Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust

East Lancashire Hospitals NHS Trust Board Meeting

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TRUST BOARD MEETING (OPEN SESSION) AGENDA

12 MARCH 2025, 12.30

BOARDROOM, BIRCH HOUSE

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

OPENING MATTERS					
TB/2025/028 12.30	**Chairman's Welcome**	Chairman	v		-
TB/2025/029 12.31	**Apologies** To note apologies.	Chairman	v		-
TB/2025/030 12.32	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	d✓	Approval	5
TB/2025/031 12.35	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 15 January 2025.	Chairman	d✓	Approval	12
TB/2025/032 12.40	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v		-
TB/2025/033 12.42	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information	36
TB/2025/034 12.45	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information	-
TB/2025/035 12.55	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information/ Approval	39
QUALITY AND SAFETY					
TB/2025/036 13.05	**Staff / Patient Story** To receive and consider the learning from a patient/staff story.	Deputy Chief Nurse	v	Information/ Assurance	-
TB/2025/037 13.15	**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	52
TB/2025/038 13.20	**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	v	Assurance/ Approval	-

TB/2025/039 13.25	**Patient Safety Incident Response Assurance Report** To receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP). This report also includes information on maternity specific serious incidents reporting as required by Ockenden recommendations.	Executive Medical Director	d✓	Information/ Assurance	90
STRATEGIC ISSUES					
TB/2025/040 13.30	**Maternity and Neonatal Services Update** *T Thompson to attend for this item.*	Deputy Chief Nurse / Divisional Director of Midwifery and Nursing	d✓	Information/ Assurance	104
ACCOUNTABILITY AND PERFORMANCE					
TB/2025/041 13.35	**Financial Performance Report Month 10 2024-25**	Executive Director of Finance	d✓	Information/ Assurance	239
TB/2025/042 13.45 13.50 13.55 14.00 14.05 14.10	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: a) Introduction (Chief Executive) b) Safe (Executive Medical Director and Chief Nurse) c) Caring (Chief Nurse) d) Effective (Executive Medical Director) e) Responsive (Chief Operating Officer) f) Well-Led (Director of People and Culture and Executive Director of Finance)	Executive Directors	**d✓**	Information/ Assurance	263
FOR INFORMATION					
TB/2025/043 14.14	**Triple A Reports from People and Culture Committee** To note the matters considered by the Committee in discharging its duties. a) December 2024 b) January 2025 c) February 2025	Committee Chair	 d✓ d✓ d✓	Information	289
TB/2025/044 14.15	**Triple A Reports from Finance and Performance Committee** To note the matters considered by the Committee in discharging its duties. a) January 2025	Committee Chair	 d✓	Information	298

	b) February 2025		d✓		
TB/2025/045 14.16	**Triple A Reports from Quality Committee** To note the matters considered by the Committee in discharging its duties. a) January 2025 b) February 2025	Committee Chair	d✓ d✓	Information	311
TB/2025/046 14.17	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information	319
TB/2025/047 14.18	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information	321
	CLOSING ITEMS				
TB/2025/048 14.20	**Any Other Business**	Chairman	v		-
TB/2025/049 14.25	**Open Forum** To consider questions from the public.	Chairman	v		-
TB/2025/050 14.26	**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/2025/051 14.27	**Message from the Board**	Chairman	v		-
TB/2025/052 14.30	**Date and Time of Next Meeting** Wednesday 14 May 2025, 12.30pm, Boardroom, Birch House	Chairman	v		-

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TRUST BOARD REPORT	**Item**	**30**
12 March 2025	**Purpose**	Approval Information

Title	Declarations of Interests Report

Summary: Section 5 of the Trust's Standing Orders describes the duties and obligations of Board Members in relation to declaring interests. The Register is available for public inspection.

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

Report linkages

Related Trust Goal	-
Related to key risks identified on Board Assurance Framework	-
Related to key risks identified on Corporate Risk Register	-
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	-
Related to ICB Strategic Objective	-

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

(30) Declarations of Interests Report

Name and Title	Interest Declared	Date Declared	Date last updated/ Confirmed
Shazad Sarwar Chairman	• Committee member of Together Housing Group (from 01.09.2021) • Non-Executive Director member of the Greater Manchester Integrated Care Board (from 01.02.2022 to July 2023). • Managing Director of Msingi Research Ltd. (from 01.07.2015) • Member of Prince's Trust Health and Care Advisory Board (until March 2024)	06.12.2023 06.12.2023 06.12.2023 06.12.2023	13.11.2024
Martin Hodgson Chief Executive	• Partner (now spouse) is the Chief Operating Officer at Liverpool University Hospital NHS Foundation Trust (prior to Trust merger partner was COO at Aintree University Hospitals NHS Foundation Trust).	25.10.2021	13.11.2024
Patricia Anderson Non-Executive Director	• Spouse is a retired Consultant Psychiatrist formerly employed at Mersey Care NHS Trust. • Assignment with Knowsley Clinical Commissioning Group, supporting the Accountable Officer for a period of six months (10.05.2019 to 01.10.2019). During this time Mrs Anderson took a leave of absence from the Trust Board at ELHT. • Partnership of East of London Collaborative – Assignment of 1.5 days per month (from 01.12.2020 until 01.02.2021)	19.09.2018 01.05.2019 31.11.2020	13.11.2024

Name and Title	Interest Declared	Date Declared	Date last updated/ Confirmed
Kate Atkinson Executive Director of Service Development and Improvement	• Brother is the Clinical Director of Radiology at the Trust • Sister-in-law is a Trauma and Orthopaedic Consultant at the Trust • Parent Governor at Blacko Primary School (from 01.04.2022 to 31.03.2026)	26.01.2022 26.01.2022 31.03.2022	13.11.2024
Professor Graham Baldwin Non-Executive Director	• Director of Centralan Holdings Limited • Director of UCLan Overseas Limited • Director CY IPS Ltd • Director UCLan Cyprus • Director UCLan Professional Services Ltd • Deputy Chair and Director of UCEA • Chair of Maritime Skills Commission • Member of Universities UK • Chair of MillionPlus • Chair of University Vocational Awards Council • Chair of Lancashire Innovation Board • Member Preston Regeneration Board	Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation 04.04.2022 24.05.2022 Awaiting confirmation	13.11.2024

Name and Title	Interest Declared	Date Declared	Date last updated/ Confirmed
	• Member Burnley Town Board • Member Burnley Economic Recovery Board	Awaiting confirmation Awaiting confirmation	
Sallie Bridgen Non-Executive Director	• Nil declaration	Awaiting confirmation	05.03.2025
Sharon Gilligan Chief Operating Officer and Deputy Chief Executive	• Positive nil declaration	12.09.2019	13.11.2024
Melissa Hatch Associate Non-Executive Director (01.12.2023)	• Business Development professional at Citizens Advice. Responsible for charitable income generation.	10.07.2024	13.11.2024
Jawad Husain	• Spouse is a GP in Oldham	30.03.2020	13.11.2024

Name and Title	Interest Declared	Date Declared	Date last updated/ Confirmed
Executive Medical Director and Deputy Chief Executive			
Tony McDonald Executive Director of Integrated Care, Partnerships and Resilience	• Spouse is an employee of Oxford Health NHS Foundation Trust • Undertaking the role as Portfolio Director for Community Transformation for Lancashire and South Cumbria Integrated Care Board commencing 1st April 2024 for 12 months in addition to ELHT Executive Director role.	05.04.2020 28.03.2024	13.11.2024
Peter Murphy Chief Nurse	• Spouse works at Liverpool University Foundation Trust.	24.03.2023	13.11.2024
Kate Quinn Executive Director of People and Culture	• Director at Lancashire Institute of Technology	Awaiting confirmation	13.11.2024
Catherine Randall Non-Executive Director	• Executive Director Derian House Lead for Clinical Services • Independent Chair at Blackburn Church of England • Honorary Professor at the University of Central Lancashire • Spouse is a GP in Blackburn with Darwen	13.09.2023 13.09.2023 11.11.2024 11.11.2024	13.11.2024

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Name and Title	Interest Declared	Date Declared	Date last updated/ Confirmed
Khalil Rehman Non-Executive Director	• Director at Salix Homes Ltd (until 1 October 2024) • Director at Medisina Foundation. • NED at Leeds Community Healthcare Trust • Vice Chair of Seacole Group • TSI Caritas Ltd • NED at UCLan • Interim Director of Finance at Touchstone Support Ltd, Charity with links to the NHS in neighbouring system (until August 2024) • Appointed as NED and Charity Trustee at NHS Charities Together (as of 1 October 2024)	31.03.2021 31.03.2021 31.03.2021 01.05.2024 Awaiting confirmation Awaiting confirmation Awaiting confirmation 13.11.2024	13.11.2024
Liz Sedgley Non-Executive Director	• Self Employed Accountant Liz Sedgley FCCA Accountancy and Management Consultancy • Governor at Nelson and Colne Colleges Group	06.09.2023 06.09.2023	13.11.2024
Sam Simpson	• Nil Declaration	Awaiting confirmation	05.03.2025

Name and Title	Interest Declared	Date Declared	Date last updated/ Confirmed
Executive Director of Finance			
Shelley Wright Joint Director of Communications and Engagement for East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BFWH)	• Post held jointly with Blackpool Teaching Hospitals NHS Foundation Trust	19.05.2021	13.11.2024

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TRUST BOARD REPORT | **Item** 31

12 March 2025 | **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 15 January 2025 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

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EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 13:00, 15 JANUARY 2025
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 S Bridgen	Non-Executive Director	
Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive	
Mr J Husain	Executive Medical Director / Deputy Chief Executive	
Mrs C Randall	Non-Executive Director	
Mr K Rehman	Non-Executive Director	
Mrs S Simpson	Executive Director of Finance	

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement
Mrs M Hatch	Associate Non-Executive Director
Mrs K Quinn	Executive Director of People and Culture
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)

IN ATTENDANCE

Mr D Byrne	Corporate Governance Officer	Minutes
Mr A Patel	Associate Director of Technology-Enabled Care	
Mrs J Pemberton	Deputy Chief Nurse	
Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council	
Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2024/155

APOLOGIES

Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary

Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience
Mr P Murphy	Chief Nurse
Mrs L Sedgley	Non-Executive Director

TB/2025/001 CHAIRMAN'S WELCOME

Mr Sarwar welcomed directors and members of the public to the meeting. He reported that the Lancashire and South Cumbria (LSC) system remained in a very challenged position on several key fronts, with its financial situation likely to be the most significant over the coming months and years. Mr Sarwar indicated that the Trust had already had to make a number of difficult choices but stressed that they, and others that would be made in the future, were needed to ensure that patients could receive the care that they needed and that its staff could operate in a manner which delivered value for money.

Mr Sarwar noted that the meeting would be Mr Husain's last in his role as Executive Medical Director. He highlighted the significant contributions that Mr Husain had made in driving quality of care both at a system and Trust level and that his care for patients had come across clearly at his many contributions made at previous Board meetings. Mr Sarwar stated that Mr Husain would be sorely missed both as a medical director but also as a colleague.

TB/2025/002 APOLOGIES

Apologies were received as recorded above.

TB/2025/003 DECLARATIONS OF INTEREST

The Directors Register of Interests was presented for approval.

RESOLVED: **Directors approved the position of the Directors' Register of Interests, pending the requested amendment.**

TB/2025/004 MINUTES OF THE PREVIOUS MEETING

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

RESOLVED: **The minutes of the meeting held on 20 November 2024 were approved as a true and accurate record.**

TB/2025/005 MATTERS ARISING

There were no matters arising.

TB/2025/006 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:

TB/2024/154: Patient Safety Incident Response Assurance Report – Mrs Quinn advised that two members of staff who had left the Trust but were still contributing the overall compliance total for the level 1b Patient Safety Training module, would be removed and that this would then bring the total to the required threshold. She confirmed that this would be actioned before the next meeting of the Board.

TB/2024/159: Ratification of Board Sub-Committee Terms of Reference – Mr Sarwar requested that the revised terms of reference for Board sub-committees were brought back to the March meeting of the Trust Board for approval.

RESOLVED: Directors noted the position of the action matrix.

TB/2025/007 CHAIRMAN'S REPORT

Mr Sarwar provided a summary of his activities since the previous meeting of the Board. He informed directors that a significant amount of his time had been taken up in attending meetings of the Provider Collaboration Board (PCB) and indicated that there had been lengthy discussions around the clinical and financial configuration of the LSC. Mr Sarwar added that he had also continued to participate in meetings of the Lancashire Place-based Partnership.

Mr Sarwar went on to inform directors that had participated in a series of activities at Trust, including a recent visit by the mayor of Blackburn with Darwen. He added that he had also participated in a Christmas lunch to recognise the ongoing contributions of volunteers to the Trust's services and stated that it had been an honour to be able to thank them in this way. Directors noted that both Mr Sarwar and Mr Hodgson had attended a recent King's Trust celebration event and the most recent meeting of the Trust's Patient Participation Panel (PPP). Mr Sarwar commented that the latter meeting had been a good opportunity to consider and discuss how the PPP could evolve and to ensure that patients remained at the heart of any changes made going forward both at the Trust and more widely across LSC.

Mr Sarwar concluded his update by confirming that the LSC system was now in a formal intervention process and explaining that a turnaround director had been appointed to work with colleagues from Price Waterhouse Cooper (PWC) and trusts to improve the system financial situation. He emphasised that this process would be crucial to ensuring that the maximum amount of benefit could be delivered with the public money that the Trust received and that the system was able to live within its means going forward.

RESOLVED: Directors received and noted the update provided.

TB/2025/008 CHIEF EXECUTIVE'S REPORT

Mr Hodgson referred to the previously circulated report and provided a summary of national, regional and Trust specific headlines to directors.

Mr Hodgson made reference to the recent media coverage of a nurse stabbed at Oldham Hospital and noted that this had resonated across the NHS. He stressed that staff safety was an area that the Trust continued to take very seriously and that it had recently reviewed its security arrangements as part of this. Mr Hodgson reported that two patients had recently been being issued with 'red cards' due to their poor behaviour towards staff and clarified that this meant that they would only receive care in a life-threatening situation.

Mr Hodgson also referred to the recent national media attention around the winter pressures on the NHS and the recent declaration of critical incidents at a range of hospitals. He noted that the expected winter pressures at the Trust had been exacerbated by a particularly potent mix of COVID-19, flu, norovirus and respiratory syncytial virus (RSV) and that this had been similarly reflected at other organisations. Mr Hodgson reported that the Trust had had a total of 76 patients with flu at its height and that this had undoubtedly affected the success of its winter plan. He indicated that a significant amount of work had been done by Mr Husain, Mr Walton-Pollard and their colleagues to look after patients on corridors and ensure that they received care in as dignified a manner as possible.

Mr Hodgson informed directors that as the new Labour Government continued to embed itself new policy statements continued to trickle out. He clarified that these included a new elective care reform plan, on the back of manifesto pledges and budget expectations, which was focused on how the NHS could continue to reduce the size of its waiting lists. Mr Hodgson added that there would also be a renewed focus on returning to 92% Referral to Treatment (RTT) targets and pointed out that there would be a number of key aspects to increasing

productivity and efficiency to the levels required to achieve this. He explained that the NHS was expected to achieve a 65% target against RTT in the 2025-26 financial year and highlighted that the Trust's performance currently stood at around 57%, in line with the national average. Directors noted that additional customer care training would be provided to non-clinical staff as part of the Further Faster 20 (FF20) programme and that national Getting It Right First Time (GIRFT) colleagues would be providing assistance to expedite care and improve the lifestyles of as many patients as possible.
Mr Hodgson went on to advise that the Secretary of State for Health and Social Care, Wes Streeting, had announced a series of measures that were linked to the elective care reform plan, including changes to allow GPs to have direct access to a range of tests and scans without having to do so via consultants. He added that there would be a significant push around reducing agency usage and spend and highlighted that the Trust continued to perform well in this area. Mr Hodgson referred to another recent announcement by the Government regarding the NHS moving back to a 'league table' system and noted that this would place even more pressure on trusts to maintain operational performance whilst living within their means financially. He confirmed that the Trust already made use of artificial intelligence (AI) in a few key areas and that this would continue to play a key role in the NHS becoming more efficient in the future.

Mr Hodgson informed directors that several developments had taken place at a Lancashire and South Cumbria (LSC) system level. He reported that LSC was currently the most financially challenged system in the country and that this had resulted in the system being placed into formal financial turnaround arrangements. Mr Hodgson stressed that there would be intense scrutiny placed on every organisation that made up the LSC Integrated Care System (ICS) and confirmed the Trust's intention to deliver the best year-end financial plan that it could by the end of March 2025. He added that all NHS organisations would be expected to work up fully developed plans for the 2025-26 financial year and reiterated that this would involve some tough decisions around changes to services which were either not delivering what was needed or had been historically underfunded. Mr Hodgson observed that this would require open and honest dialogue with the local population and advised that this was currently taking place around the recent decision to cease the Trust's shuttlebus service. He indicated that a substantial amount of detailed work had been done to reach this decision and that it had become clear through a number of assessment exercises that the service had both a relatively low number of users and that the majority of them were staff rather than patients. Mr Hodgson

confirmed that support arrangements would be put in place for any affected colleagues and reiterated that this, and other similarly difficult choices, would be needed over the coming months considering the wider financial context.

Mr Hodgson indicated that work continued to move LSC to a clinical configuration that would be resilient, provided good patient outcomes but was also affordable. He highlighted that One LSC had gone live on the 1 November 2024 and that around 3,500 colleagues had been transferred into it as a result. Mr Hodgson emphasised that the Trust, as host organisation for One LSC, would need to ensure consistency and to facilitate transformation of its services to make them as efficient as possible.

Mr Hodgson went on to provide a summary of other developments taking place at Trust level. He welcomed Mrs Bridgen to her first formal Board meeting after and noted that she would bring a wealth of experience to the Trust as a Non-Executive Director. Directors noted that a former member of the Trust Board, Dr Fazal Dad, had also recently been awarded a Commander of the Order of the British Empire (CBE) in the New Year Honours List.

Mr Hodgson referred to the recent closure of Accrington Victoria Hospital (AVH) and the relocation of services to other sites and stated that this had been another difficult decision for the Trust to make. He clarified that the primary reason for doing so had been related to concerns around the integrity of the AVH building itself, in addition to financial concerns, and confirmed that there had been a lengthy discussion and engagement process with the local population beforehand. Mr Hodgson advised that all clinical services that had been based on the site had now been successfully moved to other sites in Accrington, with office space services being moved to either Accrington or Hyndburn and reported that the feedback received from staff regarding their new working areas had been very positive.

Mr Hodgson highlighted a range of other positive developments that had taken place at Trust level, including positive results for its maternity services in a recent Care Quality Commission (CQC) survey, a substantial number of patients being reviewed by the Trust's Intensive Home Support Service (IHSS) since October 2024 and the Trust achieving the most efficient theatre utilisation in the country in December. Directors noted that the Trust had been recognised as meeting the bronze standard of the anti-racism framework by the North West Black, Asian and Minority Ethnic (BAME) Network as part of its wider goal to become an intentionally anti-racist organisation and that Mr Sarwar had subsequently led a summit that had been the culmination of a two-week programme of events.

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 Emergency Surgical Unit (ESU), the Elective Care Centre, Burnley General Teaching Hospital (BGTH) Day Theatres and Wilson Hey Theatres. He added that gold status was also being sought by wards C16 and C18a.

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

Professor Baldwin congratulated the Trust on the progress made with its anti-racism programme and indicated that discussions were taking place to launch the same campaign across the University of Central Lancashire (UCLan). He added that other organisations had signalled that they would also like to be involved in this.

Professor Baldwin went on to request clarification on the Trust's position around physician associates and whether it was considering any related opportunities in terms of workforce development.

Mr Hodgson acknowledged that the topic of physician associates had been a contentious one over recent months but stressed that they continued to be a valued member of the Trust's workforce and were well supported by other colleagues. He pointed out that the myriad of challenges facing the NHS would only be met through workforce transformation and that physician associates would be crucial to this process.

Mr Husain agreed that the future of healthcare delivery would depend on a blended workforce approach and that physician and anaesthetic associates would play a key role in this. He explained that the introduction of additional regulatory elements would help to ease some of the anxiety around these roles and confirmed that the General Medical Council (GMC) had now started this process.

Mr Sarwar noted that reform would be a continuous theme for the NHS going forward and that this would have a huge impact on the population that the Trust served. He reiterated that the Trust was being robustly challenged around how it spent its money and that this would result in difficult choices being made to ensure that it was able to live within its means and was able to prioritise safe and high-quality patient care. Mr Sarwar pointed out that the Trust had one of the busiest emergency department (ED) services in the country and that this made ensuring

it was able to secure the greatest amount of benefit from the public money that it received even more important.

RESOLVED: Directors received the report and noted its contents.

TB/2025/009 STAFF / PATIENT STORY

Mr Walton-Pollard provided a brief introduction to the patient story. He emphasised that the intention behind patient stories was to bring the experience of patients into the room to provide more clarity behind some of the decisions made by the Trust.

The patient story can be viewed by clicking the link here.

Mr Walton-Pollard observed the story had highlighted the value of specialist nurse and the ways in which they could enhance the journey of patients. He acknowledged that the issues raised in the patient's first visit to the Trust were disappointing to hear and indicated that he had reached out to colleagues from a diligence point of view to investigate these more.

Mrs Randall informed directors that the same story had been presented at the most recent meeting of the Quality Committee and that she had highlighted the value of the Oliver McGowan training programme.

Mrs Quinn commented that the story was a positive one and clearly showed how the Trust endeavoured to be personal in its approach to patient care. She noted that the story also resonated from a staff perspective, as it was known that there were a substantial number of colleagues that did not declare their disabilities and that the implementation of further reasonable adjustment would help to keep people at work.

Mr Sarwar stated that the patient's initial experience was not what should be wanted or expected and emphasised the importance of getting things right first time. He observed that the story also reflected the diversity of the population that the Trust served and that there were a number of important lessons to be learned around how patients should be treated. Mr Sarwar pointed out that the Trust's Patient Participation Panel (PPP) did not currently have any representation from patients with learning disabilities or carers and stated that he would discuss how this could be addressed with Mr Walton-Pollard after the meeting.

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

Mr Sarwar to discuss the membership of the Patient Participation Panel with Mr Walton-Pollard after the meeting.

