visit. Progress has been made locally which will be formally assessed at the 11th of September 2024 LMNS visit. ● Further progress and sustainability of current implementation plan with associated actions continues with close oversight from Obstetrics Clinical Director/ perinatal quadrumvirate
7.User Feedback		● MNVP workplan 2024-25 was presented to the LMNS Board in July 2024 and agreed. To be reviewed at Floor to Board 3rd October 2024. ● MNVP lead is included in ToR (Terms of reference) for Floor to Board. ● **Identified Risk for ongoing assurance to meet this action -** 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. Role is currently out to advert with applications closing 6th September 2024. ● Patient experience group for Maternity and Neonatology implemented to review and action CQC (Care Quality Commission) maternity survey results and FFT (Friends and Family Test) results. ● Themes identified via the above group have been shared with MNVP lead for co-production of improvements. MNVP lead attended engagement session to gather feedback on themes. This will be taken to patient experience group for review and action planning.
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** – multi-disciplinary emergency training (PROMPT) 90% attendance required as per the CNST ask. Anaesthetists' compliance has now dropped to 74% and Obstetricians to 88%. The maternity training team are closely monitoring this. An update to CNST requirements allowing a six-month grace period for rotational staff commencing in post after the 1st of July 2024 to complete training means these figures will be revised and compliance is expected to be higher. ● Updated MIS guidance states that NLS certification need only meet 'basic capability' as set out in the BAPM Neonatal Airway Capability Framework. As a result, all staff are now compliant.
9. Board Assurance		● Floor to Board bi-monthly meetings with Board-level, maternity, and neonatal safety champions in place. (Minutes to support) ● Perinatal Quality & Surveillance Model (PQSM) June 2024 data set submitted. ● Triangulation of claims, incidents, complaints bespoke exercise took place in July 2024. A working group has been formed to respond to concerns raised at this meeting that triangulation has not yet taken place. Updated scorecard to be provided early September, and a new dashboard is being developed to support triangulation.
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Assurance from governance leads that all requirements for MNSI reporting are met. Quarterly report included below (**Appendix 9**).

2.2 Key updates and exceptions per Safety Action

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

Table 1 Perinatal Mortality Review Tool – Dashboard of 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

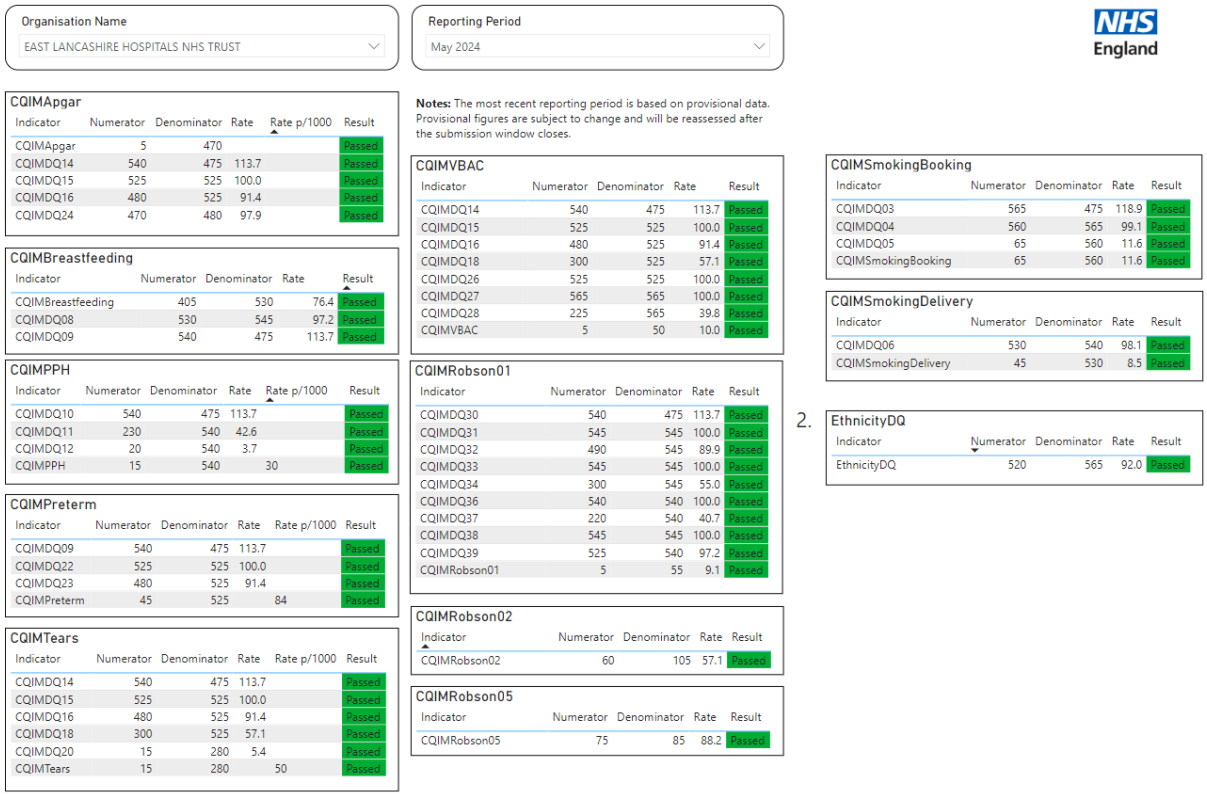
		Reporting Measure	Thresho	Nov-2	Dec-2	Jan-2	Feb-2	Mar-2	Apr-2	May-2	Jun-2	Jul-2	Monthl Trend
SAFETY ACTION 1	PMRT01a	Total Number of Stillbirths (≥ 24 weeks)		2	1	1	1	1	2	4	0	n/a	
	PMRT01b	Number of Neonatal Deaths		3	1	0	1	1	3	3	3	n/a	
	PMRT01c	Number of late fetal loss between 22+0 and 23+6 weeks		0	0	0	1	0	0	0	0	n/a	
		Total Eligible Cases		5	2	1	3	2	5	7	3	0	
	PMRT02	a) i Number of cases reported to MBRRACE within 7 days		5	2	1	3	2	5	7	3	n/a	
			100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	
	PMRT06a	c) i Number PMRT tool started 2 months		5	2	1	3	2	4	4	1	n/a	
			95%	100.0%	100.0%	100.0%	100.0%	100.0%	*	*	*	*	
	PMRT05	c) ii Number PMRT published reports by 6 months		4	2	0	0	0	0	0	0	n/a	
			60%	80.0%	100.0%	*	*	*	*	*	*	#VALUE!	
	PMRT05c	Number PMRT published reports not due		0	0	1	3	2	5	7	3	n/a	

As demonstrated via the above PMRT dashboard, all required time limits have been met to the required compliance thresholds within the reporting period.

CNST Year 6 continues the requirement for quarterly reports to be submitted to Trust Board, Quarter 4 covering January-March 2024 data was submitted to May 2024 Trust Board. The Quarter 1 report covering April-June 2024 data is attached for submission below (**Appendix 2**).

The report includes an action plan based on themes highlighted through the PMRT process. In Q1 the remaining open action is focused on improving approaches to breaking bad news to parents. Teaching materials have been developed to disseminate to junior doctors and a presentation will be given.

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: May 2024

NHS England

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	470			Passed
CQIMDQ14	540	475	113.7		Passed
CQIMDQ15	525	525	100.0		Passed
CQIMDQ16	480	525	91.4		Passed
CQIMDQ24	470	480	97.9		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	405	530	76.4	Passed
CQIMDQ08	530	545	97.2	Passed
CQIMDQ09	540	475	113.7	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	540	475	113.7		Passed
CQIMDQ11	230	540	42.6		Passed
CQIMDQ12	20	540	3.7		Passed
CQIMPPH	15	540		30	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	540	475	113.7		Passed
CQIMDQ22	525	525	100.0		Passed
CQIMDQ23	480	525	91.4		Passed
CQIMPreterm	45	525		84	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	540	475	113.7		Passed
CQIMDQ15	525	525	100.0		Passed
CQIMDQ16	480	525	91.4		Passed
CQIMDQ18	300	525	57.1		Passed
CQIMDQ20	15	280	5.4		Passed
CQIMTears	15	280		50	Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	540	475	113.7	Passed
CQIMDQ15	525	525	100.0	Passed
CQIMDQ16	480	525	91.4	Passed
CQIMDQ18	300	525	57.1	Passed
CQIMDQ26	525	525	100.0	Passed
CQIMDQ27	565	565	100.0	Passed
CQIMDQ28	225	565	39.8	Passed
CQIMVBAC	5	50	10.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	540	475	113.7	Passed
CQIMDQ31	545	545	100.0	Passed
CQIMDQ32	490	545	89.9	Passed
CQIMDQ33	545	545	100.0	Passed
CQIMDQ34	300	545	55.0	Passed
CQIMDQ36	540	540	100.0	Passed
CQIMDQ37	220	540	40.7	Passed
CQIMDQ38	545	545	100.0	Passed
CQIMDQ39	525	540	97.2	Passed
CQIMRobson01	5	55	9.1	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	60	105	57.1	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	75	85	88.2	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	565	475	118.9	Passed
CQIMDQ04	560	565	99.1	Passed
CQIMDQ05	65	560	11.6	Passed
CQIMSmokingBooking	65	560	11.6	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	530	540	98.1	Passed
CQIMSmokingDelivery	45	530	8.5	Passed

2. **EthnicityDQ**

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	520	565	92.0	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?

Q1 (April-June 2024) TC data review and audit presentation has been completed and is included for submission to Trust Board as evidence of compliance with the implementation of TC services (**Appendix 3**). The audit identified that the main reason for babies not being discharged from NICU to TC was the mother being discharged home. A review will be conducted of the readmission of mothers to TC.

Following audits, as per the CNST requirement two QIs have been registered with the central improvement team: Temperature management on CBS PNW and Caesarean sections being performed with clinical indication at appropriate gestations. Updates on progress will be provided to Floor to Board on 3rd October 2024 and the LMNS QA Panel on 19th November 2024.

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

A detailed review and analysis of the current Obstetric and Gynaecology medical workforce, aligned to current clinical activity and associated risks within the Directorate was presented to The Trust Professional Judgement review panel for Medical Staffing on the 12th July 2024 and is awaiting outcomes.

An audit for employing short and long-term locums will be completed for submission to 13th November 2024 Trust Board.

The Q1 April to July consultant attendance audit has been completed and is included for submission (**Appendix 4**). This was presented at Perinatal Governance Board on 23rd August 2024. Recommendations and actions following this discussion include circulating information to new cohort of doctors detailing which conditions consultants should be in attendance for and exploring options for adding a box to Datix to determine whether a consultant was in attendance and if not why.

As per the CNST requirement, the anaesthetic team have provided 1 month rota evidencing compliance to ACSA (Anaesthesia clinical services accreditation) standards (**Appendix 5**).

As the neonatal unit does not meet BAPM (British Association of Perinatal Medicine) standards for nursing staffing, the neonatal nursing workforce action plan submitted for MIS year 5 evidence has been updated with a full review of progress to complete the MIS year 6 reporting period. This action plan has been submitted with this report to evidence progress against actions (**Appendix 6**). All National neonatal critical care monies for cot side nurse care/ specialist and super numerary Coordinator hours have been funded/in budget and recruited.

The Neonatal Medical Workforce Report has been included to evidence compliance with BAPM standards of medical staffing (**Appendix 7**).

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

The bi-annual midwifery staffing report (detailing January-July 2024) is included as per the CNST requirement (**Appendix 8**) current risk identified is the funded midwifery staffing budget, currently not reflecting birth rate plus requirements. A business case for the deficit in funding has been completed and presented through the relevant ELHT business case process. Outcome to be confirmed.

The initial Birthrate+ exercise was completed using August-October 2021 data and the final report was published September 2022. This therefore meets compliance of being within the previous 3 years and will be revisited in 2025 to ensure continued compliance.

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.'

A quarterly review (April-June) of the 6 elements of SBL (Saving Babies Lives) is as follows, this remains at 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.'*

- 11th September 2024
- 6th November 2024
- 8th January 2024

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

ELHT collaborated with the MNVP lead to determine key themes from the CQC survey. Themes identified were: 'feeling left alone during early labour', 'gaining the help you need during labour', and 'postnatal care'. The MNVP lead attended a session at Brierfield Baby Club to gather service user feedback around these themes. Feedback will be discussed at the Patient Experience and Lessons Learned Group for Maternity and Neonatology to identify themes and actions.

Feedback cards have been developed by ELHT to collect more feedback on the 3 themes taken from the CQC survey. These cards will be distributed by ELHT midwives in the week commencing 2nd September 2024, and ELHT will engage with the MNVP lead to develop actions based on this feedback.

The MNVP lead will be attending the NICU coffee morning on 2nd September 2024 with the service user lead for the ODN (Operational Delivery Network) to engage with neonatal families. As outlined in the previous Trust Board report the presence of the service user lead for ODN serves to prevent the inadvertent retraumatisating of neonatal service users, until training can be delivered to the MNVP lead to ensure service users are protected. This reflects the technical guidance for Safety Action 7.

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 Maternity Incentive Scheme provided an update to requirements for Safety Action 8 on 27th August 2024:
'90% compliance is required for all rotational medical staff that commenced work with the Trust prior to 1 July 2024 by the end of the 12-month MIS reporting period (1 December 2023 to 30 November 2023)
For rotational medical staff that commenced work on or after 1 July 2024 a lower compliance will be accepted, provided there is a commitment and action plan approved by Trust Boards and recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust.
Evidence from rotating trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12-month period) will be accepted in line with the attached flow chart and the MIS year six technical guidance.'

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. July 2024 dashboard shows 97% 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. July 2024 dashboard shows an average of 88% attendance across all required groups.
  - Anaesthetic compliance has dropped below the required 90% from May to July due to rotational trainee anaesthetists. This is being monitored by the Maternity Training Team who are actively contacting these colleagues to arrange their training dates, and the above update to requirements for rotational trainees means these figures will be revised and compliance is expected to be higher. An update will be provided in the November Trust Board report.
  - Obstetrician compliance has dropped to 88% due to August rotations. 6 are currently non-compliant with 5 booked on for upcoming sessions. However, as above, the update to requirements means these figures will be revised and compliance is expected to be higher. An update will be provided in the November Trust Board report.
  - A new ask for 70% attendance for non-obstetric anaesthetics doctors who contribute to the on-call rota in any capacity – this has been added to the dashboard for monitoring and the July 2024 dashboard for this cohort shows 83% compliance. 1 colleague is now non-compliant, and the Maternity Training Team is monitoring this.
- **Neonatal basic life support** –

  The update published by MIS on the 24th June 2024 also states changes to the guidance for SA 8:

  ‘All neonatal staff undertaking responsibilities as an unsupervised first attender / primary resuscitator attending any birth must have reached a minimum of ‘basic capability’ as described in the BAPM Neonatal Airway Capability Framework.

  Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.

Please note that Trusts should be working towards this position for this year (year 6) of the Maternity Incentive Scheme in line with the published MIS year 6 document: A minimum of 90% of paediatric/neonatal medical staff who attend neonatal resuscitations unsupervised should have been trained and assessed in line with the guidance above.'

90% attendance for neonatal consultants, junior doctors (who attends any births unsupervised), neonatal nursers (who attend any births unsupervised), advanced neonatal nurse practitioners, and midwives. Midwives and Maternity Support Workers complete this module within the PROMPT training day, and the July 2024 dashboard confirms compliance in attendance above the 90% threshold required.
Neonatal nurses and ANNP's are meeting the 90% compliance threshold.
Neonatal consultants and junior doctors are also meeting the 90% compliance threshold.

Training compliance was discussed at Perinatal Governance Board 23rd August 2024, and it was established that a review would need to be conducted to determine whether there are sufficient numbers of PROMPT facilitators to deliver the training. The Maternity Training team will also begin to monitor the number of NLS instructors within the Trust.

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?

Perinatal Quality Surveillance Model (PQSM) Minimum Data Set June 2024:

Perinatal Quality Surveillance Dataset

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

Perinatal Data

Metric	Standard	Apr 24	May 24	June 24	July 24
1:1 care in labour	100%	100%	100%	100%	100%
Stillbirth rate	<4.4/1000	6.20	9.42	2.10	0
Term admissions to NICU	<7%	4.75%	4.21%	4.61%	4.46%
Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	3.94%	3.05%	3.19%	5.55%
3rd/4th degree perineal tear	<5%	4.46%	4.81%	3.40%	2.96%

Staffing/Training

Metric	Standard	Apr 24	May 24	June 24	July 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
Midwife to birth ratio (in post)	<1.28		<1.27	<1.27	<1.27
Training compliance for all staff groups (CNST)	>90%	>90%	>90%	>90%	>90%

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

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

Stillbirth rate:
There have been 0 stillbirths this month

Term admission to NICU:
The Term admission rate has remained below 5%. Further audit into admission for respiratory distress is in progress, and all unexpected term admissions are reviewed at a weekly MDT meeting. Any that may be avoidable are then discussed at directorate Patient Safety Meetings.

3rd/4th degree perineal tears
The number of 3rd/4th degree tears has remained stable for the last 3 months below 5%. An audit is being performed to look at the incidences for November to March to identify any themes or trends.

Training Compliance:
The average for training compliance across all staff groups remains >90% attendance including the anaesthetic team, however MIS CNST standards for year 6 suggest that all anaesthetists who may occasionally work in the birth suite must attend PROMPT. This may be difficult to achieve.

Feedback

Metric	Standard	Apr 24	May24	June24	July 24
Service user feedback (MNVP)		0 sessions attended	2 sessions attended	0 sessions attended	0 sessions attended
FFT satisfaction rated as good	>90%	86.61%	78.03%	85.48	90%
Number of level 4 complaints	-	0	0	3	1
Executive safety walkaround	Bi-Monthly	1	1	2	0
Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	1	N/A	N/A	2

External Reporting

Metric	Apr 24	May 24	June 24	June 24
Maternity incidents graded moderate or above	3	6	6	3
Cases referred to MNSI	2	2	0	0
Cases referred to coroner	1	1	0	0
Coroner reg 28 made directly to the Trust	0	0	0	0
HSIB/CQC with a concern or	0	0	0	0

CNST

Metric	Mar 24	Apr 24	May 24	June 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%

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

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 meeting was held in June with attendance from Mat/Neo services and MNVP.
There has been a service user engagement event this month – written feedback is awaited rom this.

FFT satisfaction rated as good:
There has been an increase in the number of FFT responses rating care as good. These continue to be monitored at monthly Patient experience group and an action plan is in place.

Level 4 Complaints
There has been 1 level 4 complaint in July.

Executive Safety Walkarounds:

Moderate or above incidents:
There have been 3 reported incidents: 2 are Women who had massive PPH and required hysterectomy, the other is a safeguarding incident from the postnatal ward

Coroner referral:
0 cases have been referred to the Coroner in June

MNSI referral:
There has been 0 cases referred to MNSI in June

CNST:
The current CNST standards have been published and we are working towards them. Quarterly assurance visit by LMNS in June – on track.

'Is the Trust's claims scorecard reviewed alongside incident and complaint data.'

A bespoke meeting took place on the 31st July 2024 with all safety champions and governance team colleagues to review the claims scorecard alongside the incidents and complaint data currently available. From this meeting a working group was formed to progress the triangulation of claims, incidents and complaints data. This group has met twice throughout August. A new claims scorecard will be released in early September, and this data will be used in conjunction with a dashboard that is being developed by the Trust Datix manager. An update will be provided to safety champions on 25th September 2024.

'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.

The Quadrumvirate is working with the Maternity Transformation Team to explore options for disseminating the results and themes of the survey. In addition to the infographic shared previously, a podcast will be produced to support with this dissemination, led by the Quadrumvirate and area leads.

As per previous updates, ELHT maternity and neonatal services were offered the opportunity to train Culture Coaches to hold regular culture conversations and support the delivery of local culture improvements. The Culture Coaches have now received this training from the NHS England Perinatal Culture and Leadership Team. Their next steps are to collaborate with the Quadrumvirate and access the SCORE survey results to determine how to begin culture conversations and share the feedback from these.

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 10**).

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
August 2024

Appendix 1 – CNST-MIS Y6 Guidance

MIS-Year-6-guidance.pdf

Appendix 2 – Quarterly PMRT Report

Quarterly PMRT report Q1 24.docx

Appendix 3 – Quarterly Transitional Care Audit

TC Apr-June 2024.pptx

Appendix 4 – Consultant Attendance Audit

Consultant attendance audits 2

Appendix 5 – Anaesthetic Rota

Anaesthetic Obs Rota July 2024.docx

Appendix 6 – Neonatal Nursing Workforce Action Plan

Workforce Action Plan 23 - 24.xlsx

Appendix 7 – Neonatal Medical Workforce Report

Neonatal Medical Workforce.docx

Appendix 8 – Midwifery Staffing Report

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

Appendix 9 – MNSI Reporting Overview

MNSI Reporting Overview Aug 2024.

NHS Resolution

Maternity (and perinatal) Incentive Scheme

Year Six v1.1

Conditions of the scheme

Ten maternity safety actions

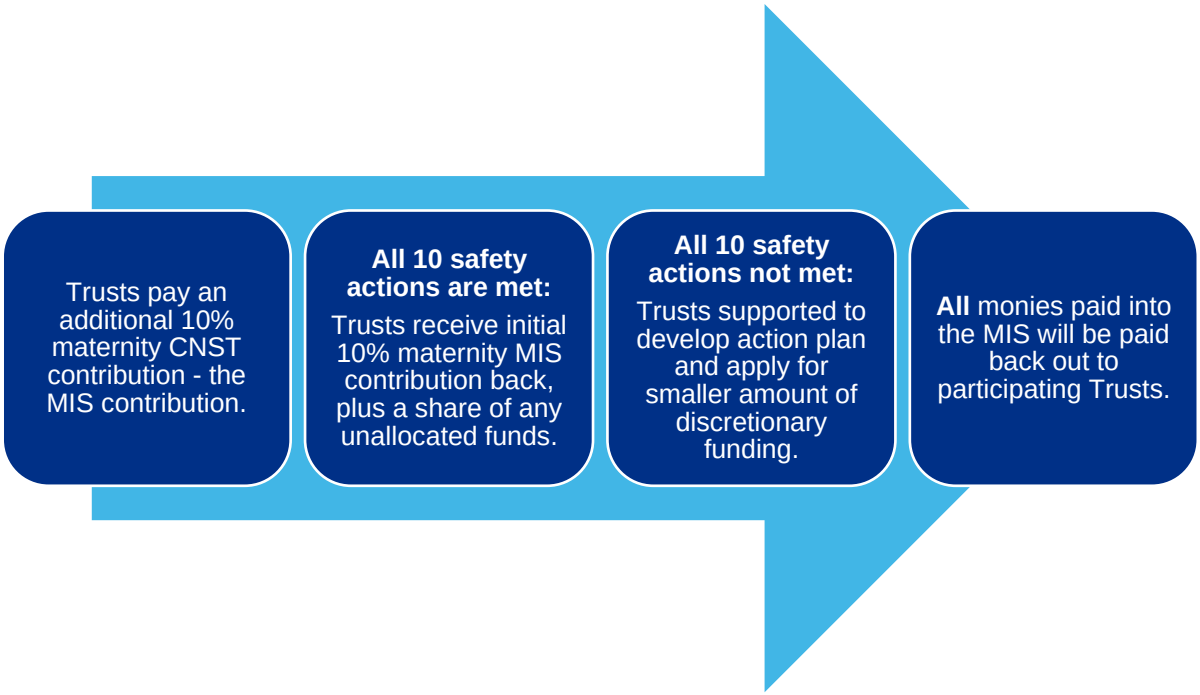
Additional guidance

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).

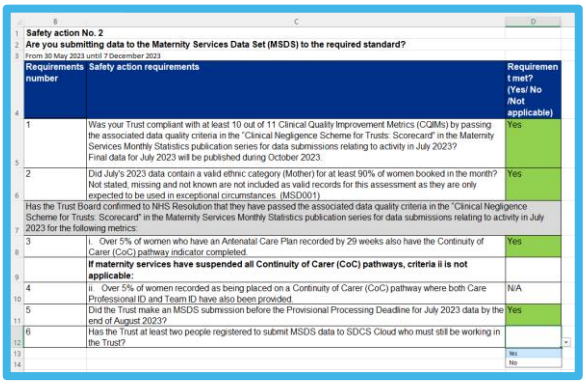
National Neonatal Research Database (NNRD), MNSI and **NHS Resolution** for the number of qualifying incidents reportable (safety action 10, standard a).

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?	
		Yes
		No

- 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:

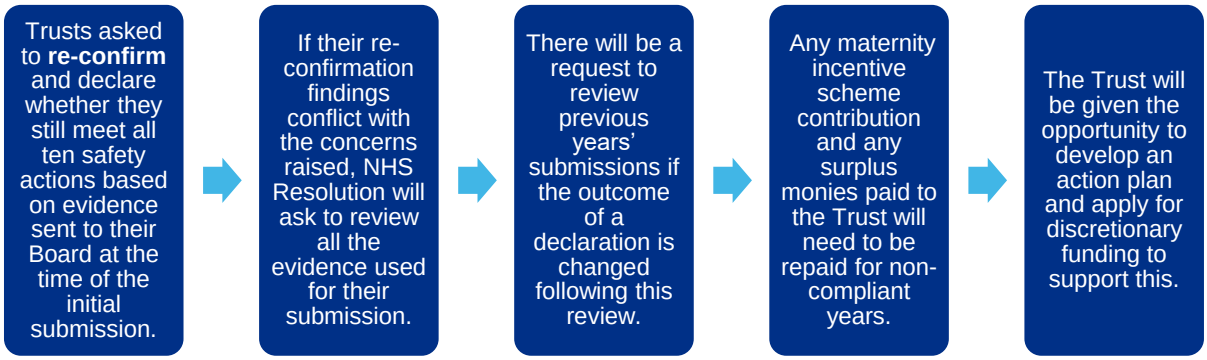
- Submitted on the action plan template in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and will enable the financial calculation 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'.

Link to Safety Action 1

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

Link to Safety Action 2

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)

Link to Safety Action 3

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.

Link to Safety Action 4

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.

Link to Safety Action 5

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.

Link to Safety Action 6

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.

Link to Safety Action 7

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 obstetric anaesthetic doctors (staff grades and anaesthetic trainees) **who contribute to the obstetric**

	rota. 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.
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 any 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. This includes the staff listed below:

Neonatal basic life support?	• 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	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.

are trained as an NLS instructor and hold the GIC qualification?	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. In line with *The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice* (April 2024) *All neonatal staff undertaking responsibilities as an **unsupervised** first attender / primary resuscitator attending any birth must have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework.* *No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required for Basic capability and most skills required for Standard capability.* Staff that attend births **with supervision at all times** will not need to complete this assessment process for the purpose of MIS compliance. *A minimum of 90% of paediatric/neonatal medical staff **who attend neonatal resuscitations unsupervised** should have been trained and assessed in line with the guidance above. 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 unsupervised** 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.

Link to Safety Action 8

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	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

Board each month?	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	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:

(PCLP), culture 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.

Link to Safety Action 9

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.

Link to Safety Action 10

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

Q1|April - June 2024

Title	**Family Care Division Quarterly PMRT Report (April-June 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 Q1

1. Deaths notified to MBRRACE within 7 working days (target 100%)
    a. **100% (n=17) notified within target time**
2. Parents given opportunities to provide feedback or raise questions/concerns (target 95%)
    a. **100% (n=16) of parents had their input sought**
3. A review of the death should be commenced within 2 months (target 95%)
    a. **100% (n=10) had a PMRT review commenced within target time**
4. A multi-disciplinary review should be completed and published by 6 months (target 60%)
    a. **88% (n=7) 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 (Q1)			
	April	**May**	**June**	**Total**
Number of cases discussed	**2**	**1**	**2**	**5**
Grading (up to birth of baby)				
A	**1**	**1**	**2**	**4**
B	**1**	**0**	**0**	**1**
C	**0**	**0**	**0**	**0**
D	**0**	**0**	**0**	**0**
Grading (following death of baby)				
A	**0**	**1**	**2**	**3**
B	**2**	**0**	**0**	**2**
C	**0**	**0**	**0**	**0**
D	**0**	**0**	**0**	**0**

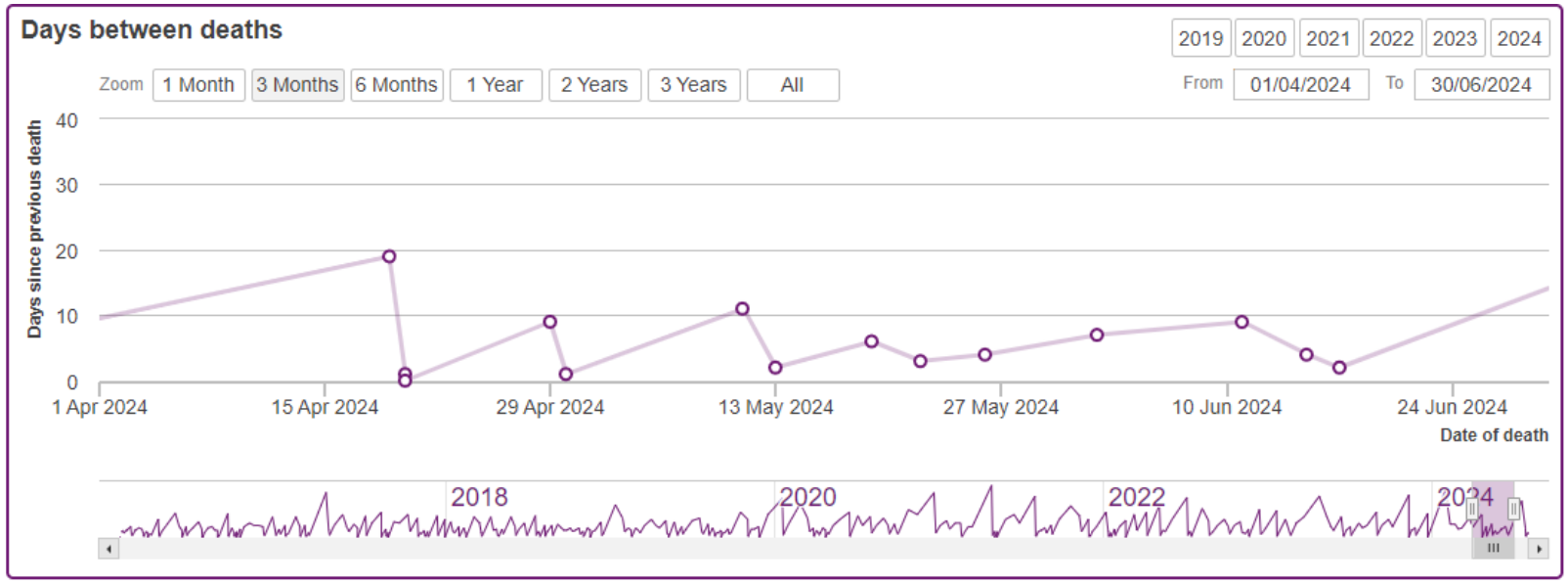
Grading of care – Neonatal deaths & Late fetal losses

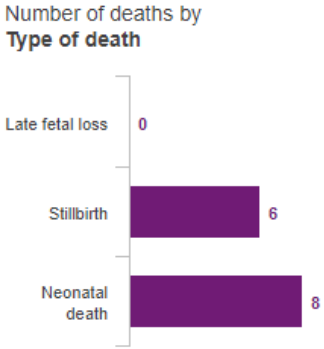
	Meeting Month (Q1)			
	April	May	June	Total
Number of cases discussed	1	1	1	3
Grading (up to birth of baby)				
A	0	1	1	2
B	1	0	0	1
C	0	0	0	0
D	0	0	0	0
Grading (from birth of baby until death)				
A	1	0	1	2
B	0	1	0	1
C	0	0	0	0
D	0	0	0	0
Grading (following death of baby)				
A	0	0	1	1
B	1	1	0	2
C	0	0	0	0
D	0	0	0	0

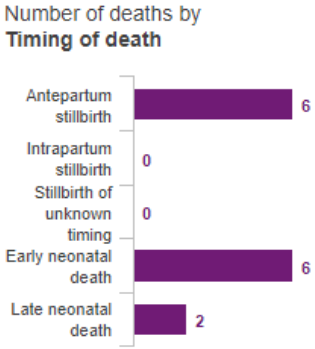
Clinical summary of new cases eligible for PMRT review occurring during Q1

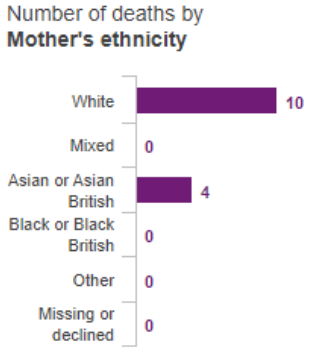
MBBRACE ID	Type of case	Gestation at birth	Date of death	Clinical summary
92928	Stillbirth	31+2	20/04/24	RFM info given in Punjabi and Urdu. Interpreter only documented as being used 10 and 12 weeks.
92919	NND	24+5	19/04/24	PPROM, born in car park
92921	NND	25+5	20/04/24	Tx from Barrow, born in ambulance en-route
93084	NND	22+6	29/04/24	Spontaneous preterm birth despite cervical suture
93113	Stillbirth	40+4	30/04/24	Attended RFM - No FH
93251	Stillbirth	26+4	11/05/24	Previous loss. LMWH not given antenatally.
93258	NND	35+6	13/05/24	Emergency CS pathological CTG. Transferred ex utero to ELHT from Stockport
93343	NND	31+1	16/05/24	Abnormal CTG. Hydropic at birth.
93363	NND	25+1	19/05/24	Spontaneous preterm labour
93424	Stillbirth	33+2	22/05/24	DCDA twins. IUD one twin.
93485	Stillbirth	27+3	26/05/24	Known lehal anomalies
93583	NND	24+3	02/06/24	Spontaneous preterm birth
93747	NND	23+2	11/06/24	IUT twin pregnancy
93802	Stillbirth	38+4	15/06/24	Low risk pregnancy – unexplained stillbirth
93846	NND	37+5	17/06/24	Multiple Anomalies/Severe ventriculomegaly and hydrocephalus

MBRRACE Real time data 1st April – 30th June









PMRT Action Tracker (as of 8th August 2024 – completed actions excluded)

ISSUE	AGREED ACTION	PROGRESS	ACTION UPDATE	LEAD	DEADLINE	STATUS	COMPLETED DATE
Breaking of bad news felt to be of poor quality by parents	Create teaching materials for dissemination to junior doctors.	Ongoing - no issues	Presentation written, awaiting date to present to junior staff at local Friday pm teaching following August rotation.	M Cocker	01/06/2024	Overdue	

TC audit –April to June 2024

Savi Sivashankar/Rebecca Fennell

Number of preterm admissions(numbers)

- 24 admissions from Apr-June 2024 of 34+0 to <37 weeks

Preterm babies- causes of admission(numbers)

- Resp disease- 9
- Hypoglycaemia -5
- Jaundice -0
- Absent end diastolic flow
- Prematurity - 4
- Other (specify)

Hypothermia-1

Obs/monitoring-1

Infection-2

Cardio/resp-1

IUGR/SGA-1

Preterm- scbu days that could have been delivered on TC

- 95 days of SCBU on NICU -total
- 53-total days could have been on TC
- Reason- mother discharged from PNW

Conclusion

- 53 days of scbu care could have been delivered on Tc
- Mother having been discharged home was the main reason for baby not to be discharged from NICU to TC

Action Plans

Accepted Recommendations	Required Action	By Date	By Whom
Review readmission of mothers to TC	Tc activity/staffing review	ongoing	Tracy Thompson

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	

Consultant Attendance audit

1st April- 31st July

Fiona Clarke

Findings 8th Dec 2023to 31st March 2024

Obstetrics Condition	No. of Patients			Consultant Attendance	Comments
Caesarean birth for major placenta praevia / abnormally invasive placenta	12			11	Perfromed by ST 6. Grade 1 LSCS as abruption, placenta posterior and ?just covering at os so by definition may have been minor not major placenta praevia , cons not informed. Blood loss 1.7l
Caesarean birth for women with a BMI >50	4			3	Performed by St 5 with competencies for senior reg rota. Grade 1 LSCS. Consultant had reviewed patient on ward round at 20.00 but was not documented if informed when went to grade 1 lscs overnight.
Caesarean birth <28/40	4			4	
Premature twins (<30/40)	1			1	
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	13			11	1. Senior speciality doctor performed 2. Senior speciality doctor- PPH settled as soon as placenta delivered so MOH only activated for few minutes.
Gynaecology					
Any laparotomy					Currently unable to identify cases after introduction of CERNER

Comments

- This block there are more cases where it is not documented the consultant was informed.
- As this is a retrospective audit most of the doctors have now rotated so direct feedback cannot be obtained
- Gynae laparotomy figures are not easily available at the moment after the loss of theatreman system .