TB/2025/010 CORPORATE RISK REGISTER (CRR) AND RISK PERFORMANCE REPORT

Mr Husain referred Directors to the previously circulated report and provided a summary of key highlights. He highlighted that there were currently 22 risks on the CRR, with two new risks added since the previous meeting, these were:

- **9777: loss of education, research and innovation accommodation and facilities**
- **10095: PAC issues impacting on efficiency and ability to meet targets and obstructive workflow**

Mr Husain advised that the score assigned to risk **6190 (insufficient capacity to accommodate patients in clinic within timescales)** had been reduced to 12 and that this would be ratified by the Executive Risk assurance Group (ERAG) prior to it being removed from the CRR. He reported that there had been no changes to the scores assigned to any other risks and that the highest scoring remained those relating to finance, data and digital, the management of medical devices and demand and capacity imbalances.
Mr Husain advised that the total number of open risks had been reduced by a further 6% since the previous meeting but explained that this had been offset by an increase of 15% in moderate risks over the same period. Directors noted that there had been a similar decrease in the numbers of risks open for three years or more by 17% as well as an increase in overdue risks. Mr Husain highlighted that there had been a significant increase in Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) compliance from 56% to 71% over recent months and paid credit to all teams involved in achieving this.

In response to a query from Mr Rehman as to whether the discussions that had taken place at the closed session of the Board around histopathology would be reflected in risk **8941 (increased reporting times in histology due to increased activity outstripping resource),** Mr Husain confirmed that this risk as updated on a weekly basis regarding the actions that were taking place to address it.

Mr Sarwar commented that it was positive to see the improvements in RIDDOR compliance, particularly when considering the capacity issues that meany colleagues were currently facing.

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

TB/2025/011 BOARD ASSURANCE FRAMEWORK (BAF)

Mrs Atkinson referred directors to the previously circulated report and requested that it was taken as read. She confirmed that all actions had been updated as part of the usual review cycle of the BAF and that any that had been completed had been moved to the controls or assurances section of each risk. Mrs Atkinson highlighted that there had been a slight change to the descriptor wording for risk 5 (Financial Sustainability) to reflect the responsibility for the Trust deliver value for money. She indicated that risk 6 (One LSC) had also started to be updated more substantially to reflect the fact that One LSC had gone live, with the relevant actions focusing on the maturing of governance and oversight arrangements.

Mrs Atkinson informed directors that the preliminary preparations were being made for the annual review of the BAF as the end of the 2024-25 financial year drew closer. In response to a request for clarification from Mr Sarwar, she indicated that this was expected to be done by the 31 March 2025 and that the plan to facilitate this would be agreed through the ERAG.
Mr Sarwar emphasised the importance of the BAF properly reflecting the scale of the financial and operational challenges facing the Trust, as well as the decision-making process and risks involved with this.

RESOLVED: Directors noted the update provided.

TB/2025/012 PATIENT SAFETY INCIDENT RESPONSE ASSURANCE (PSIRA) REPORT

Mr Husain requested that the report was taken as read and presented a summary of key highlights to directors. He reported that a new never event had been declared the previous month which related to a patient who had not had a swab removed following an emergency caesarean section. Mr Husain confirmed that this swab had been removed at a later date and that no harm had come to the patient. He explained that this incident had been caused in large part due to a change in one of the Trust's standard operating policies that had not been properly communicated to all staff and advised that clear messaging had gone out

across the organisation to reiterate the importance of this for any changes made in the future.

Mr Husain went on highlight that the total number of incidents awaiting approval had reduced significantly, as had the proportion of moderate and severe harms being reported. He informed members that there had been a total of four fatal incidents, all of which had been Strategic Executive Information System (StEIS) reported. Mr Husain added that one of these incidents was currently the subject of a Patient Safety Incident Investigation (PSII) and that two had been related to stillbirths. Directors noted that the majority of the Trust's divisions were achieving 80% compliance for incident investigations and that there were no standard operating policies (SOPs) that were currently out of date.

Mrs Bridgen commented that good assurance was provided in the report regarding the processes around managing incidents but suggested that more narrative could be included in future iterations around the learning and actions taken in response.

Addressing a request for clarification from Mr Sarwar regarding the 11 policies referred to in the report that had gone past their review dates and whether any system was in place to determine if these were a high priority or not, Mr Husain explained that he was unsure as to how colleagues differentiated the degree of importance for policy reviews but indicated that any delays were due to a lack of oversight capacity. He pointed out that the number referred to in the report was relatively low, amounting to around 5% of the Trust's total number of policies, but acknowledged that the aim should be to reduce this to zero.

Mr Sarwar suggested that more clarity was needed around the specific policies that had exceeded their review date and where they could be monitored to provide assurance or to give directors a better understanding of what these delays meant in practical terms.

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

TB/2025/013 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 10 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 explained that there had been a shortall for four reviews regarding the two-month deadline for answering all

technical guidance/Factual Questions (FQs), placing the Trust at 88.57% compliance. She confirmed that the actions taken to mitigate this risk were detailed further down in the report. Miss Thompson emphasised that other organisations were in a similar position both regionally and nationally.

Safety Action 2 - Maternity Services Data Set (MSDS): Miss Thompson confirmed that this action was now fully complete and had been signed off at the Local Maternity and Neonatal System (LMNS).

Safety Action 3 - Transitional Care (TC): Miss Thompson confirmed that the Trust continued to meet all requirements for this action.

Safety Action 4 - Clinical Workforce: Miss Thompson confirmed that the Trust was on track to achieving this action. She explained that as the Trust's neonatal unit did not meet British Association of Perinatal Medicine (BAPM) standards for nursing staffing, the neonatal nursing workforce action plan submitted for the MIS year 5 evidence had been updated with a full review of progress to complete the MIS year 6 reporting period. Miss Thompson confirmed that this action plan had been agreed and submitted in the report provided at the September meeting Trust Board report to evidence progress against actions. She added that a report evidencing neonatal medical workforce compliance with the BAPM standards for Tier 1 and 2 was also submitted to September Trust Board, which also included also detailed actions being taken to reach compliance with BAPM standards for Tier 3, with which the service was expected to achieve compliance in January.

Miss Thompson requested that this assurance was formally recorded within the meeting minutes.

Safety Action 5 - Midwifery Workforce: Miss Thompson referred Directors to the bi-annual staffing papers included in Appendix 4 of her report. She confirmed that this was aligned with Birth Rate+ findings and that a plan had been agreed to fund the associated improvement case. Miss Thompson added that a tabletop exercise had taken place to support the development of this improvement and advised that a revised and updated iteration was due to be presented to the Executive team at a later date.

Safety Action 6 - Saving Babies Lives v3 Care Bundle (SBLv3): Miss Thompson confirmed that good progress was being made against this action and was currently at 92% overall implementation following an assurance visit from the LMNS earlier in the month.

Safety Action 7 – Maternity Neonatal Voice Partnership (MNVP) User Feedback: Miss Thompson advised that an engagement lead had now been appointed to support the MNVP tasks as part of this safety action. She explained that maternity transformation colleagues

were working with this engagement lead to ensure that the asks for this action could be delivered.

Safety Action 8 – Training: Miss Thompson reported that all training threshold requirements had been successfully met by the end of the reporting period of the 30 November. She confirmed that this safety action was therefore complete.

Safety Action 9 - Board Assurance: Miss Thompson confirmed that the Trust was fully compliant against this action. She highlighted that work continued to further develop the triangulation between incidents and the Trust's complaints dashboard.

Safety Action 10 - Maternity and Newborn Safety investigation Programme (MNSI) / NHS Resolution: Miss Thompson confirmed that the Trust was fully compliant against this action and confirmed that assurance had been provided form governance leads that all requirements for MNSI reporting were being met.

Mr Hodgson extended his thanks to Miss Thompson for her update and praised the work being done by her and her colleagues in the Trust's maternity team. He pointed out that there was something of an ongoing tension between the additional staffing requirements being placed on the Trust through national initiatives such as the Ockenden review and its responsibilities to live within its financial means.

Mr Sarwar stated that the assurance provided by Miss Thompson was invaluable, particularly as it concerned a service that affected a significant amount of people's lives in profound ways.

Mrs Randall congratulated Miss Thompson and her colleagues on the exemplary rating given to the Trust's maternity services by the Care Quality Commission (CQC). She noted that such ratings were not awarded often, and this was a particularly significant achievement when considering the level of deprivation in local communities.

Mr Rehman stated that it would be helpful for the Board to view maternity data and performance through a more equity focused lens going forward. He noted that this had been one of the Trust's strategic objectives for some time.

Mrs Atkinson noted that there were numerous references to quality improvement projects in Miss Thompson's report. She emphasised that improvement practice would continue to play

a vital role in the Trust in ensuring that the limited resources available would be used as effectively as possible.

Mr Sarwar requested confirmation from Directors that they were content for both he and Mr Hodgson to sign off the CNST submission for the Trust outside of the meeting. Directors confirmed that they were content with this approach.

Miss Thompson informed Directors that a joint regional visit from NHSE, LMNS and Operational Delivery Network (ODN) colleagues would be taking place in March 2025 to assess the Trust's compliance against the NHS three-year delivery plan for maternity and neonatal services. She confirmed that a benchmarking exercise had been carried out as part of the preparations for this and that further updates would be provided to the Quality Committee and to the Trust Board at a later date.

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/2025/014 FINANCIAL REPORTING

Mrs Simpson reminded directors that she had indicated at the previous meeting that a dedicated finance report would be provided to the board at each meeting going forward. She confirmed that this was still a work in progress and that she continued to work with members of the Finance and Performance Committee to finalise the level of detail required in specific areas.

Mrs Simpson went on to report the Trust's financial position at a £32.2m deficit as of the end of the November 2024, a movement of £6.3m from the previous month. She confirmed that the deficit support funding provided to the Trust had been recognised in full as of month six and that the figures now reflected how they would have looked if this had not been phased in as it had been initially. Mrs Simpson clarified that this funding had been provided on the basis that it would allow LSC to move to a breakeven plan for 2024-25 and emphasised that it was non-recurrent. She informed directors that meeting this breakeven plan would be a significant challenge and noted that this reflected the level of operational pressures facing the Trust and LSC as a whole. Mrs Simpson reported that the Trust had delivered £17.3m of cost improvement programme (CIP) savings year to date but pointed out that some of this was also

non-recurrent. She added that one of the biggest current risks to the Trust was the impact on its cash from its capital programme and confirmed that this was being managed closely.

Mr Hodgson highlighted that good progress had been made by the Trust in a number of areas, including reducing its agency usage, but acknowledged that there were a number of significant risks to it being able to deliver on its savings plan for 2024-25. He reminded directors that LSC was now in formal financial intervention and confirmed that every effort was being made to embrace this process to take it forward and understand what could be done better.

Mr Sarwar agreed that good progress had been made in relation to agency spend but pointed out that the Trust had grown its workforce significantly over recent years and continued to see high levels of staff sickness and absence that would need to be managed more effectively. He stressed that no additional national funding would be provided for the remainder of the year and that the Trust's ability to manage the range of challenges facing it would be crucial, as would the leadership and resilience underpinning this. Mr Sarwar added that how organisations in LSC worked with each other collaboratively would be equally as important to ensuring that the system was able to meet its financial obligations.

TB/2025/015 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Mr Hodgson referred to the previously circulated report and confirmed that it covered the period up to the end of November 2024. He highlighted that there were a number of positive areas to note, including the Trust achieving its target of reducing the number of patients waiting 65 weeks or more for treatment down to zero and achieving a range of cancer targets. Mr Hodgson reported that the Trust's performance against the four-hour trolley standard remained strong but noted that there still a number of areas of concern, particularly the number of patients waiting for significant amounts of time on trolleys.

b) Safe

Mr Husain highlighted that there had been no reported cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) since the previous meeting. He explained that a number of viruses in circulation had added to the already significant pressures in UEC areas and indicated that there had been a number of outbreaks in the Trust over recent weeks. Mr Husain reported that, as of the meeting, there were three patients with COVID-19 in the Trust and 35

with flu. He added that there had been an overall increase of 146% in flu patients presenting to the organisation in the current year.

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

c) Caring

Mr Walton-Pollard highlighted that 96% of patients surveyed had recommended the Trust and had rated its care as good or above. He indicated that similar positive results had been reported in community and maternity areas, standing at 96% and 90% respectively. Mr Walton-Pollard reported that the feedback from UEC areas remained more challenged, standing at 69%, and noted that this was a slight drop from the usual levels.

Mr Walton-Pollard went on to inform directors that the Trust had recently had an inspection of its internal complaints process carried out by the Mersey Internal Audit Agency (MIAA), which had returned a rating of moderate assurance. He clarified that one area of concern identified by the MIAA had been timeliness and confirmed that new electronic processes had been implemented which had already resulted in improvements being made.

Mr Walton-Pollard reminded directors that the professional judgement review of nurse staffing levels took place on a six-monthly basis and reported that the most recent exercise had shown that the Trust's compliance for registered nurses was expected to fall between 90% and 105%.

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

d) Effective

Mr Husain informed directors that due to the ongoing issues with the quality of the Trust's mortality data, as reported at previous meetings, it was still not possible to reliably determine its Hospital Standardised Mortality Ratio (HSMR) or Summary Hospital-level Mortality Indicator (SHMI) performance. He advised that there had been a rise in the organisation's crude mortality levels over recent weeks up to 3.8% but indicated that this was expected over the winter period.

Responding to a request for clarification from Mr Sarwar, Mr Husain confirmed that colleagues in the Integrated Care Board (ICB) were fully aware of the issues with the Trust's mortality data and explained that its Senior Quality Assurance Manager for Acute, Independent Sector and Small Providers, Simon Bradley, was a regular attendee at meetings of the Quality Committee where this was discussed on a regular basis.

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 trolley standard in December as 74.4%, an increase from the previous year. She pointed out that this had been achieved despite the additional complications from the range of viruses currently in circulation and an increase of 71 in the average number of patients coming into the Trust per day. Mrs Gilligan confirmed that the Trust remained the busiest emergency department in LSC but had continued to ensure that patients were handed over from ambulances more quickly than the North West average.

Mrs Gilligan went on to provide a summary of the Trust's performance against its key cancer targets. She highlighted that the Trust had improved on its position with regard to the 62-day target since the report was published, achieving 72.2% and 73.9% in November and December respectively against the national standard of 70%. Directors noted that the Trust had achieved 94.1% against the 31-day standard and 77.4% against the faster diagnosis standard in November.

Mrs Gilligan concluded her update by reporting that 15.3% of patients had waited longer than six-weeks for a diagnostic procedure, lower than the national level of 19.9%.

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

f) Well-led

Mrs Quinn reported that sickness levels in the Trust were still high and indicated that this was due in part to the higher levels of flu and other viruses currently in circulation. She informed directors that the top reported reasons remained musculoskeletal and mental health and that

a dedicated programme had recently been implemented to specifically target areas of ongoing high sickness, in addition to other work taking place around rostering and job planning. Mrs Quinn explained that although the Trust's reduction in agency usage was a positive development, it had resulted in an increase in bank usage which would need to start being reduced in the near future.

Mrs Quinn went on to report that the Trust remained in a challenged position with regard to appraisal compliance for agenda for change staff. She indicated that the issues raised in previous meeting around core skills training compliance were also ongoing, adding that some of this was related to the organisation's medical workforce struggling to find the time required to complete face-to-face training modules. Mrs Quinn advised that information governance training compliance remained an area of particular concern and that she was working closely with Mrs Simpson to determine how this could be addressed more directly.

Mr Sarwar commented that the Trust's sickness and absence rates still standing at 1.9% above the national average was unacceptable, as was the increasing amounts of money being spent on bank shifts as a result. He requested that the matter was discussed in more detail via the People and Culture Committee and stated that he would like more information around what sickness and absence was costing both the Trust, and the LSC system as a whole. Mr Sarwar emphasised the need for the Trust to coax more staff back to work, and reduce its bank spend, as part of the wider need to manage public money as effectively as possible and ensure that the organisation was living with its means.

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.**

TB/2025/016 CARE QUALITY COMMISSION URGENT AND EMERGENCY CARE SURVEY RESULTS 2024

Mr Walton-Pollard referred directors to the previously circulated report and explained that it summarised the findings from a national questionnaire carried out by the CQC in the Trust's UEC pathways. He reported that the results from this survey made for difficult reading overall, with the Trust underperforming compared to other organisations. Mr Walton-Pollard advised that the Trust had performed much worse than other organisations in five questions, worse in

13, about the same in eight and had not performed better in any areas assessed. He added that this placed it in the bottom 20% of organisations in the country. Mr Walton-Pollard added that the themes picked up in the survey included long waiting times, overcrowding, communication issues, staff attitude and care and the general state of the ED environment. He confirmed that the patient experience team had developed an action plan to address these findings and that this would be monitored through the Patient Experience Group (PEG).

Mr Husain stated that it was important to recognise that although some areas of the survey were within the Trust's gift to address, others would be far more difficult to influence. He emphasised that a significant amount of work had been done to improve the experience of patients since the survey had taken place in February 2024 and that regular updates on this were provide at meetings of the Trust Wide Quality Group (TWQG). Mr Husain added that consideration was being given to carrying out an internal audit as a follow-up to get a better sense of the improvements made.

Mr Walton-Pollard stated that the Trust fully recognised that the ED was one of its biggest risk areas and advised that an executive quality wall had been developed to identify and monitor key performance issues. He highlighted that there were had been some positive indications of recovery over recent weeks.

RESOLVED: Directors received the report and noted its content.

TB/2025/017 FREEDOM TO SPEAK UP REPORT

Mrs Butcher requested her report was taken as read and provided a summary of its key highlights. She reported that there had been a substantial increase in the number of concerns being raised through the staff guardian service in quarter three of 2024-25 but indicated that this had since normalised to typical levels. Mrs Butcher advised that the themes identified were similar to those seen in previous quarters, including inappropriate behaviours and lack of support from managers. She highlighted that eight staff members had spoken up around potential racist discrimination since the national civil unrest seen earlier in the year, four of which had proceeded to a formal process. Mrs Butcher expressed concern regarding the length of time that some investigations were taking following staff raising concerns.

Mrs Butcher went on to inform directors that it was still being discussed as to whether staff in One LSC would come under the Trust's staff guardian service. She indicated that mutual aid had been provided by other organisations in the interim period.

Mrs Butcher referred to the requests made at previous meetings for more equality and diversity data to be included in her reports to the board and confirmed that all previous concerns raised through the staff guardian service had been reviewed to ascertain this information. She advised that this would be included in her next report provided to the board.

Mr Hodgson observed that the function of the staff guardian service had shifted over time from its initial focus on clinical concerns to more of a 'HR hotline' service. He added that it was clear that colleagues felt comfortable raising any concerns they may have through the service and that this should be seen as a positive. Mr Hodgson extended his thanks to Mrs Butcher and her team for their ongoing efforts.

Mrs Quinn agreed and stressed that the staff guardian team frequently went above and beyond for colleagues. She indicated that the advice provided in relation to One LSC had not provided the clarity required and that further work was taking place with national and regional colleagues to develop a reasonable solution to the matter.

Professor Baldwin left the meeting at this time.

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

TB/2025/018 ELHT&ME ANNUAL REPORTS AND ACCOUNTS 2023-24

The Board met as a Corporate Trustee for this item.

Mrs Simpson referred members to the previously circulated ad reports and confirmed that both the ELHT&Me annual report and annual accounts for 2023-24 had been considered and recommended to the board by the Trust Charitable Funds Committee.

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

Directors confirmed that they were content for the ELHT&ME Annual Report and Annual Accounts for 2023-24 to be submitted to the Charity Commission.

TB/2025/019 TRIPLE A REPORT FROM PEOPLE AND CULTURE COMMITTEE

Mrs Anderson informed directors that the People and Culture Committee had considered a range of topics in its most recent meetings, including the ongoing progress of the People Promise Exemplar programme.

Mrs Quinn stressed the need to recognise the direct positive impact that programmes like the People Promise Exemplar programme had on patient care and staff morale, particularly in light of the difficult choices that the Trust would have to make over the coming months from a financial perspective.

Mr Sarwar stated that it would be beneficial for a further discussion to take place at the closed and open sessions of the next Trust Board meeting around the Trust's workforce challenges and what was being done to address its high sickness and absence levels.

RESOLVED: Directors received the report and noted its content.

Further discussions on the work being done to address the Trust's high sickness and absence levels will take place at the next meeting of the Trust Board.

TB/2025/020 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/2025/021 TRIPLE A REPORT FROM QUALITY COMMITTEE

The report was presented to the Board for information.

Mrs Randall highlighted that the committee had received a detailed presentation from colleagues working at NHS Resolution regarding the Trust's CNST scorecards over the previous 10-year period and that a recommendation had been made for these results to be presented to the board at a later date for further consideration.

Mr Husain referred to the request made at previous meetings for Quality Impact Risk Assessments (QIRAs) to be considered by the committee and confirmed that a selection had been presented at recent meetings. He stressed that as there currently hundreds of QIRAs

being submitted on a monthly basis, it would be next to impossible to discuss all of them in detail.

RESOLVED: Directors received the report and noted its contents.

TB/2025/022 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2025/023 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/2025/024 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2025/025 OPEN FORUM

Directors were informed that no questions had been raised by members of the public prior to the meeting.

TB/2025/026 BOARD PERFORMANCE AND REFLECTION

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

Mr Hodgson confirmed that he felt that the board had ably demonstrated the various agendas at play across the system and how they cohered and the difficult context that the Trust was currently working in. He added that he felt that the board had also had honest discussions around stakeholder related matters such as the shuttle bus service and the closure of AVH.

Mr Walton-Pollard commented that as a member of staff whose role was mainly operational, it was good to see that the pressures facing colleagues was being clearly relayed back to the board.

Mr Sarwar agreed and emphasised the need for the board to maintain appropriate levels of challenge and transparency going forward and to be honest that it was

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

TB/2025/027 DATE AND TIME OF NEXT MEETING

Mr Sarwar informed Directors that the next Trust Board meeting would be taking place on Wednesday, 14 May 2025 at 13:00 in the Trust HQ Boardroom.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT | **Item** 33

12 March 2025 | **Purpose** Information

Title	Action Matrix
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mr S Sarwar, Chairman

Summary: The outstanding actions from previous meetings are presented for discussion. Directors are asked to note progress against outstanding items and agree further items as appropriate.

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

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

Previously considered by: Executive Team.

(33) Action Matrix

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2023/040: Maternity and Neonatal Service Update	A full business case regarding the additional funding required to satisfy the Birth Rate+ nursing and midwifery staffing recommendations will be developed and presented to the Board for approval at a later date.	Chief Nurse/ Head of Midwifery	Q1 2024-25	To Be Confirmed
TB/2024/150: Chief Executive's Report	A report will be provided at a future meeting of the Trust Board or the Finance and Performance Committee regarding the potential impact on care home providers from the changes to national insurance payments.	Executive Director of Integrated Care, Partnerships and Resilience	March 2025	Agenda Item: Finance and Performance Committee - March 2025
TB/2024/157: East Lancashire Hospitals NHS Trust Self-Assessment Report 2023-24 for Department of Education, Research and Innovation.	An update on the challenges relating to staff health and wellbeing will be provided at a future meeting of the People and Culture Committee.	Executive Director of People and Culture / Associate Director Staff Wellbeing & Engagement	February 2025	Complete: this update was provided to the People and Culture Committee at its meeting on the 3 March 2025.

Item Number	Action	Assigned To	Deadline	Status
	A report on the work being done with primary care colleagues to support placement capacity will be provided at a future meeting of the People and Culture Committee.	Executive Director of People and Culture	February 2025	Complete: It has been confirmed that the Trust is currently utilising all available placement capacity.
TB/2024/159: Ratification of Board Sub-Committee Terms of Reference	The revised terms of reference for the Finance and Performance and Trust Charitable Funds Committees will be presented at a future meeting for ratification.	Corporate Governance Manager	March 2025	Update: These terms of reference, along with those for other board sub-committees, are currently being reviewed as part of a wider governance review.
TB/2025//019: Triple A Report from People and Culture Committee	Further discussions on the work being done to address the Trust's high sickness and absence levels will take place at the next meeting of the Trust Board.	All	March 2025	A verbal update will be provided at the next meeting.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT | **Item** 35

12 March 2025 | **Purpose** Information

Title	Chief Executive's Report
Report Author	Mrs S Thomas, Head of Communications
Executive sponsor	Mr M Hodgson, Chief Executive
Date Paper Approved by Executive Sponsor	3 March 2025

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

Busiest year on record for emergency services

The NHS experienced the busiest year on record for A&E and ambulance services last year figures published by NHE England show.

The first week of January saw an average of 5,408 patients a day in hospital with flu, including 256 in critical care – 3.5 times higher than the same week last year. This caused a number of trusts to declare critical incidents, citing exceptional demand caused by the colder weather and respiratory viruses.

Ambulance teams handled 806,405 incidents in December taking the total number for 2024 to 8.94 million. A&Es saw 2.35 million attendances in December, bringing the total number of attendances in 2024 to 27.42 million – the busiest year for A&Es ever recorded and 7.1% higher than in 2023 (25.61 million).

Despite this, the NHS saw around 150,000 more patients within the A&E four-hour standard in December when compared to last year and thanks to measures like surgical hubs and community diagnostic centres, delivered 1.56 million elective treatments in November – the highest ever number of treatments delivered each day across the month and 5% more compared to the same month in November 2019.

NHS jabs tens of thousands more against flu than last winter

Almost a quarter of a million more people have been jabbed this winter compared to last year as part of the national NHS flu vaccination campaign.

NHS staff delivered 239,679 more vaccinations so far this winter compared to the same period last year. This is despite starting the full programme rollout in October, a month later than last year.

In recent weeks, flu vaccinations are up more than a quarter (27%) compared to last year with an extra 85,000 jabs delivered in the three weeks leading up to 5 January 2025.

NHS staff treated record numbers last year

Figures show that hardworking NHS staff delivered a record 18 million treatments in 2024, hundreds of thousands (4%) more than in 2023 (17.35 million) and 5% more than in 2019 (17.1 million).

In December alone, the NHS carried out 1.33 million treatments, up 6.5% on 1.25 million the year before.

The overall backlog has dropped again from 7.48 million to 7.46 million, while the estimated number of patients waiting is down from 6.28 million to 6.24 million.

NHS targets halved under new guidance
The NHS has set out a new national ambition for 65% of patients to receive elective treatment within 18 weeks by March 2026, with every Trust asked to deliver at least a 5% improvement on their performance this year.

Based on current levels of demand, the guidance sets out how NHS services will aim to see nearly 450,000 more patients treated within 18 weeks next year. Under the guidance, around 100,000 more people referred for urgent cancer checks will get a diagnosis or the all-clear within 4 weeks next year with all local systems expected to meet the Mental Health Investment Standard in 2025/26, with increased resources going to mental health services in every part of the country.

The guidance follows the publication of the government's new mandate for reform of the NHS, which sets out five core objectives for the health service to deliver, including cutting waiting times, improving access to primary care and improving urgent and emergency care.

NHS England Chief Executive to step down
Amanda Pritchard announced she will stand down as Chief Executive at the end of this financial year. Amanda has been Chief Executive of the NHS since August 2021 and chief operating officer since 2019, leading the organisation through the most challenging period in its 76-year history.

Sir James Mackey will be taking over as Transition CEO of NHS England, working closely with Amanda for the next month before taking up post formally on the first of April.

NHS rolls out lifesaving home testing for bowel cancer to over 50s
People aged 50 and 52 are now automatically receiving a home bowel cancer test kit. Around 850,000 additional people a year in England are now eligible for the screening test, with over 4 million more people invited since roll out began in 2021

Those newly eligible will be sent their test with full instructions and prepaid return packaging. This will happen automatically for people in this new age group as this rolls out across the country.

Results are sent back to participants, along with information about further tests, if needed.

NHS supports thousands more people back into work
Almost 70,000 people with mental health issues were given employment support last year as part of the national NHS Talking Therapies Programme – up nearly two-thirds on the year before, latest NHS figures show.

NHS Talking Therapies help people who struggle with their mental health, such as anxiety or depression and as part of the programme patients can be linked up with their own employment advisor if finding and keeping work is something they are keen to explore or receive help with.

67,794 people began receiving employment advice through the programme last year, compared to 41,907 in the previous 12 months – a rise of 62%.

Frontline workers in the North West have their say on the future of the NHS
Frontline NHS colleagues met NHS England's Chief Nursing Officer, Duncan Burton; Chief Midwifery Officer, Kate Brintworth; Primary Care Medical Director, Dr Clare Fuller and North West Medical Director for Primary Care, Dr Paula Cowan to discuss what they want to see from the government's 10 Year Health Plan.

Led by independent facilitators, it marked the first of a series of events where frontline NHS workers across the breadth of the NHS workforce will come together to share their views on what the future of the NHS should look like.

Colleagues from across a range of roles including GPs, nurses, optometrists, consultants, porters, pharmacists and more were nominated to attend to ensure any impact on local services is kept to a minimum.

World-leading AI trial to tackle breast cancer launched
Nearly 700,000 women across the country will take part in a world-leading trial to test how cutting-edge AI tools can be used to catch breast cancer cases earlier, the Department of Health and Social Care has announced.

Currently, two specialists are needed per mammogram screening. This technology enables just one to complete the same mammogram screening process safely and efficiently. If the trial is successful, it could free up hundreds of radiologists and other specialists across the country to see more patients, tackle rising cancer rates, save more lives and cut waiting lists.

The EDITH trial (Early Detection using Information Technology in Health) is backed by £11 million of government support via the National Institute for Health and Care Research (NIHR). It is the latest example of how British scientists are transforming cancer care, building on the promising potential of cutting-edge innovations to tackle one of the UK's biggest killers.

3. Regional Updates

Four NHS organisations in Lancashire and South Cumbria entered into a programme of national support
It has been announced that extra support will be provided to four NHS organisations in the region by NHS England's national and regional teams as part of a national recovery support programme.

Last year, Lancashire and South Cumbria was one of a number of systems included as part of an investigation and intervention process. Since then, NHS partners in Lancashire and South Cumbria have been working closely with NHS England North West to address a number of challenges around finance, performance, governance and leadership. Despite the support provided during this process, the ICB and three of the region's trusts have not improved sufficiently. A recommendation has therefore been made by NHS England to place the four organisations into NHS Oversight Framework (NOF) Segment 4 and for those organisations to begin to receive intensive support from the National Recovery Support Programme (RSP). The affected organisations are:

- East Lancashire Hospitals NHS Trust
- NHS Lancashire and South Cumbria ICB
- Blackpool Teaching Hospitals NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust

New timetable for New Hospital Programme
The government has confirmed funding and a revised timetable for the New Hospital Programme, including replacing Royal Lancaster Infirmary and Royal Preston Hospitals.

The timescales for delivering these two hospitals are now delayed, with construction expected to begin between 2035 and 2039.

- Construction work on a replacement Royal Lancaster Infirmary is expected to start between 2035 and 2038
- Construction work on a replacement Royal Preston Hospital is expected to start between 2037 and 2039.

In light of the significant delay to the timeframes, the local NHS has made the difficult decision to suspend public engagement on the proposed sites. The planned programme of public events and independent market research will be cancelled until further notice.

LSC Pathology Services to scope plans for a pathology single service
The Lancashire and South Cumbria Pathology Service Network has been asked to scope out plans to develop a pathology single service for the system, including the development of a new Target Operating Model (TOM) and commercial structure.

The proposals to develop a more unified pathology system to address network priorities and improve diagnostic services were formally endorsed by the Pathology Network Board on 25 October and the Provider Collaborative Board on 14 November. Work will now take place to develop and scope proposals for how a single system and new Target Operating Model might work.

Pop-up winter vaccines service visiting Lancashire locations
People living in Lancashire who are eligible for a free winter vaccine have been able to make use of a pop-up service visiting various locations across the region.

Vaccine teams have been heading out across the county, offering COVID-19 and flu vaccinations to those who have so far not taken up the offer.

These include a number of pop-up events in Blackburn and Burnley hospitals through February and March.

WorkWell support service launches across Lancashire and South Cumbria
Created as part of the Government's national plan to help people with health conditions back to work, the WorkWell service provides tailored help and assessment for people aged 16 and above at risk of falling out of work or for those who have had to stop working because of a health condition.

As part of the service, individuals will have access to a work and health coach, who will offer individualised support for up to 12 weeks and help create some clear objectives that address individuals' physical, psychological and social needs.

Lancashire and South Cumbria was chosen last year as one of 15 regions in England to pilot the WorkWell service and it now operates in Barrow-in-Furness, Blackburn, Blackpool, Burnley,

Lancaster, Preston and West Lancashire - although anyone who lives in Lancashire and South Cumbria can access it.

Patients in the North West using NHS 111 service for winter virus advice
Data from North West Ambulance Service shows more than 23,000 additional calls were made in December by those suffering with the symptoms of winter viruses.

Clinicians say the figures demonstrate that patients view NHS 111 as a trusted and valued service to get urgent, but not emergency medical help.

If needed it can arrange a call back from a nurse, doctor or paramedic or provide self-treatment advice over the phone 24 hours a day, seven days a week. People who urgent help for mental health can now also call 111 and select the mental health option

Targeted lung health checks in Lancashire and South Cumbria reach cancer diagnosis milestone
More than 300 people in Lancashire and South Cumbria have had cancers diagnosed early thanks to targeted lung health checks, part of a national initiative which had its first pilot in Lancashire and South Cumbria in 2021.

This life-saving programme invites people who are considered to be at risk of lung cancer for a health check with the aim of finding cancer before symptoms appear and improving patient outcomes.

More than 45,000 people In Lancashire and South Cumbria have participated in the programme with 300 of those benefitting from potentially lifesaving treatment and a better chance of recovery thanks to an earlier diagnosis. The large majority of people who participate in this initiative will receive the all-clear, giving them peace of mind.

4. Local and Trust specific updates

Accrington Victoria Community Hospital
The Trust announced in October 2024 that all services would move out of Accrington Victoria due to the critical condition of the building, which is no longer suitable as a health care facility. The moves took place in a phased approach and the building was closed as a hospital setting on 20 December 2024. In doing so we delivered on the commitment to retain key clinical services within Accrington particularly the MIU, X-Ray, PWE GP Practice and Outpatients.

Since then, a programme of decommissioning has removed all key items and equipment. This was completed by mid-January followed by further measures to secure the site, in liaison with Lancashire Police and Fire and Rescue Service. All advice and recommendations have been implemented, including:

- Stand-alone sentry CCTV across the site which is monitored 24/7 including a managed response by the provider to any incident - any remaining telecommunications connections can be disconnected easily and electricity isolated, reducing risk of fire.
- All external doorways have been firmly secured
- Additional security has been installed on internal doors to restrict movement throughout the building
- Concrete barriers have been put in place to prevent vehicle access

- The Trust's Estates and Facilities team are primed to attend the site on a 24/7 basis in the event of an incident.

The Trust continues to work closely with Police colleagues to ensure there are patrols of the area and East Lancashire divisional officers with the new Neighbourhood Inspector have both provided assurance that patrols will be prioritised.

Nevertheless, people continue to break into the site illegally and cause damage. Of course, the Trust is not the only organisation to face vandalism and criminal behaviour, but the vulnerability of the building and plans for the future means a proactive is critical.

In addition, the building was closed because of its state of repair in places and the historic nature of construction which creates a dangerous environment for anyone who enters the property. We do have clear signs in place warning people about the potential dangers of entering the building.

In the meantime, we are now working with colleagues including the local authority and MP with an aim to begin engagement on next steps with local people in the next few weeks. This will include hosting a couple of events where local residents will have the opportunity to give their feedback before any proposals are pursued.

As part of this, an exhibition at Accrington library has gone live this week, celebrating the history of the hospital and includes stories from people who wanted to share their personal experiences, photographs and some of the historic items we have temporarily recovered from the site to keep them safe. Please do go along and enjoy this – it will be open until the end of April.

The Trust is grateful that together with local people and partners in the area it can continue to work to both help deter people from the hospital site, but also to encourage ideas and suggestions for the future.

New provider for hospital shuttle bus

From Friday, 31 March the Trust will cease to operate its free shuttle bus service between Royal Blackburn Teaching Hospital and Burnley General Teaching Hospital as it can no longer afford it.

This will be replaced with a direct commercial service between Royal Blackburn Teaching Hospital (RBTH) and Burnley General Teaching Hospital (BGTH), with additional stops in Blackburn and Burnley town centres.

Moving People Bus and Coach Services intends to begin operating the service from April 1, 2025, when the existing service is closed. It will initially run between Monday and Friday, with a review once operational to consider an expansion over the weekend.

Alcohol Care Service to close after 31 March 2025

The Alcohol Care Team will cease after 31 March 2025 as funding has come to an end.

The team has been a really valuable addition to the Trust since being launched in 2022 - due to the strong relationships formed with colleagues around the Trust, they now receive around 200 referrals a month to support patients with alcohol dependency.

They have supported discharge planning, withdrawal treatment, and have made a difference to thousands of lives, something which has been valued and highlighted through independent patient feedback.

The service was funded by the NHS National Prevention Programme to reduce alcohol related harm and the impact of this within the local area. However, the funding will finish at the end of this financial year and the Trust is working with the team to support them into new roles wherever possible.

Working with care homes to save money by retrieving blankets and linen
Colleagues in the Community and Intermediate Care Division (CIC) have identified around £25,000 of savings simply by working differently with care homes in East Lancashire to retrieve hospital blankets and linen.

After being approached by a care home in Blackburn with Darwen (BwD) that had accumulated 30 hospital-issued blankets and other linens from patients being discharged from hospital, a review of laundry and logistics took place which identified there were potentially thousands of similar items across all care homes in Blackburn with Darwen (BwD) and East Lancashire which could be put back into circulation and reduce the cost of buying replacements.

As a result, CIC contacted 159 care homes and 18 have so far responded to say they have laundry that belongs to the hospital that could be collected – totalling 581 items. A plan is now in place to enable care homes to contact the Trust and request a collection when they have accumulated a certain number of items.

Medicine recycling a success
A medicine recycling scheme is on track to achieve £300,000 of savings by the end of the financial year.

The Pharmacy team installed medicine recycling units across the wards and department at all sites and colleagues are being asked to recycle any unused medicine.

Since its launch in November, the Trust has recycled over £59,000 of medicines – and hopes to achieve £300,000 by the end of the year.

Staff ideas to reduce spend and save money
Colleagues at the Trust have come together to look for ways to reduce the amount of money being spent every year.

Over 675 suggestions have been put forward, spanning all areas of activity.

Common themes included further opportunities for recycling, ways to save money in pharmacy, increased use of digital and reducing the number of missed patient appointments.

All suggestions are being reviewed and action is already being taken.

Service reviews underway to identify savings
As part of the Trust's work to reduce costs, service reviews are taking place.

All divisions and directorates are being provided with a series of tools and supported through a deep dive into current ways of working to identify if there are more efficient ways of doing things or if there is activity taking place that is currently unfunded.

There are a range of areas that are scrutinised, including workforce data, demand and capacity, performance and quality metrics, finance and waste reduction.

Among the service reviews that have taken place in the last month are HR, Quality & Safety, Service Development & Improvement, Communications, Dermatology, Paediatrics, Diabetes and Chronic Pain.

The idea is to provide dedicated time to look for current and future opportunities – and that includes considering some of the relevant suggestions that have been put forward by colleagues as part of the recent ideas scheme.

Walking aid recycling scheme at Royal Blackburn Teaching Hospital
A designated cage has been placed outside the Fracture Clinic at Royal Blackburn Hospital, where crutches, frames, and sticks can be returned and recycled for future use.

In light of the Trust's current financial situation, every saving is crucial. This new initiative allows the Trust to re-use equipment, rather than constantly replacing it, ultimately helping to reduce costs.

The scheme is one of many series of money-saving ideas that has been introduced and is something that has been suggested by a number of colleagues across the Trust.

Trust puts focus on community services
The success of community-based services has provided an opportunity for the Trust to review the number of beds needed for community and intermediate care with alternative, wraparound services proving particularly successful in supporting recovery and often avoiding hospital admission for people with long term conditions or frailty.

As a result, Reedyford Ward at Pendle Community Hospital has closed. The team on Reedyford ward has done an amazing job delivering safe, personal and effective care. However, the review has looked at the wider provision of community services and how best to support patients in the future through integrated community care, as well as the cost savings that could be made through providing services in a different way.

Improving urgent and emergency care experience for patients
A team has been brought together to focus on reducing pressures in urgent and emergency care.

They are tasked with looking at the patient journey - from pre-hospital attendance and time spent in A&E and through to being admitted into hospital and subsequent discharge.

Representatives from different specialisms and support services are identifying any opportunity to work differently to increase the speed of flow so patients spend less time in the Emergency Department.

This will help reduce the number of people waiting in the Emergency Department at any one time, so the Trust can eradicate the need for corridor care, something everyone is keen to address.

Call for Concern - patient wellness questionnaire launched
The Trust has launched the next phase of the Call for Concern initiative, also known as Martha's Rule.

This involves piloting a patient wellness questionnaire where ward nurses will ask patients or their advocates simple daily questions - 'how are you feeling today?' and 'how are you feeling compared to last time we asked you?'.

Patients will score each question from 1-5 and their responses will be compared to the previous day's scores to catch any clinical deteriorations at the earliest opportunity. The aim of the questionnaire is to ensure that when a patient states they don't feel 'well' or 'right', that that concern is taken seriously and any required action by the ward nurses, doctors and Acute Care Team is initiated. This may include increasing the frequency of observations, or a review by the parent medical team as an example.

The questionnaire is being piloted on wards B14 and B18 and 708 patients have so far been asked the questions. From those identified as requiring intervention, 75% have been resolved through nurses using their clinical judgment and putting interventions in place, and 25% have required a doctor's review.

The trial will be extended to wards 19 and 22 in Burnley later this month so the team can continue to collect data, make improvements, and work behind the scenes, with a view to a Trust-wide launch later in the year.

Breast screening information day for people with learning disabilities
The East Lancashire Breast Screening Service hosted an information day specifically aimed at people with learning disabilities.

Working in partnership with the Trust's Learning Disability and Autism Nursing team and Lancashire and South Cumbria Foundation Trust's Adult Disability Services' Health Facilitation team, the event was designed to help gauge how people with learning disabilities who are due their breast screening in the coming months, would respond to the current invite process.

Attendees also had the opportunity to ask the mammographer any questions about the screening process and were offered to have their breast screening done on the day if they wished.

Maternity discharge videos will transform new parents' experiences
A raft of new videos designed to provide crucial information to new parents in an accessible format has now been launched.

The videos are a digital version of the essential information given to parents on discharge, including safe sleeping, taking care of wounds and infant feeding. They are designed to be watched back again at any time of day – or night – when new parents might need the information the most.

They have been translated into the eight most-used languages in the communities that ELHT serves.

The videos were funded by Electricity North West, whose free Extra Care Register provides extra support to those who may need it during a power cut, including those with young children.

Outpatients Pharmacy to move to a new provider
Outpatient pharmacy services at Royal Blackburn and Burnley General Teaching Hospitals are now being delivered by Lancashire Hospital Services (LHS), a subsidiary owned by Lancashire Teaching Hospitals.

This means the service has been brought back under the NHS, rather than a commercial provider, and will support work to align services across Lancashire and South Cumbria.

There will be no change to the pharmacy service, which continues to be delivered by the same people.

Colleagues get involved on World Hijab Day
The Trust's Muslim Employee Network Group celebrated World Hijab Day by inviting colleagues and visitors to attend an event and try on a hijab.

The event opened up engaging conversations with questions answered around why Muslim women wear a hijab and the barriers and challenges faced.

New Bereavement Suite officially opens
A new bereavement suite has been opened, providing comfort and support to families experiencing the death of a loved one.

It represents a significant step forward in the Trust's ongoing efforts to improve care in the last days of life and provide excellent bereavement support.

The dedicated space has been made possible through the generous support of the hospital’s charity ELHT&Me.

The official opening of the suite was attended by Dr Kathryn Mannix, a renowned palliative medicine expert and author.

Pop-up flu vaccinations at RBTH and BGTH
A pop-up flu vaccination service has been visiting Blackburn and Burnley hospitals.

Set up by Lancashire and South Cumbria Integrated Care Board, NHS colleagues, as well as all adults aged 65 years and over, carers, pregnant women, social care workers and others that are immunosuppressed or at risk have been able to simply turn up to get their vaccine.

The bus has been visiting the sites through February and March, alongside other community locations to ensure vaccinations are as accessible as possible.

SPEC success for teams
The Neonatal Intensive Care Unit (NICU) at Burnley General Teaching Hospital and the Critical Care team at Blackburn are celebrating after receiving a Safe, Personal and Effective Care (SPEC) Award.

It is the first time NICU has been presented with the award, which recognises high ratings in three unannounced nursing inspections. – while the team at Critical Care received a gold award, as they have had high ratings in five consecutive assessments.