Recommendations

- Realtime reporting
  - These conditions are mandatory reports on DATIX. To facilitate realtime actions on each incident, need to add a box to datix to ask if consultant attended and if not why.
  - This will also allow us to collect gynae laparotomy data
  - Action- Q&S team to explore adding box to DATIX
- Need to resend out the list
  - Send to new cohort of doctors and CBS band 7s the list of conditions consultants should be in attendance for.
  - Action- rota team to send out update email

		Mon 01 Jul	Tue 02 Jul	Wed 03 Jul	Thu 04 Jul	Fri 05 Jul	Sat 06 Jul	Sun 07 Jul
BGH On Call Consultant 14859 - 6pm to 8am - 24hr @ weekend	*am*						Kurvey	Turner
	pm			Audit			Kurvey	Turner
	eve	Slack	Bigwood	Akuji	Bowler [Extra]	Shannon	Kurvey	Turner
	night	Slack	Bigwood	Akuji	Bowler [Extra]	Shannon	Kurvey	Turner
BGH.007 OBS SAS	*am*						Frenkiel	Kovacsai
	pm			Audit			Frenkiel	Kovacsai
	eve	Sharma S [Extra]	Kovacsai	Frenkiel	Vikas CESR	Elrayes	Frenkiel	Kovacsai
	night	Sharma S [Extra]	Kovacsai	Gbadebo^ ST5 [Patchwork]	Vikas CESR	Elrayes	Frenkiel	Kovacsai
BGH OBS Cons Blp 007 8am-6pm	*am*	Delivery / Obstetrics Beresford	Delivery / Obstetrics Shannon	Delivery / Obstetrics Tran	Delivery / Obstetrics Clegg	Delivery / Obstetrics Bigwood		
	pm	Delivery / Obstetrics Beresford	Delivery / Obstetrics Shannon Bruce ST5 ST5	Audit Delivery / Obstetrics Tran	Delivery / Obstetrics Clegg	Delivery / Obstetrics Bigwood		

		Mon 08 Jul	Tue 09 Jul	Wed 10 Jul	Thu 11 Jul	Fri 12 Jul	Sat 13 Jul	Sun 14 Jul
BGH On Call Consultant 14859 - 6pm to 8am - 24hr @ weekend	*am*						Akuji	Butler
	pm						Akuji	Butler
	eve	Cahill	Butler	Millar	Bowler	Tran	Akuji	Butler

	night	Cahill	Butler	Millar	Bowler	Tran	Akuji	Butler
BGH.007 OBS SAS	*am*						Elrayes	Rostron
	pm						Elrayes	Rostron
	eve	Garth ST6 ST7	Elrayes	Rostron [Extra]	Frenkiel	Vikas CESR	Elrayes	Rostron
	night	Garth ST6 [Extra]	Elrayes	Rostron [Extra]	Frenkiel	Vikas CESR	Elrayes	Rostron
BGH OBS Cons Blp 007 8am-6pm	*am*	Delivery / Obstetrics Calow	Delivery / Obstetrics Bowler	Delivery / Obstetrics Trotter	Delivery / Obstetrics Turner	Delivery / Obstetrics Akuji		
	pm	Delivery / Obstetrics Calow	Delivery / Obstetrics Bowler	Delivery / Obstetrics Trotter	Delivery / Obstetrics Turner	Delivery / Obstetrics Akuji Weekly F1 FY1		

		Mon 15 Jul	**Tue 16 Jul**	**Wed 17 Jul**	**Thu 18 Jul**	**Fri 19 Jul**	**Sat 20 Jul**	**Sun 21 Jul**
BGH On Call Consultant 14859 - 6pm to 8am - 24hr @ weekend	*am*						Clegg	Lie
	pm						Clegg	Lie
	eve	Trotter	Shawcross	Akuji	Heaps	Pollard	Clegg	Lie
	night	Trotter	Shawcross	Akuji	Heaps	Pollard	Clegg	Lie
BGH.007 OBS SAS	*am*						Elrayes	Freeman [Act Down (Time)]
	pm						Elrayes	Freeman [Act Down (Time)]
	eve	Elrayes Prakash	Kovacsai	Faruq O	Sharma S	Colebrook	Elrayes	Freeman [Act Down (Time)]
	night	Elrayes Prakash	Kovacsai	Faruq O	Sharma S	Colebrook	Vikas CESR	Freeman [Act Down (Time)]

BGH OBS Cons Blp 007 8am-6pm	*am*	Delivery / Obstetrics Pollard	Delivery / Obstetrics Tran	Delivery / Obstetrics Turner	Delivery / Obstetrics Bowler	Delivery / Obstetrics Akuji		
	pm	Delivery / Obstetrics Pollard	Delivery / Obstetrics Tran	Delivery / Obstetrics Turner	Delivery / Anaesthetics Bowler	Delivery / Obstetrics Akuji		

		Mon 22 Jul	**Tue 23 Jul**	**Wed 24 Jul**	**Thu 25 Jul**	**Fri 26 Jul**	**Sat 27 Jul**	**Sun 28 Jul**
BGH On Call Consultant 14859 - 6pm to 8am - 24hr @ weekend	*am*						Simmons	Costigan [for time back]
	pm						Simmons	Costigan [for time back]
	eve	Freeman	McIntosh	Tran	Small	Cahill	Simmons	Costigan [for time back]
	night	Freeman	McIntosh	Tran	Small	Cahill	Simmons	Costigan [for time back]
BGH.007 OBS SAS	*am*						Gbadebo^ ST5 [Patchwork]	Kovacsai
	pm						Gbadebo^ ST5 [Patchwork]	Kovacsai
	eve	Vikas CESR	Kovacsai	Colebrook [Extra]	Colebrook	Frenkiel	Gbadebo^ ST5 [Patchwork]	Kovacsai
	night	Vikas CESR	Gbadebo^ ST5 [Patchwork]	Gbadebo^ ST5 [Patchwork]	Colebrook	Frenkiel	Brooke ST6 [Patchwork]	Kovacsai
BGH OBS Cons Blp 007 8am-6pm	*am*	Delivery / Obstetrics Calow	Delivery / Obstetrics Butler	Delivery / Obstetrics Millar	Delivery / Obstetrics Turner	Delivery / Obstetrics Pollard		
	pm	Delivery / Obstetrics Calow	Delivery / Obstetrics Butler	Delivery / Obstetrics Millar Weekly F1 FY1	Delivery / Obstetrics Turner	Delivery / Obstetrics Pollard		

		Mon 29 Jul	**Tue 30 Jul**	**Wed 31 Jul**	**Thu 01 Aug**	**Fri 02 Aug**	**Sat 03 Aug**	**Sun 04 Aug**
BGH On Call	*am*						Turner [for time back]	Bigwood

Consultant 14859 - 6pm to 8am - 24hr @ weekend								
	pm						Turner [for time back]	Bigwood
	eve	Trotter	Newport M	Pollard	Lie	Slack	Turner [for time back]	Bigwood
	night	Trotter	Newport M	Pollard	Lie	Slack	Turner [for time back]	Bigwood
BGH.007 OBS SAS	*am*						Sharma S [Extra]	Faruq O [Extra]
	pm						Sharma S [Extra]	Faruq O [Extra]
	eve	Vikas CESR	Sharma S [Extra]	Vikas CESR [Extra]	Rostron	Vikas CESR	Sharma S [Extra]	Faruq O [Extra]
	night	Vikas CESR	Sharma S [Extra]	Vikas CESR [Extra]	Rostron	Vikas CESR	Vikas CESR [Extra]	Akuji [Act Down (Time)]
BGH OBS Cons Blp 007 8am-6pm	*am*	Delivery / Obstetrics Millar	Delivery / Obstetrics Shannon	Delivery / Obstetrics Turner	Delivery / Obstetrics Bigwood	Delivery / Obstetrics Trotter		
	pm	Delivery / Obstetrics Millar	Delivery / Obstetrics Shannon	Delivery / Obstetrics Turner	Delivery / Obstetrics Bigwood	Delivery / Obstetrics Trotter		

NWNODN Sample Workforce Action Plan 2023 - 24

	Aims/ Targets/ Objectives	How this will be achieved	What expected outcome will be	What evidence will support this	Lead/s	Timescales	Monitoring/ Update
1	Achievement of National Neonatal Nursing Standards: NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010)	a) Accurate data collection using: - National Nurse Workfoce Tool (NNWT) for direct Patient/Cotside Care - NWNODN Quality Nursing Roles Calculator (QNRC)- For Quality Roles b)Ongoing discussion with appropriate Organisational leads e.g. Service & Finance Leads c) Ensure Neonatal Safety Champion is aware of ongoing challenges/risks due nurse staffing shortages	a) Identification of total nursing gap/deficity against cotbase, activity & quality roles b) Organisational awareness of nurse staffing position, Generation of Action Plan for achievement of national standards c) Any challenges are escalated to Trust Board for information/action	a) Neonatal workforce calculator quarterly tool b) Neonatal nurse staffing paper completed to reflect all asks of CNST SA4, presented to Trust Board 10th January 2024. c) Any challenges with nurse staffing evidenced at bi-monthly floor to board meetings and monthly staffing papers d) Evidence of acheiving national neonatal nursing standards see action 3 below	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT. Perinatal Quadrumvirate oversight	**Jan 24 completed.**	
2	Share Nurse staffing information, workforce strategy and action plans with NWNODN as stated in Neonatal Critical Care Review and CNST	a) Work with NWNODN team to complete NNWT and QNRC b) Workforce Strategy & Action Plan shared with NWNODN	a) Completed tools to be held locally and by NWNODN b) NWNODN will use data, W/F Strategy and Action Plans to: - Identify gaps for NCCR funding - Inform ODN W/F and Education Strategy	Complete the workforce strategy and action plan, share with the NWNODN in timeframe given to be put forward for the NCCR	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**Jan 24 completed.**	
3	Recruitment of registered nurses in line with BAPM recommendations with regards to safe staffing levels against patient ratios	a)Current on-going recruitment campaign to recruit to establishments b)Ensuring applications shortlisted in timely way and assessment panels and interview panels set up in advance and to keep to weekly timetable schedule	a) Staffing levels to reflect funded establishment until BAPM funding available. b) To complete a business case to fulfil and address deficiences in nurse staffing aligned with BAPM recommendations. c) Continue with bids via the neonatal critical care process as an enabler for income to be received to support BAPM recommendations.	a) Monthly PWR Data for neonatal nurse staffing. b) Business case to complete. c) Neonatal Critical Care bids.	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**Dec-24**	
4	Ensure the recruitment process minimises the time to hire	a).Regular meetings with recruitment team b)Review Assessment Selection tools to assist with recruitment to ensure right calibre of candidates c)Implement Values based assessment centres c) Regular Workforce meetings to discuss all issues.	a) Recruitment in line with Trust policies and procedures. b) Opportunity for recruitment events if needed.	a)Timely start dates with close monitoring. b) Robust inductions. c) Risk assessments to support staffing skill set for supernumary periods when required.	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**Jan 24 completed/ to continue.**	
5	Develop a recruitment media strategy in order to attract a broader range of candidates	a) Work with recruitment and HR colleagues to develop brand. b)Continue to develop innovative Recruitment Solutions such as use of Social Media e.g. Twitter,	a) Brand reflects Divisional vision and values	a) Recruitment campaigns. b) Minutes of workforce meeting. c) Enhanced ELHT neonatology website	Ruth Dawson/ NICU coordinators	**Dec-24**	
6	Review of roles to manage skill mix and encourage inivitive roles.	a) Introduction of New roles b) Review of AHP services and how these support the nursing workforce.	a) Implementation of new roles and associated competencies. b) Funding to be received via additional bid through neonatal critical care monies	a) Role diversity, recruit AHP's as agreed in the plan following neonatal critical care bid. b) Recruit to roles	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**Dec-24**	

7	Monitoring of Staffing levels to ensure levels are in line with acuity	a)Daily reviews using North West connect tool aligned with professional judgement as MDT team. b) Risk assessment if shortfalls are deemed to be deficient.	a) Clear review of staffing on a daily basis. b) Report of staffing deficiencies to relevant internal and external workforce groups including Floor to Board. c) Monitoring of data via the Clevermed and e-rostering systems.	a) Monthly Reports b) Clevemed Staffing data, complete daily staffing tool from NWNODN	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**Jan 24 completed/ to continue.**	
8	Review of Exit Interview process and understanding of why staff stay	a)Review of current Exit Process and Leavers Policy b)Review to be conducted and recommendations on how returns can be improved c)Action plan to ensure feedback is acted on.	a)Improved positive feedback from staff through exit interviews, questionnaires and staff survey.	a) All staff complete exit interview b) Positive exeriances reported by all staff, c) Formulate spreadsheet with all leaver information comments supportive meeting with Manager	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**Dec-24**	
9	Retention Rate	a)To listen to staff and understand the key drivers that retain staff and how staff would value being recognized. b)Improvement in staff engagement scores and staff reporting positive experiences at work	a) Improved retention b) Improved attrition	a)over 89% Target for retention Staff report positive experiences of their membership of the workforce b) Score of over 3.8 in staff survey. c) Perinatal Quadrumvirate SCORE survey results.	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**8/1/2024, completed will continue to review**	
10	Training and development opportunities are taken up and positively evaluated by all staff	a)To promote ascending and aspiring Talent b) Review funding for continuing education. c) Ensure all staff are facilitated to maintain mandatory competencies and monitor compliance.	a) Yearly Training Needs anaysis completed and training delivered.	a) Service specification of 70% staff QIS maintained. b)compliance maintained across all areas of mandatory training	Neonatal education team leads	QIS currently at 70% and ongoing monitoring of mandatory training.	
11	Attendance at work to be monitored and in line with Trust policy	a)Absence monitoring meetings arranged timely with relevant health and wellbeing support.	a) Absence levels to be below the Trust target	a) Absence levels to be below the Trust target b) To ensure timely absence meetings with offers of approriate health & wellbeing signposting c) The offer of Lets Flex policy when returning from any long term sickness periods or maternity leave if required. d) Roster support management to be discussed as an interim period if required to support work life balance following short term sickness. e) Offer / package to be introduced to all staff returning from long term sick and/or maternity leave to aid as an induction.	Ruth Dawson/ Matron for NICU. Band 7 leads with support from Maternity Recruitment & Retention Lead	**Dec-24**	
12	Robust and effective roster approval process	a) Review of current process against KPIs	a) Roster standards Met aligned with KPIs	a)Roster completed aligned with final approval dates. b) Roster meets all requirements of Trust Policy and Standards.	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**Jan-24 completed / to continue**	

13	Strengthen, simplify and unify processes throughout the recruitment pathways of authorising and approving temporary/ agency staff	a) Reduce use of temporary/ agency staffing to improve quality standards and reduce costs	a) Robust risk assessments for acuity and activity daily and at least a week in advance to ensure risk is reduced in booking agency staff.	a) Monthly PWR data for neonatal nurse staffing. b) Close monthly monitoring of agency use and spend. c) Risk assessment and cheif nurse sign-off prior to any agency use. d) Monitor savings aligned with non-agency spend. e) Continue to drive bank shifts as a primary approach to mitigate shortfalls in nurse staffing.	Ruth Dawson/ Matron for NICU with Divisional Director of midwifery/ Nursing and Assistant Director of midwifery at ELHT.	**Jan-24 completed / to continue**	

CNST Safety action 4

2024

NICU

Neonatal Intensive Care 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 1 neonatal rota at LWNC Burnley has an FY2 and either an ANNP/ST1-2 trainee or Junior clinical fellow at ST1-2 level.

Tier 1 rota template

			ANNP	ANNP	JCF(St1-2)	JCF(ST1-2)
	05/04/2023		LD		SD	SD
	06/04/2023		SD		LD	SD
BH	07/04/2023			SD - AL	SD - off	
	08/04/2023					
	09/04/2023					
BH	10/04/2023	wk2	Night	SD - AL	LD	
	11/04/2023		Night	SD	LD	

Tier 2

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)

LWNC Burnley has around 2000 ITU days/year and there is an ST4-8 trainee or ANNP or Senior Clinical Fellow ST4-8 level on call all times.

Tier 2 rota template

CNST 4 TIER2.xlsx

Tier 1 and 2 are compliant with BAPM standards.

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.

LWNC Burnley has 9 WTE consultants in the rota. They are resident for 12 hours for 4 days of the week. Another job has been awaiting approval, following which 12 hours availability on site will be met. Estimated time of meeting this criteria will be January 2025. We provide roughly 2000 ITU days /year.

PUBLIC TRUST BOARD REPORT **Item**

11th September 2024 **Purpose** Assurance

Title	**Maternity safe staffing/ Biannual report - January 2024 – July 2024**
Report Author	**Tracy Thompson. Divisional Director of Midwifery & Nursing/Family care Division**
Executive sponsor	**Peter Murphy, Chief Nurse Executive Director of Nursing.**

Summary: This Biannual maternity staffing oversight report provides assurance of any midwifery staffing and safety issues related to staffing from the period of 1st January 2024 to 31st July 2024.

Maternity staffing assurances align with the national directives for all Trusts to provide evidence of an effective system of safe midwifery workforce planning in part fulfilment of the evidential requirements of the Maternity Incentive Scheme Year six (Reference – **Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard.)**

To achieve safety 5: A formal birth rate plus assessment must be completed for all trusts within a three-year period. Completion of the assessment supports maternity services to undertake a maternity workforce gap analysis with a phased stepwise approach to meet all birth rate plus requirements. Following publication of the first Ockenden report in December 2020 all maternity providers in the UK were asked to undertake a maternity work-force gap analysis, with a plan in place to meet the Birth-rate Plus (BR+) (or equivalent) the ask is for a timescale for implementation of the required funding.

ELHT (East Lancashire Hospital Trust) Trust completed an independent Birth Rate plus assessment. The final report was received in September 2022. Aligned with this national directive, ELHT have prebooked for the next birth rate plus assessment to be completed in 2025.

Recommendation: ELHT trust board members together with the Executive and Non-executive maternity Board safety champions are asked to receive and acknowledge this first / Bi- annual 2024 maternity staffing report.

Report linkages

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

Impact *(delete yes or no as appropriate. If yes, you must state reasons)*

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

Previously considered by:

Purpose -The aim of this report is to provide assurance to ELHT Trust board that safety action 5 of the maternity incentive scheme (MIS) year 6 v1,1 July 2024 required standards and evidential requirements have been met including full review of the technical guidance. This report will detail a professional judgment review, alongside the Birth Rate plus review of maternity staffing requirements in line with national guidance and Ockenden maternity workforce planning recommendations.

Following the final report of ELHT birth plus findings in September 2022 all funded posts following business case (BC). submission 1 are now in budget reflected as phase one. Business case two submission in June 2024 includes the additional workforce analysis/ requirements following the overall birth rate plus full requirements. This BC has been submitted through the BC process at ELHT.

Background

Safety action 5/ technical guidance recommend Trust Boards to be informed of the following standards as follows.

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. **(Yes)**

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. **(No) Business case completed/ agreed plan/ timescales/ mitigation for shortfalls all reflected in the action plan as directed by MIS where B is not met.**

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. **(Yes)**

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

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. **(Yes)**

The minimal evidence requirements for trust boards are as follows:

The midwifery staffing report submitted will comprise evidence to support a, b, c and d progress or achievement. To 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.
This to include 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.

Supporting guidance for reference

In England, the CNO's Compassion in Practice strategy includes 'ensuring we have the right staff, with the right skills in the right place'. It recommends that trust boards sign off and publish

evidence-based staffing levels at least every six months, providing assurance regarding the impact on quality and experience of care. Directors of Midwifery and Directors of Nursing should agree appropriate staffing levels through the application of evidence-based tools such as Birth-rate Plus. All nursing and midwifery staffing levels and quality metrics should be discussed at public board meetings.

In July 2016 the National quality board (NQB) published a safe staffing improvement resource titled "**Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, Sustainable and productive staffing".**

This report advises Trust Boards to ensure this triangulated approach is both sufficient and sustainable using a set of key principles and tools to facilitate and support midwifery workforce planning at a local level. These Key principles and tools also guide trusts to complete an annual strategic staffing review followed by a six-month comprehensive staffing report to update trust boards on these recommendations.

The National Institute for Health and Care excellence (NICE) published a guideline in February 2015: **Safe midwifery staffing for maternity settings** (NG4). This guideline makes recommendations on safe midwifery staffing requirements for maternity settings, based on the best available evidence. The guideline covers safe midwifery staffing in all maternity settings, including at home, in the community, in day assessments units, in obstetric units and in birth units led by midwives both co located and stand-alone birth centres. The guideline also includes setting the midwifery staffing establishment and midwifery red flag events.

ELHT follow a trust wide document/ local policy for safe nursing and midwifery staffing escalation. These policies and national documents inform this Trust wide document. (ELHT/C135 version 3)

Birth rate plus

Birth-rate Plus is a workforce planning and decision-making system for assessing the needs of women for midwifery care throughout pregnancy, labour, and the postnatal period both in hospital and community settings.

The methodology has been in constant use in the UK since 1988. It calculates the required number of midwives to meet all the needs of women and babies in relation to defined standards and models of care, whilst incorporating local workforce planning factors.

Not every woman requires the same level of care nor the same amount of midwifery time during her pregnancy, labour, and postnatal period. Using the Birth-rate Plus tool supports service leaders to match their staffing requirements to the clinical needs of women.

It is sensitive and adaptable to changes in national policy which may influence how maternity care is provided such as the provision of continuity of carer and local workforce planning needs.

Birth rate plus recommendations reflect the case mix acuity and activity in all areas of maternity services. What it does not reflect is additional resource requirements because of the many initiatives aligned with national directive, hence further reviews are recommended with a workforce assessment tool to be completed as minimum triennially.

Birth outcomes are not influenced by staff numbers alone, hence a recognised tool such as Birth rate plus is essential for determining the number of midwives to ensure each woman receives one to one care in labour and safe care in all areas of maternity services.

ELHT Birth Rate Plus Findings – September 2022

Current Clinical Funded Bands 3 – 7

- Band 3 (Maternity support worker) – 16.55wte
- Band 5 – 7 (Midwives) – 232.95wte
- Contribution from midwifery specialist roles – 12.40wte

Total current funded establishment **- 261.90wte**

Comparison/ Recommended birth rate plus - Bands 3- 7

- Total current funded establishment required – 269. 40 wte
- Variance – Bands 3-7 -7.50 WTE shortfall

Clinical Specialist Midwives

The specialist midwives have both clinical and non-clinical elements within their roles, which are calculated by Birthrate+ individually.

The review of senior midwifery management team demonstrates that 59.3% (12.40wte) of the total wte contributes to the clinical staffing element of the roles. The remaining 40.7% (8.52wte) is included in the non-clinical role element.

Non-Clinical Midwifery Roles

The total clinical establishment as produced from Birth-rate Plus of 269.40wte which excludes the non-clinical midwifery roles needed to provide maternity services, as summarised below:
Divisional Director of Midwifery/ Assistant Director of Midwifery, Midwifery Matrons/managers with additional hours for team leaders to participate in strategic planning & wider Trust business.
Also included in these calculations where additional time for specialist midwives to undertake audits, staff training, quality and service improvement, people management, and budget management.

Current Clinical specialist midwives funded- 13.52wte
Comparison/ Recommended specialist midwives birth rate plus- 26.94wte
Variance – 13.42 WTE shortfall

Historical birth rate plus assessments did not include the calculations for clinical specialist midwives and non – clinical posts to support such roles. As reflected in minimal evidence requirements, this is now a MIS recommendation within SA5.

Whilst there is a shortfall of 13.42 further work force analysis is now completed. This supports further understanding and demonstrates the clinical and non-clinical midwifery requirements guided for costing and reflected in a business case listed for resubmission with a phased plan for implementation in quarter four financial year 2023/24.

In addition, important to note within the birth rate plus findings the recommended uplift for maternity staff training of is based on 25%, as opposed to the funded 22% as set within roster key performance indicators (KPIs) this is due to the amount mandatory training requirements including essential to role and MIS safety action 8 MDT training and core competency Version 3 curriculum. This has been reflected within ELHT Business case 2, inclusive in the midwifery workforce calculator as a system wide standard approach within L@SC system.

Recruitment of posts following business case one / birth rate plus/ application of professional judgement.

ELHT maternity services were allocated funding prior to the birth rate plus taking place following the abridged professional judgement findings to fill some of the posts required to deliver on the national maternity safety programmes, and work towards the birth rate plus expected requirements. The clinical and non-clinical posts funded in budget are as follows:

1. Consultant Midwife – band 8B (1wte)
2. Antenatal Clinic Service Lead/Matron - 8A (1wte)
3. Additional Quality and safety lead for Maternity & Neonatology to cover PMRT, MNSI, ATAIN/CNST/Ockenden requirement – Band 8A (1wte)
4. Additional Central Birth Suite Co-ordinator Band 7 (1wte)
5. Fetal Medicine Specialist Midwife - Band 7 (1wte)
6. Fetal Monitoring Lead Midwife - Band 7 (0.6wte - already in post 0.4)
7. Prevention Lead Specialist Midwife – Band 7 (1wte) – CNST/Ockenden requirements
8. Maternal Medicine Lead - Band 7 (1wte) - Ockenden requirement
9. Project Manager/QI Support – Band 4 (1wte) - CNST/ Ockenden requirement
10. Fail/safe officer/ Administrator – Band 4 (1wte) – Ante natal and new-born screening.

Progress/ Monitoring, Assurance aligned with SA5/ MIS technical guidance

ELHT maternity services hold safety huddles four times within 24-hour period / 7 days a week, safe staffing levels are risk assessed at each safety huddle. If maternity staffing is risk assessed with unpredicted shortfalls, additional leadership/ staffing huddles are scheduled to enable protected time to allow for escalation and address any shortfalls with timely planning. This includes roster management of a substitute coordinator, supported by an eroster coordinator and staffing lead to actively redeploy with the clinical oversight and cover shifts to meet the daily staffing acuity and activity

Any potential midwifery red flags are reflected at the safety huddles to mitigate and resolve. (Local and regional policies, safety huddles, staffing numbers, shortfalls, mitigation, and plans are evidenced and accessible on Maternity SharePoint.)

Details of planned versus actual midwifery staffing levels are calculated daily, reflected monthly and formulate part of the overall ELHT nursing and midwifery monthly staffing report, NICE midwifery red flags are reflected in the monthly report.

Over the last six months Minimum midwifery red flags under the category of a delay of two hours or more between admission for induction and beginning the process have been reported The midwifery red flags are also reflected as part of the perinatal quality surveillance model (PQSM) dashboard which is an ask of CNST - safety action 9 (Part A) this dashboard is a minimum dataset. this dashboard is presented at every trust board for oversight.

Careful planning with the redeployment of midwives and maternity support workers who have the appropriate skills and competencies to work within the areas of shortfalls is well led within the culture of ELHT maternity services. Daily/ weekend and BH staffing plans are available on the maternity SharePoint portal. Cross divisional working with neonatology is key to address any shortfalls to cover transitional care on the post-natal ward to aid zero separation policies aligned with MIS - safety action three.

Each month the midwife to birth ratio is calculated and monitored against the required midwife/birth ratio of 1:28. Following introduction of the Birth rate plus acuity tool in January 2023. ELHT can demonstrate roster planning to achieve 100% compliance at the start of every shift for a supernumerary labour ward co-ordinator status and substitute Coordinator is present this has been reflected in the last 6-month period. Birth rate plus acuity app also compliments action.

L@SC/ LMNS (Local Maternity and Neonatal Support) system escalation

In May 2022, the Northwest maternity escalation policy and operational pressures escalation levels framework (OPELF) was launched. 10am daily staffing huddles as a part of the Lancashire and South Cumbria LMNS system take place with a report generated daily to support system working.

This policy supports ELHT to work within the local system to maintain quality and patient safety should any shortfalls occur aligned with the eight escalation triggers within the policy. These include any shortfalls in midwifery staffing.

7. Conclusion

In conclusion the Birth Rate Plus workforce assessment tool completed in September 2022 demonstrated the following:

(i) A short fall of 7.50 WTE staff at bands 3 – 7

(ii) A short fall of 13.42 specialist midwives which may include some non- clinical support, to be completed as part of the workforce analysis.

(iii) With recurrent income received to date and based on professional judgment the net effect of the shortfall is accepted as an accurate assessment.

(iv) ELHT maternity services have completed recruitment of BC 1/ income received to increase Birthrate+ Staffing requirements and have completed a second business case for the above.

(v) ELHT maternity services can offer assurances and evidence that robust governance mechanisms are in place and aligned with the required standards to achieve CNST Safety Action 5/ year 6.

(vi) Current Evidence reflected within maternity services SharePoint portal

Appendix 1

National (NICE midwifery red flags)

Midwifery red flag events (ELHT/C135- Nursing and Midwifery safe staffing policy – Version 3 (Nice guidance/ Appendix 6, page 24)

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

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

(NICE, 2021)

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	N/A
Abdullah	Cooled baby	Yes	Yes	Yes	Yes	Accepted	Yes	Yes
Bell	Cooled baby	Yes	Yes	Yes	Yes	No	N/A	N/A
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	Yes	Yes	Yes M24CT645/022
Arthern	Intrapartum stillbirth	Yes	Yes	N/A	Yes	Yes	N/A	N/A
Imran	Maternal Death	Yes	Yes	N/A	Yes	Yes	N/A	N/A
Naz	Cooled baby	Yes	Yes	Yes	Yes	Yes	Yes	Yes M24CT645036
Mahmood	Cooled baby	Yes	Yes	Yes	Yes	Yes	Yes	Yes M24CT645/034
Imran	Maternal death	Yes	Yes	N/A	Yes	Yes	N/A	N/A

Evidence of letters and referrals and acceptance are on Sharepoint;

MNSI rejection and acceptance information CNST year 6

Evidience of MNSI NHSR DOC letters given to families

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** 129

11 September 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 July 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 77% target in July at 81.81%.
- Performance against the ELHT four hour standard was 80.89% in July.
- No patients waited over 78 weeks.
- The number of RTT pathways over 65 weeks is below trajectory at 212.
- In July, there were 3,450 breaches of the RTT >52 weeks standard, which is below the trajectory.
- The Cancer 28 day faster diagnosis standard was above target in June at 80.2%.
- Performance against the cancer 62 day standard was above the 70% threshold in June at 70.4%.
- Friends & family scores remain above threshold for inpatients, outpatients, and community in July.
- The overall Trust performance from the range of patient experience surveys was above the threshold of 90% for 4 of the 4 competencies.
- There were no stillbirths no maternal deaths in July.
- The Trust turnover rate continues to show usual variation compared to pre-covid levels at 7.62% and remains below threshold.

Areas of Challenge

- There was 1 Steis reportable incident in July. This was not a never event.
- There were 13 healthcare associated clostridium difficile infections identified in July.
- There were 11 post 2 day E.coli bacteraemia identified in July.
- There were 2 P.aeruginosa bacteraemia identified in July.
- There was 1 Klebsiella detected in July.
- 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 were 907 breaches of the 12 hour trolley wait standard (61 mental health and 846 physical health).
- There were a total of 3180 ambulance attends with 588 ambulance handovers > 30 minutes and 61 > 60 minutes.

- Friends & family scores in A&E and maternity are below threshold.
- Performance against the cancer 31 day standard remains below the 96% threshold in June at 93.7%.
- The 6wk diagnostic target was not met at 15.9% in July.
- In July, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 72,342.
- In July, there were 6 breaches of on the day operations cancelled and not rebooked within 28 days.
- The Trust vacancy rate is above threshold at 7.5%.
- Sickness rates are above threshold at 6.46%
- Compliance against the Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 13%.
- The Trust is reporting a deficit of £20.4m for the 2024-25 financial year to date, £1.3m behind plan.

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	Jul-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		
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		Awaiting update following resubmission
HSMR	Dr Foster	Performance team		Awaiting update following resubmission
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		CQUINs paused nationally 2024/25
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 lengths of stay		Corporate information		
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	11		
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	2		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	n/a	37		
M124	E-Coli (HOHA)	n/a	9		
M124.ii	E-Coli (COHA)	n/a	2		
M124.iv	E-Coli cumulative from April (HOHA & COHA)	n/a	47		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	1		
M155.ii	P. aeruginosa bacteraemia (COHA)	n/a	1		
M155.3	P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)	n/a	3		
M157	Klebsiella species bacteraemia (HOHA)	n/a	0		
M157.ii	Klebsiella species bacteraemia (COHA)	n/a	1		
M157.3	Klebsiella species bacteraemia cumulative from April (HOHA& COHA)	n/a	16		
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	34.8		
M69	Serious Incidents (Steis)	No Threshold Set	1		
M70	Central Alerting System (CAS) Alerts - non compliance	0	1		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	85%		

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	27%		
C40	Maternity Friends and Family - % who would recommend	90%	86%		
C42	A&E Friends and Family - % who would recommend	90%	78%		
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	14%		
C44	Community Friends and Family - % who would recommend	90%	93%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	96%		
C15	Complaints – rate per 1000 contacts	0.40	0.20		
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	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	0		
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)	77.0%	80.9%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	77.0%	81.8%		
M62	12 hour trolley waits in A&E	0	907		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	588		
M84	Handovers > 60 mins (Arrival to handover)	0	61		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	40.2%		
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set	56.3%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	74,733	72342		
C37.4	Referral to Treatment (RTT) 65 Weeks (Ongoing)	220	212		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	3452	3450		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	5.0%	15.9%		
C50.1	62d General Standard	70.0%	70.4%		
C50.2	31d General treatment standard	96.0%	93.7%		
C50.3	28d General FDS	75.0%	80.2%		
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	6		
M138	No.Cancelled operations on day	No Threshold Set	92		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re-admissions within 30 days				
M91.1	Emergency average length of stay (excluding 0 and 1 days)	No Threshold Set	11.5		
M91.2	Emergency average length of stay (including 0 and 1 days)	No Threshold Set	8.6		

Well Led

	Indicator	Target	Actual	Variation	Assurance
M77	Trust turnover rate	12.0%	7.6%		P
M78	Trust level total sickness rate	4.5%	6.5%		?
M79	Total Trust vacancy rate	5.0%	7.5%		F
M80.3	Appraisal (Agenda for Change Staff)	90.0%	83.0%		F
M80.35	Appraisal (Consultant)	90.0%	98.0%		?
M80.4	Appraisal (Other Medical)	90.0%	98.0%		?
M80.2	Safeguarding Children	90.0%	94.0%		P
M80.21	Information Governance Toolkit Compliance	95.0%	92.0%		?
F8	Temporary costs as % of total paybill	4%	12.6%		F
F9	Overtime as % of total paybill	0%	0%		
F1	Cumulative variance to planned financial performance (deficit) (£m)	£0.0	-£1.3		
F2.1	WRP achieved YTD - variance to plan (£m)	£0.0	£0.0		
F3	Liquidity days	-21.1	-17.8		
F4	Capital spend v plan	85.0%	97%		
F18a	Capital service capacity	0.3	-0.1		
F19a	Income & Expenditure margin	-4.4%	-8.5%		
F21d	Agency spend as a proportion of total pay bill (£m)	3.2%	2.2%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	90.6%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	97.0%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	95.9%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	98.4%		

NB: Finance Metrics are reported year to date.

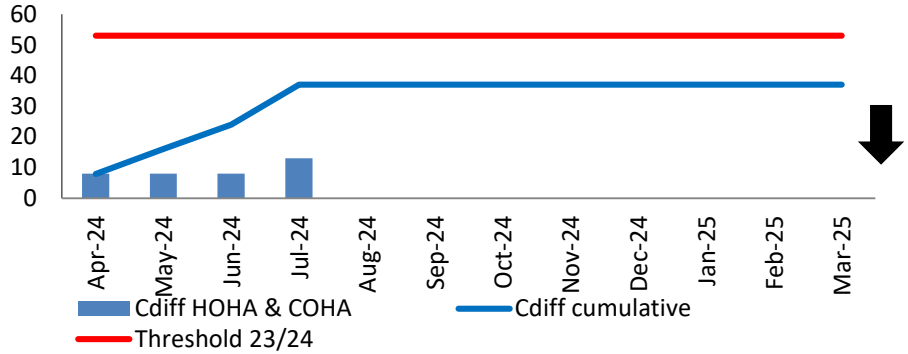
KEY

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 as per updated guidance from UKHSA (UK Health Security Agency). Where a patient has been admitted directly after attendance to A&E it is requested the decision to admit date is entered as the A&E decision to admit date rather than the inpatient admission date.

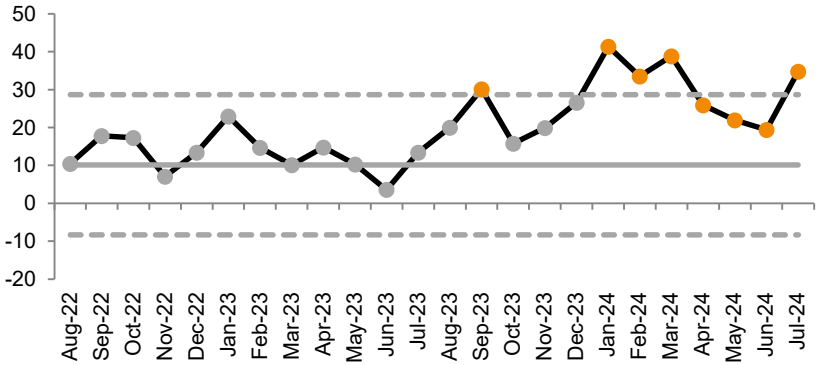
There were 0 post 2 day MRSA infection reported in July. So far this year there has been 1 case attributed to the Trust.

The Clostridium difficile objective for 2024/25 has not yet been set by NHS England. 2023/24 was 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.

There were 13 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in July; 11 HOHA and 2 COHA.

The detailed infection control report will be reviewed through the Quality Committee.

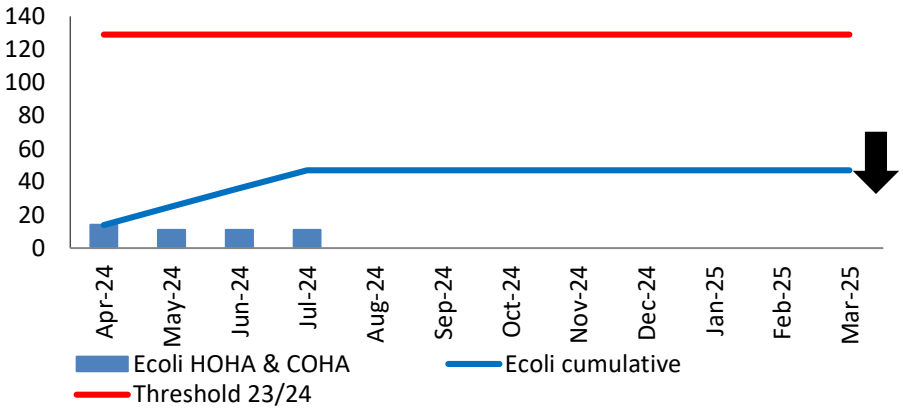
C Diff per 100,000 Occupied Bed Days (HOHA)



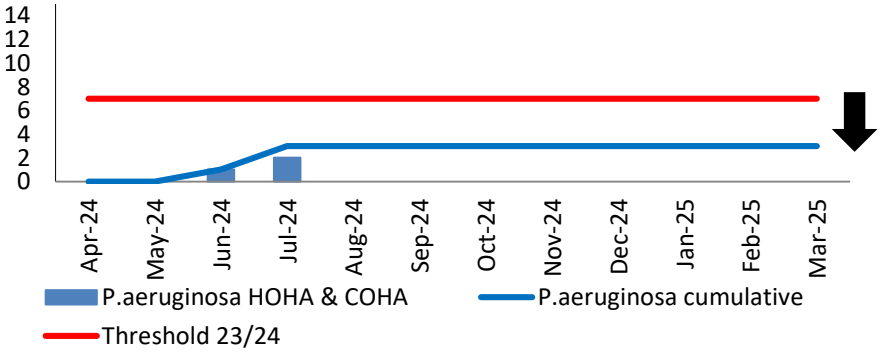
The rate of HOHA infection per 100,000 bed days is significantly higher than normal variation in July.

SAFE

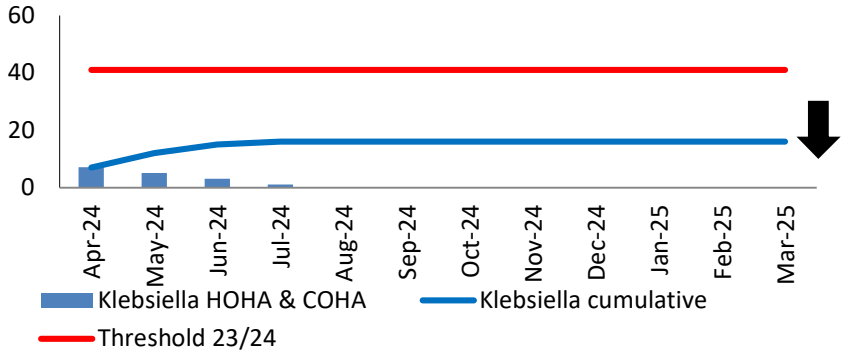
E. Coli (HOHA & COHA)



P.aeruginosa



Klebsiella



The UK Government has developed a new AMR 5 year national action plan, 'Confronting antimicrobial resistance 2024 to 2029', which builds on the achievements and lessons from the first national action plan. Its overall aims are to:

* optimise the use of antimicrobials.
* reduce the need for, and unintentional exposure to, antibiotics.
* support the development of new antimicrobials.

The National action plan contains a number of ambitions, including:

* By 2029, we aim to prevent any increase in a specified set of drug resistant infections in humans from the 2019 to 2020 financial year baseline.
* By 2029, we aim to prevent any increase in gram-negative bloodstream infections (which are described as difficult to treat infections) in humans from the FY 2019 to 2020 baseline.
* By 2029, we aim to increase UK public and healthcare professionals' knowledge on AMR by 10%, using 2018 and 2019 baselines, respectively.
* By 2029, we aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline.
* By 2029, we aim to achieve 70% of total use of antibiotics from the access category (new UK category) across the human healthcare system.

No trajectories have been set for 2024-25 by NHS England.

The 23-24 trajectory for reduction of E.coli was 129 HOHA & COHA. The total for 2023-24 was 134.

There were 11 reportable cases of E.coli bacteraemia identified in July; 9 HOHA and 2 COHA.

There were 2 reportable case of Pseudomonas identified in July, 1 HOHA and 1 COHA.

There was 1 reportable cases of Klebsiella (COHA) identified in July.

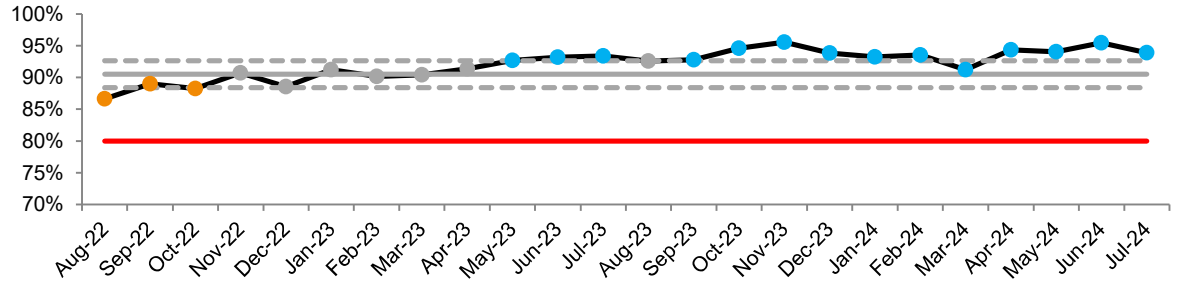
Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

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

SAFE

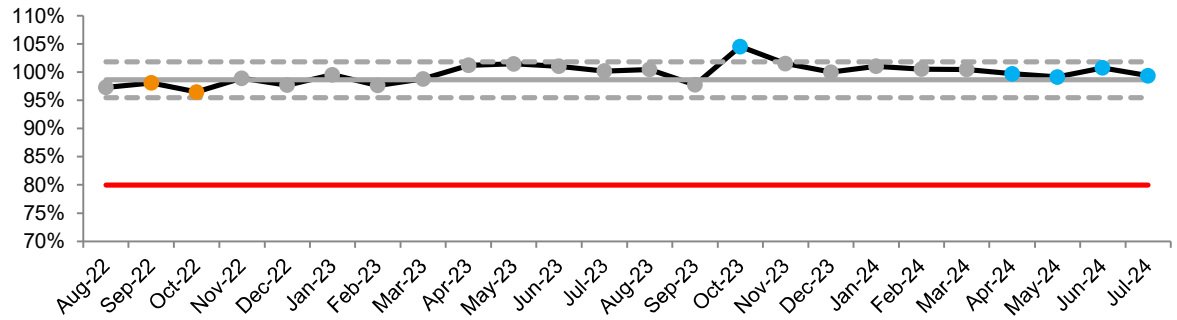
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



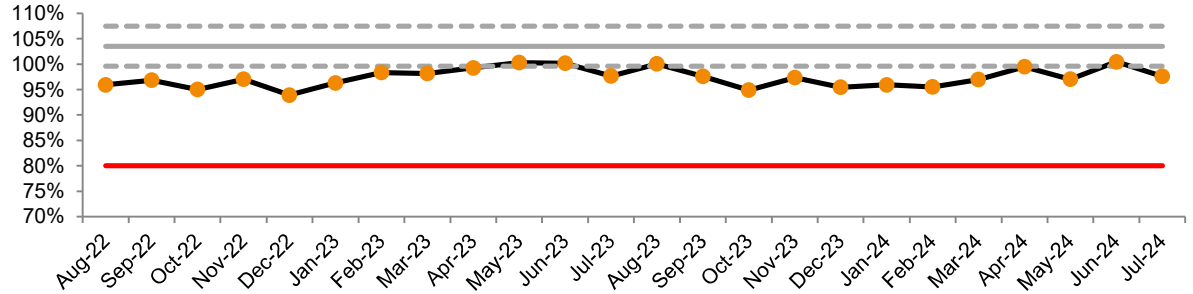
The average fill rate for registered nurses/ midwives during the day is showing improving variation when compared to the pre covid levels. Based on current variation it will consistently be above threshold.

Registered Nurses/ Midwives - Night



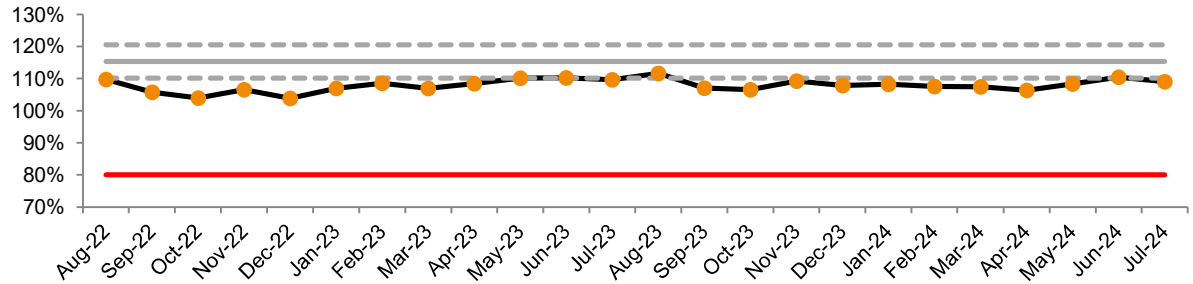
The average fill rate for registered nurses/ midwives at night is showing improving variation when compared to pre-covid levels. Based on current variation it will consistently be above threshold.

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 43 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 the overall fill rates and the average fill rates per hospital site at ELHT in July.

	Day Average Fill Rate %		Night Average Fill Rate %	
Hospital site	**Registered nurses / midwives (%)**	**Care staff (%)**	**Registered nurses / midwives (%)**	**Care staff (%)**
Royal Blackburn	93.4	95.0	99.5	111.1
Burnley General	94.9	98.9	97.7	104.8
Clitheroe Community	85.2	117.3	101.1	112.1
Pendle Community	100.6	109.6	104.0	101.8
Total	**97.6**	**97.6**	**99.4**	**109.1**

*Clitheroe Community (Ribblesdale Ward) have high long and short sickness, this was 13.7% in April, reduced to 11.25% in July, no particular themes. 1.88 WTE band 5 vacancies with 1.88 WTE NQN allocated to commence in September. Due to the geographical location it is difficult to place internationally recruited nurses here. The ward was safely staffed throughout July.

Latest Month - Average Fill Rate

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Jul-24	93.9%	97.6%	99.4%	109.1%	31,622	8.24	2	1	0	0

Monthly Trend

The table below demonstrates the month-on-month overall average fill rate, CHPPD and wards < 80%.

	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 (%)
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
Apr-24	94.3%	99.5%	99.7%	106.4%	30,852	8.05	0	1	1	1
May-24	94.1%	97.1%	99.2%	108.3%	31,886	8.02	0	1	0	0
Jun-24	95.5%	100.5%	100.7%	110.4%	30,887	8.34	0	1	0	0
Jul-24	93.9%	97.6%	99.4%	109.1%	31,622	8.24	2	1	0	0

SAFE

During July <80% fill rate:

< 80% Registered staff		
Day	Blackburn birth centre	79.90
Day	Burnley birth centre	71.60
Night	-	-

< 80% Care staff		
Day	NICU	71
Night	-	-

Blackburn Birth Centre – In July this is largely due to staffing gaps due to vacancies and short term sickness and the BBC being on divert to staff to support other areas. Safely staffed for acuity.

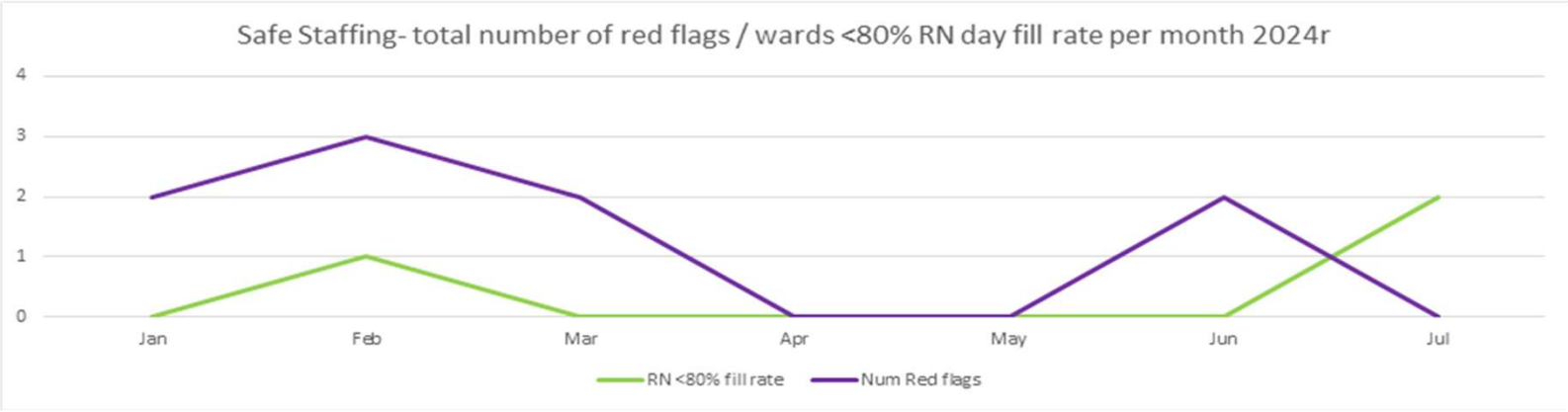
Burnley Birth Centre - In July this is largely due to staffing gaps due to vacancies and short term sickness and the BBC being on divert to staff to support other areas Safely staffed for acuity.

NICU – NICU HCA funded establishment does not cover all shifts. Safely staffed for acuity.

National Red Flags

0 national nursing red flags reported in July.
0 maternity red flags reported in July.

The graph below demonstrates the number red flags and wards < 80% RN day fill rate per month trend.



Family Care

Month	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Staffed to full Establishment	01:26	01:26	01:26	01:26	01:27	01:26	01:26	01:26	01:25	01:26
Excluding mat leave	01:26	01:26	01:26	01:27	01:26	01:27	01:27	01:27	01:26	01:28
Maternity leave	3.04	5.04	4.40	6.40	6.40	6.40	9.60	9.60	15.76	17.12
With gaps filled through ELHT Midwife staff bank Per week	Bank Usage 22.26	Bank Usage 16.12	Bank usage 15.60	Bank usage 24.36	Bank usage 24.19	Bank usage 23.16	Bank usage 28.47	Bank usage 20.65	Bank usage 9.20	Bank usage 19.92
Midwifery vacancies (Maternity VRS) -11wte	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	15 wte Backfill 11 for Maternity leave incl	15 wte Backfill 11 for Maternity leave incl	12 wte Backfill 6 for Maternity leave incl	6 wte Backfill 11 wte for maternity leave

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. There has been an increase in bank filled duties which was low last month, this is due to short term sickness and vacancies.
Recruitment within maternity is a constant with a successful 'Recruitment Drive' in May 2024 has been successful in offering 16.25 WTE midwifery posts which are expected to commence in September. All Student Midwives have been offered substantive posts as per the Trust initiative for this year, and there are 6 WTE vacancies currently due to ongoing turnover of staff which will be going to advert shortly.
Antenatal Clinic Outpatients services throughout July/Aug have reduced staffing levels due to vacancies and sickness. A rota is in place for Specialist Midwives to support clinical shifts across this area of Maternity to support safe staffing.
Local midwifery red flags noted at each handover and reviewed by the local governance team on a weekly basis.

Neonatology –Staffing levels meet the requirements for the acuity/ activity aligned with the NW connect safe staffing tool. The planned versus actuals meet the safe staffing requirements for the days in month of July 2024, this is equal to the number of infants required intensive, special, and high dependency care. Daily maternity/ Neonatology safety huddles inclusive of safe staffing tool completed twice daily, more frequently if required. Risk assessments prior to agency nurse cover requests are discussed with the Deputy Chief Nurse and Chief Nurse.

Paediatrics – No staffing exceptions

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

Nurse and Midwifery Staffing Data - July

Current vacancies

Vacancies	Establishment	SIP	Vacant	Vacant %
Midwife	292	281	11	3.68%
Nurse	2835	2685	150	5.30%
HCA	1338	1163	175	13.09%
Grand Total	**4465**	**4129**	**336**	**7.53%**

Ethnicity

Ethnicity	HCA	Midwife	Nursing	Grand Total
BME	257	39	856	1152
Not Stated	9	0	12	21
White	1086	305	2100	3601
Grand Total	**1352**	**344**	**2968**	**4664**

Gender

Gender	HCA	Midwife	Nursing	Grand Total
Female	1187	343	2777	4307
Male	165	1	191	357
Grand Total	**1352**	**344**	**2968**	**4664**

Age Band	HCA	Midwife	Nursing	Grand Total
<=20 Years	31			31
21-25	85	22	167	274
26-30	118	50	411	579
31-35	179	52	522	753
36-40	169	57	446	672
41-45	139	52	337	528
46-50	149	35	335	519
51-55	183	27	343	553
56-60	188	33	235	456
61-65	98	15	147	260
66-70	10	1	19	30
>=71 Years	3	0	6	9
Grand Total	**1352**	**344**	**2968**	**4664**

SAFE

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 Heads of Nursing. The meeting is outcome focused and manages the risk across the Trust.

Recruitment/retention nursing and midwifery trust activity overview

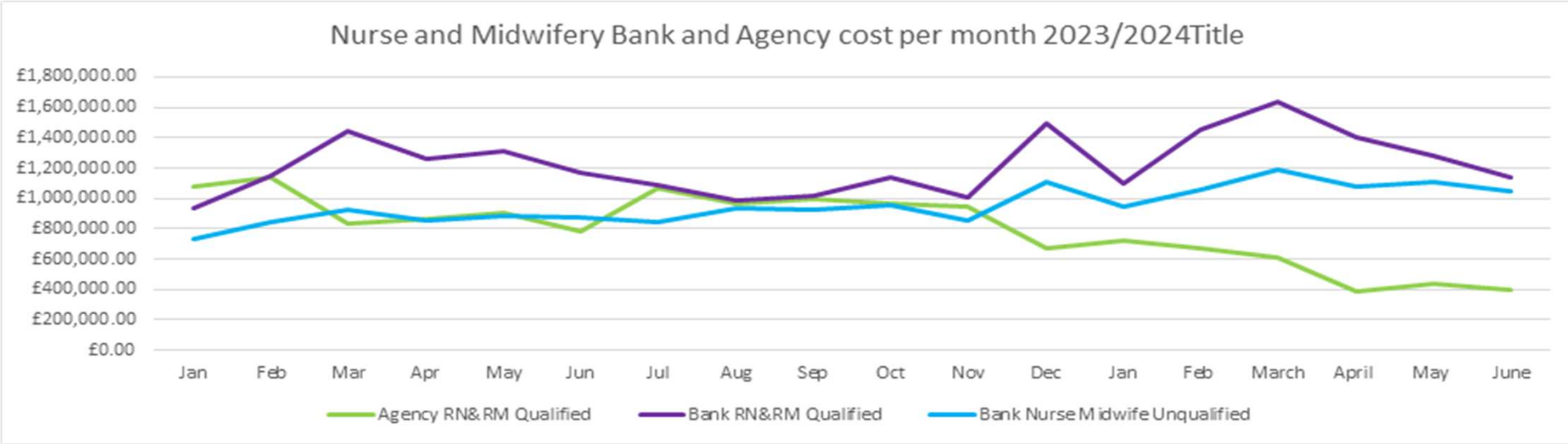
International Nursing Recruitment - remains paused, this is largely due to an evidenced reduction in appropriate band 5 nursing vacancies and to accommodate NQN September intake. Still under review. 20 in April, 18 in May, 20 in June, 20 in July, 20 in August, 20 in September, 16 in October, 16 in November, 11 in December, 8 in January, Paused, 5 due in May, 5 due in July, Paused indefinitely.

HCA Recruitment / Retention - ESR data 106 band 2 WTE HCA vacancies. HCA recruitment event is planned for August to recruit 34 staff.

Trainee Nurse Associate –recruited 20 to commence in Sept 2024 and 20 agreed to recruit in March 2025.

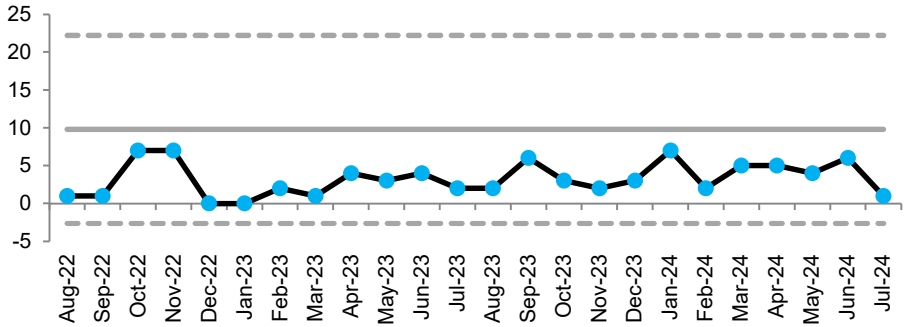
RNDA – Recruit 12 in September 2024 and 20 in September 2025.

Nursing and Bank and Agency Spend



SAFE

Serious Incidents



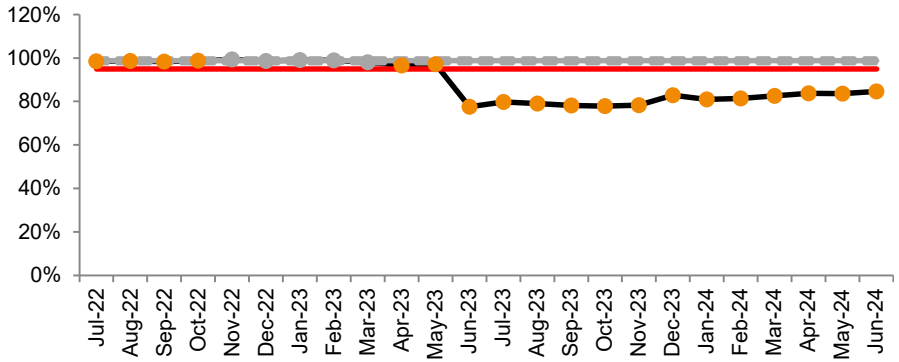
There were no never events reported in July.

One incident meeting a national or local priority and whereby a patient safety incident investigation (PSII) are underway, have been reported onto STEIS in July.The Trust started reporting under these priorities on 1st December 2021.

A detailed report providing assurance on the management of each of the STEIS reported incidents is submitted monthly to the Trust Board and Quality Committee.

PSIRF Category	No. Incidents
National priority - incident resulting in death	1

VTE assessment



Venous Thromboembolism (VTE) data between June 23 and March 24 was not submitted nationally, figures are calculated retrospecively.

SAFE

Pressure Ulcers

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

	Total Number of Incidents developed under ELHT Care		
	2022-2023	2023 - 2024	1.4.2024 – 31.7.2024
	717	847	197
Category of Pressure Ulcer	Total Number of Lapses in Care		
2	73	78	8
3	6	17	18
4	9	10	0

Since the 1st April 2024, 197 pressure ulcer incidents have been reported on patients under the care of the ELHT with 26 confirmed lapses in care (9%) – however there are 36 outstanding checklists from the 1st April 2024 to be finalised which may alter the numbers of lapses in care. The lapses of care are not raised.

The Trust continues to see high attendances through the ED department of complex and high acuity patients which has resulted in long waits within the ED department, following a decision to admit, despite increasing the bed base across the inpatient sites. An increase in activity is also reflective within the District Nursing service which is averaging over 1300 visits per day as from the 1st July LSCFT (BWD) Physical Health Services transferred into ELHT, this is reflected in more reporting and more investigations.

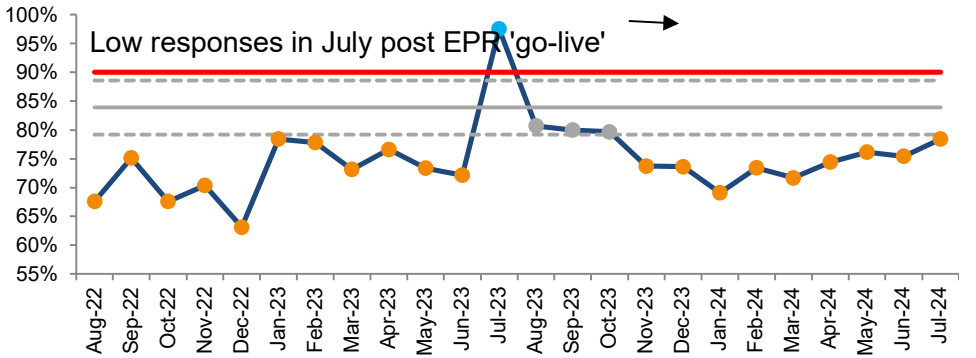
Compliance with the pressure ulcer and moisture associated damage e-learning is 90.74% and 91.02% retrospectively -each Divisional Lead as part of the Pressure Ulcer Steering Group has actions in place to increase the compliance to 95%.A Quality Improvement project continues to focus on improving the delivery of continence care within the Trust. As part of that project the inpatient continence formulary is being reviewed which will aim to ensure that the right product is prescribed for the patient.

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.