The nursing assessments were introduced by the Trust in 2015 as part of ongoing quality checks. They include a comprehensive assessment of standards, linked to themes monitored by the Care Quality Commission, the independent regulator of health and social care.

King Charles awards Dr Newport with humanitarian medal
Consultant in Anaesthetics and Prehospital Emergency Medicine, Dr Matthew Newport has been awarded a Humanitarian Medal by King Charles.

Dr Newport, who works at the Royal Blackburn Hospital, has deployed to Gaza five times over the past 12 months as part of the Government's humanitarian response to the Israel/Gaza crisis.

During his time there, he worked alongside multinational health professionals to build and operate a tented field hospital on the Southern coast of Gaza that sees upwards of 500 patients a day. The field hospital received regular mass casualty events alongside a constant stream of trauma and medical cases, including many children.

Dr Newport was one of 14 frontline medical responders to attend a ceremony at Buckingham Palace to receive the medal which was first introduced in 2023 to recognise the service of people who work to support human welfare during or in the aftermath of a crisis.

Raising awareness of ketamine abuse
The Trust is grateful to locum consultant urologist Mr. Haytham Elsakka who has been talking in the media about the use of ketamine and its effect on the urinary system. He was most recently interviewed on BBC Radio 4 to help to raise awareness of the significant risks associated with recreational use of the substance, which is an issue in East Lancashire and particularly among young people. Mr Elsakka was recommended to the journalist by a patient who had experienced positive outcomes from their treatment. In his interview Mr Elsakka describes how the number of patients suffering from ketamine abuse is increasing and raising awareness of the impact is a key approach to preventing abuse. If you’re interested in finding out more you can read the interview on the BBC website or catch it on BBC Sounds.

Specialist endometriosis centre accreditation achieved again
The Trust has again achieved the standard to be accredited as a specialist endometriosis centre for the 10th year in a row in recognition of the work of the team at the Lancashire Women’s and Newborn Centre at Burnley General Teaching Hospital. The evidence this year showed a further increase in the number of surgical procedures for people suffering from endometriosis, which has been bolstered by a number of new specialist clinical colleagues joining the team.

JAG accreditation achieved again
The Trust has met all the requirements to achieve accreditation for the Joint Advisory Group (JAG) for GI endoscopy, following submission of an annual review. Colleagues from JAG have written to the Trust with this outcome, which includes their desire to congratulate the team for the high standard of achievement and for their hard work during the accreditation process.

ENDS

TRUST BOARD REPORT | **Item** 37

12 March 2025 | **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	18 February 2025

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

Recommendation: Directors are asked 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?

Executive Summary

1. A summary of key points to note since the last meeting.
   a) The corporate risk register has twenty three risks, an increase since the last report. One risk has a reduced risk score of sixteen from twenty and one risk has a reduced risk score of twelve awaiting approval for it to be removed. There has been no movement or change in any other 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) The Trust continues to advance its risk maturity and movement towards a more integrated risk management enterprise model.

Risk management and the impact of taking / not taking action

2. A summary of the importance of risk management is outlined below.
   a) Risk management is defined as being '…*a planned, systematic process for identifying, assessing, managing, controlling and reviewing risks and mitigating unacceptable risks in order to minimise harm, improve safety and performance…*'.
   b) It is a statutory health and safety legal requirement and fundamental health and safety principle that remains highly integral to the effectiveness of a robust organisational safety management system.
   c) Is a key line of enquiry used by regulatory bodies such as the Health and Safety Executive (HSE) and Care Quality Commission (CQC) when conducting visits or inspections to monitor quality and safety standards and service provision.
3. The benefits of good risk management are that it:
   a) Protects patients, staff and the organisation from harm.
   b) Minimises loss.
   c) Ensures compliance with legal, regulatory and accreditation requirements.
   d) Helps maintain license to operate requirements.
   e) Facilitates strategic and operational planning.
   f) Enhances decision making.
   g) Improves organisational resilience.
   h) Optimises better use and allocation of resource.
   i) Improves organisational efficiency and drives innovation
   j) Reduces financial, legal and insurance costs.
   k) Enhances stakeholder confidence.

l) 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 CRR has twenty three risks, an increase since the last report. One risk has a reduced risk score of sixteen from twenty and one risk has a reduced risk score of twelve awaiting approval for it to be removed. There has been no movement or change in any other 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 twelve (52%) are clinical management risks, four (17%) are data and digital risks, three are health and safety risks (13%), two are financial risks (10%) and one (4%) is a medical devices risk and one (4%) is a patient safety risk.

d) A breakdown of risks by division shows ten (43%) are Trust wide, six (26%) are corporate services, two (9%) are diagnostic and clinical services, two (9%) are surgical and anaesthetic services, two (9%) are within medicines and emergency care services and one (4%) is within family 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 595 in Q4 2024-25 to present, a decrease of 13%.

b) Risks scoring between 9-12 identified as being significant or moderate have increased, from 215 risks in Q4 2023-24 to 233 in Q4 2024-25 to present, an increase of 8%.

c) Risks remaining open over 3 years old are down from 400 risks in Q4 2023-24 to 311 in Q4 2024-25 to present, a decrease of 22%.

d) Overdue risks have increased from 107 in Q4 2023-24 to 118 in Q4 2024-25 to present, an increase of 10%.

e) 8% 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 (41%) followed by health and safety (16%).

g) A breakdown of clinical management risks shows the highest risk sub types are concerning capacity and demand (22%) followed by assessment / diagnosis (9%), standards of care (8%) and treatment or procedure (7%).
h) A breakdown of health and safety risks shows the highest risk sub types relate to buildings and infrastructure (32%) followed by security management (18%) and fire safety (8%).
i) Highest numbers of risks are held within the diagnostic and clinical service division (27%) followed by surgical and anaesthetic services (22%).
j) Highest numbers of directorate risks are held Trust wide (11%) and radiology (11%) followed by pathology (10%), theatres and day surgery (7%).

Mitigations for risks and timelines

6. A summary of recent mitigations for risks and timelines to note.
   a) A comprehensive and detailed exercise to improve overall risk identification accuracy to ensure all risks are categorised appropriately has been completed. These include:
      i. The identification of strategic and operational risks benchmarked against strategy, legislation, set regulatory standards and practice.
      ii. An extensive list of new risk type and sub type categories and supporting risk descriptors that provide a better risk assurance framework model.
   b) Improved risk governance by way of:
      i. The mapping of risk type and sub types to nominated committees and groups.
      ii. A nominated committee, group and executive lead to oversee and seek assurances risk types and sub types are being suitably managed.
      iii. Better use of lead specialisms or subject matter experts with responsibility for managing risks within their areas of responsibility and control.
      iv. The review of risks through standardised terms of reference, regular and annual performance reporting.
      v. A review of the effectiveness of Divisional Quality and Safety Board meetings in scrutinising risks before their presentation at Risk Assurance Meetings (RAM).
   c) Improved risk management performance including:
      i. The continued reaffirmation of the risk management framework (RMF) and process of escalation.

ii. A series of measures to drive improvements regarding the management of risks scoring fifteen or above not on the CRR.

iii. Improved scrutiny and challenge of risk scores, controls and assurances against catastrophic, severe and moderate consequence scoring criteria.

vi. More detailed assurance requirements within divisional reporting.

vii. Specific inclusion, monitoring and achievement of KPI metrics.

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

ix. Targeted review of all live and tolerated risks whereby the current risk score has met its target score and of their subsequent closure.

x. Engagement with relevant lead specialisms and subject matter experts to improve the management of clinical and corporate risk types.

xi. Addressing challenges of risk handlers or leads being unable to present risks at risk assurance meetings due to conflicting priorities and urgent work activity.

d) Improved risk management competencies of managers and key staff. These include:

i. The coaching of managers and staff with responsibility for managing risks, along with the issue of new guidance.

ii. The completion of a risk management training needs analysis and its approval by the Core and Essential Skills Group onto the competency framework.

e) System improvements to the Datix risk management module. These include:

i. The review of RL Datix system upgrade and capabilities.

ii. Profiling and mapping of risks into 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 fifteen or above on the CRR to the board assurance framework (BAF).

vi. The creation of a mandatory actions required to be taken section.

vii. Limiting access to the risk register to improve ownership and the management of risks and prevent the risk register from 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. The use of mandatory field and minimum characters to avoid sections of risks being left blank.

Challenges

7. A number of challenges 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:
   a) External and internal drivers e.g. industrial action.
   b) Financial pressures and budgetary constraints.
   c) Major organisational system and process change e.g. electronic patient record system.
   d) Changes to strategic direction and operational frameworks.
   e) Changes to governance and assurance systems.
   f) Increasing service demands and competing priorities.
   g) Workforce transformation.
   h) Resources and staffing limitations.
   i) Staffing levels and pressures.
   j) Evolving nature of risks e.g. digital systems and storage etc.
   k) Resistance to change in established practices.
   l) Past, historical risk management cultural norms and performance.
8. The decision not to implement a new total quality management system has restricted 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.
9. Delays in upgrading Datix servers, competing organisational priorities and work projects, in particular, 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.
10. 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 risk governance and assurance systems.
11. Work to address risk management and risk assessment training and its delivery remains very challenging due to limited capacity and resource.
12. 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.

13. Quality improvements continue to be made regarding the management of risks held on the risk register resulting in a number of challenging key performance indicator targets introduced being met or exceeded.

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

14. Effective leaders and managers know the risks its organisation faces, prioritises them in order of importance and takes action to eliminate or reduce them to their lowest level practicable. A strong, effective governance and risk management framework (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

15. The health, safety and risk management team continue to operate with extremely limited resources and capacity, with increasing service demands, many competing priorities and overreliance from services delaying progress. This is further compounded by much challenging work still required to address past, historical risk management cultural norms and performance.

Benchmarking Intelligence

16. Risks, whilst remaining diverse in nature, are identified using various methodology and are measured more intensively in an effort to proactively influence, promote and drive a more positive risk management culture. These include the following:
    a) Existing or proposed legislation and regulatory standards.
    b) Case law reviews and the outcome of key consultative documents.
    c) Publications and guidance from professional bodies.
    d) Influence of external regulators.
    e) Changes or developments in organisational strategy and objectives.
    f) Workforce structures, service delivery models and job design.
    g) Competencies and behavioural frameworks.
    h) Incident reporting and investigation, thematic review and lessons learned.
    i) The effectiveness of risk assessment processes.

j) Statistical analysis and key performance indicators.
k) Results of audits, inspections and or surveys.
l) Use of focus groups and external benchmarking.

Conclusion of Report

17. Overall the Trust continues to make good progress in its risk management efforts and it remains fully committed to effective risk management being a cornerstone of safe and sustainable healthcare service delivery.
18. The risk management approach and culture remains cautious but continues to mature and evolve, with desired outcomes becoming much more visible as a result of improved risk management leadership and direction.
19. Much significant and challenging work still remains in advancing risk management capabilities to deeply embed the management and ownership of risks, improve risk governance and performance monitoring, increase levels of education, training and competency and remove past historical risk management cultural norms and performance so as to achieve the desired benefits of good risk management as detailed within the report.

Recommendations

20. The importance of risk profiling and mapping, improving the quality and quantity of risks, better utilisation of clinical and corporate lead specialisms and subject matter experts, increasing awareness and understanding of the RMF and escalation process and the review of risks in accordance with risk review cycles remains a key area of focus. This is heavily impacting on the quality of risks held on the risk register.

Next Actions

21. A summary of key focused activity:
    a) Work to avoid duplication, improve standardisation and the quality and quantity of risks held on the risk register remains ongoing.
    b) The RMF, process of escalation and more effective use of risk scoring criteria to assess and score risks continues to be reaffirmed.
    c) Review of all live risks associated with One LSC.
    d) Review and strengthening of the risk management strategy and framework.
    e) Improving the BAF and links to the risk register.
    f) Developing clearer risk appetite statements.

g) Strengthening risk governance including board reporting and senior management overview.
h) Better development, use and or completion of generic risk assessments.
i) Enhancements to risk management software for better tracking and performance.
j) Improved awareness, education, training and competence in risk management including risk assessment through development of training modules.
k) More effective use of the risk register.
l) Improve risk management audit outcomes.
m) More proactive response and focus on emerging risks.
n) Expanding stakeholder engagement initiatives to improve risk awareness and ownership.
o) The use of risk management KPI and target criteria remains a key area of focus and driver.
p) Longer term plan to integrate health and safety and risk management strategic frameworks to form a single, more unified approach.

How the decision will be communicated internally and externally

22. Decisions regarding the review and approval of risks and the validity of risk scores are made via Divisional Quality and Safety Board meetings, at Committees and or Groups, and escalated through the approved governance framework.

How progress will be monitored

23. 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.
24. 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

18 February 2025

Lancashire and South Cumbria Provider Collaborative

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Summary of the Corporate Risk Register

	ID	Risk Type	BAF	Division	Title	Likelihood Score	Consequence Score	Risk Score	Exec Lead	Effectiveness of Controls	Risk Movement	Committee / Group
1	10082	Financial	5	Trust wide	Failure to meet internal and external financial targets for 2024-25	5	5	25	S Simpson	Limited	↔	Finance & Performance Committee
2	10086	Clinical	2	Trust wide	Lack of adequate online storage for images may result in missed or delayed diagnosis	5	4	20	S Simpson	Inadequate	↔	Data & Digital Senate
3	9755	Clinical	2	Family Care	Delays undertaking elective caesarean sections	4	5	20	P Murphy	Limited	↑	New Risk
4	9336	Clinical	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
5	8941	Clinical	2	DCS	Increased reporting times in histology due to increased activity outstripping resource	5	4	20	J Husain	Limited	↔	Elective Productivity & Improvement Group
6	8126	DDaT	2	Corporate	Poor records management due to sub optimal implementation of new e-PR system	5	4	20	J Husain	Adequate	↔	Data & Digital Senate
7	10062	Clinical	2	Trust wide	Risk of harm and poor experience for patients with mental health concerns	4	4	16	P Murphy	Inadequate	↔	TWQG A / Quality Committee
8	9777	Corporate	2	Corporate	Loss of education, research and innovation accommodation and facilities	4	4	16	T McDonald	Limited	↑	New Risk
9	9746	Financial	5	Corporate	Inadequate funding model for research, development and innovation	4	4	16	K Quinn	Limited	↔	People & Culture Committee / Finance & Performance Committee
10	9545	Clinical	2	SAS	Potential interruption to surgical procedures due to equipment failure	4	4	16	S Simpson	Limited	↓	Medical Devices Steering Group
11	8061	Clinical	2 / 3	Trust wide	Patients experiencing delays past their intended clinical review date may experience deterioration	4	4	16	S Gilligan	Limited	↔	Elective Productivity & Improvement Group
12	8033	Clinical	2	Trust wide	Increased requirement for nutrition and hydration intervention in patients resulting in delays	4	4	16	P Murphy	Limited	↔	Nutrition & Hydration Streeting Group
13	7165	H&S	2	Corporate	Failure to comply with RIDDOR	4	4	16	T McDonald	Limited	↔	Health & Safety Committee
14	10095	MEC	3	Cardiology	PAC issues impacting on efficiency and ability to meet targets and obstructive workflow	5	3	15	S Simpson	Inadequate	↑	New Risk
15	10065	Clinical	2	DCS	Pharmacy Technical Service refurbishment programme	3	5	15	J Husain	Inadequate	↔	TWQG B / Quality Committee
16	9900	NICE	2	Trust wide	Poor identification, management and prevention of delirium	5	3	15	J Husain	Limited	↔	TWQG B / Quality Committee
17	9895	Clinical	3	SAS	Patients not receiving timely emergency procedures in theatres	5	3	15	J Husain	Limited	↔	SAS DQSB
18	9851	DDaT	2	Trust wide	Lack of standardisation of clinical documentation processes and recording in Cerner	5	3	15	P Murphy	Limited	↔	Data & Digital Senate
19	9653	Clinical	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 & Improvement Group
20	9301	H&S	2	Trust wide	Risk of avoidable patient falls with harm	3	5	15	P Murphy	Limited	↔	Falls Strategy Group / TWQG A
21	8808	H&S	2	Corporate	Breaches to fire stopping and compartmentalisation at BGH	3	5	15	T McDonald	Adequate	↔	Fire Safety Committee / TWQG B
22	4932	Clinical	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 A
23	6190	Clinical	3	Trust wide	Insufficient capacity to accommodate patients in clinic within timescales	3	4	12	S Gilligan	Limited	↓	Elective Productivity & Improvement Group

Corporate Risk Register Detailed Information

No	ID	Title
1	10082	**Failure to meet internal and external financial targets for 2024-25**

Lead	Risk Lead: A Hussain Exec Lead: S Simpson	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.	**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 risks.
Controls and Assurances in place	**Controls** 1. Robust financial planning arrangements to ensure financial targets are achievable within the Trust. 2. Accurate financial forecasts. 3. Financial performance reports distributed across the Trust to allow service managers and senior managers to monitor financial performance. 4. Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made within delegated limits. **Assurances** 1. Frequent, accurate and robust financial reporting and challenge by the way of:- • Trust Board Report • Finance and Performance Committee Finance Report • Audit Committee Reports • Integrated Performance reporting • Divisional and Directorate Finance reports • Budget Statements • Staff in Posts Lists • Financial risks • External Reporting and Challenge		

Update since the last report	**Update 17/02/2025** **Risk reviewed. No change in risk score** **Progress Update** Deficit: £41.6m, against a planned £8.6m, £33.0m shortfall from revised plan. Monthly Deficit: £9.3m, deterioration of £3.0m. Breakeven Plan: Revised annual plan includes a £59.7m waste reduction programme; reliant on non-recurrent deficit support funding. Cost Pressures: Extra ward areas, increased ED staffing, corridor care, sickness, waiting list initiatives, anesthetic, and theatre costs. ERF Overperformance: Potential for increased activity and income; overperformance was removed from financial position. Depreciation Income: Expected additional income for depreciation not received. Capital Programme: £33.6m funding, slight forecast expenditure increase. Year-to-date £16.0m ahead due to early lease expenditure recognition. Cash Balance: £10.2m as of 31st December, supported by £18.2m PDC; anticipated challenges in quarter four. Payment Performance: Withheld supplier payments; BPPC below target. Risk of falling below NHS invoice payment target in last quarter. Agency Staff Spend: 1.9% of total pay, below NHSE ceiling of 2.9%. Waste Reduction Programme: £16.2m achieved against £29.8m plan by Month 9. **Next Review Date 14/03/2025**	**Date last reviewed**	**17/02/2025**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			25	**25**	**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	Risk Lead: D Hallen Exec Lead: S Simpson	Current score	20	Score Movement	⟺

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.

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 07/02/2025
Change of risk lead. No change in risk score.
Risk has been reviewed by the Chief X Information Officer. Assurance of compliance against national guidance for the storage of clinical images is being reviewed which will help support mitigation of this risk and a reduced risk score.

Next Review Date 07/03/2025

Date last reviewed	07/02/2025			
Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	20	20	20	20
8-week score projection	12			
Current issues	System wide external influences			

No	ID	Title
3	9755	**Delays in undertaking elective caesarean sections**

Lead	Risk Lead: C Aspden Exec Lead: P Murphy	Current score	20	Score Movement	⇧

Description	There is a deficit in capacity for elective caesarean sections against annual increasing demand. The current delivery model and mitigation to meet the gap have implications for clinical and patient safety risks and compromises emergency operative availability
Controls and Assurances in place	**Controls** 1 Antenatal inpatient manager and Consultant Obstetric lead undertake daily review of planned elective caesarean sections to monitor and manage planned waiting list. 2 Weekly meeting to pick up any reutilised list. Hoping that where there is an available list that obstetric capacity and midwifery bank will pick up the sessions. Where there isn't a list for reutilisation, a capacity request is submitted. 3 Using on-call obstetric staffing and central Birth Suite Midwifery and maternity support worker staffing to do elective activity in addition to their job planned work. 4 Improvement case drafted and submitted for decision (included in documents) proposal to move back to a 5-day model (Ockenden recommendation is to aspire to a 5-day (10 session model). 5 Established a task & finish group to maximise efficiencies and see improved utilisation of current capacity. **Assurances** 1 The only confidence in controls is that the overspill of elective caesarean sections are managed on the emergency pathway but this is not a sustainable or safe control. 2 Monthly escalation meeting hosted by Divisional Director of Operations and Divisional Director of Midwifery & Nursing. 3 Weekly review of capacity requirements and planned activity.
Gaps and potential actions to further mitigate risk	**Gaps / weaknesses in controls** 1 Limitations for Antenatal Inpatient Manager and Consultant Obstetric Lead to undertake daily review of elective caesarean section demand. with potential single point of failure in times of sickness or unavailability. Business case seeks approval of elective admissions clerk to support the process and remove burden off clinical team. 2 Additional capacity sessions - unsustainable, costly, unreliable, dependent on availability of theatre/anaesthetic cover and midwifery staffing. There is a decline in staff who pick up bank shifts/capacity. Antenatal Ward Manager often stepping in to cover sections taking her away from substantive duties. 3 Availability of extra sessions further impacted by lifecycle works reducing number of lists available for re-utilisation, with activity moved from Blackburn to Burnley theatres. 4 Programme of theatre lifecycle work commenced that necessitates more elective work to be undertaken in the Lancashire Women & Newborn Centre. As a result maternity services will not have access to Gynae Theatre 4 as a 2nd emergency obstetric theatre during this time. On days elective caesarean section lists are taking place there will only be one available emergency theatre (obstetric theatre 1). 5 Category 3 caesarean sections should be risk assessed by the Obstetric Consultant on call and Band 7 Co-ordinator to be facilitated when safe to do proceed. 6 Additional elective work (category 4) should be conducted on days without concurrent elective lists, housed on gaps in the elective lists or escalated to the Maternity Triad to secure additional capacity if required. 7 Ongoing assessment of risk and work around the demand and capacity for caesarean sections is continuing. 8 Unable to guarantee requests for extra theatre capacity - if additional elective capacity is not available women are often listed from Central Birth Suite into emergency capacity, however given the above availability of gynae 4 due to Lifecycle works this mitigation is now not often an option. 9 Inefficient use of staffing resource which will cause additional hidden tasks for Acute lead consultant, midwifery leaders and ward clerks. 10 A business case was originally submitted in 2022/23 which proposed moving back to a 5-day delivery model, at the time it paused as part of the Trust Business Case Stock take exercise and put on hold due to the 22/23 financial position of the Trust. 11 Revised business case re-submitted in 2024/2025 - no decision taken as yet (17.09.24). In August 2024 current business case has been added to the urgent case review tracker. 12 Increasing elective work impacts availability of emergency theatre. Impact of grade 3s on acute workload, has caused delay to emergency work (increased requirement to break into a second emergency theatre, staffing pressures). 13 Approval of the business case will further exacerbate SAS risk 10139 availability of theatres, due to the fact that it will reduce