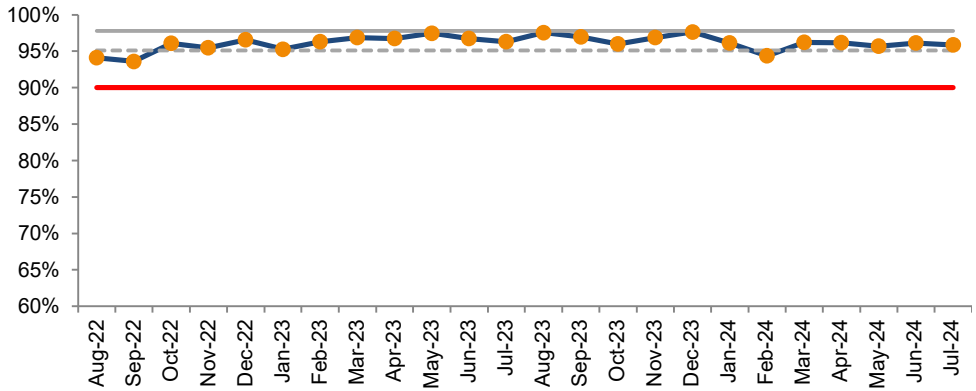
Baseline period for SPC comparison is Apr 18 - Mar 20

Friends & Family A&E



A&E scores are below threshold in July. 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.

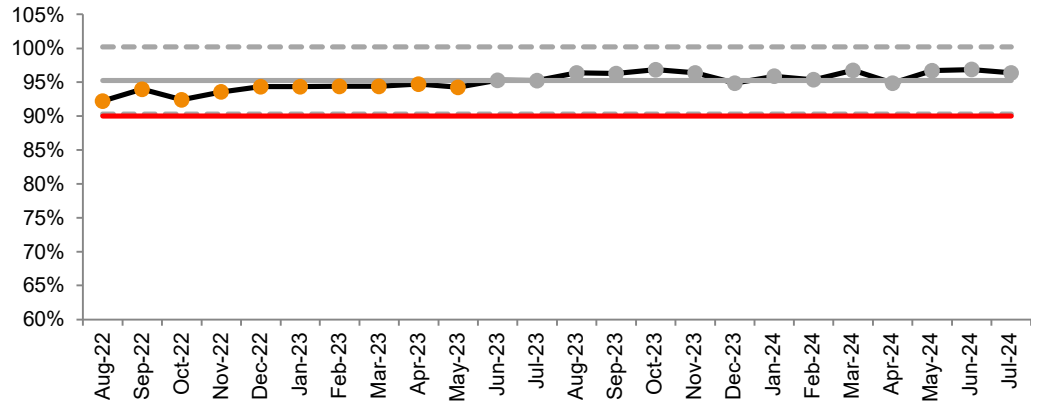
Friends & Family Inpatient



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.

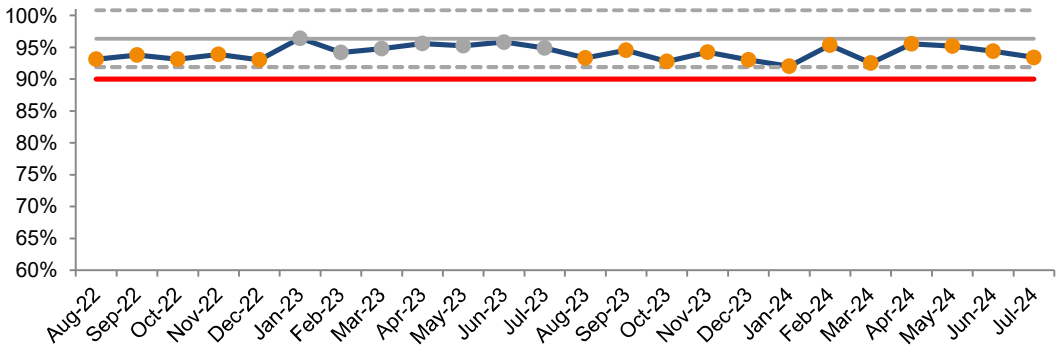
CARING

Friends & Family Outpatients



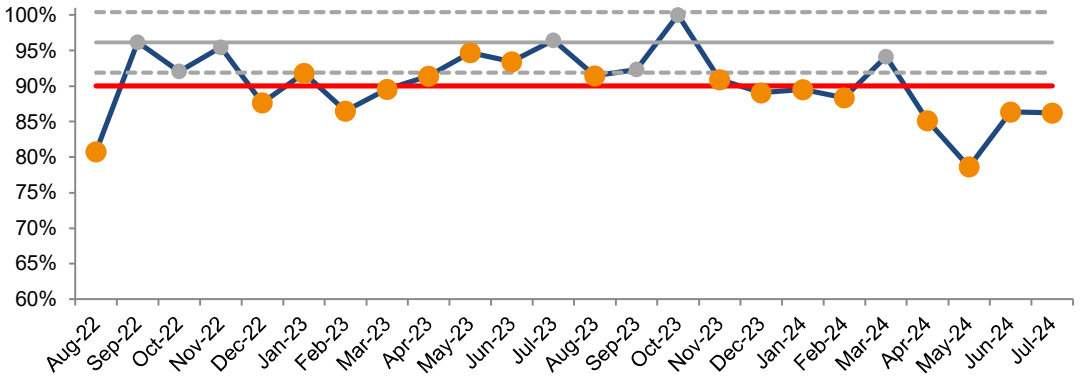
Outpatient scores continue to be above target and are within the normal range when compared to the pre-covid baseline. Based on current variation this indicator should consistently hit the target.

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.

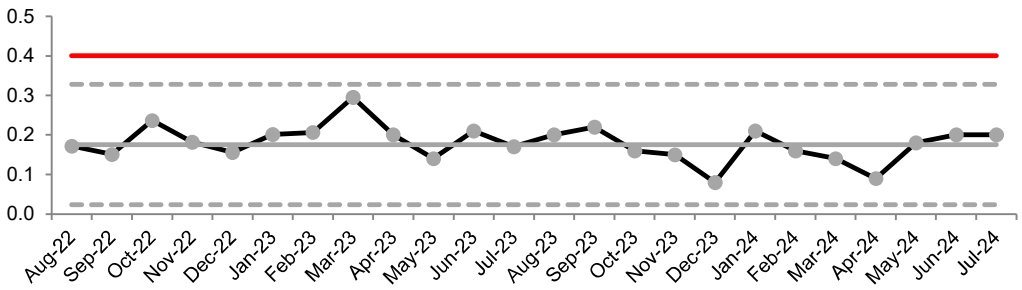
Friends & Family Maternity



Maternity scores are below target this month and show deterioration when compared to the pre-covid levels.Based on normal variation this indicator would consistently hit the target.

CARING

Complaints per 1000 contacts



The Trust opened 29 new formal complaints in July.

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

For July the number of complaints received was 0.20 Per 1,000 patient contacts.

The trend is showing usual variation and based on variation will consistently acheive the target.

Patient Experience

		Dignity	Information	Involvement	Quality	Overall
Type	**Division**	Average Score	Average Score	Average Score	Average Score	Average Score
Antenatal	Family Care	100.00		100.00	100.00	100.00
Community	Community and Intermediate Care Services	94.31	92.45	92.97	92.35	93.06
Community	Diagnostic and Clinical Support	100.00	100.00	100.00	100.00	100.00
Community	Family Care	100.00	100.00	100.00	100.00	100.00
Community	Surgery	98.80	97.78			98.05
Delivery	Family Care	100.00		100.00	100.00	100.00
ED_UC	Diagnostic and Clinical Support				97.50	97.50
Inpatients	Community and Intermediate Care Services	85.14	78.17	83.25	85.24	82.73
Inpatients	Diagnostic and Clinical Support	98.74	92.62	93.09	95.82	95.71
Inpatients	Family Care	95.69	92.45	94.23	93.13	94.00
Inpatients	Medicine and Emergency Care	91.83	96.26	88.18	89.88	88.84
Inpatients	Surgery	94.19	88.54	93.07	92.88	92.23
OPD	Diagnostic and Clinical Support	100.00	99.19	100.00	92.06	98.66
OPD	Family Care	91.67	75.00	100.00	0.00	67.50
OPD	Medicine and Emergency Care	98.91	97.76	98.47	96.96	97.87
Postnatal	Family Care	100.00	100.00	100.00	100.00	100.00
SDCU	Family Care	97.73	97.50	91.67	98.21	95.64
	Total	**95.16**	**92.76**	**92.15**	**93.22**	**93.27**

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

The Trust has an established mortality steering group which meets monthly to review performance and develop specific action plans for any alerting mortality groups identified.

EFFECTIVE

Structured Judgement Review Summary

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 - Mar 24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	TOTAL
Deaths requiring SJR (Stage 1)	47	212	250	262	214	163	231	167	14	12											26
Allocated for review	46	212	250	262	214	163	231	132	2	2											4
SJR Complete	46	212	250	262	214	162	230	94	0	0											0
1 - Very Poor Care	1	1	0	0	1	1	1	1	0	0											0
2 - Poor Care	8	19	22	34	35	22	41	17	0	0											0
3 - Adequate Care	14	68	70	70	65	49	75	23	0	0											0
4 - Good Care	20	106	133	129	103	78	106	49	0	0											0
5 - Excellent Care	3	18	25	29	10	12	7	4	0	0											0
Stage 2																					
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	42	22	1	0											1
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	0	0	1	0											1
Allocated for review	6	18	21	30	35	22	42	22	0	0											0
SJR-2 Complete	6	18	21	30	35	22	42	20	0	0											0
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0											0
2 - Poor Care	3	6	7	13	13	10	21	8	0	0											0
3 - Adequate Care	2	10	13	13	21	10	16	8	0	0											0
4 - Good Care	0	1	0	2	1	1	4	4	0	0											0
5 - Excellent Care	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 - Mar 24	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	1	0	0	0	0	0	0	35	12	10											22
stage 1 requiring completion	0	0	0	0	0	1	1	38	2	2											4
Stage 1 Backlog	1	0	0	0	0	1	1	73	14	12											26
stage 2 requiring allocation	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											0
Stage 2 Backlog	0	0	0	0	0	0	10	2	0	0											0

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.

The post responsible for managing Doctors revalidation reports and the SJR process is vacant as of 30 June 24. An improvement case (reband + additional hours) was submitted 17/7 and is awaiting consideration by Execs. There has been long delays internally getting to this point. There is currently no capacity to complete this work which has been escalated.

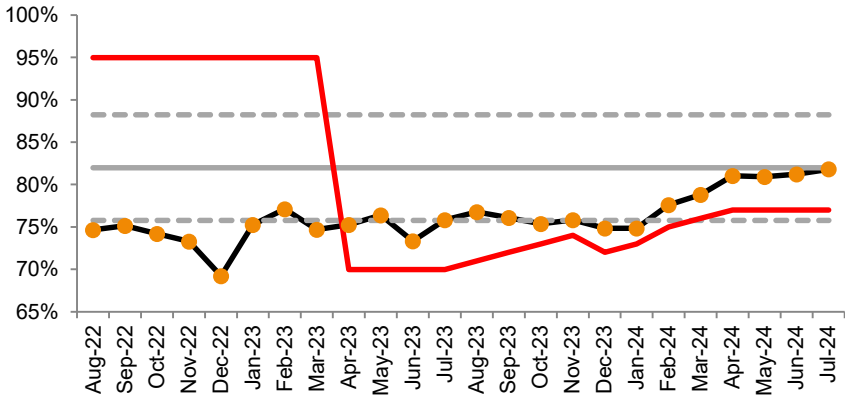
This gap is impacting both processes which are essentially paused and Doctors revalidations are having to go ahead without the required information and the SJR backlog is increasing significantly.

Learning Disability Mortality Reviews

3 completed reviews in July 2024
There are currently 14 reviews outstanding for SJR1
1 referred for SJR2
2 Deaths notified in July 2024
Issues for escalation:
Carer in BIM rather that NOK or advocate as required under MCA 2005
Documenting Carer as NOK on patient record
Please note actions from LeDeR learning are agreed and monitored at Safeguarding Committee.

RESPONSIVE

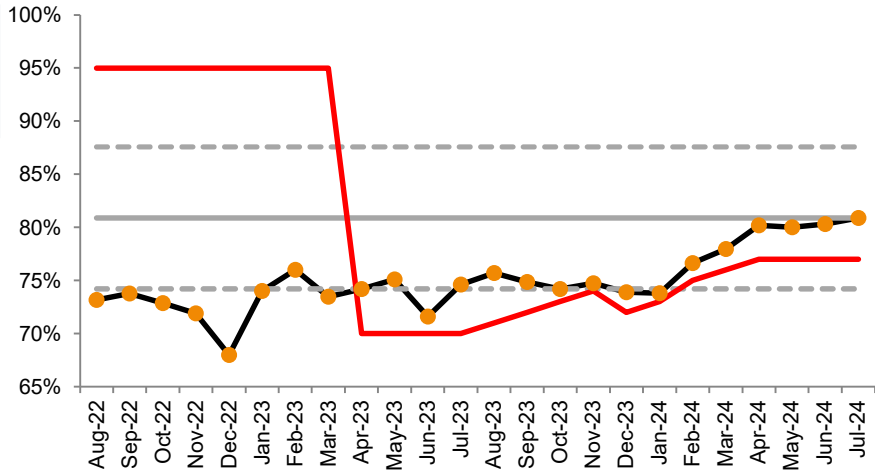
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 81.81% in July, which is above the 77% target.

The trend continues to show a deterioration on previous performance but may deliver the 77% target.

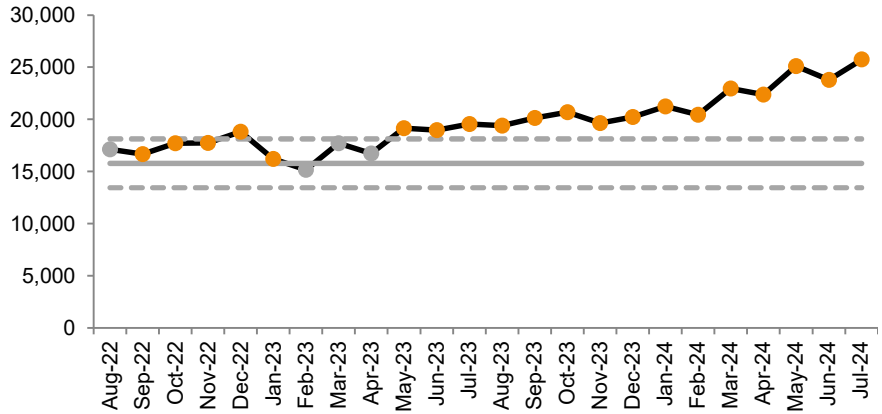
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 80.89% in July, above the 77% trajectory.

The national performance was 75.2% in July (All types).

A&E Attendances - Trust

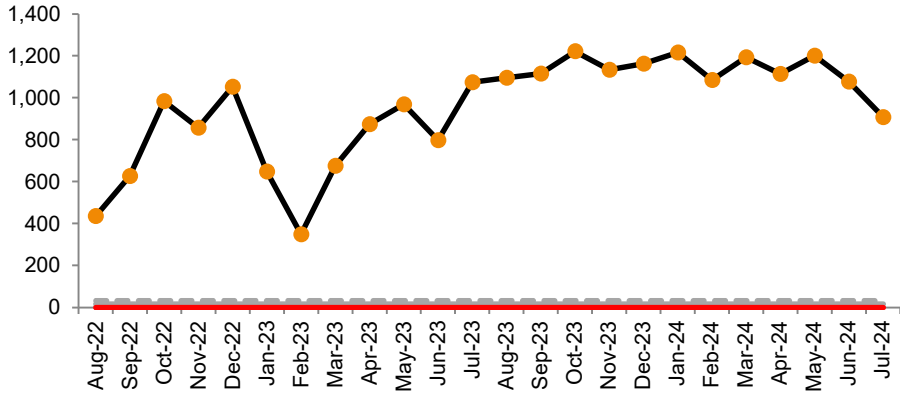


The number of attendances during July was 25,741, which is above the nornal range when compared to the pre-covid baseline.

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

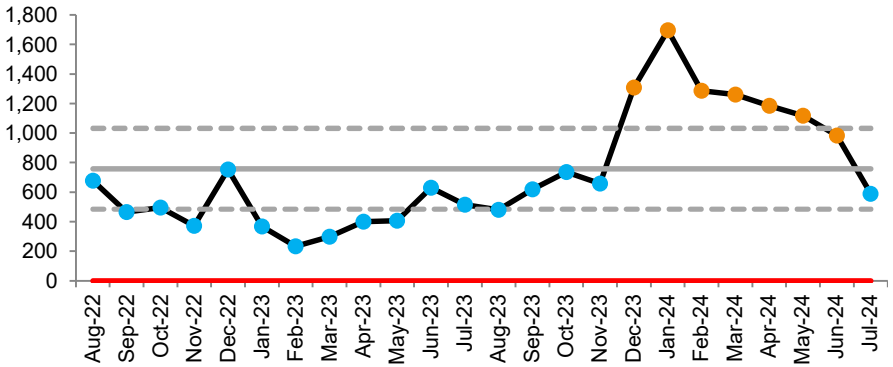


There were 907 reported breaches of the 12 hour trolley wait standard from decision to admit during July, which is higher than the normal range. 61 were mental health and 846 were physical health.

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	61	846
Average Wait from Decision to Admit	37hr 21min	22hr 21min
Longest Wait from Decision to Admit	83hr 0min	59hr 47min

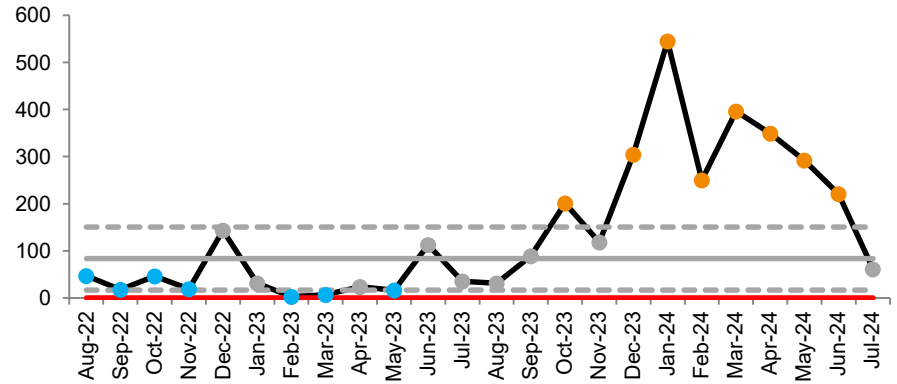
Ambulance Handovers - >30Minutes



There were 588 ambulance handovers > 30 minutes in July. The trend is showing a reduction in recent months, and based on current variation is not capable of hitting the target routinely.

There were a total of 3180 ambulance attends with 588 ambulance handovers > 30 minutes and 61 > 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 23 minutes in July.

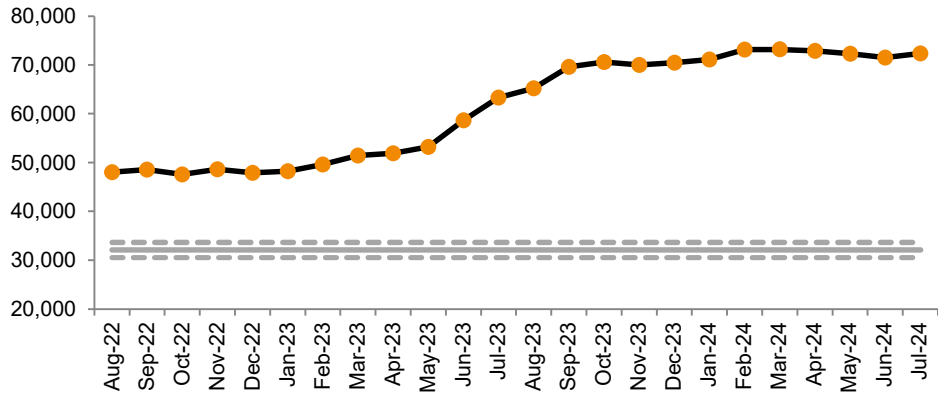
The longest handover in July was reported by NWAS as 3hr 32 minutes. We are working with NWAS to reduce longer waits due to cohorting since the introduction of the HALO system.

RESPONSIVE

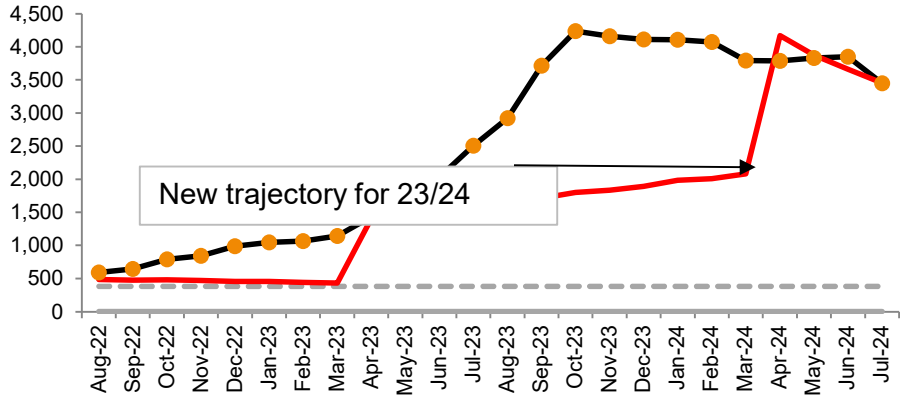
At the end of July, there were 72,342 ongoing pathways, which has increased on last month and is above pre-COVID levels.

There were 3450 patients waiting over 52 weeks at the end of July which has reduced on last month and is below trajectory.
There were 212 patients waiting over 65 weeks at the end of July 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.

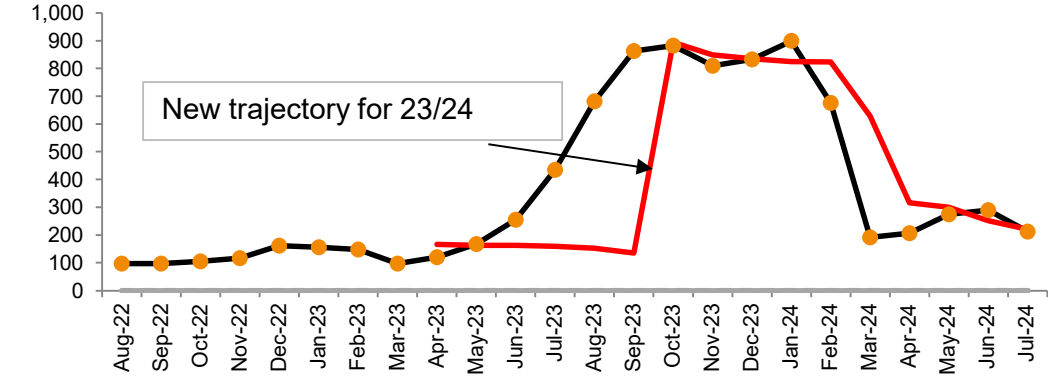
Referral to Treatment (RTT) Total Ongoing



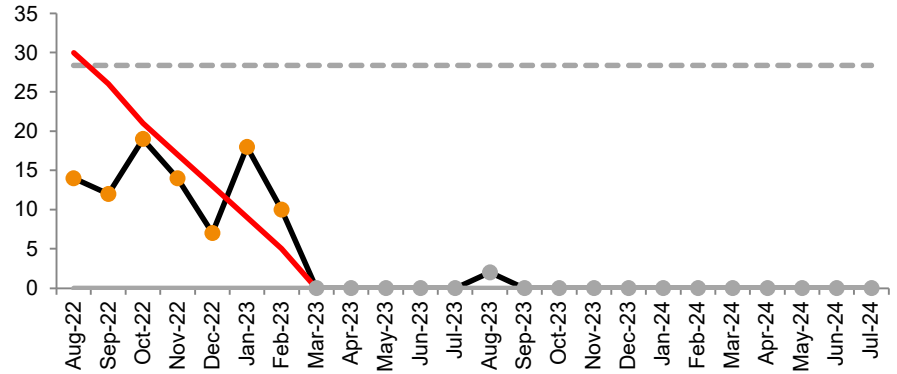
RTT Total Over 52 wks



RTT Total Over 65 wks



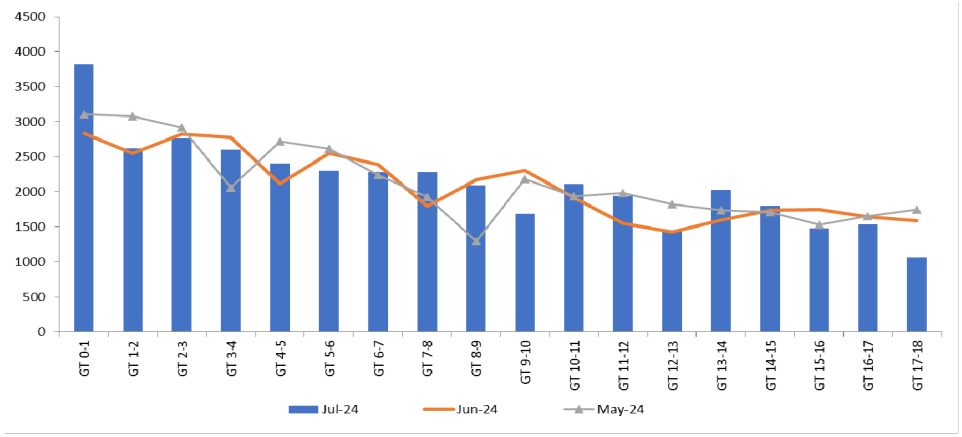
RTT Total Over 78 wks



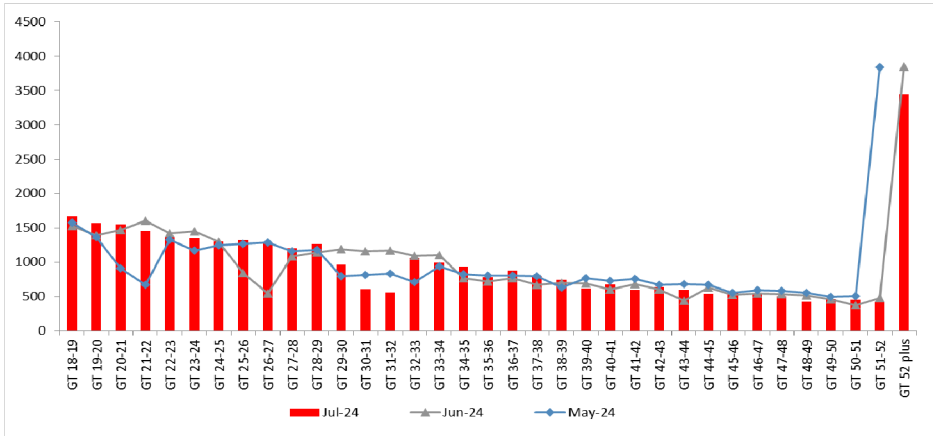
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

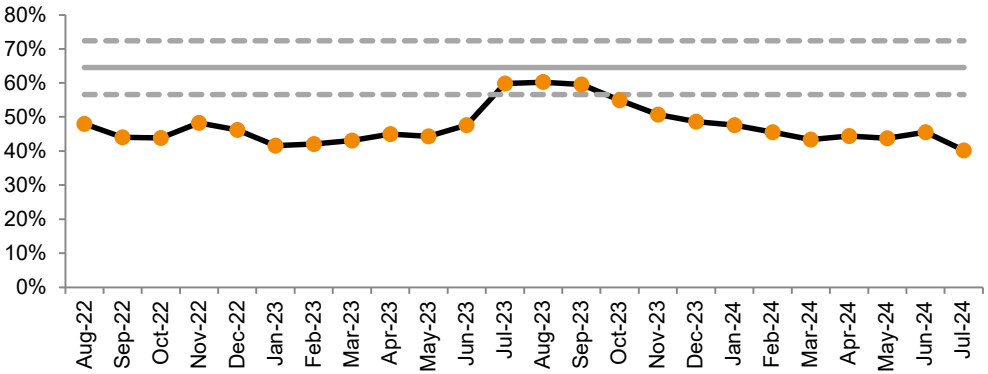


RTT Over 18 weeks

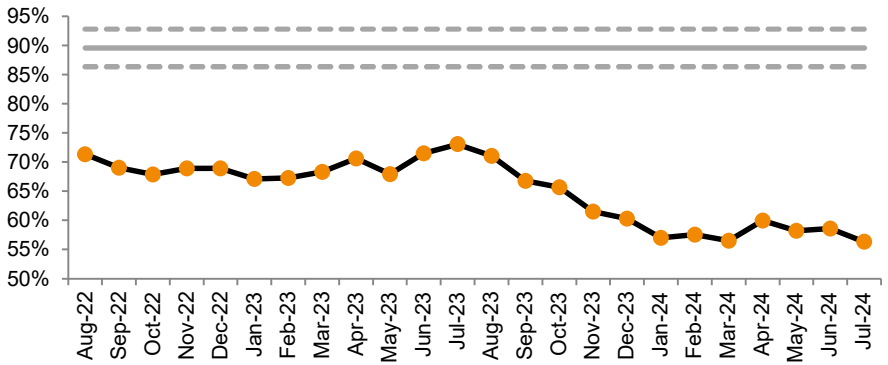


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted



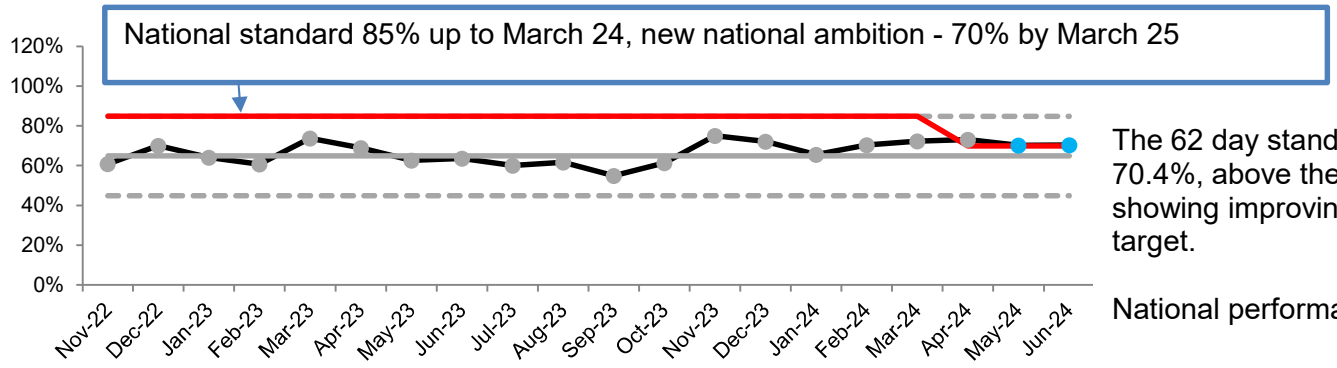
RTT Non-Admitted



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

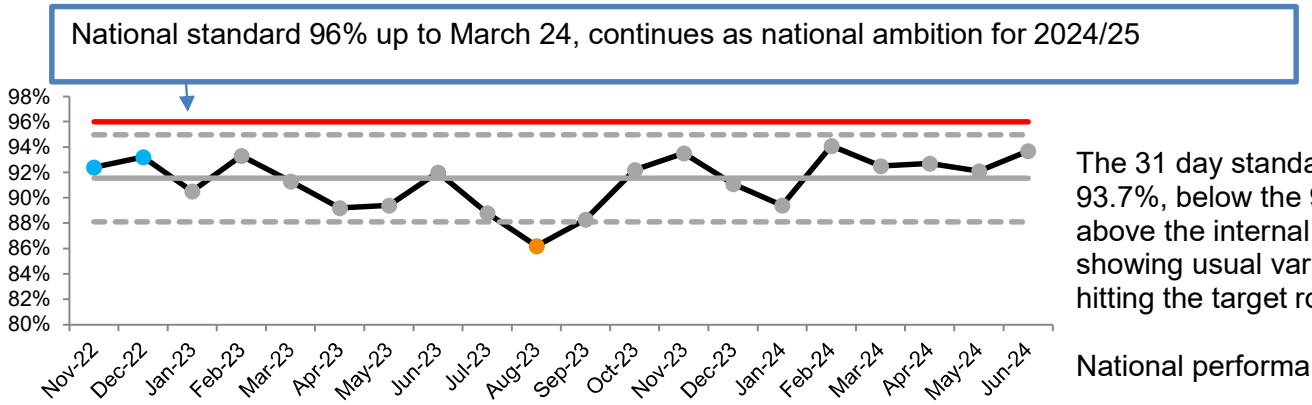
Cancer 62 day general



The 62 day standard was acheived in June at 70.4%, above the 70% trajectory. The trend is showing improving variation and may deliver the target.

National performance June - 67.4%

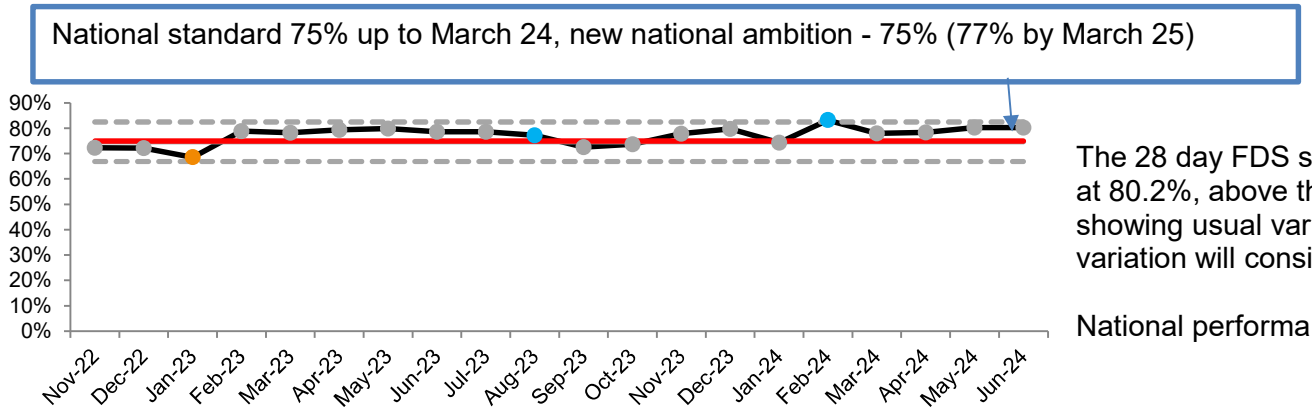
Cancer 31 day general treatment



The 31 day standard was not achieved in June at 93.7%, below the 96% trajectory. However this is above the internal trajectory of 90%. The trend is showing usual variation but is not capable of hitting the target routinely.

National performance June - 90.9%

28 day general FDS

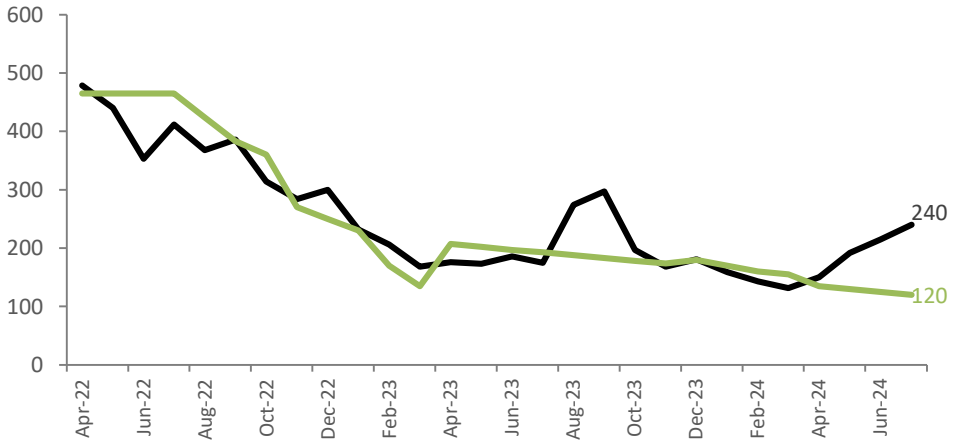


The 28 day FDS standard was achieved in June at 80.2%, above the 75% trajectory. The trend is showing usual variation and based on current variation will consistently hit the target.

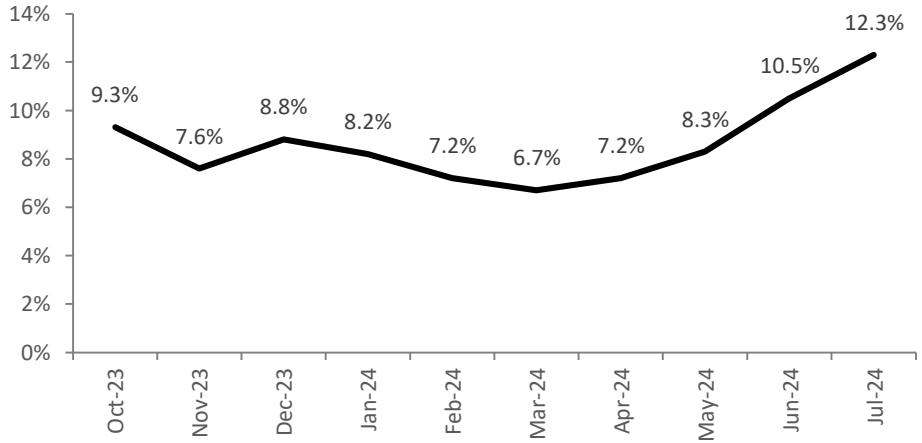
National performance June - 76.3%

RESPONSIVE

Cancer >62 day vs trajectory



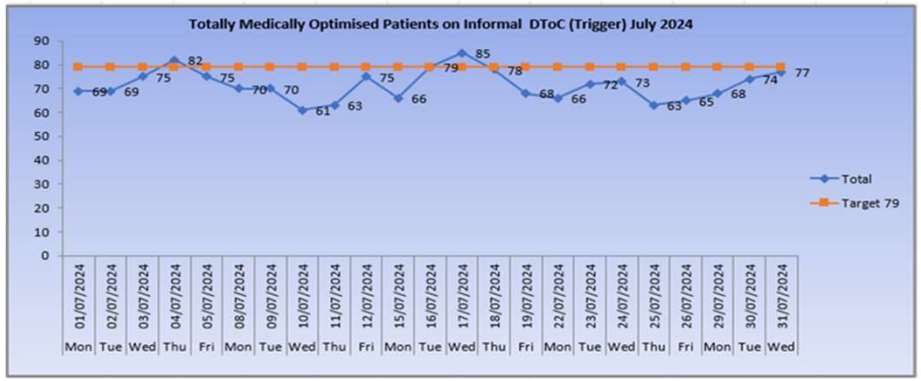
Cancer % Waiting >62days (Urgent GP Referral)



At the end of July the number of patients >62 days was 240 vs 120 trajectory. This was 12.3% of the total wait list.

RESPONSIVE

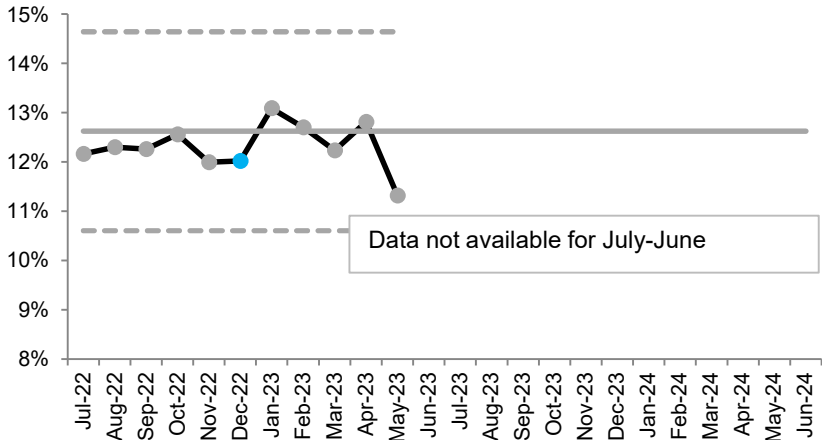
Delayed Discharges



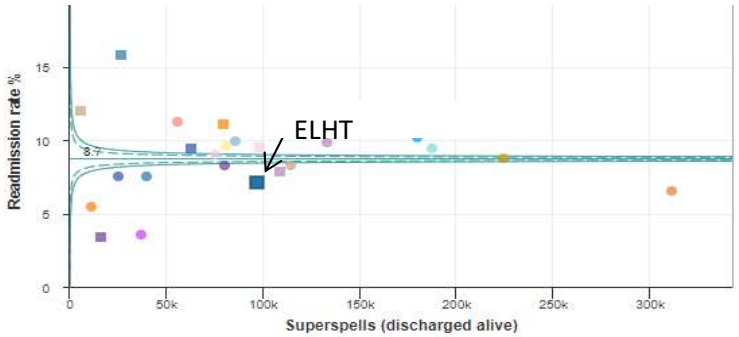
We continue to discharge patients using the rapid discharge principles set out in the Hospital discharge and community support: policy and operating model government guidance, utilising pathways 0-3. Pathways are being used to ensure patients have a discharge plan identified from admission, with pathway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

Dr Foster benchmarking shows the ELHT readmission rate is lower than the North West average. April and May 23 data is missing from this period for ELHT.

Emergency Readmissions

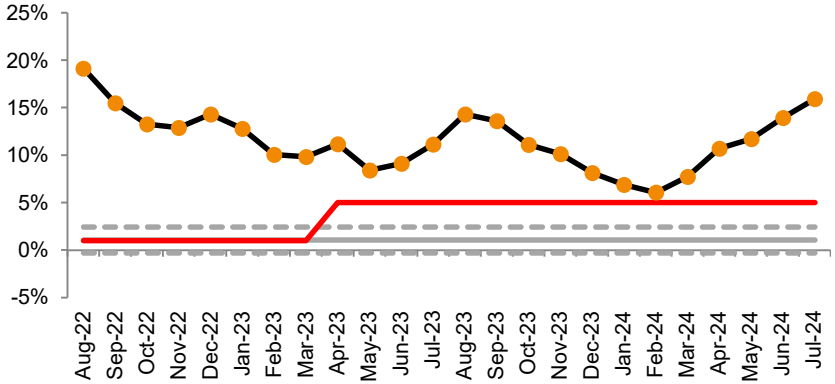


Readmissions within 30 days vs North West - Dr Foster



Data not available for emergency readmissions.

Diagnostic Waits



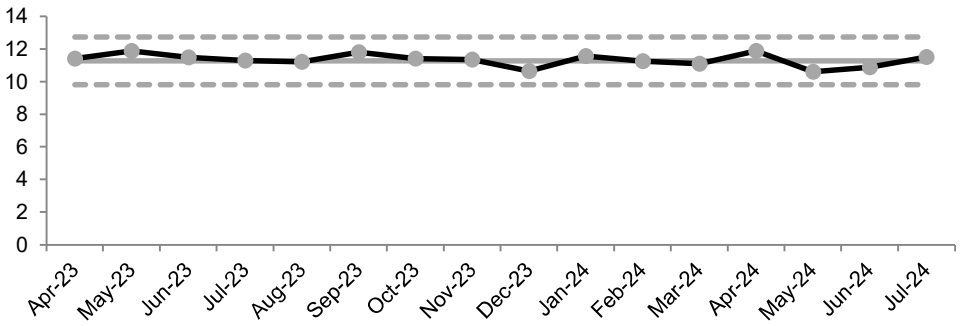
In July, 15.9% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is above the 5% threshold. (95% of patients to receive a diagnostic test within 6 weeks by March 2025)

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

Nationally, the performance is failing the 5% target at 22.9% in June.

RESPONSIVE

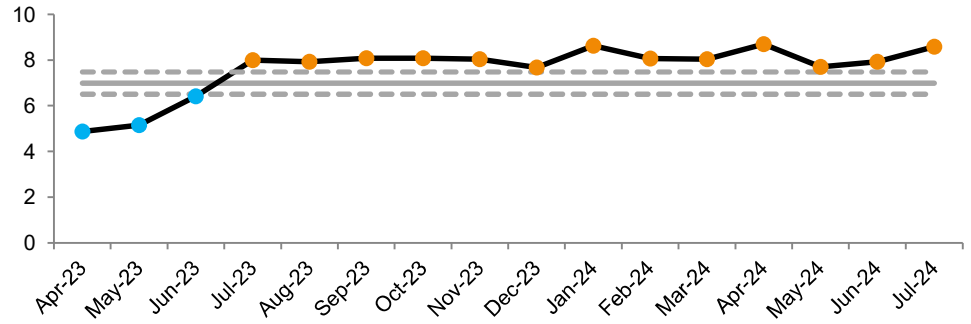
Emergency average length of stay - excluding 0 and 1



Emergency average length of stay methodology in model health excludes 0 and 1 days. Using this methodology, July 24 is within normal variation for this time period.

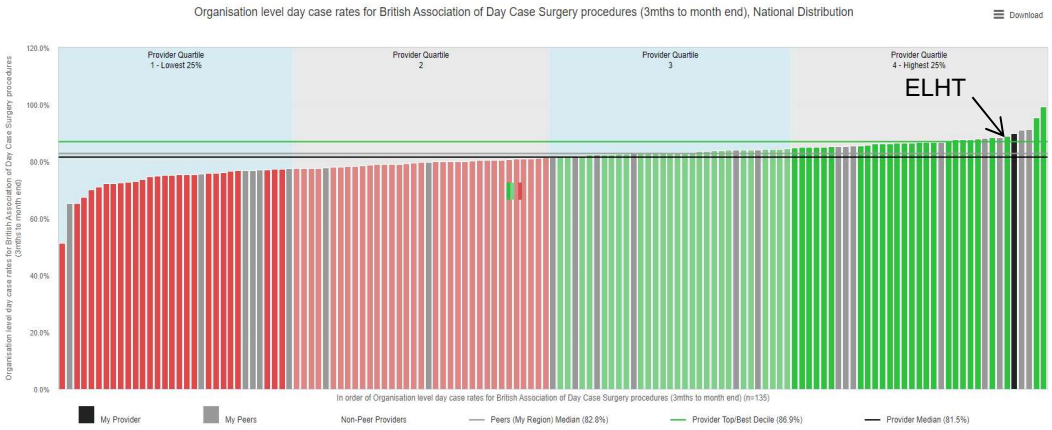
Please note, there are known data quality issues with recorded discharge date after true discharge discharges.

Emergency average length of stay - including 0 and 1



Step change from June 23 is due to the removal of Same Day Emergency Care (SDEC) activity which was previously recorded as a non-elective admission and is now recorded as a type 5 A&E attendance.

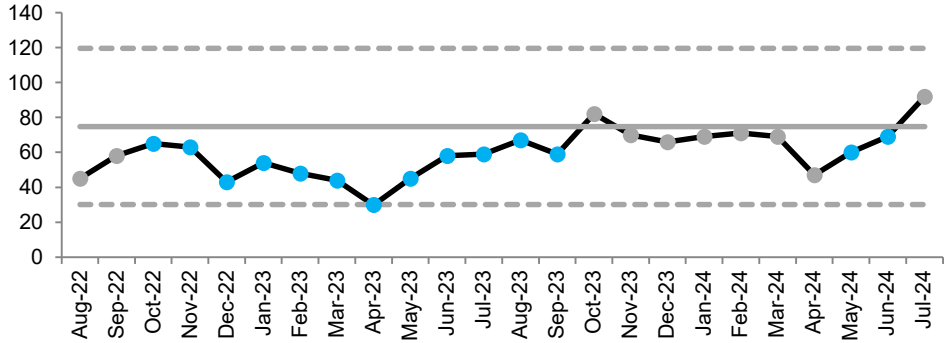
Daycase Rate



Model health system data shows ELHT in the fourth quartile for daycase rates at 89.9% (January-March 24). Data is for adults only. The backlog in coding will impact this figure due to it being based on BADS procedures. The daycase rate from local data is 89.3% for the latest period (April-July 24). This rate includes all procedures.

RESPONSIVE

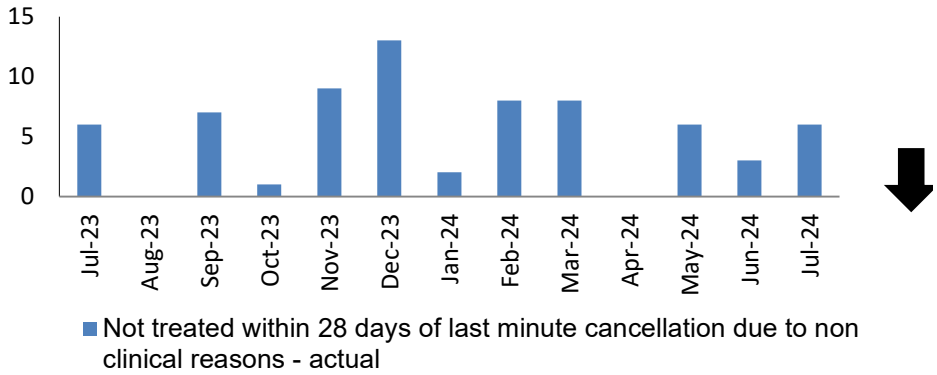
Operations cancelled on day



There were 92 operations cancelled on the day of operation - non clinical reasons, in July. Work is ongoing to better understand the reason for these cancellations with a view to reducing them.

The trend is similar to pre-covid levels.

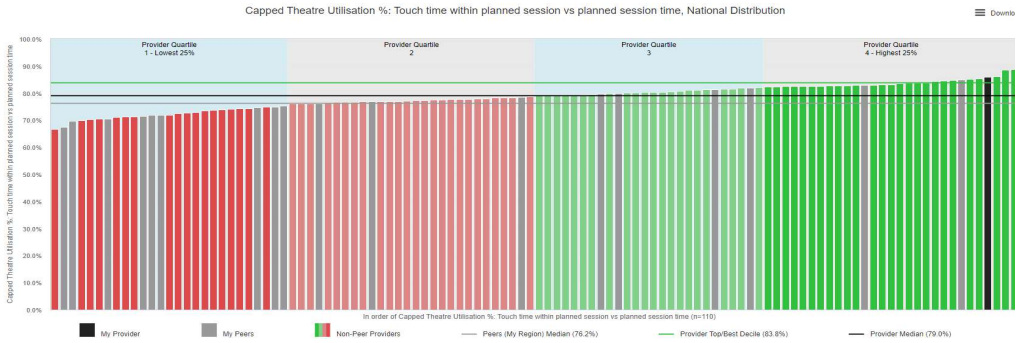
Operations cancelled on day - breaches of 28 day



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

Patients that had procedures cancelled on the day are monitored regularly to ensure dates are offered within the 28 days. Risks are escalated to senior managers and escalated at the weekly operations meeting.

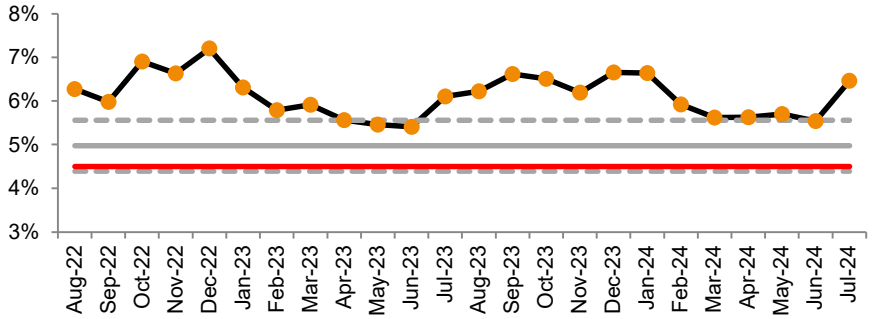
Theatre Utilisation



Data taken from 'The model hospital' shows capped theatre utilisation at 86.0% for the latest period. This is in the fourth quartile nationally, with 4 being the highest and 1 the lowest.

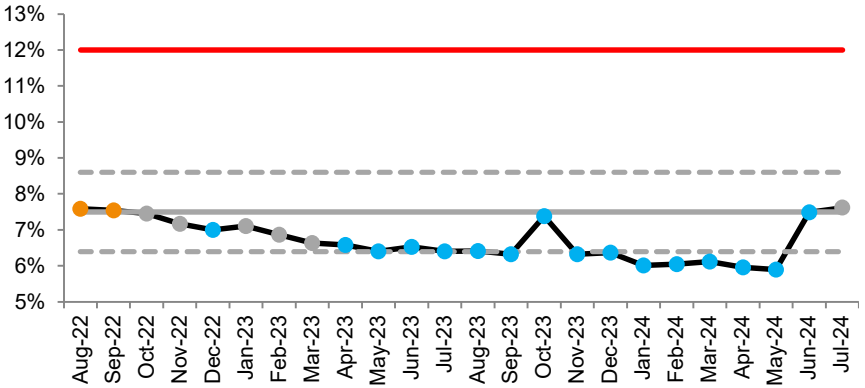
WELL LED

Sickness



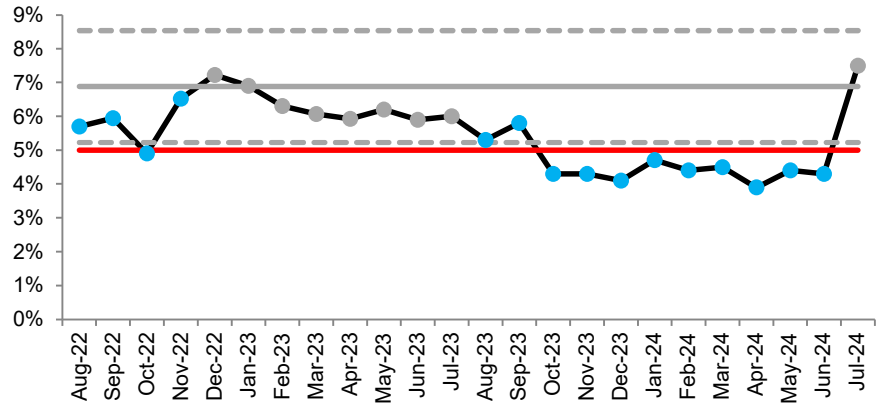
The sickness absence rate was 6.46% for July which is above the threshold of 4.5%. The trend is significantly higher than the pre covid baseline and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 7.62% in July and remains below threshold. This is showing usual variation this month when compared with baseline. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



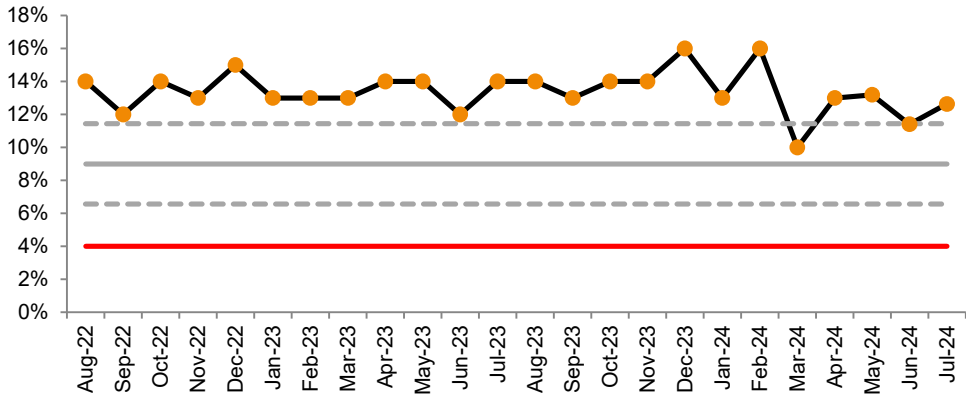
The vacancy rate is 7.5% for July which is above the 5% threshold. The trend is showing usual variation and this indicator is not capable of hitting the target routinely.

A detailed action plan has been developed and a quarterly progress update will be provided to the Trust Board.

Vacancies within the trust have shown a slight increase due to data timeliness of budgets being amended in ESR. Main services causing the differences are related to ELCAS teams moving out of ELHT and the TUPE transfer of the BwD/0-19 services into the organisation.

WELL LED

Temporary costs and overtime as % total pay bill



In July 2024, £5.9 million was spent on temporary staff, consisting of £1.0 million on agency staff and £4.9 million on bank staff.

WTE staff worked (10,048 WTE) was 173 WTE less than is funded substantively (10,221 WTE).

Pay costs are £2.7m more than budgeted establishment in July 2024.

At the end of July 24 there were 759 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

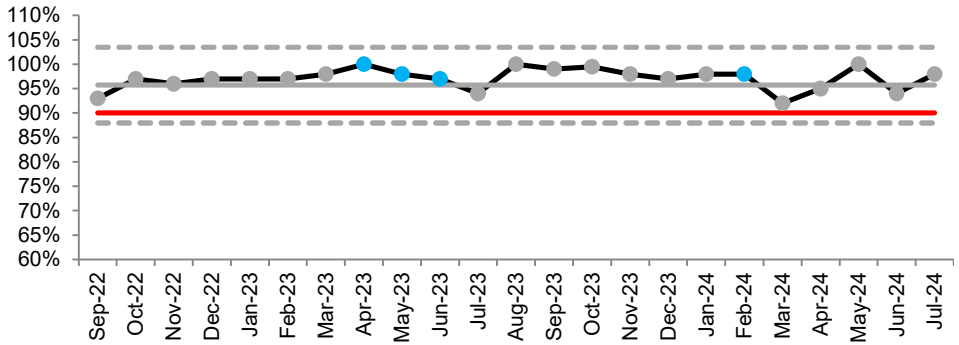
Stage	Consultants	Non consultant grades
Awaiting Signatures	155	50
Complete	44	13
Due Soon	23	3
In Progress	110	20
No Current Job Plan	12	10
Not Started	27	11
Referred Back	6	2
Uploaded	2	0
Total	379	109

As at July 2024, the table shows the numbers in each stage of the job planning process.

Job Planning Consistency panels are scheduled with directorates over August, September and October 24. The purpose of the panel is to provide additional scrutiny and to ensure fairness and equity Trust wide. The panels will form part of the final sign off process.

WELL LED

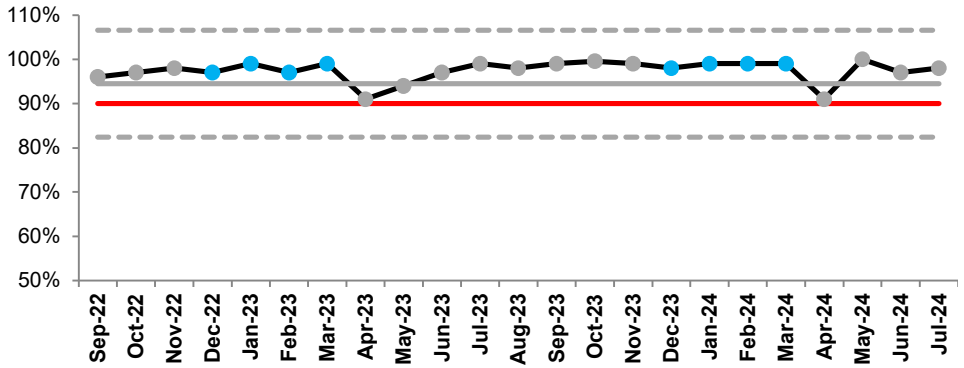
Appraisals, Consultant



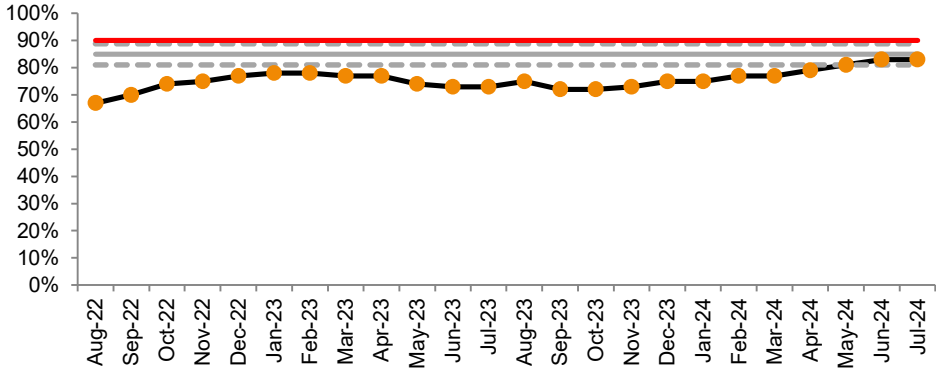
The appraisal rates for consultants and career grade doctors are reported for July 24 and reflect the number of reviews completed that were due in this period.

They both continue to be above target with 98% completed that were due in the period.

Appraisals, Other Medical



Appraisals Agenda for Change (AFC) Staff



The AFC appraisal rate continues to be reported as a rolling 12 month figure and remains below threshold. Appraisals were suspended until March 21, due to COVID pressures.

The trend is significantly lower than previous levels and based on current variation the indicator is not capable of achieving the target

There has been a range of Trust wide actions to support compliance which are on-going. These actions are monitored through the Finance & Performance Committee.

WELL LED

Core Skills Training % Compliance

	Frequency	Target	Compliance at end July
Basic Life Support	2 years	90%	89
Conflict Resolution Training L1	3 years	90%	96
Equality, Diversity and Human Rights	3 years	90%	96
Fire Safety L1	2 years	95%	94
Health, Safety and Welfare L1	3 years	90%	95
Infection Prevention L1	3 years	90%	96
Infection Prevention L2	1 year	90%	90
Information Governance	1 year	95%	92
Preventing Radicalisation Level 1	3 years	90%	95
Preventing Radicalisation Level 3 †	3 years	90%	94
Safeguarding Adults L1	3 years	90%	96
Safeguarding Adults L2	3 years	90%	95
Safeguarding Adults L3*	3 years	90%	79
Safeguarding Children L1	3 years	90%	94
Safeguarding Children L2	3 years	90%	93
Safeguarding Children L3	3 years	90%	87
Safeguarding Children L4	3 years	90%	75
Safer Handling Level 1	3 years	95%	94
Safer Handling Level 2 (Patient Handling)	3 years	95%	88

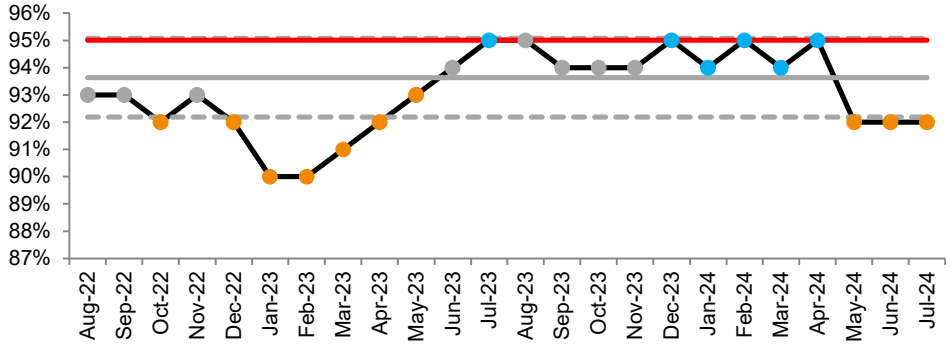
The core skills framework consists of eleven mandatory training subjects, with 19 modules in total. Training is via a suite of e-learning modules and knowledge assessments on the learning hub.

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

8 of the 19 modules are below threshold in July. Preventing Radicalisation Level 3 and Safeguarding Adults Level 3 are new mandatory requirements for some staff from April 23.

New starters are now being requested to complete as much of their Core Skills e-Learning requirements as possible prior to attending the Trust Induction training programme via the e-Learning for Healthcare platform. Additionally, there will be a limited amount of time for new starters to undertake any incomplete Core Skills e-Learning/training during the one-day Trust Induction training programme.

Information Governance Toolkit Compliance

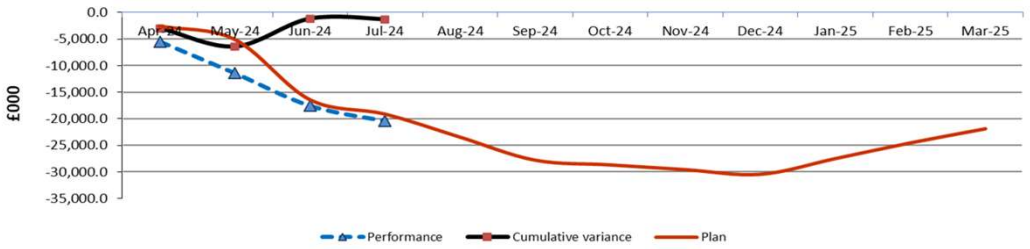


Information governance toolkit compliance is 92% in July which is below the 95% threshold. The trend is at risk of not meeting the target.

WELL LED

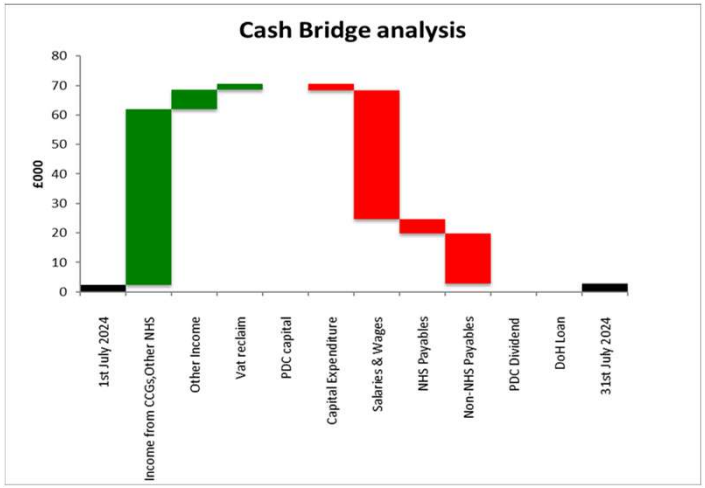
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



The Trust is reporting a £20.4m deficit for the 2024-25 financial year to date, £1.3m behind plan.

Cash



The Trust's cash balance is £2.8m as at 31st July 2024.

The Trust is reporting a deficit of £20.4m for the 2024-25 financial year to date, £1.3m behind plan.

The 2024-25 capital programme has increased by £0.5m to £33.1m following the sale of two properties on Infirmary Road in Blackburn. At £3.6m, year to date capital spend is £0.1m behind plan.

The cash balance on 31st July was £2.8m, an increase of £0.5m compared to the previous month. This position is supported by £18.2m of Provider Revenue Support Public Dividend Capital.

The Trust has met three of the four the Better Payment Practice Code (BPPC) to pay 95% of invoices on time for the financial year to date but is below target for non-NHS invoices by volume at 90.6%.

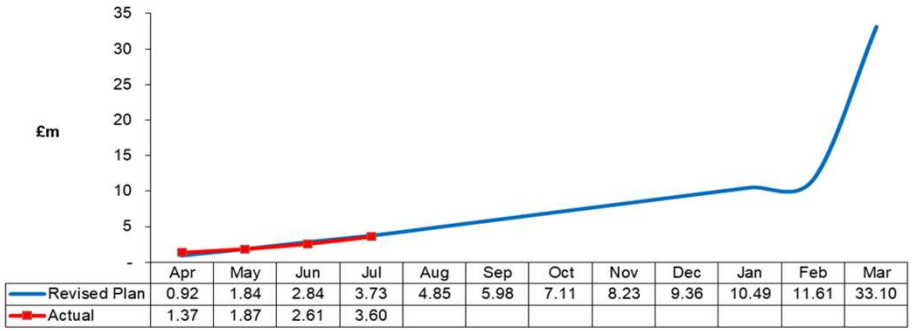
Year to date spend on agency staff represented 2.2% of total pay against the ceiling set by NHS England for 2024-25 of 3.1%.