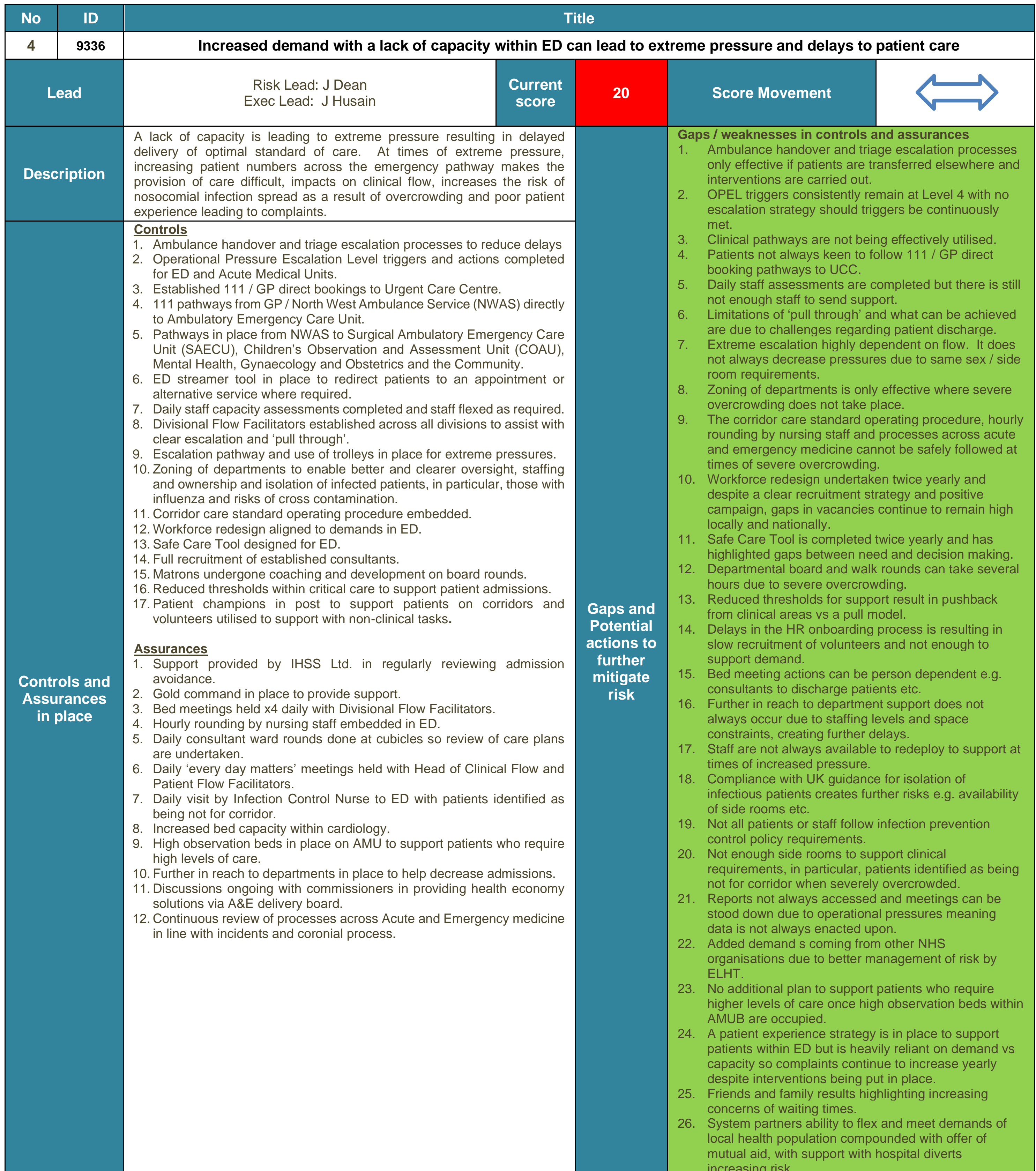
<table>
<tr><td></td><td></td><td></td><td colspan="4">availability of a second emergency theatre on Mondays and Fridays.
14 Gynae 4 the second emergency obstetric theatre has planned elective work listed - where there is need to break into this theatre for an emergency obstetric case, this impacts on productivity of Trust level elective recovery plans and long waiting patients.

Gaps / weaknesses in assurances

1 Limited assurance due to the lack formalisation of the processes identified within the controls and actions.
2 There remains an ongoing pressure on the emergency team and risk of delay to emergency cases, with the potential for poor maternal and/or foetal outcomes.</td></tr>
<tr><td rowspan="5">Update since the last report</td><td rowspan="5">Update 06/02/2025
New Risk
There remains a significant and daily risk whilst the service demand requires using the emergency team to undertake elective work. The controls currently in place do not mitigate these risks.

Next Review Date 06/03/2025</td><td>Date last reviewed</td><td colspan="4">06/02/2025</td></tr>
<tr><td rowspan="2">Risk by quarter 2024-25</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td></td><td></td><td></td><td>20</td></tr>
<tr><td>8-week score projection</td><td colspan="4">20</td></tr>
<tr><td>Current issues</td><td colspan="4">System wide external influences</td></tr>
</table>

Safe | Personal | Effective



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		Current score		Score Movement	
Lead	Risk Lead: J Dean Exec Lead: J 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.

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.

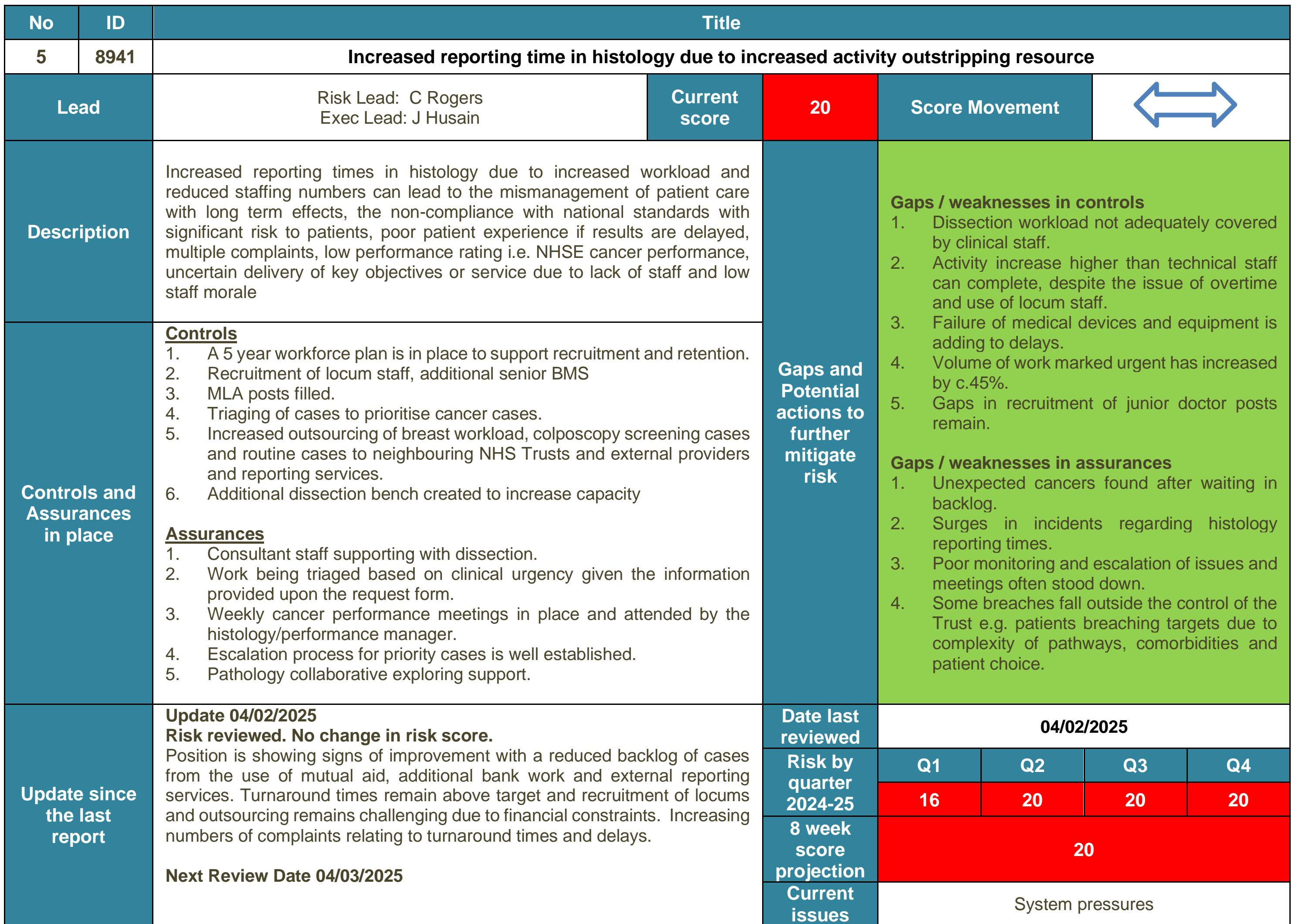
Gaps and Potential actions to further mitigate risk

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

<table>
<tr><td rowspan="5">Update since the last report</td><td rowspan="5">Update 10/02/2025
Risk reviewed. No change in risk score
ED continue to see increased pressure on pathways and subsequent overcrowding and daily utilisation of corridor spaces. Additional medical wards have been opened whereby all clinical space at this point is in use. There has been an increase in the RN establishment so all ED corridor spaces can be fully recruited to and continuous positive RN recruitment, with minimal vacancies now.

Next Review Date 10/03/2025</td><td>Date last reviewed</td><td colspan="4">10/02/2025</td></tr>
<tr><td rowspan="2">Risk by quarter 2024-25</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>20</td><td>20</td><td>20</td><td>20</td></tr>
<tr><td>8 week score projection</td><td colspan="4">20</td></tr>
<tr><td>Current Issues</td><td colspan="4">Recovery and restoration pressures, recruitment and retention</td></tr>
</table>



No	ID	Title
5	8941	**Increased reporting time in histology due to increased activity outstripping resource**

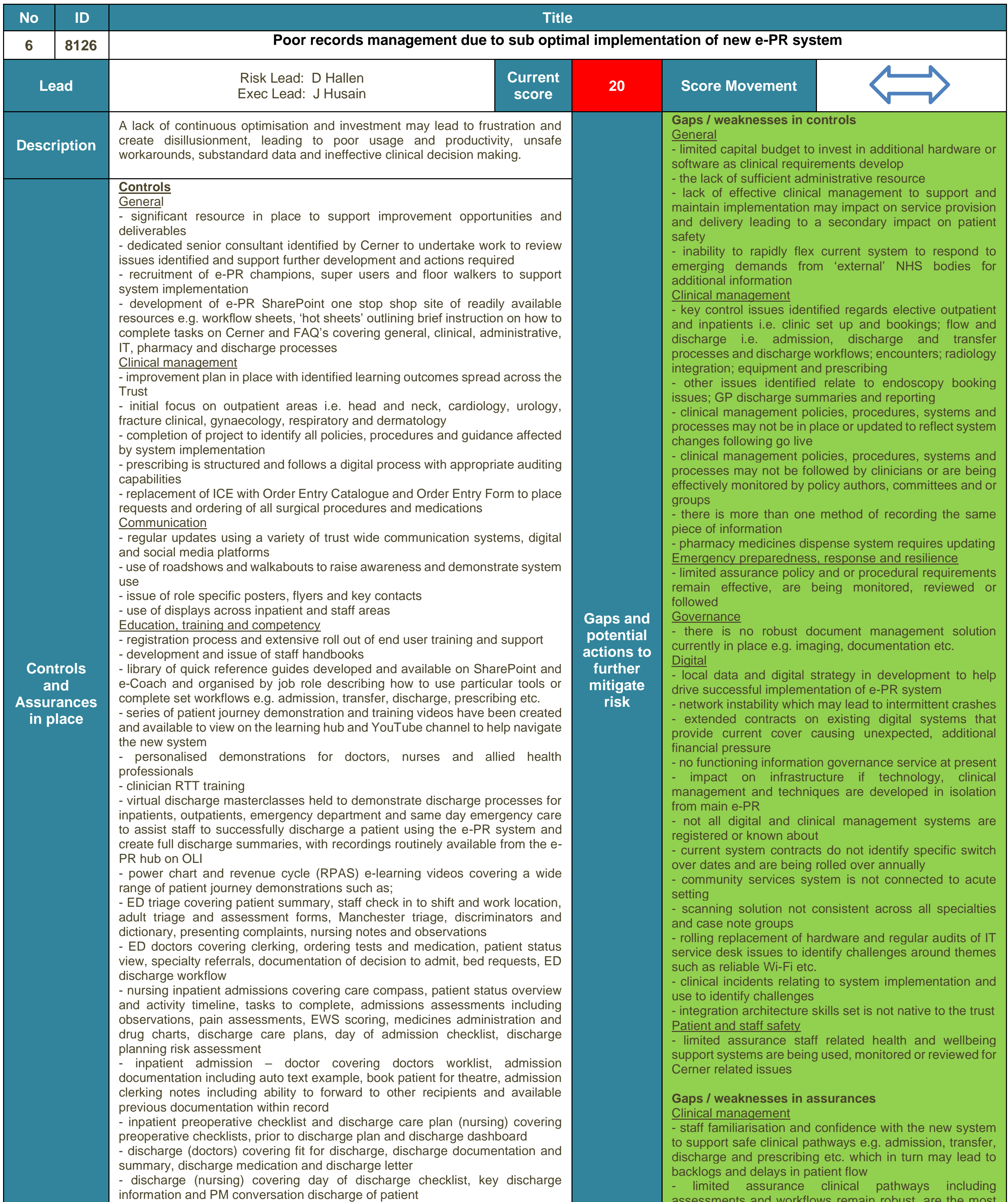
Lead	Risk Lead: C Rogers Exec Lead: J Husain	Current score	20	Score Movement	⟺

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. Recruitment of locum staff, additional senior BMS 3. MLA posts filled. 4. Triaging of cases to prioritise cancer cases. 5. Increased outsourcing of breast workload, colposcopy screening cases and routine cases to neighbouring NHS Trusts and external providers and reporting services. 6. Additional dissection bench created to 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 in place and attended by the histology/performance manager. 4. Escalation process for priority cases is well established. 5. Pathology collaborative exploring support.		

Update since the last report	**Update 04/02/2025** **Risk reviewed. No change in risk score.** Position is showing signs of improvement with a reduced backlog of cases from the use of mutual aid, additional bank work and external reporting services. Turnaround times remain above target and recruitment of locums and outsourcing remains challenging due to financial constraints. Increasing numbers of complaints relating to turnaround times and delays. **Next Review Date 04/03/2025**	**Date last reviewed**	**04/02/2025**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			16	20	20	20
		8 week score projection	20			
		Current issues	System pressures			

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust



No	ID	Title
6	8126	**Poor records management due to sub optimal implementation of new e-PR system**

Lead	Risk Lead: D Hallen Exec Lead: J 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

Safe | Personal | Effective

	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

<table>
<tr><td></td><td>- 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</td><td></td><td colspan="4"></td></tr>
<tr><td rowspan="5">Update since the last report</td><td rowspan="5">Update 18/02/2025
Risk reviewed. No change in risk score
Data and digital board is working on addressing the risk by segmenting into various functional components. These will reflect challenges that range from embedding of the system to upgrades required to maintain the functionality of EPR. A number of work stream are currently looking into coding, training, data accuracy and optimising of the pathways to improve the functionality of EPR

Next Review Date 07/03/2024</td><td>Date last reviewed</td><td colspan="4">18/02/2025</td></tr>
<tr><td rowspan="2">Risk by quarter 2024-25</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>20</td><td>20</td><td>20</td><td>20</td></tr>
<tr><td>8-week score projection</td><td colspan="4">15</td></tr>
<tr><td>Current issues</td><td colspan="4">System wide external influences</td></tr>
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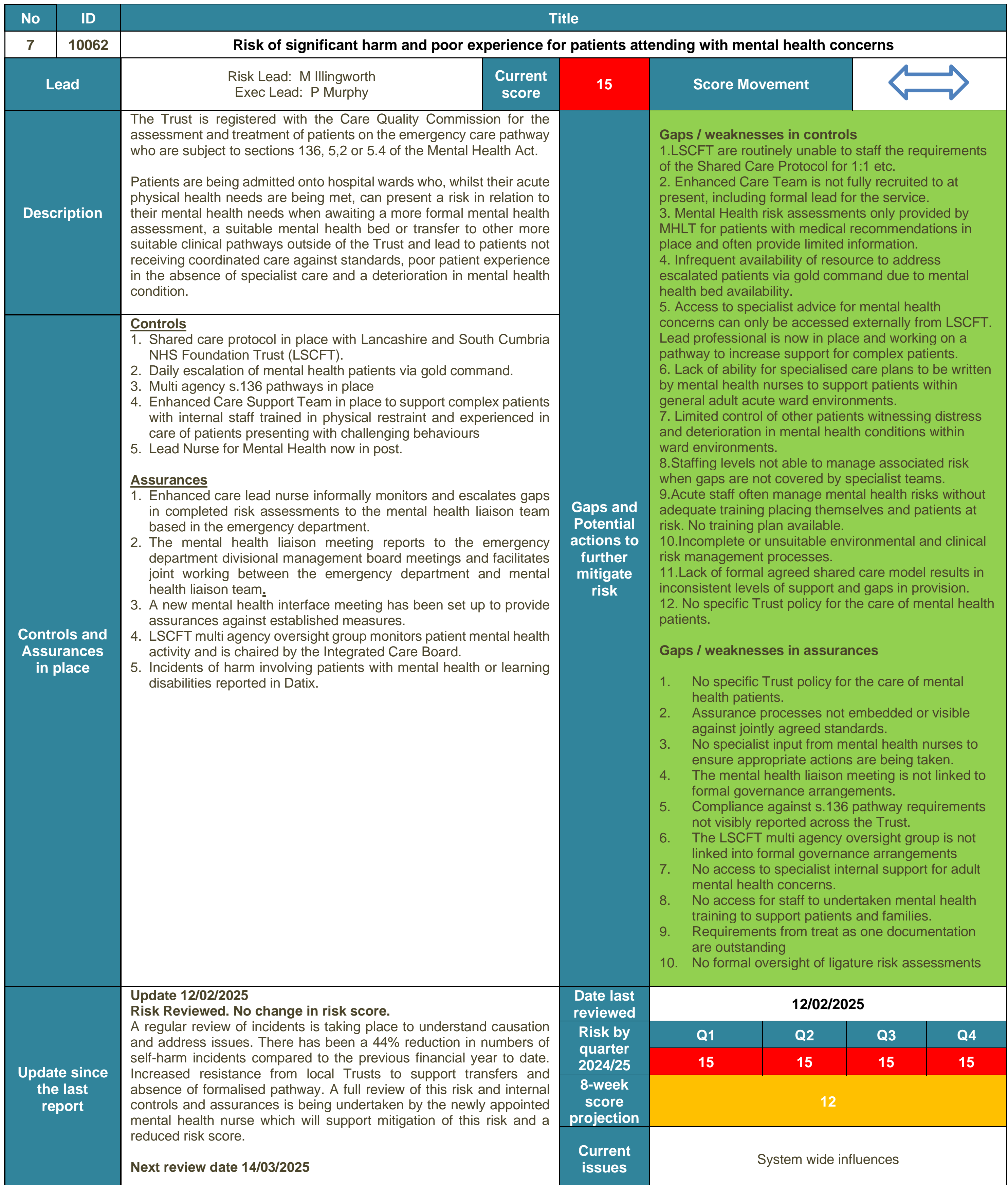


No	ID	Title
7	10062	**Risk of significant harm and poor experience for patients attending with mental health concerns**

Lead	Risk Lead: M Illingworth Exec Lead: P 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.

Controls and Assurances in place

Controls

1. Shared care protocol in place with Lancashire and South Cumbria NHS Foundation Trust (LSCFT).
2. Daily escalation of mental health patients via gold command.
3. Multi agency s.136 pathways in place
4. Enhanced Care Support Team in place to support complex patients with internal staff trained in physical restraint and experienced in care of patients presenting with challenging behaviours
5. Lead Nurse for Mental Health now in post.

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.

Gaps and Potential actions to further mitigate risk

Gaps / weaknesses in controls

1.LSCFT are routinely unable to staff the requirements of the Shared Care Protocol for 1:1 etc.
2. Enhanced Care Team is not fully recruited to at present, including formal lead for the service.
3. Mental Health risk assessments only provided by MHLT 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 mental health bed availability.
5. Access to specialist advice for mental health concerns can only be accessed externally from LSCFT. Lead professional is now in place and working on a pathway to increase support for complex patients.
6. Lack of ability for specialised care plans to be written by mental health nurses to support patients within general adult acute ward environments.
7. Limited control of other patients witnessing distress and deterioration in mental health conditions within ward environments.
8.Staffing levels not able to manage associated risk when gaps are not covered by specialist teams.
9.Acute staff often manage mental health risks without adequate training placing themselves and patients at risk. No training plan available.
10.Incomplete or unsuitable environmental and clinical risk management processes.
11.Lack of formal agreed shared care model results in inconsistent levels of support and gaps in provision.
12. No specific Trust policy for the care of mental health patients.