The Waste Reduction Programme for the 2024-25 financial year is £59.7m, of which £6.3m has been delivered in the year to date, in line with plan, including £6.0m of recurrent efficiencies.

WELL LED

Capital expenditure

Capital expenditure profile



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	0.92	1.84	2.84	3.73	4.85	5.98	7.11	8.23	9.36	10.49	11.61	33.10
Actual	1.37	1.87	2.61	3.60								

The Trust is £0.1m behind planned capital spend as at 31st July 2024.

Waste reduction programme

WRP schemes analysis

2024-25 Divisional Performance to Date

Division	Annual Target £000s	Identified £000s	To Identify £000s	Number of Schemes	Annual Achieved £000s	Annual To Achieve £000s	Year to Date Target £000s	Year to Date Achieved £000s	Year to Date Variance £000s	Recurrently Achieved £000s	Next Year Identified £000s
Trust Wide Schemes	7,727	46,843	(39,116)	59	4,292	(3,435)	(11,040)	4,292	15,332	4,292	0
Medicine & Emergency Care	11,620	4,695	6,925	24	1,001	(10,619)	3,873	913	(2,960)	1,001	0
Community & Intermediate Care	3,358	2,889	469	19	27	(3,331)	1,119	16	(1,103)	27	0
Surgical & Anaes Services	11,649	730	10,919	17	322	(11,327)	3,883	107	(3,776)	322	0
Family Care	7,302	336	6,966	14	226	(7,076)	2,434	75	(2,359)	226	0
Primary Care	261	3	258	1	0	(261)	87	0	(87)	0	0
Diagnostic & Clinical Support	8,485	1,564	6,921	37	284	(8,202)	2,828	95	(2,734)	284	0
Estates & Facilities	4,498	1,481	3,017	18	28	(4,470)	1,499	8	(1,492)	28	0
Corporate Services	3,604	809	2,795	7	474	(3,130)	1,201	443	(758)	0	0
Education, Research & Innov'N	1,175	328	847	3	328	(847)	392	328	(64)	328	0
Total	59,679	59,679	(0)	199	6,982	(52,697)	6,277	6,277	(0)	6,508	0

Schemes to the value of £6.3m have been transacted in the year to date. Additional identified schemes will be assessed for delivery throughout

TRUST BOARD REPORT **Item** **130**

11 September 2024 **Purpose** Approval

Assurance

Title	SPE+ Improvement Practice Update
Report Author	Mrs H Rollé, Associate Director of Improvement
Executive sponsor	Mrs K Atkinson, Director of Service Development and Service Improvement
Date Paper Approved by Executive Sponsor	2 September 2024

Summary: The reports sets out the progress of the SPE+ continuous improvement strategic objectives in the Trust from April 2024**.** This includes the adoption of NHS IMPACT aligned with the SPE+ Strategy and an update to key activities provided to the organisation by the Improvement Hub team.

Recommendation: The Trust Board is asked to note the report as assurance of progress made against supporting the delivery of SPE+ strategy.

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 may be 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 2024-25 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 its inability 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 6 (As Host of One LSC): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services. (As Partner of One LSC): One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.
Related to key risks identified on Corporate Risk Register	-
Related to recommendations from audit reports	-
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

Purpose

1. The SPE+ Improvement Practice Update report sets out the progress of the SPE+ (Improving Safe, Personal and Effective Care) continuous improvement practice delivery plan in the Trust from April 2024**.** This includes the adoption of NHS IMPACT aligned with the SPE+ Strategy and an update to key activities provided to the organisation by the Improvement Hub team.

Background

2. East Lancashire Hospital Trust has been on a journey of continuous improvement for a number of years. Through the completion of the NHS Vital Signs Programme and the development of the original 7 steps to Safe, Personal and Effective care, the SPE+ methodology for improvement at the Trust was designed. The simple 6 phased approach of understand, co-design, test and adapt, embed, spread and sustain can be applied to all the science-based improvement methodologies including Institute for Healthcare Model of Improvement, Engineering Better Care and Lean.
3. To support building a continuous improvement philosophy across the organisation, an SPE+ Improvement Practice Strategy was devised as part of the Quality Strategy which comprised of 3 key elements which are encapsulated into an Improvement Practice development plan. The practice plan has been in place since 2022 and comprises of:
    - Practice Co-Production System (delivering improvements across Delivery, Quality, People and Cost through application of an improvement approach using evidence based improvement science/methodology)
    - Practice Training System (supporting staff to develop their improvement skills through training and coaching support)
    - Practice Management System (embedding improvement as part of how we work so we constantly seek to improve)
4. The Improvement Practice plan covers the breadth of strategic to daily operational management with the aim of ensuring all individuals within the organisation being able to contribute through having the skills and structures in place for every individual to be able to understand their work and improve their work.

NHS Impact and SPE+ Improvement Strategy

5. NHS IMPACT (Improving Patient Care Together) has been launched by NHS England to support all NHS organisations, systems and providers to have the skills and techniques to deliver continuous improvement.
6. NHS IMPACT's five components underpin a systematic approach that includes: Building a shared purpose and vision; Investing and people and culture; Developing leadership behaviours; Building improvement capability and capacity; and embedding improvement into management systems and processes.
7. In January 2024, the Trust Board undertook a self-assessment and facilitated review of the NHS IMPACT core components. The self-assessment scores were discussed in relation to where we do well as an organisation and what future opportunities could be developed. The components of NHS IMPACT have been mapped against the SPE+ Strategy and therefore further development will continue based within the delivery of the improvement practice plan. Examples of opportunities for improvement include:

NHS Impact Component	**Opportunity to Develop**
Building a Shared Purpose and Vision	Links to: ***SPE+ Practice Management System*** • Strategy alignment and strategy deployment incorporates improvement demonstrated in the accountability framework • Build on visible leadership from Board and Senior Leaders to promote and translate vision • Development of improvement boards • Engagement in programmes that directly support the delivery of the organisation's goals • Develop plans to enable lived experience to drive improvements
Investing in People and Culture	Links to: ***SPE+ Practice Management System & SPE+ Practice Training System*** • Development of education and training applicable for all staff • Encourage wider learning development through engagement of system wide delivery programmes • Trust Induction to include design and contribution to improvement methodology • Engage staff and patients to adopt the co-design of improvement work • Develop an organisation wide approach to daily management
Developing Leadership Behaviours	Links to: ***SPE+ Practice Training System & SPE+ Practice Management System*** • Develop board sessions at system level • Align leadership to SPE+ moving away from heroic management • Develop an organisation wide approach to incorporate the 6 components of daily management

NHS Impact Component	Opportunity to Develop
Building Improvement Capability and Capacity	Links to: ***SPE+ Co-Production System & SPE+ Practice Training System*** • Widen accessibility to improvement training and improvement delivery styles and encourage team training • Align improvement measurement to align to accountability framework • Design and contribute improvement methodology to be delivered at Trust Induction
Embedding into Management Systems and Processes	Links to: ***SPE+ Practice Management System*** • Align improvement measurement to the accountability framework • Embed improvement through organisation business • Link improvement method to core organisation processes e.g. NAPF • Develop approach of data quality customers; making data count

8. Each year opportunities to further develop the SPE+ Improvement Practice will be identified and monitored to meet the aims of NHS Impact alongside delivery of key improvement programmes.
9. The SPE+ Improvement Practice development is aligned to Board Assurance Framework risk 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. This recognises the role of the SPE+ improvement Practice as central to delivery of Trust and system priorities.

Improvement Hub Team Activity

10. Activities undertaken within the improvement hub include training and education, supporting teams/individuals to register improvement projects, providing an improvement report out and supporting the delivery of key delivery and improvement priorities including leading events and workshops and facilitating improvement activities for specific improvement projects.
11. From April 2023 – March 2024 the following activity should be noted:
    - Training: 477 members of staff have received some form of improvement training
    - Improvement Projects: 115 new projects were registered
    - Improvement Report out: 14 projects were showcased and celebrated
    - Events/workshops: 49 events/workshops were delivered/facilitated by the Improvement Hub team

Current developments since April 2024

12. Through the 'Year of Improvement' programme (refer to paragraph 20 below), since May 2024, the delivery of training has changed to bitesize, face to face, team-based training. This has received excellent feedback and currently 220 staff have received at least 1 of the components.
13. Since April 2024 a total of 36 improvement projects have been registered with the improvement hub from across the organisation. It is recognised that there are additional improvement projects underway in the organisation, and work continues through the Waste Reduction links, to support and facilitate work where required and to capture all improvement work to ensure there is one register to support visibility of work and promote opportunity to learn and share.
14. To test a new way of delivering Improvement Report Outs, work through the 'Year of Improvement' programme has designed new methods of providing communications and shared learning with the support of the communications team. This is currently still in the test phase and includes bitesize report out videos which are being regularly shared on the staff intranet page and via social media.

ELHT Star Awards 2024

15. The SPE+ Improvement Award was introduced at the Star Awards in 2023 to recognise colleagues or teams undertaking improvement work. The winner of the 2024 SPE+ Improvement Star Award was the 'Engineering Better Care Frailty Project'. This team are continuing to work on a project that uses whole system working and system design thinking to address the needs of the population for Frailty. With a multi-disciplinary approach, the focus was primarily on the identification and assessment of Frailty. The Project aims to avoid hospital attendances and develops means to care for patients in their own homes, developing guideline and care plans. This programme of work will be showcased at the national NHS Impact conference in September and a summary of the project can be found in Appendix 2

Programme Delivery

16. In April 2024 following the operational planning process, the resource of the Improvement Hub team was assigned across several programmes of work, all supporting the delivery of the Trust's key delivery and improvement priorities and aligned to key Trust strategies

and delivery of organisational goals (Appendix 1: Key Delivery and Improvement Priorities 2024/25).

17. Each programme of work is assigned an Executive Sponsor and an Improvement lead coach to both provide guidance to the direction of the programme of work, but also to provide valuable coaching for the members of the team working directly in the service. It is noted that varying improvement methodologies are used including the Institute for Healthcare Breakthrough Series Collaborative, Engineering Better Care and Lean Value Stream methodology. This reflects the breadth of programmes currently assigned, and each method is assigned to glean the best results.
18. To report the programmes of improvement, it is now agreed to which Trust sub-committee each programme reports through within the organisation, ensuring regular updates of the work are linked to the wider agenda, and also sharing ongoing learning from an improvement lens.
19. A short summary of key programmes and outcomes as at the end of August can be found in the appendix 2 (Appendix 2: Improvement Programme summaries).

Training and Education and "Year of Improvement"

20. At the time of writing 1540 staff have been trained in the last 2 years in some element of the SPE+ improvement methodology. Recognising challenges for staff accessing training due to limited capacity, agreement was sought to review the training offer in 2024.
21. The programme titled "Year of Improvement" launched in April 2024 with a key focus to address the challenges with access to improvement education. Challenges noted were reduction in attendance and variable uptake of application of theory to practice. In addition to addressing these challenges, new methods are being developed to encourage a 'train the trainer' and team training approach supporting the ability to share with a wider audience.
22. Since April 2024, the Improvement Hub have led on 2 full Rapid Improvement Workshops (RPIW) engaging with key stakeholders across the organisation. RPIW #1 had a key focus on changing the delivery method for our traditional level 2 training and RPIW#2 focussed on improving communications about SPE+ throughout the organisation. Next steps include further RPIW's to focus on the principles of daily management and the offer of level 3 training.

Clinical Quality Academy

23. In July 2023, the Trust partnered with Blackpool NHS Foundation Trust to collaborate on the running of the Clinical Quality Academy. The programme focussed on the IHI methodology and Improvement Science and offers the opportunity for teams to come together to learn about improvement and apply this to an improvement project. Four clinical teams from ELHT commenced the programme, each with a Consultant Lead. The team topics were:
    - Anti-racism and Inclusion: Team Arushi
    - Pain Management in the Emergency Department
    - Developing the Hospital at Home service
    - The Learning Tree
24. The teams have now completed the year long programme and have completed their posters outlining their learning and ongoing developments of practice, which will be shared when published. Each team will now attend a celebration event to present their work and share with colleagues their key learning.
25. The cohort of 2024-2025 is being hosted by Northwest Ambulance with colleagues from the Trust and Blackpool on the expert faculty. It is anticipated that ELHT will join the collaboration with other system partners and will enable a further 4 teams to attend.

Student Education: SSC4 Improving the Experience

26. The Improvement Hub have continued to support the SSC4 Medical Students at UCLan who are one of the main undergraduate trainee groups at ELHT. For the academic year 2023 - 2024 we have trained 175 students in Level 3: leading SPE+ improvement methodology across eight workshops. For this cohort they have been required to undertake a theoretical quality improvement project over a nine-month period, we have provided 15 case studies based on 'live' improvement projects aligned to our strategic priorities such as Nutrition & Hydration, reducing number of Ambulance Conveyances and supporting a greener NHS. It is expected that the same provision will be provided to the next cohort of SSC4 students across the 2024-2025 academic year.

Staff in training: Improvement Education

27. In addition to student education, the Improvement Hub team also deliver training to staff in training groups including Nursing preceptorship, Foundation years 1 and 2 doctors, junior clinical fellows, internal medicine trainees, and trainee Advanced Clinical Practitioners.

Summary and Next Steps: The next 6 months

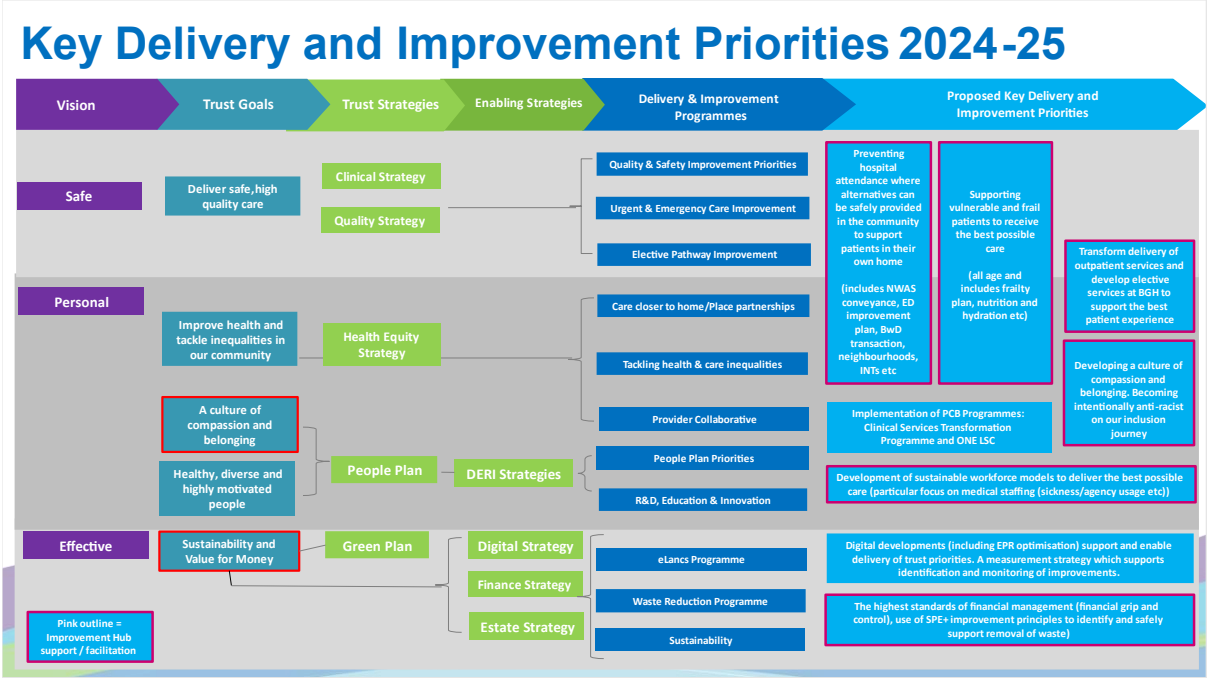
28. With the alignment of the Improvement Hub resource to the core organisational key delivery and improvement programmes/priorities, the SPE+ improvement practice focus continues to drive the work contributing to the overall organisational goals. For the next 6 months, these programmes of work will continue to support changes in clinical practice to support better outcomes alongside an increasing focus on supporting teams in delivery of waste reduction projects.
29. Further work will also continue to further mature our measurement strategy linking improvement work to supporting improving outcomes for patients and demonstrating results across the 4 domains of delivery, quality, people and cost.
30. In addition to this, the education and training offer will continue to evolve to support the staff with the skills and knowledge they require to support them to undertake their roles successfully within the organisation. This will include further adaptations of method delivery as well as the development of daily management skills. The latter will support the managerial approach to addressing the financial agenda.
31. Finally, the refreshment of the SPE+ improvement practice strategy and practice plan will be undertaken in collaboration with colleagues to ensure that NHS IMPACT components are built in, but also to ensure that the work continues to provide the best value to the staff and organisation and to support embedding an improvement approach across the organisation. This revised strategy and plan will be presented for approval for the start of 2025-26 financial year.

Recommendation

32. The Trust Board is asked to note the SPE+ Improvement Practice update as assurance of progress made against supporting the delivery of SPE+ Improvement Strategy.

Appendices

Appendix 1: Key Delivery and Improvement Priorities 2024-25



Appendix 2: Improvement Programme summaries

Trust Key Delivery and Improvement Priority: Preventing Hospital Attendance where alternative care can be safety provided in the community to support patients in their own home

ED Improvement Plan

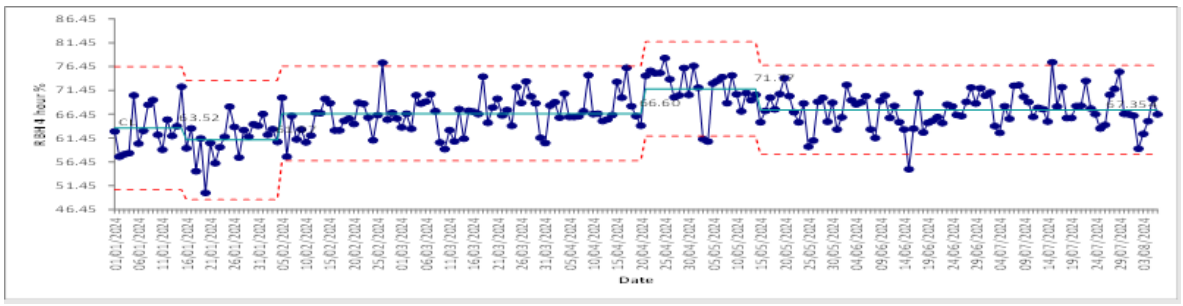
The ED Improvement Plan forms part of the wider Urgent and Emergency Care Improvement Plan. The method has followed an A3 approach, supporting the delivery of everyday improvement methods such as weekly improvement huddles which are supporting continuous improvement within the Emergency Department. The focus is to improve key ED metrics across the delivery, quality, cost and people quadrants, supporting the routine of improvement and team working to improve patient care delivered within the department.

Over the course of 2024 (to date) we have seen improvement in many metrics through small tests of change including initial triage through the Acuity Project, utilisation of ED hourly nursing checklists and pain score documentation, a reduction in Bank and Agency spend, and staff turnover and sickness reduced. Next steps will include running a Perfect Ambulance

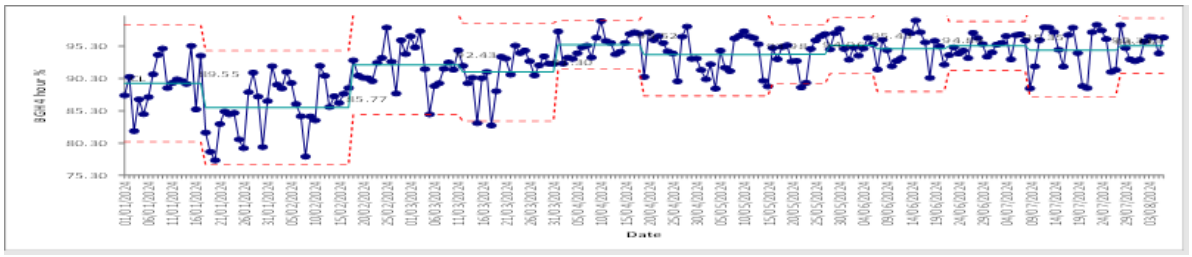
Handover Week and also running a focus week assessing 'walk in' patients. From a quality perspective the team have also seen an improvement in their NAPF scores.

Key ED measure – 4 hour target (% of patients seen, treated and discharged within 4 hours)

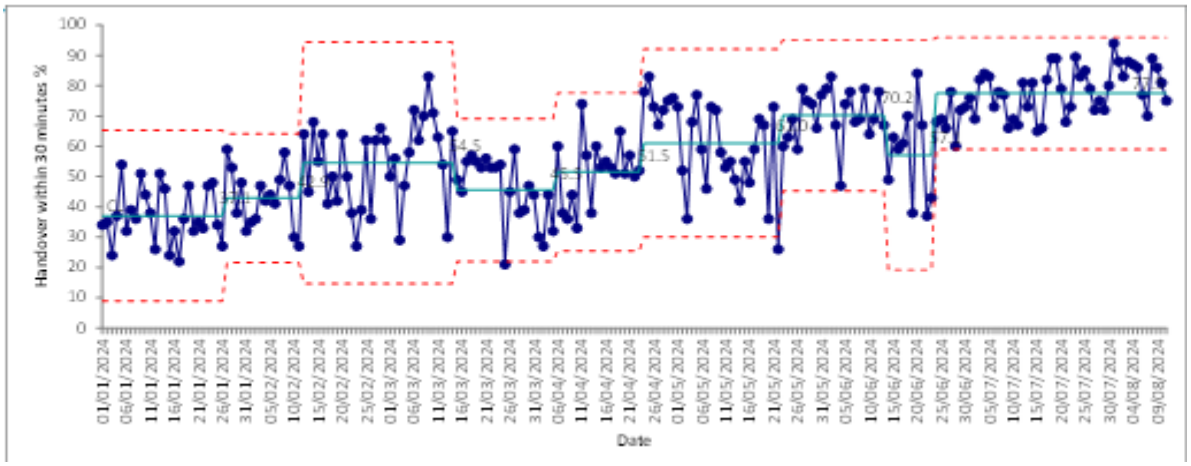
Royal Blackburn Teaching Hospital



Burnley General Teaching Hospital



NWAS Ambulance Handovers within 30 minutes



Longer Length of Stay

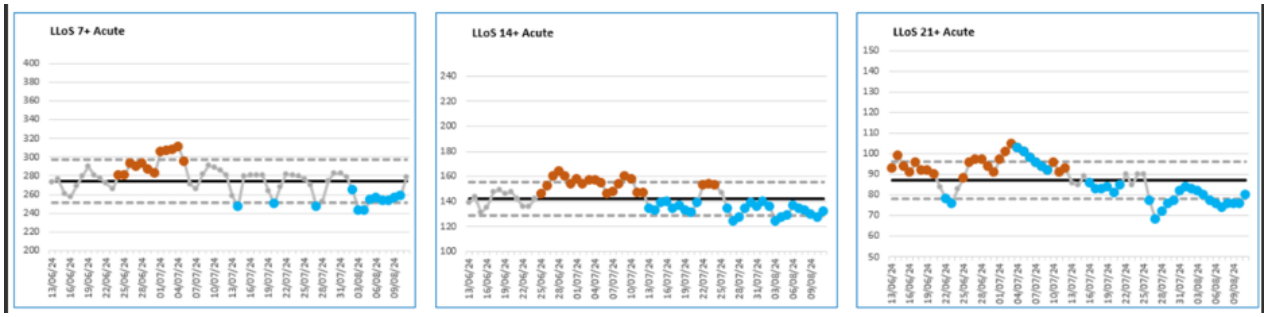
Focus upon length of stay has been undertaken through new refreshed work on Multi-Disciplinary Team (MDT) Board Rounds. Celebrations for work so far include a pilot area being identified for discharge modelling, Right size bed base, process optimisation and links to the Frailty Pathway. It is also noted that the first version of the discharge dashboard utilising the electronic patient record (ePR) has been rolled out across the organisation. Further work is

taking place on an updated version of the dashboard and is pending acceptance at the ePR change board. This work will also now link to the MDT board round work to improve MDT discussion and planning which is currently in the understand phase. Communications of the new dashboard has been completed and is due to go out on the organisation's intranet.

Next steps include the planning of Acute Frailty and Discharge training for the September 2024, planning for discharge pathway personas supported by the Chief Nurse and filming for the Discharge Dashboard to commence.

The focus on longer length of stay has resulted in special cause improvements in length of stay across 7, 4 and 21 days. This is illustrated in the SPC charts below.

Long Length of Stay 7, 14,and 21 + Days



Trust Key Delivery and Improvement Priority: Supporting vulnerable and frail patients to receive the best possible care

Frailty

The Frailty improvement programme commenced in April 2022 following the Engineering Better Care Improvement methodology and has involved system partners at place and across Lancashire and South Cumbria. The new GP Quality contract for Frailty was rolled out on 1st April 2024 and is supporting implementation of key improvement opportunities to identify patients at risk of Frailty and ensure that proactive care plans are developed to support the most appropriate care to be delivered to improve patient outcomes and reduce attendance and admission to hospital.

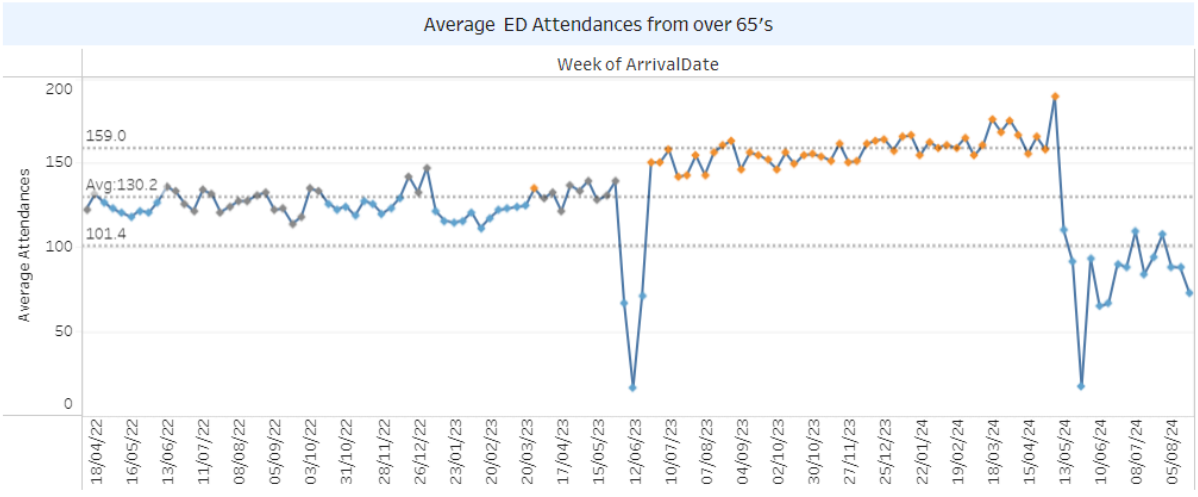
Actions in Quarter 1 2024-25 have focussed on engagement and training to support successful implementation of the GP quality contract. By September 2024 there will be a significant proportion of the 65 years + population risk stratified across Pennine Lancashire with a clinical frailty score and associated proactive care plans in place. This will support targeted interventions associated with the development of care plans to impact positively on supporting care at home and attendances / admissions and reductions in length of stay.

Successes noted since April 2024:

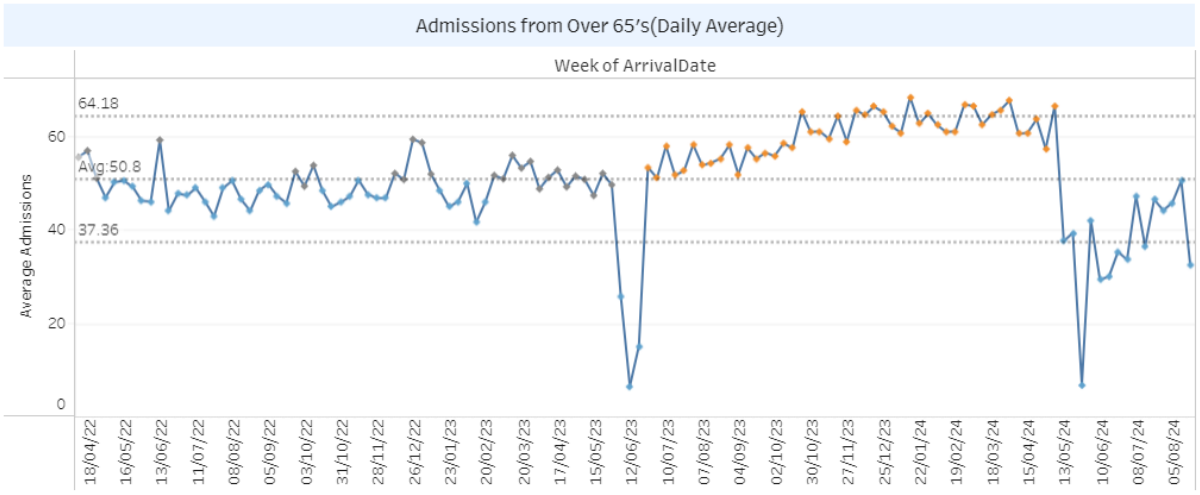
- Initial data for Pennine Lancashire demonstrates an improvement for attendances, admissions and length of stay improvement have been observed for over 65s (refer to SPC charts below
- Training in frailty identification and care planning has been delivered to nearly 1000 staff across primary and community care with 4 more Primary Care Networks events planned for Autumn 2024. The training events have also provided opportunities for PCNs to work to together to identify pathway improvement opportunities
- Piloting of direct referrals to the Older Peoples Rapid Assessment (OPRA) unit as a more appropriate pathway for patients requiring acute specialist assessment

Next steps include continuing to support education and partnership working with primary care regarding frailty and in addition, link the work together with the opportunities with reducing conveyance to hospital/urgent care work.

Average ED Attendances from over 65s, East Lancashire and Blackburn with Darwen



Average Admissions from over 65s, East Lancashire and Blackburn with Darwen



PSIRP: Nutrition and Hydration Breakthrough Series Collaborative

The Nutrition and Hydration IHI Breakthrough Series Collaborative commenced in April 24 with a delivery timescale of 18 months. The aim of the work is to get back to basics for Nutrition and Hydration for patients within the organisation. The measures for success include meal service delivery, documentation, patient experience and food waste. A total of 12 teams have signed up to the programme from across the organisation.

The programme includes three face to face learning sessions (6 days). So far, 2 out of 3 of the learning sessions have now been completed. Learning session 3 is scheduled for November 2024. During this action period, all teams are undertaking PDSA tests of change and continue to collect data. There is provision of an electronic measure's workbook within a dedicated team's channel to support each.

Next steps will include executive sponsor visits between September 2024 and November 2024.

Trust Key Delivery and Improvement Priority: Transforming Outpatient Services

Gynaecology – Outpatient Transformation

The Improvement work within the Gynaecology department commenced in July 2024 with a focus to transform outpatient services. With support of the involvement of GIRFT Further Faster review, opportunities will support reducing the longest waits in routine referrals and

develop further partnership working with primary care. To commence the programme, a workshop event has been held in July 2024 to identify scope and opportunity, and to engage with stakeholders within the pathway. Following this, the scope has been agreed and potential workstreams of key areas for improvement identified. The team are currently collating baseline data and prioritising opportunities for tests of change. Next steps will include reviewing the value stream for waste reduction opportunities, agreeing the Aim statement and designing an implementation road map for each workstream.

Trust Key Delivery and Improvement Priority: Development of sustainable workforce models to deliver the best possible care

Pathology – Blood Sciences

Support in Pathology started in January 2024. Phase I: (January – March) focused on developing a demand forecast model to support the improvement case to implement a sustainable workforce model. Phase II (March onwards) has focused on implementing the first round of improvement ideas including reducing that volume of samples processed after 4pm (which was identified as the root-cause for the high dependency on over-time, bank and agency spend). When comparing April through to June (2024 vs. 2023) we have observed a 6% reduction and further data is being collected to confirm if this is special cause improvement.

The following improvement work will be prioritised leading to December to further support the reduction in volume processes late in the day: increasing capacity BGTH to ensure samples collected from the Burnley area are processed in Burnley (“consuming their own smoke”); Adjusting collection times to ensure samples are available for collection at the time when drivers are scheduled to pick-up preventing unnecessary delays; and, evaluating the temporary storage (and refrigeration) of samples that would normally be collected late evening so that they can be collected (and processed) at the earliest next-day opportunity.

Other implemented improvements have included increasing capacity across key processes by reducing unplanned equipment down-time (monthly performance reports provided by Siemens confirm a 50% reduction in calls logged from an average of 40 in January to an average of 21 in June).

Other improvements include partnering with BGH Outpatients to reduce the number of urine samples received in the incorrect tube (each of which needs a member of staff to manually transfer the liquid). BGH Outpatients no longer appear in the top 20 list and the improvements are now being extended to other referrers. The Improvement team have also supported delivery of improvements to both in and outbound call handling including the in-bound menu system and updating the out-bound phone directory.

Pathology – Cellular Pathology

Support in Pathology was extended to include Cellular Pathology in June 2024. This has included developing a demand model (in the form of a value stream map (VSM)) to support the development of solutions for a sustainable workforce model. This model was presented to the Pathology Senior Management team on 21.08.24 and the business case is being prepared. The VSM analysis has also helped to identify other improvement opportunities – including (1) reducing the time wasted searching for / locating slides and blocks and (2) prioritising the allocation of staff to the cutting and embedding processes (as these two steps are limit the volume that can be processed through the labs. The Improvement team has also supported re-establishing daily huddles, and these meetings are being used to cascade key messages, agree priorities and to apply concepts that have been trained around waste identification and improvement (Timwoods, 5 Whys and 6S).

Trust Key Delivery and Improvement Priority: The highest standards of financial management

Supporting the Waste Reduction Programme using SPE+ improvement approaches

Support for the organisation's waste reduction programme is provided with a senior improvement coach. It is recognised that waste reduction is present within all improvement programmes and so this assigned resource supports the coordination and delivery of the work, collaborating with finance and divisional colleagues to link all the work of the team to identify cost reduction and efficiencies. In addition, resource is provided to support divisional colleagues deliver their improvement ideas such as reducing postal spend, reducing taxis spend and medical staffing (focus on reducing sickness absence).

TRUST BOARD REPORT | **Item** | **131**

11 September 2024 | **Purpose** | Approval / Assurance / Information

Title	Annual Report to Board on Medical Appraisal, Revalidation, Professional Standards and Related Governance
Report Author	Dr U Krishnamoorthy, Associate Medical Director, Appraisal and Revalidation Miss S Gawne, Deputy Medical Director, Professional Standards
Executive sponsor	Mr J Husain, Executive Medical Director and Responsible Officer
Date Paper Approved by Executive Sponsor	22 August 2024

Summary: This report provides assurance to Trust Board on compliance against GMC and NHS England standards for medical appraisal and revalidation as well as professional standards and related governance. The report provides assurance that Trust is fulfilling all Statutory responsibilities that are expected under Responsible officer regulations 2010 updated 2013. The recommended higher level regional office report template is used to comply with NHS England recommendations as this report further to Board approval and sign off needs to be submitted to NHS England by 31/10/2024 .

Recommendation: The Board is asked to approve the report and sign the compliance statement for submission to NHS England.

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 may be 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 2024-25 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 its inability 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 6 (As Host of One LSC): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services. (As Partner of One LSC): One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.
Related to key risks identified on Corporate Risk Register	NA
Related to recommendations from audit reports	NA
Related to Key Delivery Programmes	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

Previously considered by:

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

Lancashire and South Cumbria Provider Collaborative

East Lancashire Hospitals NHS Trust
A University Teaching Trust

NHS England North West
Medical Directorate
Professional Standards Team

2023-2024 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	East Lancashire Hospitals NHS Trust
What type of services does your organisation provide?	Secondary Care Trust

	Name	**Contact Information**
Responsible Officer	Mr. Jawad Husain	Jawad.husain@elht.nhs.uk
Medical Director	Mr. Jawad Husain	Jawad.husain@elht.nhs.uk
Medical Appraisal Lead Associate Medical Director Appraisal and Revalidation	Dr. Uma Krishnamoorthy	Uma.krishnamoorthy@elht.nhs.uk
Appraisal and Revalidation Manager	Mrs Susan Smith	Su.Smith@elht.nhs.uk
Additional Useful Contacts		
Deputy Medical Director - Professional Standards	Ms. Suzanne Gawne	Suzanne.gawne@elht.nhs.uk
Appraisal and Revalidation Administrator	Rachael Spencer	uma.krishnamoorthy@elht.nhs.uk

Service Level Agreement Do you have a service level agreement for Responsible Officer services? If yes, who is this with?

Nil Applicable

Organisation: East Lancashire Hospitals NHS Trust has its own formally appointed Responsible Officer.

Please describe arrangements for Responsible Officer to report to the Board: Mr Jawad Husain continues as the Responsible Officer for East Lancashire Hospitals NHS Trust (ELHT) and he is also the executive Medical Director and reports directly to the Trust Board.

Date of last RO report to the Board: 8/11/2023

Action for next year: Continue as at present and also see section 3

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 – Summary and conclusion Section 4 – Statement of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of East Lancashire Hospice can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Mr Jawad Husain continues as the Responsible Officer for East Lancashire Hospitals (ELHT) NHS Trust.
Comments:	Appraisal policy for ELHT has been updated and ratified as per last year's action plan
Action for next year:	Continue as at present. See section 3 for actions planned and appendix 1 for policy.

1A(ii) Our organisation provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	Yes, RO role is well supported with sufficient funding, capacity and resources. For the reporting period, there were 727 doctors connected to ELHT as their Designated Body which is an increase by 7.5% from the previous year's figure of 676. There is a year-on-year increase in number of connected doctors to ELHT evidenced since 2015 and an 84% increase compared to the number of connections five years ago reflecting a positively enhanced work force with added demands on the medical appraisal and revalidation (A&R) team.
Comments:	There is an increased need for appraisers (presently n=103) who need to be supported with appropriate PA allocation in their job plan for the appraiser role through directorates/divisions. As the RO does not hold separate dedicated budget for A&R, this is historically supported, directly through the Divisions and this needs to continue to be supported through Divisional budgets in the absence of a separate central RO budget.
Action for next year:	Continue as at present and see section 3 and appendix 1 Continue new appraiser recruitment and training in line with increasing demands and backfill for those retiring or relinquishing appraiser role due to other reasons.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Nil action and Nil issues
Comments:	There are robust and clear Standard Operating Procedures for the management of new starters at the Trust and leavers from the Trust and to enable GMC connections for starters and disable GMC connection for leavers.
Action for next year:	Continue as at present

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Appraisal policy for ELHT hospitals has been updated and ratified as per last year's action plan
Comments:	See policy in Appendix 1
Action for next year:	Continue as at present

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Peer review was undertaken in summer 2023
Comments:	See Appendix 2 for the peer review report received by ELHT further to Blackpool Hospital team reviewing our A&R functions
Action for next year:	Continue as at present

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	YES Also see under Section 1B and section 3
Comments:	All locum and short- term doctors are treated equitably in line with Trust processes and policies and have access to all supportive resources so that their outcomes and experiences with A&R are positive. The medical appraisal policy under section 18.1 clearly states how it supports locum or short-term placement doctors working in the organisation including those with a prescribed connection to another organisation. There were 201 under the temporary or short -term contract holder doctors for the appraisal year 2023/24 and a further 92 under 'other doctors with a prescribed connection' who come under Medical Bank only which is a total of 293 doctors in this cohort. This is a significant increase of 17.6% compared to figures last year at 249. Of the total 293, there were 292 (99.7%) who had appraisals completed (category 1). 177 had appraisals completed with submissions returned within 28 days. Only one doctor in this cohort (0.3%) had an approved missed appraisal due to her joining ELHT only on 21st February 2024 and her precedent history of being out of clinical practice for a long time to allow time to enable her preparedness for a comprehensive appraisal portfolio with adequate supporting information. The focused work over the years has resulted in this demonstrable improvement over the years from 80% appraisal completion for this cohort in 2017 to consistently high figures, above 95% over the past five years and close to 100% this year at 99.7%. Very short -term agency locum doctors are supported, with provision of exit reports signed by their line manager.

	All doctors employed at ELHT including locum and short term employed doctors have access to all the learning and development resources available through the learning hub, and e-learning for health online and have access to the varied courses through learning and development team as well as Post Graduate Medical Education training resources on offer to keep up their Continuing Professional development (CPD). All are supported with corporate induction as well as specialty specific induction besides accessible core skills and mandatory training resources. All job plans are supported with core SPA of 1.5 (equivalent to six hours per week) to support CPD activities including clinical audit, Quality improvement initiatives, research and encouraged to attend educational activities in house and external. Those doctors who are locum/short term and connected to ELHT as their Designated Body are supported with their appraisal and revalidation like substantively employed doctors. Appraisers receive a collated annual feedback report to enable their own reflections in their role as appraiser to be included within whole scope of work appraisal discussions at their own annual appraisal. There is a good leadership development training package offer for all new consultants and clinical directors besides a Trust wide generic offer for all staff through the learning hub.
Action for next year	Also see action under response to Section 1B below

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	The above process is well embedded in our organization Medical appraisal policy section 11 covers this comprehensively. Also see details under 1A (vi) & section3
Comments:	All doctors connected to ELHT are supported with an annual governance report (as an extracted report from Datix). This covers all complaints, significant events, incident reports, claims and coroners inquest cases related to the doctor. The

	doctor is provided with this report the month before the appraisal so that there is sufficient time for them to complete their reflections and formulate appropriate action plans that can feed into appraisal discussions and finally their PDP. ELHT doctors have always been supported with Dr Fosters Clinical Outcome Benchmarking Performance data report as part of supporting information provided by the Trust. This helps identify and exploratively reflect and discuss on any outlying clinical outcomes for actions as appropriate and also applaud excellence and good practice when noted. Those doctors who are short term and locum and connected to another DB are also supported with a Governance report at request through appraisal and revalidation team. ELHT doctors who work in other organisations including private/independent sector are mandated to submit a Letter of good standing from them to cover the requisite assurances under Whole scope of their work adequately. This is checked and monitored closely through QA review processes. It is acknowledged there may be exemptions to this which is covered under a new SOP number 14 (see appendix3) developed for 'Management of agreed exceptions for letter of good standing for non-ELHT work'.
Action for next year:	Dr Fosters performance data for each consultant has been in place for more than ten years and A&R team were updated that this will be decommissioned from summer 2024 onwards and an alternative Performance data report would be developed and enabled internally through ELHT informatics team. This performance report for doctors must be developed in a timely manner and enabled seamlessly in line with existent SOP without disruption by Trust Informatics team (Section3). Please also see under section 1A (vi)

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	There are robust processes in line with Appraisal policy and SOP for postponement of appraisals and monitor delayed/missed appraisals if any with effective governance. Also see response under 1B(i) regarding new SOP number 14 (see appendix3) developed for 'Management of agreed exceptions for letter of good standing for non-ELHT work'.
Comments:	As above
Action for next year:	Continue as at present, see section 3 and appendix,1 and 3

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Appraisal policy for ELHT has been updated and ratified as per last year's action plan- see appendix 1
Comments:	See Appendix 1 which has the medical appraisal policy ratified version. All relevant governance and HR policies linked to appraisal policy are referred to within the supporting documents in the policy itself in pages 1-3 as well as the references and appendices in pages 43-48
Action for next year:	Continue as at present as nil actions related to policy for next year as the policy renewal due date is Jan 2027.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	ELHT A&R team continually monitors the supply and demand for appraisers in line with number of connected doctors and ensures there are enough trained appraisers to effectively support and deliver the appraiser functions.
Comments:	There is an increased need for appraisers (n=103 as of 31.3.2024) who need to be supported with appropriate PA allocation in their job plan for the appraiser role through directorates/divisions. As the RO does not hold separate dedicated budget for A&R, this is historically supported, directly through the Divisions and this needs to continue to be supported through Divisional budgets in the absence of a separate central RO budget.
Action for next year:	Continue as at present and see section 3 and appendix1 Continue new appraiser recruitment and training in line with increasing demands and backfill for those retiring or relinquishing appraiser role due to other reasons.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	Quarterly appraiser network events continue for the above. In house tailored QA review is undertaken for all appraisals (100%) submitted to RO. In addition to the above, a sample undergoes PROGRESS QA review annually. This is currently in progress as delayed from last year as highlighted under the actions in section 3 and the cohort includes one appraisal at least for each appraiser (n=97) See under section 8.2 and 14.13 for details regarding the above within the medical appraisal policy in appendix 1.
Comments:	An e-learning module was developed for appraisers as part of new appraiser training as well as part of appraiser refresher training for all. New appraiser recruitment and training is held at least twice every year. Quarterly appraiser network and training sessions enable CPD for appraisers, network opportunities with peers and calibration and peer review opportunities.
Action for next year:	Continue as at present and see section 3

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	L2P appraisal and revalidation management system is in use since April 2015 and is well embedded. Robust QA processes are in place by the firm which passes on assurance annually. Due diligence is undertaken before each contract renewal.
Comments:	As above
Action for next year:	Continue as at present

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Yes- the above is followed robustly in line with GMC requirements and RO regulations
Comments:	Please see section 4 in medical appraisal policy-appendix 1 . Also see SOP 9 for management of non-engagement and relevant escalation routes as well as SOP 12 for medical revalidation readiness assurance checklist developed and implemented at ELHT to enhance the robustness of this process within medical appraisal policy under appendix 1.
Action for next year:	Continue as at present

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	Yes- the above process is robustly embedded
Comments:	As above. Please also see response under section 1C(i) as well regarding recommendations for revalidation. For those doctors who require a deferral recommendation for valid reasons, these reasons are discussed as a team within A&R fortnightly catch ups for RO to have a good understanding of reasons for deferral. A deferral action plan is documented and shared and agreed with the doctor ahead of recommendation and this is also shared as an RO note in the L2P system with the appraiser as well as the doctor. This acts as a prompt for timely completion of agreed actions with clarity on expectations from doctor and appraiser thus enabling timely recommendation post deferral within agreed timescales and avoidance of a second deferral.
Action for next year:	Continue as at present

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Yes. Effective clinical governance is well embedded in our policies and processes, and this continues to grow, evolve and progress. The appraisal policy in appendix 2 and the range of SOPs within the policy cover this comprehensively
Comments:	As above and our responses to all the above questions 1A-1D as well as the following questions under remaining subsections of 1D up to 1G covers this with added assurance in addition to details below. Patient centered care and clinical effectiveness that promotes and enhances patient safety and quality of care is always promoted and actively nurtured at ELHT through its Governance structures, policies and systems. Doctors are contractually obliged to follow Trust policies that adhere to the above commitment by Trust. All doctors are supported with appropriate resources to keep self-UpToDate with CPD in addition to core CPD allocation of 1.5 SPA time for all consultants and similar for others at non consultant grade. All support is provided for doctors with A&R across the range of Supporting information needed that

	reduces bureaucracy and pressure on them to seek data . example: governance report and performance data provision besides appraiser feedback individually and collectively as annual report and support in a streamlined manner with collation of patient and colleague feedback in every revalidation cycle. Clinical audit and effectiveness department has a robust process of annual forward planning trust wide and within every specialty which enables doctors to actively participate in clinical audits, QI projects and other clinical effectiveness initiatives. Research and innovation are actively encouraged for all medical professionals. The A&R team is accessible to all, friendly and approachable and fully trained and responsive to all queries to support doctors as needed always. The Trust Quality strategy and its closely linked Behavioral framework have a key focus on Compassion and Compassionate and Inclusive values and leadership. Compassionate and Inclusive approaches are therefore inbuilt into the related policies and processes Trust wide. These are embedded into medical A&R policy as well as those linked to managing concerns regarding doctors and Freedom to speak up, disciplinary, grievance and resolution and other HR policies. The Trust has been an active participant as a pilot site in first wave of the NHS resolution offer of Compassionate conversations training in 2023/24. Trust has also offered to become a pilot site among one of the six organizations in the Northwest to implement and embed the LOTUS Compassionate leadership framework and toolkit by NHS England at the time of writing this report. Trust is currently progressing an innovative inclusion initiative on Anti Racism in collaboration with Care quality academy and been the proud recipients of the BAME assembly Bronze award at the time of this report in spring 2024. This is testament to the Trust striving continually to create a more compassionate and inclusive culture and environment which in turn fosters effective governance positively.
Action for next year:	Continue as at present

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Yes. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organization. This is covered within relevant policies as referred to within the medical appraisal policy itself. (appendix 1) Professional standards group as a multi-disciplinary advisory group chaired by Head of HR, supports the RO functions related to this aspect. Clear Terms of reference are in place for this group approved by the JLNC- Joint Local negotiating Committee which also act as a consultation body for all related policies prior to formal ratification. There are appropriate support systems for reflections on related events from doctors as advised by RO feeding to appraisals. Formal investigations and/or other similar additional evidence advised by RO - appears as RO note for appraiser, doctor and appraisal lead to ensure is part of appraisal discussions and QA reviews.
Comments:	See appendix 4 which is Board report 2022/23 under section 6.1
Action for next year:	Continue as at present

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	Yes, doctors are supported will all relevant information as per below in comments section in a convenient format to include at their appraisal.
Comments:	• Dr Fosters Performance report – activity and performance benchmarked against peers and national data set. • Governance data annually – incidents, claims, complaints, coroners' inquests, significant events • Annual appraiser feedback collated as report, • RO note shared with appraiser and doctor if any additional information is requested by RO to share at appraisal. • Deferral action plans if any are shared as RO note so that actions are clear with timelines for completion. • All relevant guidelines and resources are accessible for all connected doctors in the L2P resource section.
Action for next year:	Continue as at present

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practice, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practice concerns.

Action from last year:	Yes. This is in place as policies below.
Comments:	HR 39 Version 5.2: Responding to concerns about clinical performance. HR09: Trust Disciplinary Policy HR06: Trust Sickness Absence Policy HR20: Freedom to Speak up Policy. HR 07: Early Resolution Policy HR36: Study and professional Leave Policy HR51: Guidelines for Consultants and SAS e-job planning HR46: Medical Appraisal Policy
Action for next year:	Continue as at present

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Yes – robust systems are in place for all of the above
Comments:	• All policies are in place and UpToDate subject to appropriate policy council ratification and Equality impact assessments before approval. • Appropriate robust processes to operationalize policies as Standard operating procedures are in place subject to similar governance approval processes. • A multi-disciplinary Professional standards group is in place as an advisory body for the RO on matters related to concerns regarding doctors. This is chaired by Head of HR and has in its core membership the DMD Professional standards, AMD A&R, Director of Medical Education, Head of legal, Head of HR, AD for patient experience, Head of Occupational health/wellbeing team etc among other co-opted members as needed. • Good relationships are in place with GMC ELA with whom periodic meetings are held with regards to cases needing escalations and reporting to GMC.

	• Discussions are also held by DMD Professional standards with the NHS Resolution Practitioner Performance Advisory • Service (PPAS) advisor of a legal background as well as periodic updates with the Designated Non-executive director. • Support is also available from the Trust Freedom to speak up Guardian and champions who are independent and are available to support doctors. • Bi-Annual analysis and review audit is undertaken by DMD professional standards on the type and outcome of concerns as well as demographics of the doctors involved (including age, gender, specialty, ethnicity, country of primary medical qualification, length of time working in the UK) . This was presented as appendix 2 within last year's report and will be shared again with next years annual report as only done once every two years. This data was also submitted as part of the new National medical WRES data set. • Please also see responses related to this under section 1D (i-iv)
Action for next year:	Continue as at present

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Yes- MPIT is used effectively as per policy besides any other RO to RO means of communication as appropriate.
Comments:	Any concerns identified about locum doctors on their exit report are sent by medical staffing to the DMD for Professional Standards who liaises directly with the doctor's RO to ensure support for the doctor and that any learning is identified and actioned. Please also see SOPs 3,4 in medical appraisal policy (appendix1)
Action for next year:	Continue as at present

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	Yes above safeguards are in place and well embedded at ELHT
Comments:	• EDI annual mandatory training is part of induction and annual update training. • Equality Impact assessment is undertaken for all policies before ratification. • PSG is a multi-disciplinary body bringing diverse voices. • ELHT has a thriving staff inclusion network with at least nine different staff networks feeding into this. • Please also see response under 1D(iv)
Action for next year:	Continue as at present

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports, and enquiries, and integrate these into the organization's policies, procedures and culture (give example(s) where possible).

Action from last year:	Yes. Few examples only included below among many
Comments:	• GMC expert speaker was invited to deliver a session at the appraiser network on updated Good Medical Practice guidance and a focus on Challenging Discriminatory Behavior and Bystander Duties • Sexual safety in health care organizational charter and Royal College of Surgeon's report was focus of a workshop for appraiser network emphasizing leadership role expected of appraisers in creating fair and equitable, compassionate and inclusive environments for all to thrive and flourish. • Regional and National inquiries and reports are part of the agenda included for appraiser networks periodically. • All relevant national and NICE guidance are part of the key reference documents for all policies that are implemented to guide the local clinical practice. • NHS people plan and promise besides principles of NHS constitution and National documents are part of Trust clinical strategy and all related Trust work. • ELHT has a dedicated Quality Improvement Faculty as well as Clinical effectiveness and audit team that continually work towards driving evidence-based improvements as well as development requirements and opportunities in relation to governance from the wider system that ELHT is well integrated with (at ICB level and Nationally)

	• Please also see responses under other 1D (i-vii)
Action for next year:	Continue as at present

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	Nil actions from last year. Robust systems are in place for this
Comments:	• All relevant policies are current and UpToDate and in line with Regulatory and national requirements. • They are all, subject to Equality Impact Assessment for fairness and equity with transparency. • All professional standards concerns about doctors escalated to the DMD for professional standards are discussed at inhouse Professional Standards Group (PSG). The Employee Case Review meeting takes place monthly and discusses professional standards concerns for all other staff and members and is also chaired by the Head of HR and attended by other members of the PSG to provide consistency. • The RO has oversight of all formal cases as does the Designated Non-executive director, GMC ELA and PPAS advisor. • Any decisions to exclude a doctor would be discussed with the CEO also as per Trust policy (this has not been required in the last 3 years). • Reporting of concerns to Trust Board takes place quarterly and includes any restrictions on practice. • All professional standards concerns are discussed with GMC ELA and inhouse Multidisciplinary group involving HR, CEO, MD and RO amidst others as appropriate. • On reviewing the Messenger review, the DB is assured of all key recommendations being fulfilled at the organization and continuing in an ongoing manner. • Please also see responses under 1D (i-Viii)
Action for next year:	Continue as at present

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Nil pending actions
Comments:	• Robust pre-employment checks in place through medical staffing team and HR that ensures that all doctors employed by Trust including locum and short-term doctors have qualifications and are suitably skilled and knowledgeable to undertake professional duties. • Processes are in place to ensure that professional references are checked by medical staffing team as well as by Specialty Clinical Director and/or their delegated deputy for all appointments. • Any queries or concerns arising from references or special support and/or supervision needs are discussed with DMD for professional standards or the MD/RO.
Action for next year:	Continue as at present

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Yes.
Comments:	Professional standards are linked directly to Trust values as highlighted within the Trust Quality strategy and its closely linked Behavioral framework. Both have a key focus on Compassion and Compassionate and Inclusive values and leadership. Compassionate and Inclusive approaches are therefore inbuilt into the related policies for managing concerns to compassionately support doctors who are subject of performance concerns and/or investigations whether internal or through external GMC/others. Professional standards group models the multi-disciplinary framework that nurtures diversity inclusion and belonging to be fostered through its diverse membership and expert inputs and insights for advisory consensus. ELHT was one of the five pilot sites who are successfully implementing the NHS Resolution “Compassionate Conversations Training” through a cascaded training via the Train the trainer approach which is in progress positively. ELHT is also a regional early adopter site for the NHS England Regional initiative on the LOTUS compassionate

	leadership framework and toolkit and further details related to this work will be included in next year's report. All doctors on whom performance concerns investigations are initiated are provided with supportive Trust resources through OH and wellbeing team as well as external resources such as • Employee Assistance Program. 24/7 telephone support • Occupational Health and Wellbeing Department. • Wellbeing website • Practitioner Health Service • Access to Work Mental Health Support by Able Futures • Practitioner Performance Advisory Service • Freedom to Speak Up Guardians Please also see responses under 1D(i-ix)
Action for next year:	Continue as at present

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	Yes
Comments:	There is a newly developed process in place to enhance compassion and fairness while upholding EDI principles to ensure that staff exclusively in the Trust bank are supported through long term leave without risk of being removed from the system after few months as it used to be in the past. Please see appendix 5 for the new process developed with the medical staffing team for management of long-term leave request for staff in bank system (maternity leave, paternity leave, planned sickness absence and career breaks included).This ensures that bank staff working exclusively in bank requiring long term leave as above are supported fairly, compassionately and inclusively. Please also see under 1F(i)
Action for next year:	Continue as at present

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	Yes to all above.
Comments:	Dedicated Freedom to speak up Guardian in place that doctors can approach. Please see responses under earlier 1D and 1F (i-ii)

Action for next year:	Continue as at present

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Yes to above.
Comments:	Formal complaints procedure in place and covered by related policies all of which are referred to under supporting documents within the medical appraisal policy. See under 1D
Action for next year:	Continue as at present

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	Yes, this is done.
Comments:	Please see under responses in 1D
Action for next year:	Continue as at present

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Yes, to all above
Comments:	RO and team attend all Regional RO network meetings RO and team attend GMC RO Reference Events AMD A&R chairs the Quarterly appraiser networks at ELHT Peer review undertaken for ELHT in summer 2023
Action for next year:	Continue as at present

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 to 31 March 2024.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2024	**727**

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**716**
Total number of appraisals approved missed	**11**
Total number of unapproved missed	**0**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	**148**
Total number of late recommendations	**0**
Total number of positive recommendations	**141**
Total number of deferrals made	**7**
Total number of non-engagement referrals	**0**
Total number of doctors who did not revalidate	**0**

2D – Governance

Total number of trained case investigators	**58**
Total number of trained case managers	**9**

Total number of new concerns registered	**7**

Total number of concerns processes completed	**5 formal MHPS**
Longest duration of concerns process of those open on 31 March Note: (doctor had episode of sickness which halted the investigation)	**238 days**

Median duration of concerns processes closed	**125 days**
Total number of doctors excluded/suspended	**0**
Total number of doctors referred to GMC	**4** (cases opened by the GMC formally)

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organization Substantive: 193 Bank Only - 224	**417**
Number of new employment checks completed before commencement of employment. Pre-employment checks are made for ALL colleagues who are employed by ELHT prior to commencing employment - except for deanery trainees hosted by the Trust during their rotation. Checks that are already made by the Deanery (HEE) would be used for those colleagues who are completing additional paid shifts via ELHT Medical Bank while on a formally recognised Training Program.	**417 (see narrative)**

2F – Organisational culture

Total number claims made to employment tribunals by doctors	**1**
Number of these claims upheld	**0**
Total number of appeals against the designated body's professional standards processes made by doctors	**0**
Number of these appeals upheld	**NA**

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report All actions from last year have been fully completed or in progress. The Quality assurance review of appraisals is currently in progress. The appraisers' input on future of ELHT appraisals was initially undertaken as a forum discussion at appraiser network. Subsequently, based on their input, a QI questionnaire survey has been developed with plans to be launched this year.
Good assurance on all aspects of NHS England and GMC requirements as per responses detailed above in the report content. Nil further details to add here. Appendix 1: Medical Appraisal Policy HR46 v3.7 Appraisal Policy Consultants A Appendix 2: Peer review report Peer Review Report ELHT 07.07.23.pdf Appendix 3: SOP14- Management of agreed exceptions for letter of good standing for non ELHT work SOP 14 for Management of agr Appendix 4: Board report 2022/23 AOA 2022-23 Annual Report Subr Appendix 5: Long term leave request from medical bank (Maternity leave, Paternity leave, sickness absence, career break) MB4 - LTLR Form (Long-Term Leave Re
Actions still outstanding
Progress QA review of an annual sample is in progress. Questionnaire survey of appraisers developed and to be launched shortly
Current issues
Nil

Actions for next year 2024/25 are as follows:

1. Ensure appropriate number of appraisers are continually recruited and trained to keep up with demand for capacity. AMD A&R and team
2. Ensure that appraisers continue to be supported with 0.25 SPA in job plans for appraiser role through directorates and divisions. RO, DMDs and CDs
3. Launch the questionnaire survey of appraisers for their views on satisfaction in appraiser role and intention to continue and support resources that they need which Trust can offer for long term. AMD A&R and team
4. Continue the Quality assurance review on 100% appraisals as it is presently and complete the ongoing additional Quality assurance review using PROGRESS tool on a sample of appraisals with at least one for each appraiser. AMD A&R and team
5. New service user pilot in palliative care and anesthetics is in progress and nearing conclusion. Develop a new SOP once fully completed. DMD PS and team
6. Repeat the analysis of doctors with performance concerns as reaudit every two years. DMD PS and HR team
7. Ensure that a seamless process is developed locally to provide activity and performance data for reflection at appraisals to all consultants – Head of Performance and Informatics with AMD A&R and team By Sept 2024

See above for action plans summary. Continue all good practices in line with medical appraisal policy and all supporting referenced guidance/policies linked to professional standards and clinical governance included within it as at present

Overall concluding comments (consider setting these out in the context of the organization's achievements, challenges and aspirations for the coming year):

- Good assurance is in place at ELHT on effective processes to support medical appraisal and revalidation and related governance processes. Has been a good year overall with 98.5% appraisal rates and Nil missed appraisals. Trust has always consistently achieved high medical appraisal rates above 95% since 2015 and this continues.
- 100% of those requiring revalidation having a timely recommendation made to the GMC with 141 positive recommendations (95.3%) and only 7 approved deferrals (4.7%) and Nil non engagement.
- All relevant policies and SOP's for enhancing robustness of governance at ELHT linked to statutory for responsibilities are current and UpToDate and formally ratified further to equality impact assessment. ELHT leads on supporting neighboring Trusts across the system with regards to medical appraisal and revalidation matters. The peer review in summer 2023 positively acknowledged our areas of good practice.
- 100% of appraisals are subject to Quality assurance review with feedback enabled to appraisers besides the provision of annual collated feedback report to all appraisers as part of supporting information in their role as appraiser for their appraisals.
- This report provides assurance to Trust Board on compliance against GMC and NHS England standards for medical appraisal and revalidation as well as professional standards and related governance.
- The report provides assurance that Trust is fulfilling all Statutory responsibilities that are expected under Responsible officer regulations 2010 updated 2013.

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body
East Lancashire Hospitals NHS Trust

Name:	Martin Hodgson
Role:	Chief Executive Officer
Signed:	
Date:	

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

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

11 September 2024 **Purpose** Information

Title	Emergency Preparedness, Resilience and Response (EPRR) Annual Statement
Report Author	Mrs H Taylor, Head of EPRR
Executive sponsor	Mr T McDonald, Executive Director of Integrated Care, Partnerships and Resilience

Summary: This paper describes the Trusts current position with regards to emergency preparedness, resilience and response (EPRR) pending the submission of a formal Statement of Assurance by 31 October 2024.

Recommendation:

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

b) To give delegated authority to the Chief Executive and the Executive Director of Integrated Care and Partnerships to submit the EPRR Assurance Statement on behalf of the Trust. The final Assurance Statement will be presented to the Trust Board at its next meeting.

Report linkages

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

Related to recommendations from audit reports	N/A
Related to Key Delivery Programmes	N/A
Related to ICB Strategic Objective	State which ICB Strategic Objective the paper relates to here.

Impact

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

Previously considered by:

Executive Summary

1. This paper summarises the current position of the Trust in relation to the NHS Core Standards Assurance for emergency preparedness, resilience and response (EPRR) and provides the Trust Board with assurance that ELHT meets its statutory duties under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012 and its other non-statutory obligations.

2024/25 EPRR Assurance Process

2. The EPRR Core Standards Assurance Process commenced in July this year. This process requires the Trust to complete a comprehensive self-assessment in relation to compliance against a set of national core standards. The process this year is back to a Trust self-assessment where Lancashire and South Cumbria ICB will then complete a dip sampling of up to 6 core standards to assess compliance.

3. The process for 2024 will require a statement of assurance in relation to 10 specific areas:

- **a.** Domain 1 - Governance
- **b.** Domain 2 - Duty to risk assess
- **c.** Domain 3 - Duty to maintain plans
- **d.** Domain 4 - Command and Control
- **e.** Domain 5 - Training and Exercising
- **f.** Domain 6 - Response
- **g.** Domain 7 - Warning and Informing
- **h.** Domain 8 - Cooperation
- **i.** Domain 9 - Business Continuity
- **j.** Domain10 - CBRN

4. As per previous years, alongside the annual assurance process, a 'deep dive' is conducted to gain valuable insight into a specific area. Following recent incidents and common health risks raised as part of last year's annual assurance process the 2024/25 EPRR annual deep dive will focus on responses to cyber security and IT related incidents.

5. For the period 2024/25, the Trust is aiming to maximise our compliance from last year's submission. The Trust will be receiving a pre-assessment visit from the Head of EPRR for Lancashire and South Cumbria ICB on the 9th and 10th September which will help to

support and inform our final compliance position. As previously reported, this is a process of continuous improvement over a two-year cycle where we hope to be fully compliant across all standards by our 2025/26 submission. The Trust will now progress towards fully achieving these core standards with a robust action plan.

6. The Trusts EPRR Assurance Statement will be submitted to the ICB by 31st October 2024. As these are nationally prescribed timescales and do not align to the existing Trust Board schedule, the Trust Board are requested to give delegated authority to the Chief Executive and the Executive Director of Integrated Care, Partnerships and Resilience to issue the assurance statement on behalf of the Trust. The final Assurance Statement will be presented to the Trust Board at its next meeting.

Recommendations

7. The Trust Board is asked to:

- **a.** To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it fulfils its statutory and non-statutory duties and obligations.
- **b.** To give delegated authority to the Chief Executive and the Director of Integrated Care and Partnerships to submit the EPRR Assurance Statement on behalf of the Trust. The final Assurance Statement will be presented to the Trust Board at its next meeting.

Heather Taylor, Head of EPRR, 28th August 2024.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**133a**
11 September 2024		**Purpose**	Approval
Title	Ratification of Board Sub-Committee Terms of Reference: Quality Committee		
Report Author	Miss K Ingham, Corporate Governance Manager		

Summary: The terms of reference for the Committee have been reviewed in line with the current work of the Committee and best practice. They have been presented to the Committee at its meeting in August 2024 and have been agreed by the members.

Recommendation: The Board is asked to ratify the revised terms of reference.

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.