Gaps / weaknesses in assurances

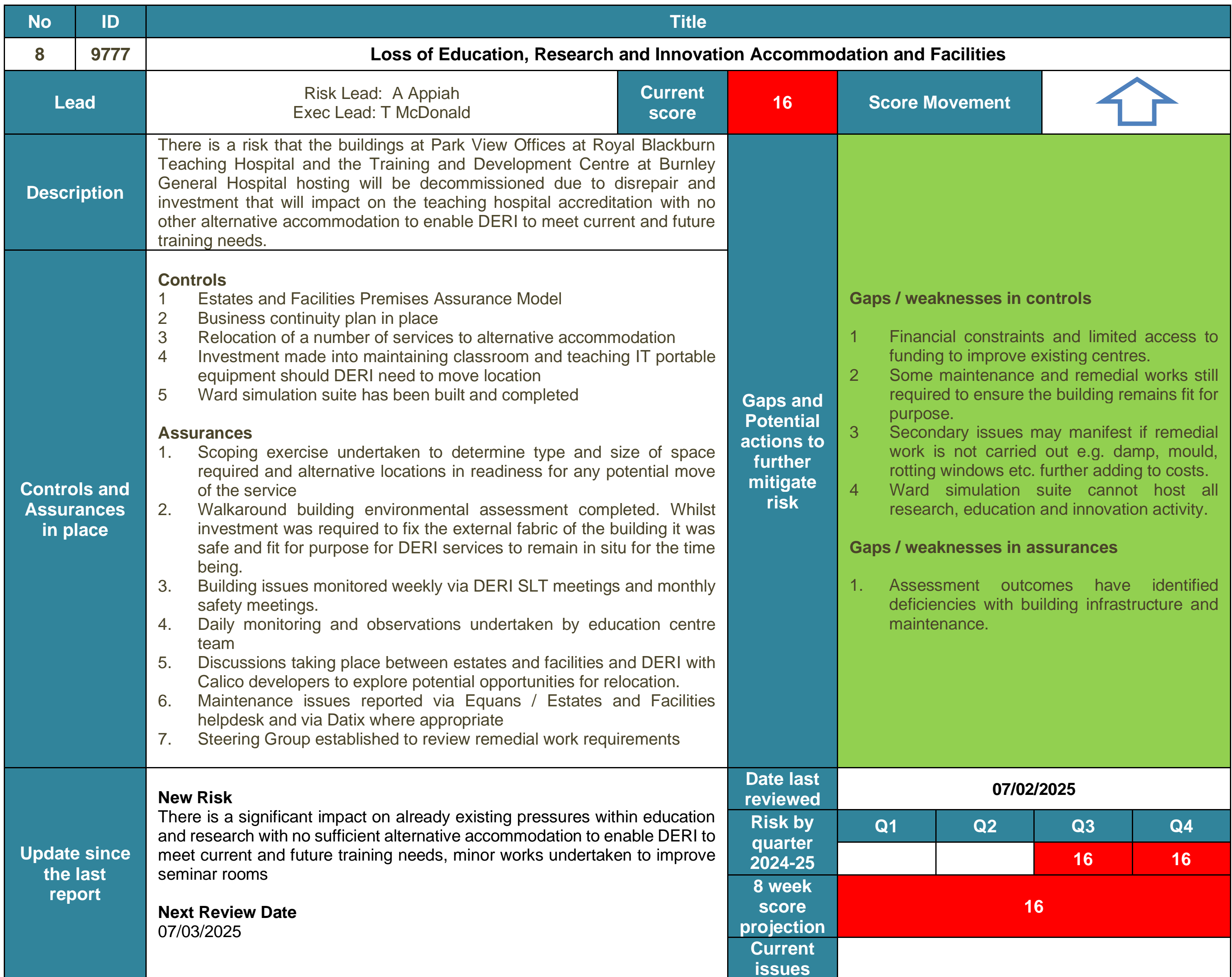
1. No specific Trust policy for the care of mental health patients.
2. Assurance processes not embedded or visible against jointly agreed standards.
3. No specialist input from mental health nurses to ensure appropriate actions are being taken.
4. The mental health liaison meeting is not linked to formal governance arrangements.
5. Compliance against s.136 pathway requirements not visibly reported across the Trust.
6. The LSCFT multi agency oversight group is not linked into formal governance arrangements
7. No access to specialist internal support for adult mental health concerns.
8. No access for staff to undertaken mental health training to support patients and families.
9. Requirements from treat as one documentation are outstanding
10. No formal oversight of ligature risk assessments

Update since the last report

Update 12/02/2025
Risk Reviewed. No change in risk score.
A regular review of incidents is taking place to understand causation and address issues. There has been a 44% reduction in numbers of self-harm incidents compared to the previous financial year to date. Increased resistance from local Trusts to support transfers and absence of formalised pathway. A full review of this risk and internal controls and assurances is being undertaken by the newly appointed mental health nurse which will support mitigation of this risk and a reduced risk score.

Next review date 14/03/2025

Date last reviewed	12/02/2025			
Risk by quarter 2024/25	Q1	Q2	Q3	Q4
	15	15	15	15
8-week score projection	12			
Current issues	System wide influences			

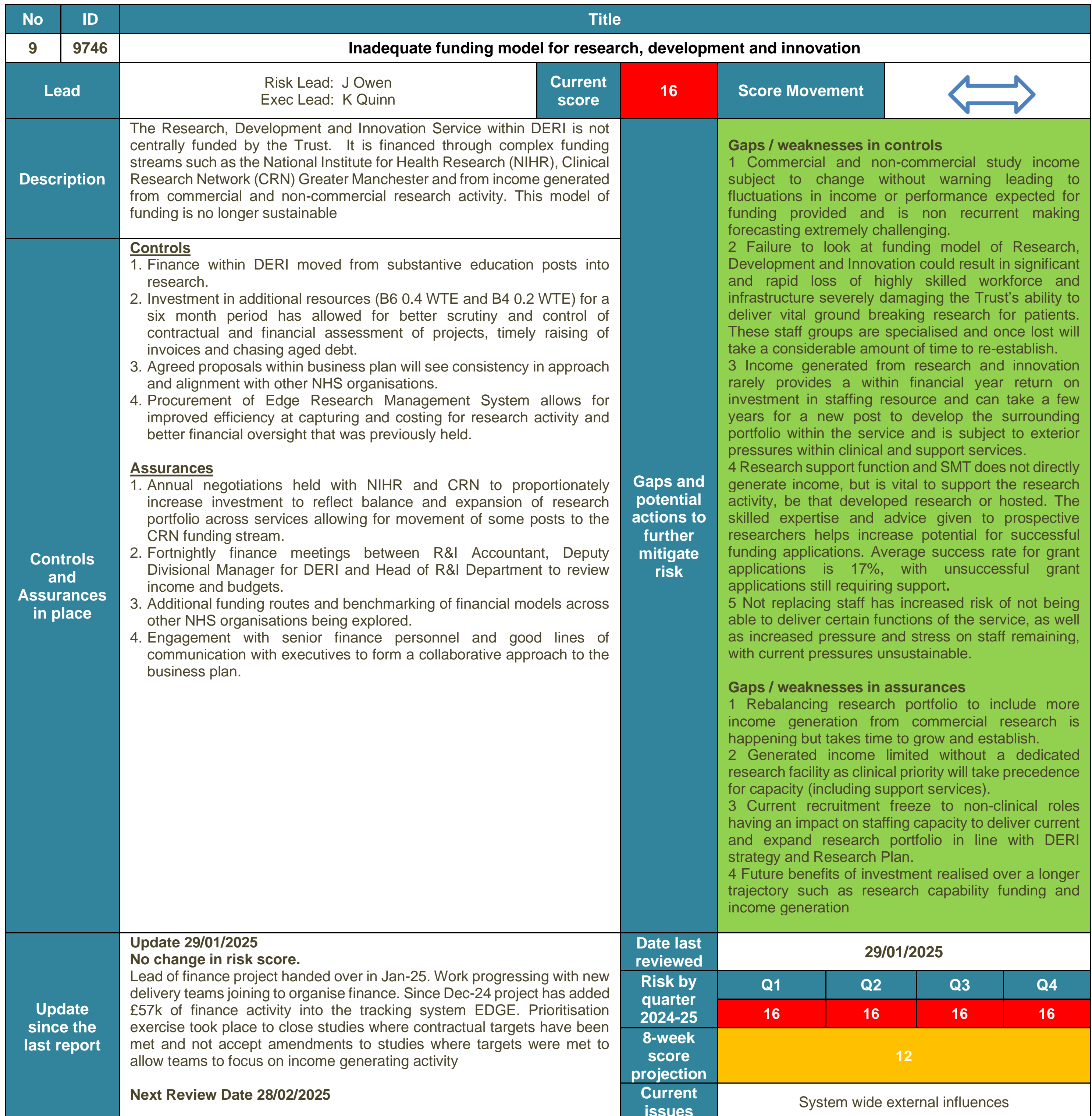


No	ID	Title
8	9777	**Loss of Education, Research and Innovation Accommodation and Facilities**

Lead	Risk Lead: A Appiah Exec Lead: T McDonald	**Current score**	16	**Score Movement**	⇧

Description	There is a risk that the buildings at Park View Offices at Royal Blackburn Teaching Hospital and the Training and Development Centre at Burnley General Hospital hosting will be decommissioned due to disrepair and investment that will impact on the teaching hospital accreditation with no other alternative accommodation to enable DERI to meet current and future training needs.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Financial constraints and limited access to funding to improve existing centres. 2 Some maintenance and remedial works still required to ensure the building remains fit for purpose. 3 Secondary issues may manifest if remedial work is not carried out e.g. damp, mould, rotting windows etc. further adding to costs. 4 Ward simulation suite cannot host all research, education and innovation activity. **Gaps / weaknesses in assurances** 1. Assessment outcomes have identified deficiencies with building infrastructure and maintenance.
Controls and Assurances in place	**Controls** 1 Estates and Facilities Premises Assurance Model 2 Business continuity plan in place 3 Relocation of a number of services to alternative accommodation 4 Investment made into maintaining classroom and teaching IT portable equipment should DERI need to move location 5 Ward simulation suite has been built and completed **Assurances** 1. Scoping exercise undertaken to determine type and size of space required and alternative locations in readiness for any potential move of the service 2. Walkaround building environmental assessment completed. Whilst investment was required to fix the external fabric of the building it was safe and fit for purpose for DERI services to remain in situ for the time being. 3. Building issues monitored weekly via DERI SLT meetings and monthly safety meetings. 4. Daily monitoring and observations undertaken by education centre team 5. Discussions taking place between estates and facilities and DERI with Calico developers to explore potential opportunities for relocation. 6. Maintenance issues reported via Equans / Estates and Facilities helpdesk and via Datix where appropriate 7. Steering Group established to review remedial work requirements		

Update since the last report	**New Risk** There is a significant impact on already existing pressures within education and research with no sufficient alternative accommodation to enable DERI to meet current and future training needs, minor works undertaken to improve seminar rooms **Next Review Date** 07/03/2025	**Date last reviewed**	07/02/2025			
		Risk by quarter 2024-25	Q1	Q2	Q3	Q4
					16	16
		8 week score projection	16			
		Current issues				

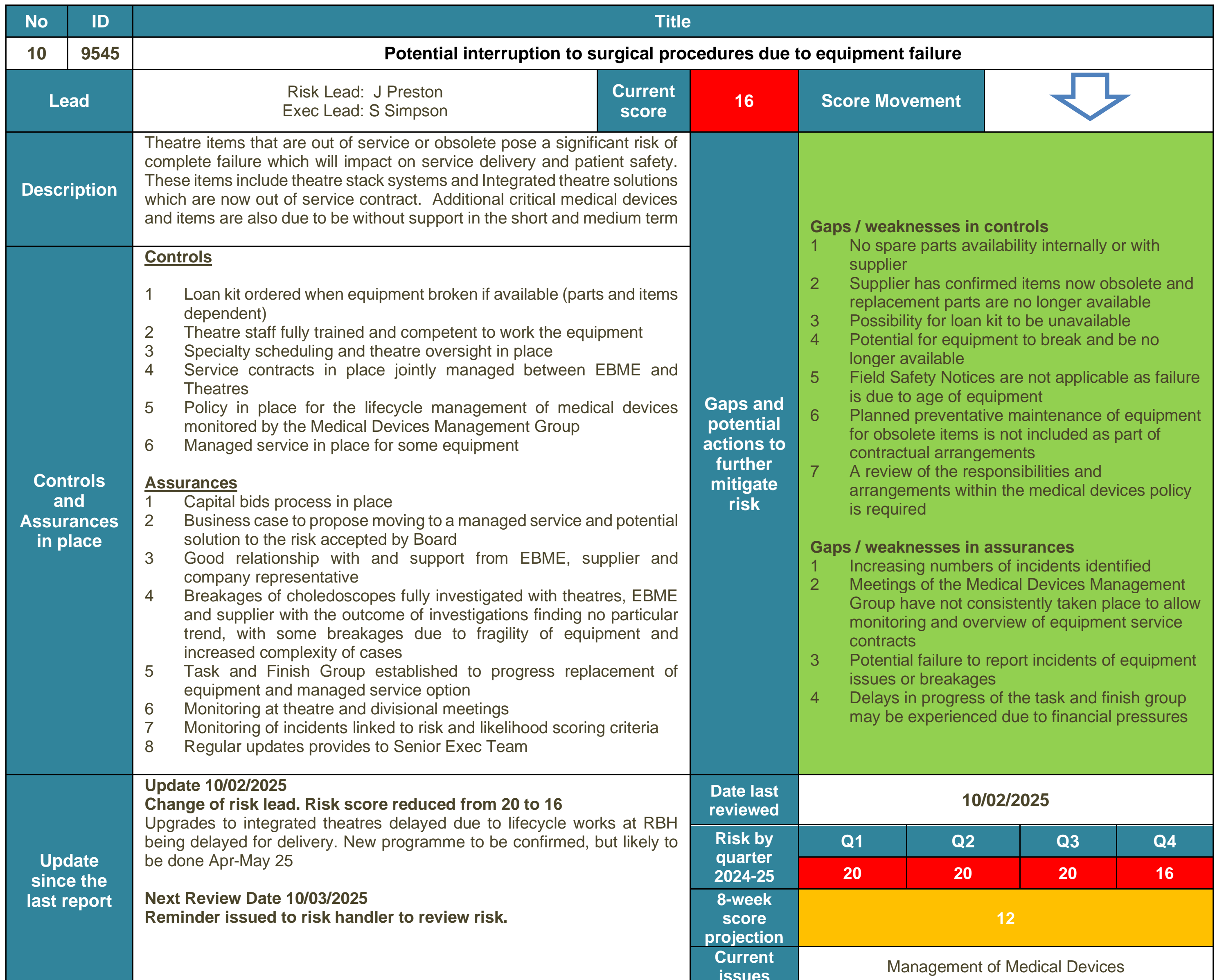


No	ID	Title
9	9746	**Inadequate funding model for research, development and innovation**

Lead	Risk Lead: J Owen Exec Lead: K Quinn	Current score	16	Score Movement	⟺

Description	The Research, Development and Innovation Service within DERI is not centrally funded by the Trust. It is financed through complex funding streams such as the National Institute for Health Research (NIHR), Clinical Research Network (CRN) Greater Manchester and from income generated from commercial and non-commercial research activity. This model of funding is no longer sustainable	**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Commercial and non-commercial study income subject to change without warning leading to fluctuations in income or performance expected for funding provided and is non recurrent making forecasting extremely challenging. 2 Failure to look at funding model of Research, Development and Innovation could result in significant and rapid loss of highly skilled workforce and infrastructure severely damaging the Trust's ability to deliver vital ground breaking research for patients. These staff groups are specialised and once lost will take a considerable amount of time to re-establish. 3 Income generated from research and innovation rarely provides a within financial year return on investment in staffing resource and can take a few years for a new post to develop the surrounding portfolio within the service and is subject to exterior pressures within clinical and support services. 4 Research support function and SMT does not directly generate income, but is vital to support the research activity, be that developed research or hosted. The skilled expertise and advice given to prospective researchers helps increase potential for successful funding applications. Average success rate for grant applications is 17%, with unsuccessful grant applications still requiring support. 5 Not replacing staff has increased risk of not being able to deliver certain functions of the service, as well as increased pressure and stress on staff remaining, with current pressures unsustainable. **Gaps / weaknesses in assurances** 1 Rebalancing research portfolio to include more income generation from commercial research is happening but takes time to grow and establish. 2 Generated income limited without a dedicated research facility as clinical priority will take precedence for capacity (including support services). 3 Current recruitment freeze to non-clinical roles having an impact on staffing capacity to deliver current and expand research portfolio in line with DERI strategy and Research Plan. 4 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 29/01/2025** **No change in risk score.** Lead of finance project handed over in Jan-25. Work progressing with new delivery teams joining to organise finance. Since Dec-24 project has added £57k of finance activity into the tracking system EDGE. Prioritisation exercise took place to close studies where contractual targets have been met and not accept amendments to studies where targets were met to allow teams to focus on income generating activity **Next Review Date 28/02/2025**	**Date last reviewed**	**29/01/2025**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			16	16	16	16
		8-week score projection	12			
		Current issues	System wide external influences			



No	ID	Title
10	9545	**Potential interruption to surgical procedures due to equipment failure**

Lead	Risk Lead: J Preston Exec Lead: S Simpson	Current score	16	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

Controls and Assurances in place

<u>Controls</u>

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
6 Managed service in place for some equipment

<u>Assurances</u>

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 provides to Senior Exec Team

Gaps and potential actions to further mitigate risk

Gaps / weaknesses in controls

1 No spare parts availability internally or with supplier
2 Supplier has confirmed items now obsolete and replacement parts are no longer available
3 Possibility for loan kit to be unavailable
4 Potential for equipment to break and be no longer available
5 Field Safety Notices are not applicable as failure is due to age of equipment
6 Planned preventative maintenance of equipment for obsolete items is not included as part of contractual arrangements
7 A review of the responsibilities and arrangements within the medical devices policy is required

Gaps / weaknesses in assurances

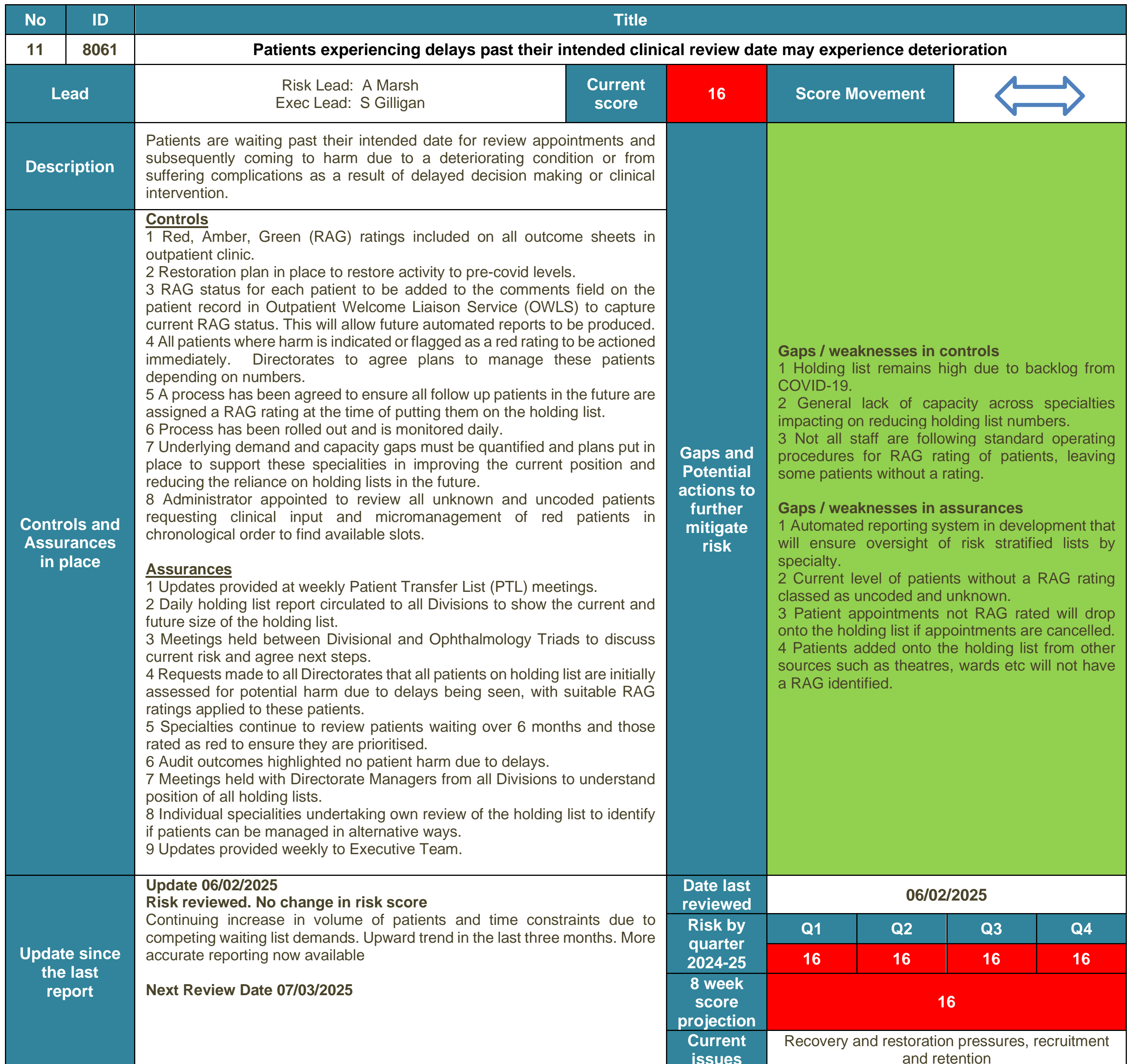
1 Increasing numbers of incidents identified
2 Meetings of the Medical Devices Management Group have not consistently taken place to allow monitoring and overview of equipment service contracts
3 Potential failure to report incidents of equipment issues or breakages
4 Delays in progress of the task and finish group may be experienced due to financial pressures

Update since the last report

Update 10/02/2025
Change of risk lead. Risk score reduced from 20 to 16
Upgrades to integrated theatres delayed due to lifecycle works at RBH being delayed for delivery. New programme to be confirmed, but likely to be done Apr-May 25

Next Review Date 10/03/2025
Reminder issued to risk handler to review risk.