	6	(As Host of One LSC): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services. (As Partner of One LSC): One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.
Related to key risks identified on Corporate Risk Register	None	
Related to recommendations from audit reports	-	
Related to Key Delivery Programmes	-	
Related to ICB Strategic Objective	N/A	

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

TERMS OF REFERENCE: QUALITY COMMITTEE

Constitution

The Trust Board has established a Committee with delegated authority to act on its behalf in matters relating to patient and staff safety and governance to be known as the Quality Committee.

The Committee will provide assurance to the Board and to the Audit and Risk Committee which is the high-level risk Committee of the Board, on all matters that it considers and scrutinises on behalf of the Board.

Purpose

The purpose of this Committee is to provide assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board.

Duties and Responsibilities

The Committee will:

- Review and approve the Trust's Risk Management Strategy (and supporting documents) under the delegated authority from the Board and assuring the Board that it contains the information necessary to support good governance and risk management throughout the Trust. Including that the Trust meets the requirements of all mandatory and best practice guidance issued in relation to clinical and corporate governance.
- Have the responsibility for scrutinising the Trust's (Corporate) Risk Assurance Framework on a regular basis and satisfying itself that the identified risks are being managed appropriately within the divisions, departments and at executive level.
- Be responsible for ensuring that those risks, within its remit, which are escalated to the Corporate Risk Register and Board Assurance Framework (BAF) are appropriate and proportionate, seeking further assurance from the executive team and escalating to the Board, concerns relating to unresolved risks that may require executive action or pose significant threats to the operation, resources or reputation of the Trust.
- Assure itself that adequate and appropriate integrated governance structures, processes and controls (including Risk Assurance Frameworks at all levels) are in

place across the Trust.

- Receive reports from its sub-committees at which the patient safety and quality issues and risk management processes in the Divisions are debated and monitored collectively.
- Receive and oversee the production of the Trust's Quality Account and, review and endorse them for approval by the Trust Board.
- Oversee the development and implementation of the Trust's Quality Strategy.
- Receive professional staffing reviews relating to both nursing and midwifery services.
- Scrutinise the effective and efficient use of resources through evidence based clinical practice and assure itself that there is an appropriate process in place to monitor and promote compliance across the Trust with all standards and guidelines issued by the regulators, NHS England/Improvement, NHS Resolution, the Royal Colleges and other professional and national bodies.
- Promote a culture of open and honest reporting of any situation that may threaten the quality of patient care and oversee the process within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, complaints and litigation.
- Satisfy itself that examples of good practice are disseminated within the Trust, ensuring that its sub-committees have adequately scrutinised the investigation of incidents and that there is evidence that learning is identified and disseminated across the Trust.
- Satisfy itself that Safeguarding Children and Vulnerable Adults is at the heart of everything we do, ensuring that the Trust meets all of its obligations in respect of safeguarding at all times. This includes satisfying itself that all staff have training to the standard and frequency required. It will also satisfy itself that the Trust captures the learning from nationally published reports and that the learning is embedded in the practices, policies and procedures of the Trust.
- Satisfy itself that the appropriate actions in respect of patient safety and governance have been taken following recommendations by any relevant external body. This includes monitoring the Trust's compliance with the Care Quality Commission registration requirements and any reports resulting from visits.
- Receive a detailed annual report on the activity of the PALs service and complaints and litigation.
- Consider matters referred to it by other committees and groups across the Trust

provided they are within the Committee's remit.

Reflection

The Committee shall allocate a short amount of time at the end of each meeting to reflect on the discussions that have taken place, assurances gained and, where appropriate, challenge the purpose, focus and length of the papers presented. Specific areas of focus will be whether the papers have been aligned to these terms of reference and the clarity and assurances that they provide as well as issues escalated from sub-committees.

The Committee will have a specific agenda item for matters escalated to them from other Committees, for matters to be escalated to the Board and actions to be delegated to other Board Committees. This item will be clearly captured in the minutes of the meeting and will feature in reports from the Committee to the Board.

System Working

There is an increasing expectation for the Trust, and others within the Lancashire and South Cumbria Integrated Care System, to work together as a system for the betterment of the health of the population. With this in mind, the provider Boards and their sub-committees, within the Lancashire and South Cumbria (LSC) Integrated Care System (ICS), have, following the Board agreement, supported the delegation of the following functions to the PCB Joint Committee, where such matters affect the Trusts and can benefit the population of LSC.

a) service transformation priorities as defined by the ICS and commissioners
b) priorities for provider productivity improvement
c) opportunities for developing standardised approaches to service change and delivery
d) Shared clinical services for community services
e) Shared corporate services for bank and agency workers procurement
f) Pathology Collaboration Network strategic decisions
g) And other matters as determined from time to time

In exercising these delegated functions, the PCBJC shall provide a single, collective view of the Provider Trusts and agree an annual work programme, each year, relating to the delegated functions, that promotes the best interests of the whole population.

The Trust Board and its sub-committees will ensure that they are fully involved in the decision making and engagement process in relation to the strategic collaborative items

and this will be enacted through an Executive function with representation from the Non-Executive contingent of directors.

Membership

Three Non-Executive Directors/Associate Non-Executive Directors (a Non-Executive Director will be the Chair of the Committee)
Chief Nurse
Executive Medical Director

Executive Director of Integrated Care, Partnerships and Resilience

The Executive Director of Service Development and Improvement will attend the Committee meeting on a quarterly basis to provide an update on the Trust's Improvement Programme. Other officers of the Trust may be invited to attend the Committee to report on items within their remit, such as the Executive Director of People and Culture.

Attendance

The Director of Corporate Governance/Company Secretary and the Associate Director of Quality and Safety will be in attendance at meetings. A representative of the Trust's Internal Audit function will be invited to attend and observe each meeting. The Committee may direct the attendance of others at meetings as the Chair of the Committee deems appropriate.
A representative of the Lancashire and South Cumbria Integrated Care Board, such as the Senior Quality Assurance Manager, will be invited to attend and observe each meeting.

Frequency

The Committee will meet at least 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee as provided for in the Trust Standing Orders and Standing Financial Instructions.

Quorum

Two Non-Executive Directors/Associate Non-Executive Directors and two Executive Directors. A quorum must be maintained at all meetings. Members are expected to attend all meetings but will attend at least 75% of meetings. Members who are unable to attend will arrange for

the attendance of a nominated deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend but they will not count towards the quorum.

Regular Reports

Monthly Items

Patient Story

Patient Safety Incident Response Framework Report

Integrated Performance Report (including Infection Prevention and Control)

Trust-Wide Quality Group Triple A Report

Cancer Update

Alternate Months

Board Assurance Framework

Corporate Risk Register

Records Management Report

Nursing Assessment Performance Framework

Head of Midwifery/Maternity Floor to Board Report (to be received in the months where there is no Trust Board)

Quarterly

Mortality

Clinical Harms Review Management Report

Inquests/Claims

Improvement Update

End of Life Care

Twice per year

Patient Participation Panel

Nurse and Midwifery Staffing (Professional Judgement)

Focused GIRFT Report

Learning Disability Improvement

Annually

Clinical Audit

Annual Safeguarding

Medicines Management

Annual Transfusion

Annual Infection Prevention and Control

Learning from Deaths

Health, Safety and Security

Winter Planning

Patient Safety Partners

Organ Donation

National Cancer Patient Survey

Annual Complaints including PHSO Complaints Standards

Risk Management Strategy

Quality Account

Patient Led Assessment of the Care Environment (PLACE)

Authority

The Committee has no executive powers other than those specified in these Terms of Reference and by the Trust Board in its Scheme of Delegation.

The Committee is able to summon reports (and individuals) to enable the Committee to discharge its duties.

The Committee forms the high-level Committee for quality and safety reporting.

The Committee is authorised to investigate any issue within the scope of its Terms of Reference.

The Committee is authorised, with the support of the Director of Corporate Governance/Company Secretary, to obtain any independent professional advice it considers necessary to enable it to fulfil these Terms of Reference.

Reporting

The Committee will report to the Trust Board via the presentation of a 'Triple A' report, which includes items discussed that the Board can take assurance from, or need to be alerted to or advised of.

In addition, the Committee will report any specific risks or matters identified for escalation to the Audit and Risk Committee.

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board business cycle and reported to the Board.

The Committee will provide regular reports on its activities to the Trust Board. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit and Risk Committee through the internal and external auditors and external regulatory bodies.

Committee Support

Lead Directors: Executive Medical Director and Chief Nurse

Secretarial Support: Corporate Governance Team

Committees reporting

Trust-Wide Quality Governance Group

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**133b**
11 September 2024		**Purpose**	Approval
Title	Ratification of Board Sub-Committee Terms of Reference: Audit Committee		
Report Author	Miss K Ingham, Corporate Governance Manager		

Summary: The terms of reference for the Committee have been reviewed in line with the current work of the Committee and best practice. They have been presented to the Committee at its meeting in August 2024 and have been agreed by the members.

Recommendation: The Board is asked to ratify the revised terms of reference.

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.

	6	(As Host of One LSC): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services. (As Partner of One LSC): One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.
Related to key risks identified on Corporate Risk Register	None	
Related to recommendations from audit reports	-	
Related to Key Delivery Programmes	-	
Related to ICB Strategic Objective	N/A	

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

TERMS OF REFERENCE: AUDIT AND RISK COMMITTEE

Constitution

The Board has resolved to establish a Committee of the Board to be known as the Audit and Risk Committee. The Committee is an independent Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. The Audit and Risk Committee is the high-level risk committee operating on behalf of the Board and concerns itself with the function and effectiveness of all committees. It is the Committee that brings all aspects of governance and risk management together.

Purpose

The Audit and Risk Committee is charged with ensuring that the Board and Accounting Officer of the organisation gain the assurance they need on governance, risk management, the control environment and on the integrity of the financial statements, as well as other elements of the Annual Report and Accounts.

The role of the Audit and Risk Committee is a challenging one and it needs strong, independent members with an appropriate range of skills and experience. The Committee acts as the "conscience" of the organisation and demonstrates strong constructive challenge where required. For example, risks arising from increasing fiscal and resource constraints, new service delivery models, information flows on risk and control and the agility of the organisation to respond to emerging risks. In addition, it has a role in assuring the effectiveness of other Board sub-committees, but this should not interfere with the requirement for the Audit and Risk Committee to maintain independence.

The Audit and Risk Committee fulfils a major role in providing independent and objective assurance through the work of internal and external auditors and counter fraud, reviewing reports and intelligence from external bodies including regulators and seeking assurance from internal teams and the sub-committees of the Board, such as the Finance and Performance Committee and Quality Committee.

It is essential that the Audit and Risk Committee understands how the governance arrangements support the achievement of the Trust's strategies and objectives, especially:

- The Trust's vision and purpose.
- The mechanisms in place to ensure effective organisational accountability, performance and risk management.

- The roles and responsibilities of individuals and Committees and other groups to support the effective discharge of the Trust's responsibilities, decision making and reporting.

The Committee must also understand the organisation's business strategy, operating environment and the associated risks. It must take into account the role and activities of the Board and other Committees in relation to managing risk and should ensure that the Board discusses its policies, attitude to and appetite for risk to ensure these are appropriately defined and communicated so management operates within these parameters.

Duties and Responsibilities

The duties of the Committee are categorised as follows:

Governance, Risk Management and Internal Control

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular the Committee will review the adequacy and effectiveness of:
  - All risk and control related disclosure statements, in particular the Annual Governance Statement together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to their endorsement by the Board.
  - The underlying assurance processes that indicate the degree of achievement of the corporate objectives, the effectiveness of the management of the principal risks and the appropriateness of the above disclosure statements.
  - The policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
  - The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.
- In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors, managers and sub-Committees of the Board as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with

indicators of the effectiveness.

- This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

- The role of the Audit and Risk Committee in relation to internal audit should include advising the Accounting Officer and the Board on the:
  - Internal Audit Charter and periodic internal audit plans, forming a view on how well they reflect the organisation's risk exposure and support the Head of Internal Audit's responsibility to provide an annual opinion.
  - adequacy of the resources available for internal audit.
  - terms of reference for internal audit.
  - results of internal audit work, including reports on the effectiveness of systems for governance, risk management and control, and management responses to issues raised.
  - annual internal audit opinion and annual report.
- The Committee shall ensure that there is an effective internal audit function that meets mandatory *NHS Internal Audit Standards* and provides appropriate independent assurance to the Audit and Risk Committee, the Chief Executive and the Board. This will be achieved by:
  - consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
  - review and approval of the Internal Audit Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
  - considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.
  - ensuring that the internal audit function is adequately resources and has appropriate standing within the organisation.
  - the annual review of the effectiveness of internal audit.

External Audit

- The Committee shall review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:
  - consideration of the appointment of external auditors acting as the Auditor Panel and the performance of the external auditors, as far as the rules governing the appointment permit.
  - discussion and agreement with the external auditors, before the audit commences, of the scope and nature of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
  - discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
  - review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- The Committee shall review and monitor the external auditor's independence and objectivity.
- The Committee will also review the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements.

Other Assurance Functions

- The Audit and Risk Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications for the governance of the organisation.
- These will include, but will not be limited to, any reviews by Department of Health and Social Care arms-length bodies or regulators/ inspectors and professional bodies with responsibility for the performance of staff or functions.
- In order to preserve the independence of the Committee Chair and members, the Committee will receive matters of escalation from the Board Sub-Committees, particularly the Finance and Performance Committee, Quality Committee and People and Culture Committee.
- To ensure that the Committee maintains a strategic focus the Committee will continue to strengthen its links with the Board Assurance Framework (BAF) and will focus its

agendas, where appropriate, on matters contained within the BAF, including the annual review of the BAF.

- To seek assurance on the implementation of guidance and recommendations from external inspection and accreditation visits from the Quality Committee.
- In addition, the Committee will review the work of all other committees within the organisation whose work can provide relevant assurance to the Audit and Risk Committee's own scope of work. This will particularly include the work and functionality of the Quality Committee, Finance and Performance Committee and People and Culture Committee, which report to the Board on all aspects of clinical and financial governance, people and risk management.
- The Audit and Risk Committee will approve the Quality Account prior to publication on behalf of the Board and on the recommendation of the Quality Committee.

Counter Fraud

- The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Financial Reporting

- The Audit and Risk Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance and review significant financial reporting judgements contained within them. The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
- The Committee will receive the quarterly report on waivers.
- The Audit and Risk Committee will review the annual report and financial statements before submission to the Board, focussing particularly on:
  - The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
  - Changes in and compliance with accounting policies, practices and estimation techniques
  - Unadjusted mis-statements in the financial statements
  - Significant judgements in preparation of the financial statements
  - Significant adjustments resulting from the audit

- Letter of Representation
- Qualitative aspects of financial reporting,
- whether the annual report and accounts, taken as a whole, are fair, balanced and understandable, and provide the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy.

- In reaching a view on the accounts, the Committee will consider:
  - key accounting policies and disclosures;
  - assurances about the financial systems which provide the figures for the accounts;
  - the quality of the control arrangements over the preparation of the accounts;
  - key judgements made in preparing the accounts;
  - any disputes arising between those preparing the accounts and the auditors; and
  - reports, advice and findings from external audit (especially the Audit Completion Report – ISA 260 Report)

Whistleblowing

- The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical, safety or governance matters and ensure that any such concerns are investigated proportionately and independently.

Management

- The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.
- The Committee shall receive the annual report on the declarations of interest and the Trust's registers of gifts and hospitality will be presented twice per year in accordance with best practice.

System Working

In addition to the statutory duties to collaborate there is an increasing expectation for the Trust, and others within the Lancashire and South Cumbria Integrated Care System, to work together as a system for the betterment of the health of the population. With this in mind, the provider Boards, within the Lancashire and South Cumbria (LSC) Integrated Care System (ICS) have agreed to delegate the following functions to the PCB Joint Committee, where such matters affect the Trusts and can benefit the population of LSC.

a) service transformation priorities as defined by the ICS and commissioners
b) priorities for provider productivity improvement
c) opportunities for developing standardised approaches to service change and delivery
d) Shared clinical services for community services
e) Shared corporate services for: bank and agency workers procurement
f) Pathology Collaboration Network strategic decisions
g) And other matters as determined from time to time

In exercising these delegated functions, the PCB shall provide a single, collective view of the Provider Trusts and agree an annual work programme, each year, relating to the delegated functions, that promotes the best interests of the whole population.

The Trust Board will ensure that it is fully involved in the decision making and engagement process in relation to the strategic collaborative items and this will be enacted through an Executive function with representation from the Non-Executive contingent of directors.

As a host and partner organisation of One LSC ELHT has a pivotal role in relation to central services collaboration. The Audit and Risk Committee will have a standing item on its agendas on One LSC and will provide assurance to the Board about the appropriateness of the governance arrangements and risk management systems. It will also consider matters in relation to collaborative working of providers and other stakeholders.

As a host organisation the Trust's Audit and Risk Committee will be responsible for receiving at least an annual report, but more frequently if required, from the Managing Director of One LSC in relation to the total remuneration packages of the One LSC Directors, specifically setting out the confirmation that the correct governance and decision making processes have been followed by the PCBJC and CSEC as the decision making bodies in this matter, before

any implementation instructions are delivered to payroll.

Reflection

- The Committee shall allocate a short amount of time at the end of each meeting to reflect on the discussions that have taken place, assurances gained and, where appropriate, challenge the purpose, focus and length of the papers presented. Specific areas of focus will be whether the papers have been aligned to these terms of reference and the clarity and assurances that they provide as well as issues escalated from sub-committees.
- The Committee will have a specific agenda item for matters escalated to them from other Committees, for matters to be escalated to the Board and actions to be delegated to other Board Committees. This item will be clearly captured in the minutes of the meeting and will feature in reports from the Committee to the Board.

Membership

The Committee members are appointed by the Board from amongst the independent and objective Non–Executive Directors and the Associate Non-Executive Directors of the Trust and consist of no less than three members.

One of the members of the Committee will have the required qualifications to be an Audit and Risk Committee Chair and will be appointed Chairman of the Audit and Risk Committee by the Board.

The Audit and Risk Committee should corporately possess knowledge/ skills/ experience/ understanding of:

- accounting;
- risk management;
- internal / external audit; and
- technical or specialist issues pertinent to the organisation's business.
- experience of managing similar sized organisations;
- the wider relevant environments in which the organisation operates
- the accountability structures
- collaboration and system working

The Chairman of the Trust shall not be a member of the Committee.

In Attendance

The Executive Director of Finance and Director of Corporate Governance/Company Secretary. and appropriate internal and external audit representatives shall normally attend meetings. The Executive Medical Director and Chief Nurse shall attend on a rotational basis. At least once a year the Committee members will meet privately with the external and internal auditors.

The Chief Executive or their deputy will be requested to attend the meeting where the Trust's Annual Governance Statement and Annual Accounts/Report are presented/ approved. They will also be invited to attend when the Committee considers the draft internal audit plan. All other Executive Directors will be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

Frequency

A minimum of four meetings per annum will be held in accordance with the timetable agreed by the Trust Board and an additional meeting to approve the annual accounts and report. Members or their nominated representative are expected to attend at each meeting.

The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

It is good practice for the Chair of the Audit and Risk Committee to meet with the Accounting Officer, the Executive Director of Finance, the Head of Internal Audit and the external auditor's senior representative outside of the formal Committee structure.

Quorum

Two members of the Committee must be present to ensure quoracy.

Members are expected to attend at least 75% of the meetings but in the unusual event that a member of the Committee cannot attend the following are the delegated deputies.

- Chair of the Committee – A member of the Committee
- Member of the Committee – A Non-Executive Director or Associate Non-Executive Director
- Executive Directors, who would normally be in attendance or in attendance because of the nature of the agenda items, may deputise to a senior manager within their corporate structure if they are unable to attend the meeting.

Acting as the Auditor Panel

- Under Section 9 of the Local Audit and Accountability Act 2014, the Trust is required to appoint an Auditor Panel.
- The role of the Auditor Panel is to advise on the selection, appointment and removal of the external auditors as well as on the maintenance of an independent relationship with that auditor, including dealing with possible conflicts of interest.
- The Trust has agreed that the Auditor Panel will be made up of the Non-Executive Directors serving on the Audit and Risk Committee and the Executive Director of Finance.
- The Auditor Panel will have a role in establishing and monitoring the Trust's policy on the awarding of non-audit services.
- The Trust must consult and take account of the Auditor Panel's advice on the selection and appointment of the external auditor. The advice given by the Panel must be published and should the Trust not follow that advice, the reasons for not doing so must also be published.
- The Auditor Panel must have at least three members, including a Chair who is an independent Non-Executive member of the Trust Board, in this case the Panel Chair will be the Chair of the Audit and Risk Committee. The majority of the Panel's members must also be independent and Non-Executive Directors/Associate Non-Executive Directors of the Trust Board.
- In order to take a decision, the Auditor Panel must be quorate, which means that the independent members (NEDs and Associate NEDs) must be in the majority and there must be at least 2 independent members present or 50% of the Auditor Panel's total membership, whichever is the highest.
- Proceedings are valid only if the majority of the members of the Panel present at the meeting are independent members.
- The Auditor Panel is an advisory body only. Responsibility to the actual procurement and appointment of the auditors remains with the Trust Board. The Chair of the Auditor Panel will be required to provide a report to the Board about the activities and decisions of the Panel.

Other Matters

- The minutes of the Audit and Risk Committee meetings shall be formally recorded by

the Corporate Governance Team and a 'Triple A' (Assurance, Alert and Advise). summary report submitted to the Board. From each meeting the Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

- For monitoring compliance purposes, the Committee will report to the Board after each meeting. At least once each calendar year it will, as part of its regular reporting to the Board, the Committee will report specifically cover the statement about the fitness for purpose of the Board Assurance Framework (following the annual review by the Committee), and assurance that the risk management system is complete and embedded in the organisation and the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the Quality Accounts.

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or agent and all employees are directed to co-operate with any request made by the Committee.

As well as having the permanent members of the Committee, the Committee is empowered to co-opt Non-Executive members for a period of time (not exceeding a year, and with the approval of the Board) to provide specialist skills, knowledge and experience which the Committee needs at a particular time and procure specialist advice at the expense of the organisation on an ad-hoc basis to support them in relation to particular pieces of committee business.

Reporting

The Committee will report to the Trust Board.

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board business cycle and reported to the Board. The Committee will provide regular reports on its activities to the Trust Board. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit and Risk Committee through the internal and external auditors and external regulatory bodies.

Committee Services

Lead Director: Executive Director of Finance

Secretarial Support: Corporate Governance Team

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**134a**
11 September 2024		**Purpose**	Assurance Information
Title	Triple A Report from Finance and Performance Committee		
Report Author	Mrs L Sedgley, Non-Executive Director		

Summary: This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 29 July 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 July 2024
Committee Chair:	Mrs L Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting Estates Strategy Improvement Update Integrated Performance Report Community Services Transfer PWE GP Practices Update Contract over £1,000,000 System Issues

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 increase in infection control due to increases in Covid but is struggling for side rooms to isolate patients given the high occupancy rates across all sites.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- A log has been set up to record all the requests for various reviews that are being made on the Trust.
- The Committee heard that the NCC index score for 2023/24 is predicted at 97 which is an improvement from 102 in 2022/23.
- The Committee noted the ongoing Estates review to look at occupancy rates and costs to deliver services. It will also include a review of the current risks of the Estate.
- The Committee received the improvement update which focused this month on elective productivity and outpatient services. In September the Changeology review will start on outpatients and a workshop will be held with primary care and Gynaecology bringing all the teams together to review pathways.

- The committee heard an update on the Grip and Control measures put in place to reduce the run rate in 2024/25.

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 noted its thanks to all the teams involved in the transfer of services from Blackburn with Darwen Council and to Lancashire and South Cumbria Foundation Trust. The Committee heard that Albion Mill currently has 13 patients admitted up from the 2 patients when we took over on 1 July.
- PWE GP Services is moving into the Community Division and will benefit from the support and governance structures of the Divisional management structure. The team are looking at developing a specific Integrated Performance Report for PWE and the workforce of the practice has been significantly enhanced by the appointment of 3 part time GPs and an offer has gone out to 1 full time GP. The transition to permanent roles will reduce costs and enhance both quality and patient experience.
- The Committee heard that work is ongoing to address the issues on the Private Finance Initiative contracts and the team will continue to request support at a national level given the number of Trusts which are dealing with similar issues.

TRUST BOARD REPORT		**Item**	**134b**
11 September 2024		**Purpose**	Assurance Information
Title	Triple A Report from Finance and Performance Committee		
Report Author	Mrs L Sedgley, Non-Executive Director		

Summary: This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 2 September 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:	2 September 2024
Committee Chair:	Mrs L Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting Finance, Performance and Workforce Divisional Meeting Summaries Improvement Update Integrated Performance Report Board Assurance Framework Corporate Risk Register Community Services Transfer LSC Pathology Service Business Case Tenders Update Contract over £1,000,000 Private Finance Initiative Update System Issues

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 pressure on cash and capital spend after the Trust's application for Public Dividend Capital funding was rejected in August.
- The Committee received the PSC report on the Pennine Lancashire Urgent and Emergency Care system which highlighted the lower spend on primary care across Pennine Lancashire and in particular that of Blackburn with Darwen which has 31% fewer GPs per population than the national average, whereas Lancashire and South Cumbria as a whole has 12.5% fewer GPs than the national average.
- The Committee heard that the current financial position is carrying unfunded pressures of £2million due to the recent strike action and the consultant pay award.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Chief Executive briefed the committee on the introduction of the IMT cell structure to manage the current financial position of the Trust as if it were a major incident. The first week of the cell has identified £4million of opportunities for savings and the opportunities in addressing weaknesses within the absence management and rostering systems. Week 2 of the cell is looking at medical pay, Strategic Outline Cases and reviewing the top 20 earners within the Trust. The Committee heard that this approach is being well received across the organisation and there is excellent engagement and an impressive commitment from the divisions to address the financial issues.
- The divisions are all looking at similar issues and are sharing learning and best practise in order to improve the run rate.
- The Committee received papers for assurance purposes from the Financial Assurance Board on the Waste Reduction Plan and the ELHT Finance IMT – Better Care Better Value. The Committee also received the Finance, Performance and Workforce Divisional meeting summaries and discussed the information that it contained.
- The Committee approved the winter plan and the Pennine Lancs UEC Improvement case which will reduce staff costs by £700,000.
- The Committee noted that the first report from the review by PA Consultancy identified significant opportunities for savings within variable pay but recognised the pressures the organisation faced with the continuing demand for emergency care.

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 noted the submission of the revised FOT on 30 August showing deficit of £31.6m and received updates on the controls put in place to reduce the current run rate.
- The Committee had an update on the Pathology business case and noted that only one option that of the centralised laboratory met the minimum criteria of a benefit to cost ratio of 4:1.
- The Committee heard that after careful consideration the Trust would not be submitting a tender to run the NW Critical Care Service. This was on the basis that whilst the Trust had ambitions and the expertise to run such services the financial and operational risks in the current climate were too great.
- The Committee received an update on the improvement projects within Urgent and Emergency Care to reduce admissions through a screening pilot, which since April

had resulted in 370 fewer admissions and 80% of patients screened though the pilot stayed at home, and were still at home 72 hours later.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

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

11 September 2024 | **Purpose** | Assurance / Information

Title	Triple A Report from Quality Committee
Report Author	Mrs C Randall, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Quality Committee meeting held on 7 August 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 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	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement 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:	Quality Committee
Date of Meeting:	7 August 2024
Committee Chair:	Catherine Randall
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update Quality Impact Risk Assessments Safer Staffing Report NAPF Update Report Safeguarding Annual Report 2023-24 Health and Safety Annual Report 2023-24 Patient Safety Incident Response Framework Report Update on Community Transfer and Albion Mill CQC Update Regulation 28 Notices

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.

- Ongoing issues with the Trust's mortality data.
- Examples of racist abuse being directed towards Trust staff and concerns around their safety following the riots and civil unrest over recent weeks.
- Potential industrial action by GP colleagues.
- Issues with the flow of inpatients and ongoing use of corridor care.
- An increase in reported pressure ulcer incidents.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- Annual Safeguarding Report – members noted that there had been a sustained improvement position regarding adult agendas, particularly in terms of compliance with level one and two training modules.
- Health and Safety Annual Report – it was highlighted that work had taken place to better align the Trust with health and safety models used by regulators. Members noted that the Trust's Health and Safety Committee continued to meet on a regular basis and was performing well.
- Patient Safety Incident Response Assurance update and the elimination of all overdue Patient Safety Incident Investigations.
- Safer Staffing Report and summaries of future workforce projections.
- Improvements in urgent and emergency care areas.
- Ongoing monitoring of key quality metrics by the Trust Wide Quality Group.
- The successful transfer of community services and Albion Mill into the Trust.

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.

- A paper will be provided to the Board regarding the work taking place in urgent and emergency care areas.
- A 'deep dive' into two selected Quality Impact Risk Assessments will take place at future meetings of the Committee.
- A paper will be provided to the Board regarding the work taking place in the Trust around its anti-racism programme and in response to the increase in racial abuse being directed towards staff.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **136a**

11 September 2024 **Purpose** Approval / Assurance / Information

Title	Triple A Report from Audit Committee
Report Author	K Rehman, Chair of Audit committee
Date Paper Approved by Executive Sponsor	3 September 2024

Summary: This report sets out the summary of the items discussed at the Audit Committee meeting held on 28 June 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	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
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:	**28 June 24**
Committee Chair:	**Khalil Rehman**
Attendance:	Quorate
Key Items Discussed:	Head of Internal Audit Opinion, Audit completion report, Letters of Representation, Review & Approval of Audited Accounts, Review of Annual Report & Annual Governance Statement. Modern Slavery Statement & Quality Account 23-24 sign off.

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

- Although we received a positive Head of Internal Audit Opinion for FY23_24, MIAA offered an assessment of **Moderate** assurance. This is one category below FY22_23 where we received a Substantial opinion. The Committee and Executive will review any learning lessons and areas for improvement in the FY24/25 audit plan.
- At the meeting, the Committee noted some material challenges raised by the Auditors in completing the review of the Audited Accounts. Executive had secured appropriate time extensions from NHSE. The Committee also noted the finance team were working extremely hard to achieve completion.
- It was agreed to accept the accounts & financial statements subject to final confirmation from the auditors via email.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The committee noted and approved the remaining reports regarding the Quality Account & Modern Slavery Statement.

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.

n/a

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **136b**

11 September 2024 **Purpose** Assurance Information

Title	Triple A Report from Audit Committee
Report Author	K Rehman, Chair of Audit committee
Date Paper Approved by Executive Sponsor	3 September 2024

Summary: This report sets out the summary of the items discussed at the Audit Committee meeting held on 8 July 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	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
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:	**8 July 24**
Committee Chair:	**Khalil Rehman**
Attendance:	Quorate
Key Items Discussed:	Corporate Risk Register, BAF & Risk Appetite Statement, One LSC, Standing Orders & Financial Instruments Annual Review, AC TOR. Internal Audit & Management Responses. Anti-fraud Work plan

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

- n/a

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The committee reviewed the Corporate Risk Register & noted the substantial work and progress across divisions regarding risk management. The RAM and ERAG mechanisms provide additional assurance and scrutiny within our risk framework.
- The committee received a briefing on the annual BAF review, risk appetite statements/scores. The corporate governance team's comprehensive approach was appreciated.
- The suggested SFI/SO changes/updates were accepted.
- Noted and approved the FY24-25 anti-fraud plan
- The committee noted the internal audit plan update and in particular the management response and progress in moving our assurance rating on Trust risk management systems (assessed as moderate in FY22-23) to substantial.

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 on-going work on 1LSC and community care transfers may require an in year review of the BAF and internal audit plan.

TRUST BOARD REPORT		**Item**	**137**
11 September 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 11 July, 29 July and 22 August are presented for 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: **11 July 2024**

Committee Chair: **Khalil Rehman, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 11 July 2024, the following matter was discussed in private:

a) Recruitment Process for Executive Director of Finance

Meeting: **Remuneration Committee**

Date of Meeting: **29 July 2024**

Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 29 July 2024, the following matters were discussed in private:

a) Proposed Recruitment Timeline and Remuneration Arrangements for Executive Director of Finance
b) Remuneration Arrangements for Interim Director of Finance

Meeting: **Remuneration Committee**

Date of Meeting: **22 August 2024**

Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 22 August 2024, the following matters were discussed in private:

a) Annual Report on the Remuneration of Executive Directors and Very Senior Managers/Staff
b) Executive Director Pay Award Briefing
c) Executive Director Succession Planning
d) Remuneration Policy Review and Approval
e) Annual Fit and Proper Persons Test Report

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **138**

11 September 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 10 July 2024.

As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders would not be applicable in this instance.

Report linkages

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

	5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to here.
Related to ICB Strategic Objective	State which ICB Strategic Objective the paper relates to here.

Impact

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

Previously considered by:

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

Date of Meeting: **10 July 2024**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 15 May 2024 were approved as a true and accurate record.

The minutes of the Extraordinary Trust Board held on 23 April 2024 were also approved as a Trust and accurate record.

ITEMS DISCUSSED

At the meeting of the Trust Board on 10 July 2024, the following matters were discussed in private:

a) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.
b) Blackburn with Darwen Community Services and Albion Mill Update
c) Nursing Professional Judgement Review
d) One LSC Strategic Collaboration Agreement
e) Data and Digital Update Report
f) Tenders Update
g) Fire Remediation Programme Update: Burnley General Teaching Hospital
h) Fire Remediation Programme Update: Royal Blackburn Teaching Hospital
i) Emergency Preparedness Resilience and Response Progress Update
j) The Future of ELHT PACS-VNA and RIS

ITEMS RECEIVED FOR INFORMATION

None.