Date last reviewed	10/02/2025			
Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	20	20	20	16
8-week score projection	12			
Current issues	Management of Medical Devices			

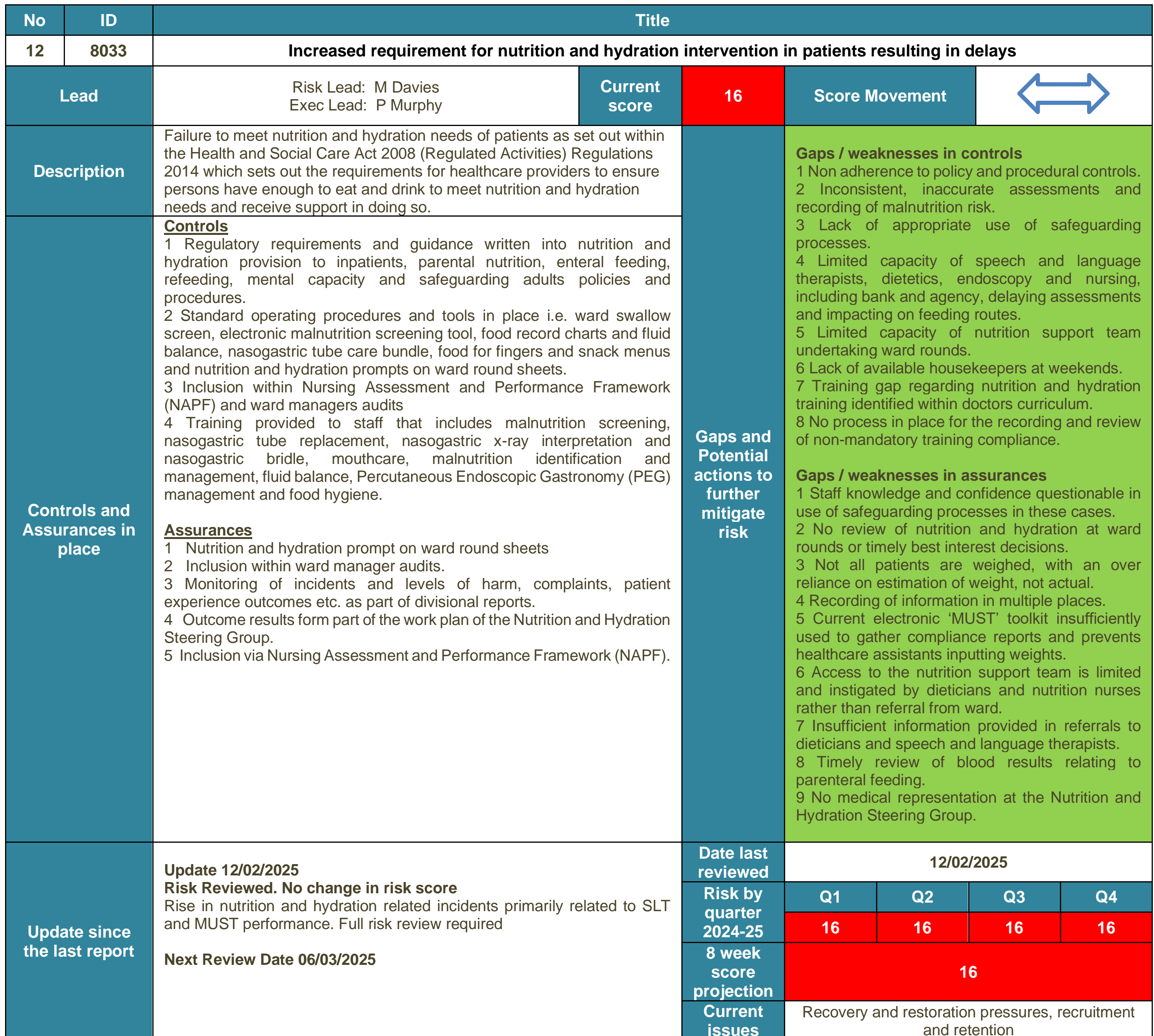


No	ID	Title
11	8061	**Patients experiencing delays past their intended clinical review date may experience deterioration**

Lead	Risk Lead: A Marsh Exec Lead: S 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**	**Gaps / weaknesses in controls** 1 Holding list remains high due to backlog from COVID-19. 2 General lack of capacity across specialties impacting on reducing holding list numbers. 3 Not all staff are following standard operating procedures for RAG rating of patients, leaving some patients without a rating. **Gaps / weaknesses in assurances** 1 Automated reporting system in development that will ensure oversight of risk stratified lists by specialty. 2 Current level of patients without a RAG rating classed as uncoded and unknown. 3 Patient appointments not RAG rated will drop onto the holding list if appointments are cancelled. 4 Patients added onto the holding list from other sources such as theatres, wards etc will not have a RAG identified.
Controls and Assurances in place	**Controls** 1 Red, Amber, Green (RAG) ratings included on all outcome sheets in outpatient clinic. 2 Restoration plan in place to restore activity to pre-covid levels. 3 RAG status for each patient to be added to the comments field on the patient record in Outpatient Welcome Liaison Service (OWLS) to capture current RAG status. This will allow future automated reports to be produced. 4 All patients where harm is indicated or flagged as a red rating to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers. 5 A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at the time of putting them on the holding list. 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.		

Update since the last report	**Update 06/02/2025** **Risk reviewed. No change in risk score** Continuing increase in volume of patients and time constraints due to competing waiting list demands. Upward trend in the last three months. More accurate reporting now available **Next Review Date 07/03/2025**	**Date last reviewed**	06/02/2025			
		Risk by quarter 2024-25	Q1	Q2	Q3	Q4
			16	16	16	16
		8 week score projection	16			
		Current issues	Recovery and restoration pressures, recruitment and retention			



No	ID	Title
12	8033	**Increased requirement for nutrition and hydration intervention in patients resulting in delays**

Lead	Risk Lead: M Davies Exec Lead: P 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 12/02/2025** **Risk Reviewed. No change in risk score** Rise in nutrition and hydration related incidents primarily related to SLT and MUST performance. Full risk review required **Next Review Date 06/03/2025**

Date last reviewed	12/02/2025			
Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	16	16	16	16
8 week score projection	16			
Current issues	Recovery and restoration pressures, recruitment and retention			

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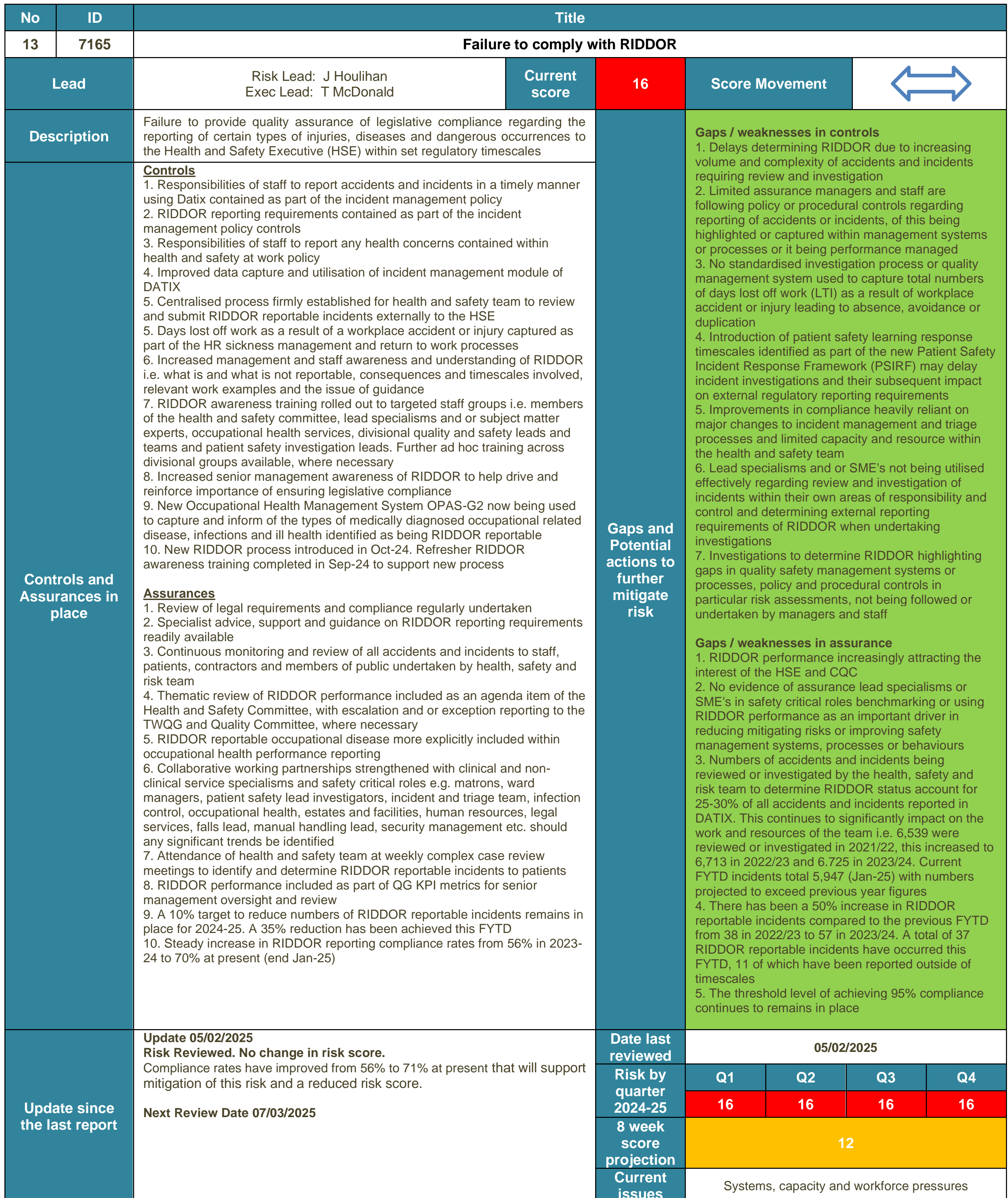

No	ID	Title
13	7165	**Failure to comply with RIDDOR**

Lead		Current score		Score Movement	
Lead	Risk Lead: J Houlihan Exec Lead: T 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. Responsibilities of staff to report accidents and incidents in a timely manner using Datix contained as part of the incident management policy
2. RIDDOR reporting requirements contained as part of the incident management policy controls
3. Responsibilities of staff to report any health concerns contained within health and safety at work policy
4. Improved data capture and utilisation of incident management module of DATIX
5. Centralised process firmly established for 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 HR 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 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 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
10. New RIDDOR process introduced in Oct-24. Refresher RIDDOR awareness training completed in Sep-24 to support new process

Assurances
1. Review of legal requirements and compliance regularly undertaken
2. Specialist advice, support and guidance on RIDDOR reporting requirements readily available
3. Continuous monitoring and review of all accidents and incidents to staff, patients, contractors and members of public undertaken by health, safety and risk team
4. Thematic review of RIDDOR performance included as an agenda item of the Health and Safety Committee, with escalation and or exception reporting to the TWQG and 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 identify and determine RIDDOR reportable incidents to patients
8. RIDDOR performance included as part of QG KPI metrics for senior management oversight and review
9. A 10% target to reduce numbers of RIDDOR reportable incidents remains in place for 2024-25. A 35% reduction has been achieved this FYTD
10. Steady increase in RIDDOR reporting compliance rates from 56% in 2023-24 to 70% at present (end Jan-25)

Gaps and Potential actions to further mitigate risk

Gaps / weaknesses in controls
1. Delays determining RIDDOR due to increasing volume and complexity of accidents and incidents requiring review and investigation
2. Limited assurance managers and staff are following policy or procedural controls regarding reporting of accidents or 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 numbers of days lost off work (LTI) as a result of workplace accident or injury leading to absence, avoidance or duplication
4. Introduction of patient safety learning response timescales identified as part of the new Patient Safety Incident Response Framework (PSIRF) may delay incident investigations and their subsequent impact on external regulatory reporting requirements
5. Improvements in compliance heavily reliant on major changes to incident management and triage processes and limited capacity and resource within the health and safety team
6. Lead specialisms and or SME's not being utilised effectively regarding review and investigation of incidents within their own areas of responsibility and control and determining external reporting requirements of RIDDOR when undertaking investigations
7. Investigations to determine RIDDOR highlighting gaps in quality safety management systems or processes, policy and procedural controls in particular risk assessments, not being followed or undertaken by managers and staff

Gaps / weaknesses in assurance
1. RIDDOR performance increasingly attracting the interest of the HSE and CQC
2. No evidence of assurance lead specialisms or SME's in safety critical roles benchmarking or using RIDDOR performance as an important driver in reducing mitigating risks or improving safety management systems, processes or behaviours
3. Numbers of accidents and incidents being reviewed or investigated by the health, safety and risk team to determine RIDDOR status account for 25-30% of all accidents and incidents reported in DATIX. This continues to significantly impact on the work and resources of the team i.e. 6,539 were reviewed or investigated in 2021/22, this increased to 6,713 in 2022/23 and 6.725 in 2023/24. Current FYTD incidents total 5,947 (Jan-25) with numbers projected to exceed previous year figures
4. There has been a 50% increase in RIDDOR reportable incidents compared to the previous FYTD from 38 in 2022/23 to 57 in 2023/24. A total of 37 RIDDOR reportable incidents have occurred this FYTD, 11 of which have been reported outside of timescales
5. The threshold level of achieving 95% compliance continues to remains in place

Update since the last report

Update 05/02/2025
Risk Reviewed. No change in risk score.
Compliance rates have improved from 56% to 71% at present that will support mitigation of this risk and a reduced risk score.

Next Review Date 07/03/2025

Date last reviewed	05/02/2025			
Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	16	16	16	16
8 week score projection	12			
Current issues	Systems, capacity and workforce pressures			

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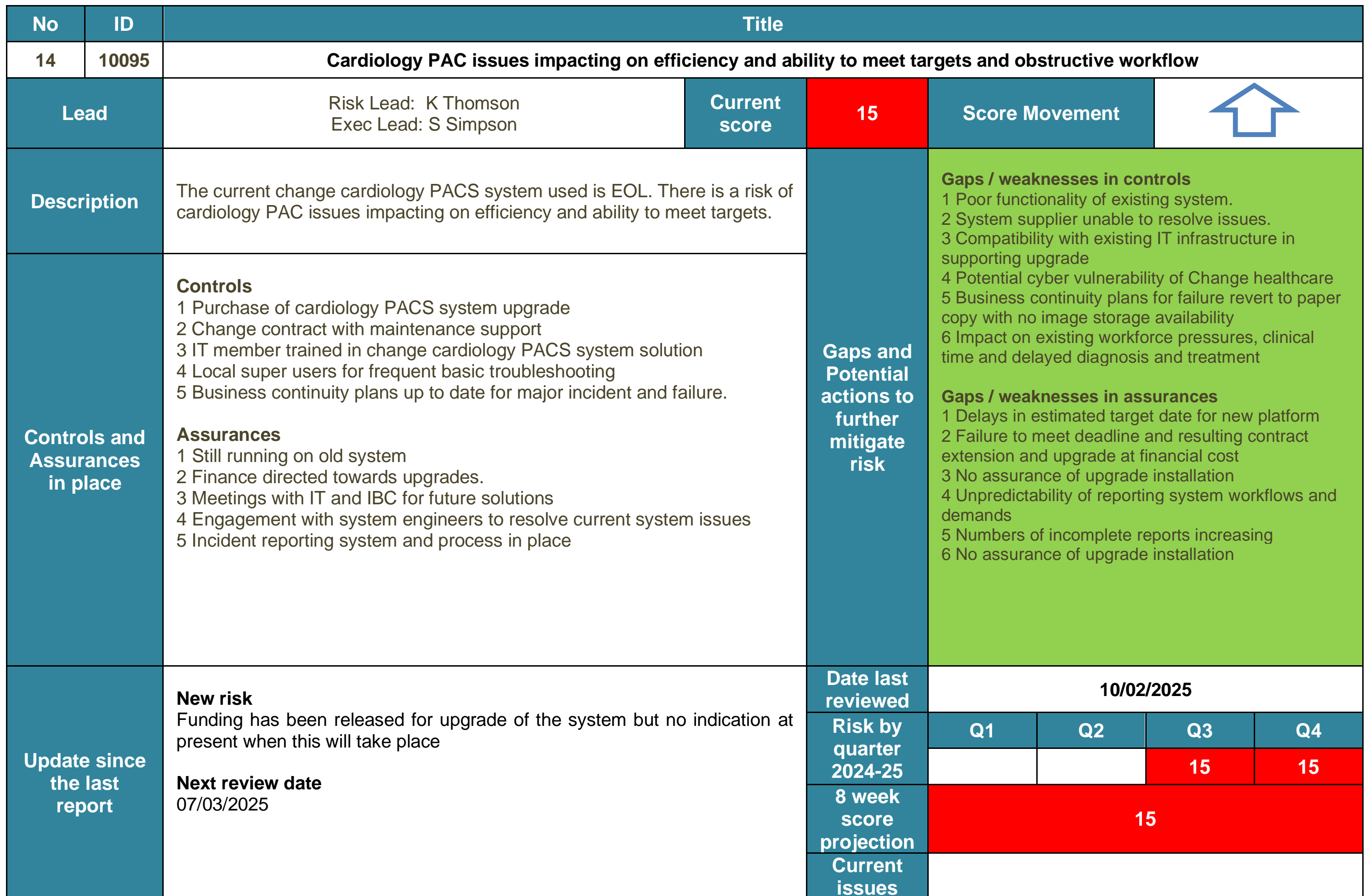
Retain 30 years
Destroy in conjunction with National Archive Instructions

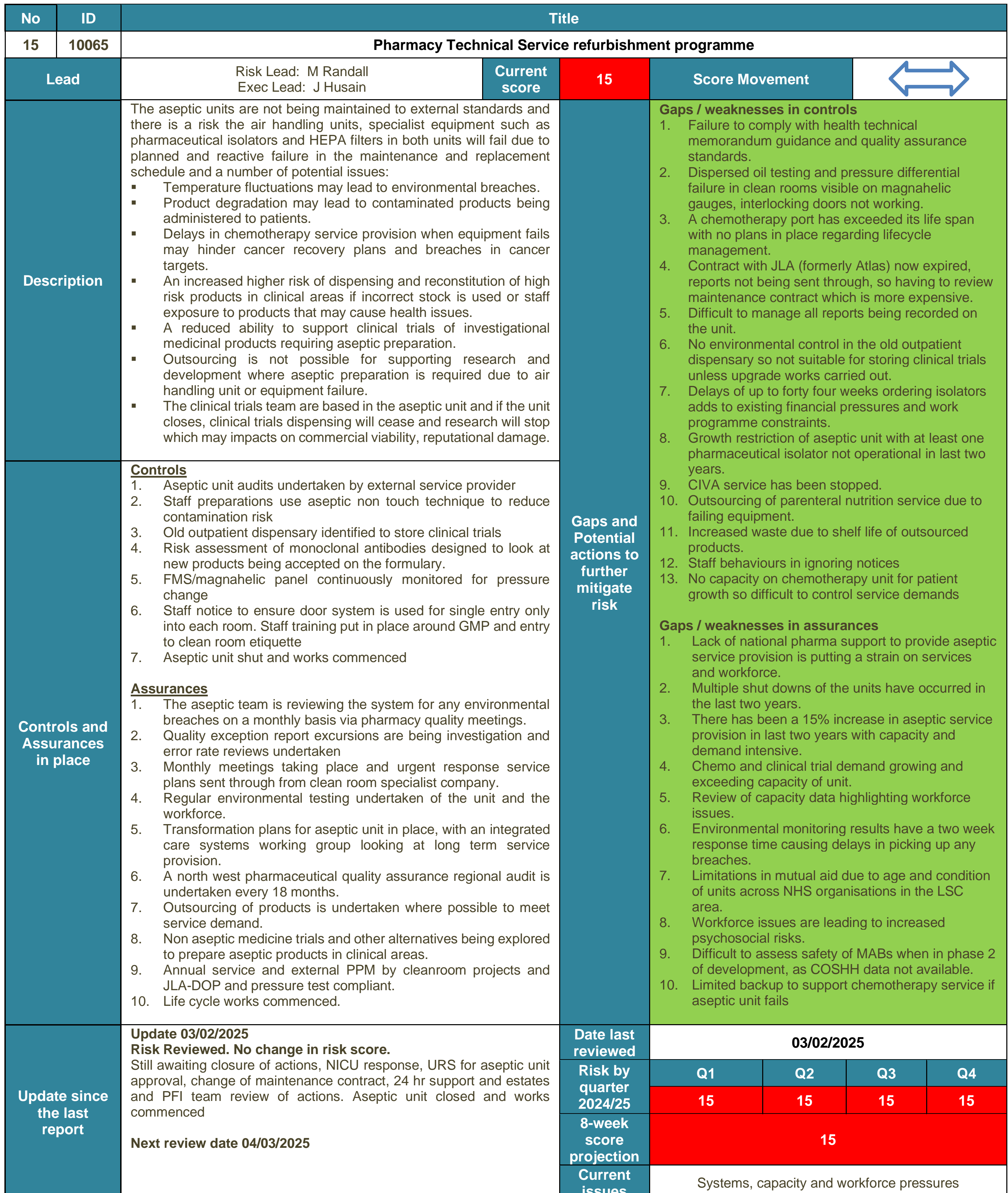


No	ID	Title
14	10095	**Cardiology PAC issues impacting on efficiency and ability to meet targets and obstructive workflow**

Lead	Risk Lead: K Thomson Exec Lead: S Simpson	Current score	15	Score Movement	⇧

Description	The current change cardiology PACS system used is EOL. There is a risk of cardiology PAC issues impacting on efficiency and ability to meet targets.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Poor functionality of existing system. 2 System supplier unable to resolve issues. 3 Compatibility with existing IT infrastructure in supporting upgrade 4 Potential cyber vulnerability of Change healthcare 5 Business continuity plans for failure revert to paper copy with no image storage availability 6 Impact on existing workforce pressures, clinical time and delayed diagnosis and treatment **Gaps / weaknesses in assurances** 1 Delays in estimated target date for new platform 2 Failure to meet deadline and resulting contract extension and upgrade at financial cost 3 No assurance of upgrade installation 4 Unpredictability of reporting system workflows and demands 5 Numbers of incomplete reports increasing 6 No assurance of upgrade installation
Controls and Assurances in place	**Controls** 1 Purchase of cardiology PACS system upgrade 2 Change contract with maintenance support 3 IT member trained in change cardiology PACS system solution 4 Local super users for frequent basic troubleshooting 5 Business continuity plans up to date for major incident and failure. **Assurances** 1 Still running on old system 2 Finance directed towards upgrades. 3 Meetings with IT and IBC for future solutions 4 Engagement with system engineers to resolve current system issues 5 Incident reporting system and process in place		

Update since the last report					
New risk Funding has been released for upgrade of the system but no indication at present when this will take place **Next review date** 07/03/2025	Date last reviewed	10/02/2025			
	Risk by quarter 2024-25	Q1	Q2	Q3	Q4
				15	15
	8 week score projection	15			
	Current issues				



No	ID	Title
15	10065	**Pharmacy Technical Service refurbishment programme**

Lead	Risk Lead: M Randall Exec Lead: J 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.

Controls and Assurances in place

Controls

1. Aseptic unit audits undertaken by external service provider
2. Staff preparations use aseptic non touch technique to reduce contamination risk
3. Old outpatient dispensary identified to store clinical trials
4. Risk assessment of monoclonal antibodies designed to look at new products being accepted on the formulary.
5. FMS/magnahelic panel continuously monitored for pressure change
6. Staff notice to ensure door system is used for single entry only into each room. Staff training put in place around GMP and entry to clean room etiquette
7. Aseptic unit shut and works commenced

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.
9. Annual service and external PPM by cleanroom projects and JLA-DOP and pressure test compliant.
10. Life cycle works commenced.

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.
12. Staff behaviours in ignoring notices
13. No capacity on chemotherapy unit for patient growth so difficult to control service demands

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. There has been a 15% increase in aseptic service provision in last two years with capacity and demand intensive.
4. Chemo and clinical trial demand growing and exceeding capacity of unit.
5. Review of capacity data highlighting workforce issues.
6. Environmental monitoring results have a two week response time causing delays in picking up any breaches.
7. Limitations in mutual aid due to age and condition of units across NHS organisations in the LSC area.
8. Workforce issues are leading to increased psychosocial risks.
9. Difficult to assess safety of MABs when in phase 2 of development, as COSHH data not available.
10. Limited backup to support chemotherapy service if aseptic unit fails

Update since the last report

Update 03/02/2025
Risk Reviewed. No change in risk score.
Still awaiting closure of actions, NICU response, URS for aseptic unit approval, change of maintenance contract, 24 hr support and estates and PFI team review of actions. Aseptic unit closed and works commenced

Next review date 04/03/2025

Date last reviewed	03/02/2025			
Risk by quarter 2024/25	Q1	Q2	Q3	Q4
	15	15	15	15
8-week score projection	15			
Current issues	Systems, capacity and workforce pressures			

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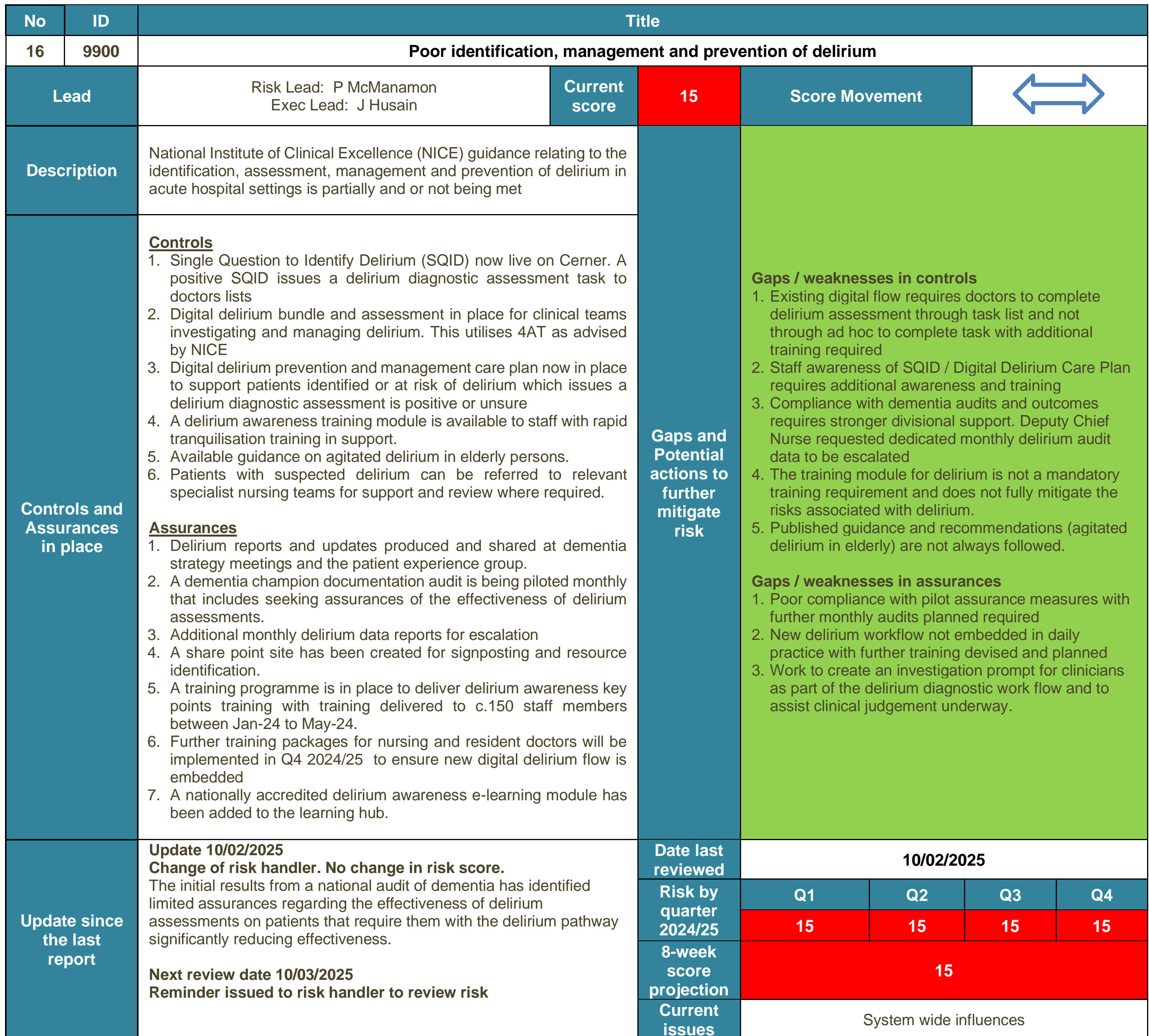

No	ID	Title
16	9900	**Poor identification, management and prevention of delirium**

Lead	Risk Lead: P McManamon Exec Lead: J 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	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Existing digital flow requires doctors to complete delirium assessment through task list and not through ad hoc to complete task with additional training required 2. Staff awareness of SQID / Digital Delirium Care Plan requires additional awareness and training 3. Compliance with dementia audits and outcomes requires stronger divisional support. Deputy Chief Nurse requested dedicated monthly delirium audit data to be escalated 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 with further monthly audits planned required 2. New delirium workflow not embedded in daily practice with further training devised and planned 3. Work to create an investigation prompt for clinicians as part of the delirium diagnostic work flow and to assist clinical judgement underway.
Controls and Assurances in place	**Controls** 1. Single Question to Identify Delirium (SQID) now live on Cerner. A positive SQID issues a delirium diagnostic assessment task to doctors lists 2. Digital delirium bundle and assessment in place for clinical teams investigating and managing delirium. This utilises 4AT as advised by NICE 3. Digital delirium prevention and management care plan now in place to support patients identified or at risk of delirium which issues a delirium diagnostic assessment is positive or unsure 4. A delirium awareness training module is available to staff with rapid tranquilisation training in support. 5. Available guidance on agitated delirium in elderly persons. 6. 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. A dementia champion documentation audit is being piloted monthly that includes seeking assurances of the effectiveness of delirium assessments. 3. Additional monthly delirium data reports for escalation 4. A share point site has been created for signposting and resource identification. 5. A training programme is in place to deliver delirium awareness key points training with training delivered to c.150 staff members between Jan-24 to May-24. 6. Further training packages for nursing and resident doctors will be implemented in Q4 2024/25 to ensure new digital delirium flow is embedded 7. A nationally accredited delirium awareness e-learning module has been added to the learning hub.		

Update since the last report	**Update 10/02/2025** **Change of risk handler. 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. **Next review date 10/03/2025** **Reminder issued to risk handler to review risk**	**Date last reviewed**	**10/02/2025**			
		Risk by quarter 2024/25	Q1	Q2	Q3	Q4
			15	15	15	15
		8-week score projection	15			
		Current issues	System wide influences			

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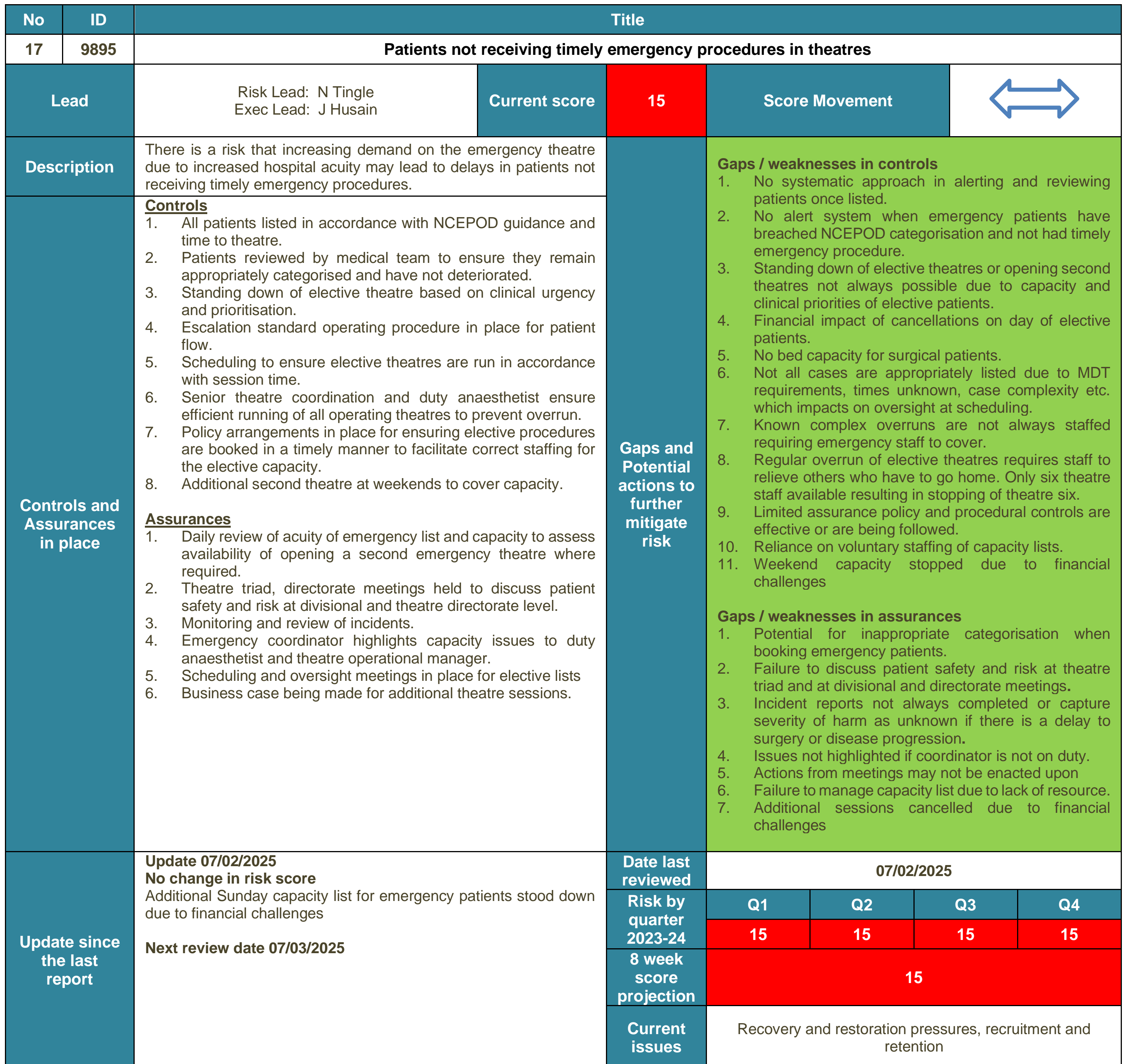
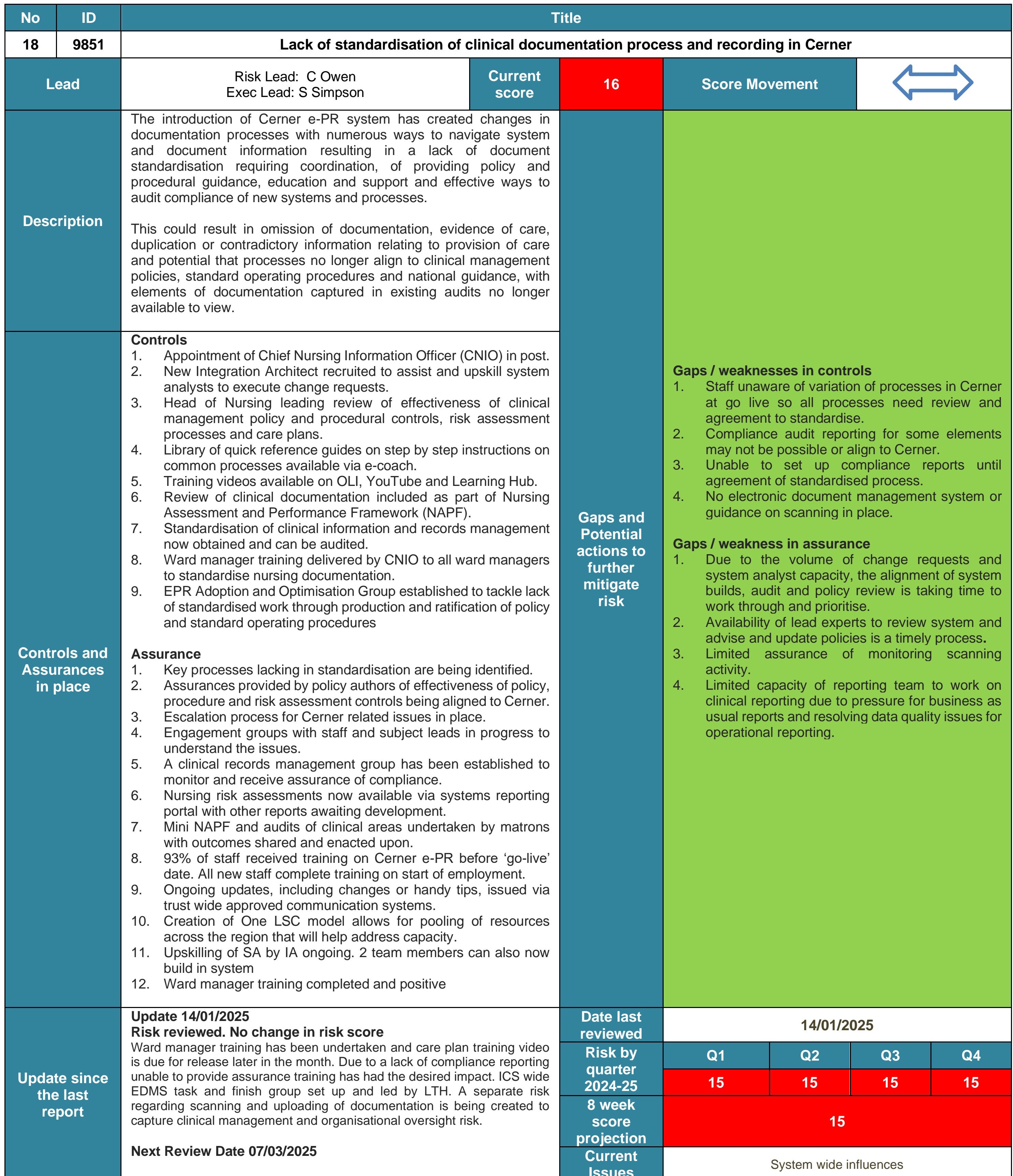


No	ID	Title
17	9895	**Patients not receiving timely emergency procedures in theatres**

Lead	Risk Lead: N Tingle Exec Lead: J 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. 11. Weekend capacity stopped due to financial challenges **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. 7. Additional sessions cancelled due to financial challenges
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 07/02/2025** **No change in risk score** Additional Sunday capacity list for emergency patients stood down due to financial challenges **Next review date 07/03/2025**	**Date last reviewed**	07/02/2025			
		Risk by quarter 2023-24	Q1	Q2	Q3	Q4
			15	15	15	15
		8 week score projection	15			
		Current issues	Recovery and restoration pressures, recruitment and retention			



No	ID	Title
18	9851	**Lack of standardisation of clinical documentation process and recording in Cerner**

Lead	Risk Lead: C Owen Exec Lead: S Simpson	Current score	16	Score Movement	⟺

Description

The introduction of Cerner e-PR system has created changes in documentation processes with numerous ways to navigate system and document information resulting in a lack of document standardisation requiring coordination, of providing policy and procedural guidance, education and support and effective ways to audit compliance of new systems and processes.

This could result in omission of documentation, evidence of care, duplication or contradictory information relating to 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.

Controls and Assurances in place

Controls

1. Appointment of Chief Nursing Information Officer (CNIO) in post.
2. New Integration Architect recruited to assist and upskill system analysts to execute change requests.
3. Head of Nursing leading review of 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 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.
8. Ward manager training delivered by CNIO to all ward managers to standardise nursing documentation.
9. EPR Adoption and Optimisation Group established to tackle lack of standardised work through production and ratification of policy and standard operating procedures

Assurance

1. Key processes lacking in standardisation are being identified.
2. Assurances provided by policy authors of effectiveness of policy, procedure 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 received training on Cerner e-PR before 'go-live' date. All new staff complete training on start 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.
11. Upskilling of SA by IA ongoing. 2 team members can also now build in system
12. Ward manager training completed and positive

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.

Update since the last report

Update 14/01/2025
Risk reviewed. No change in risk score
Ward manager training has been undertaken and care plan training video is due for release later in the month. Due to a lack of compliance reporting unable to provide assurance training has had the desired impact. ICS wide EDMS task and finish group set up and led by LTH. A separate risk regarding scanning and uploading of documentation is being created to capture clinical management and organisational oversight risk.

Next Review Date 07/03/2025

Date last reviewed	14/01/2025			
Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	15	15	15	15
8 week score projection	15			
Current Issues	System wide influences			

No	ID	Title
19	9653	**Increased demand with a lack of capacity within ELHT can lead to extreme pressure**

Lead	Risk Lead: J Dean Exec Lead: P Murphy	Current score	16	Score Movement	⟺

Description

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. Ward area risk assessments in place and reviewed where escalation bed space is to be opened.
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 beds 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. 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.
10. When appropriate patients cannot be sourced to fill a surge trolley and the Trust is under extreme pressures and requires this capacity, beds will be utilised in the surge spaces as appropriate to maximise the use of these areas and increase overall capacity on the wards across MEC and SAS

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 17/01/2025
Risk reviewed. No change in risk score.
Difficulties in sourcing appropriate patients at times of extreme pressure to be nursed on trolleys as a surge patient on the ward. SAS have reviewed this position and have sourced beds to allocate patients onto instead of surge trolleys to maximise the use of these areas. This does reduce space between these two bed and has been risk assessed.

Next Review Date 07/02/2025

Date last reviewed	17/01/2025			
Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	15	15	15	15
8 week score projection	15			
Current Issues	System wide influences			

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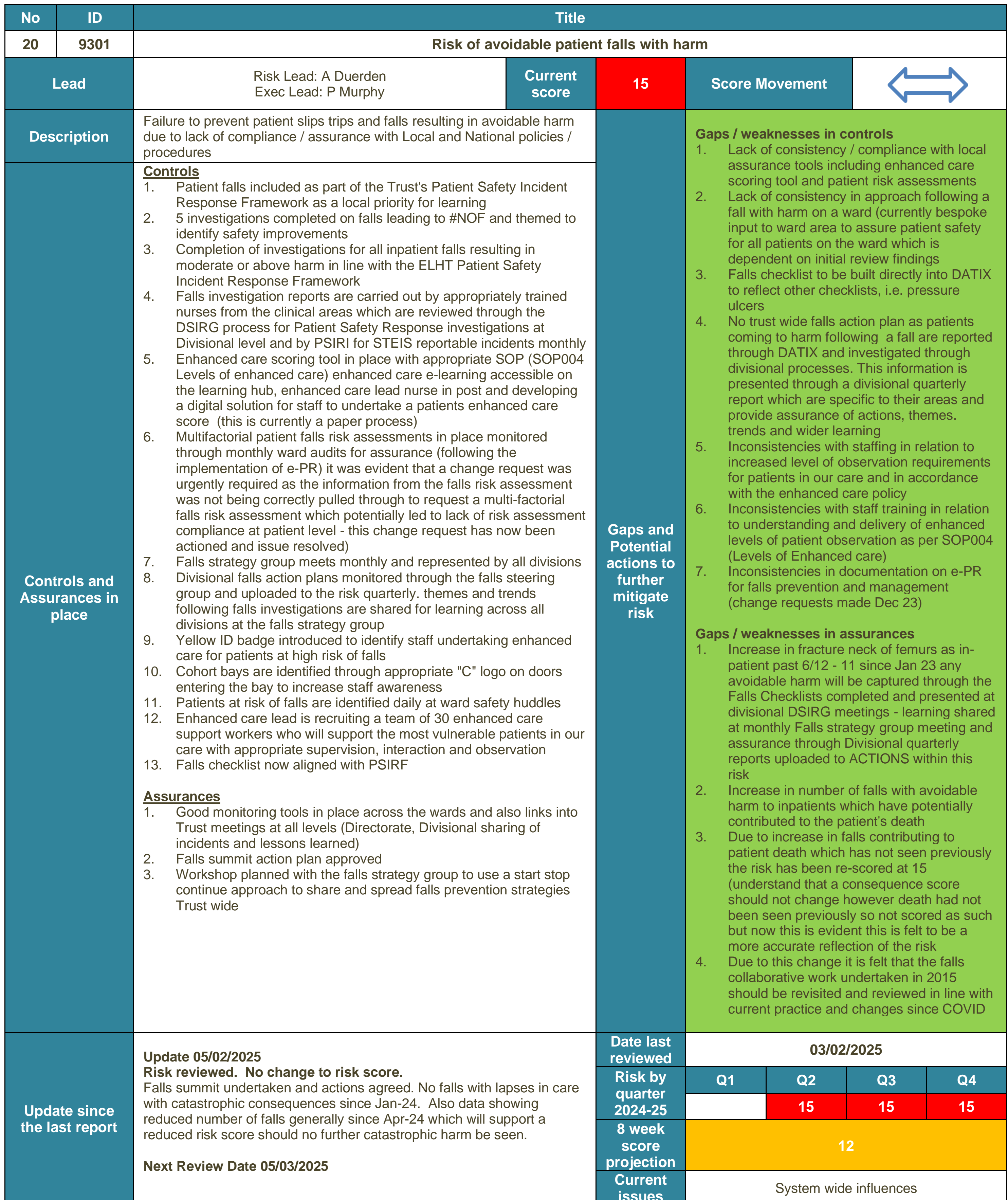


No	ID	Title
20	9301	**Risk of avoidable patient falls with harm**

Lead	Risk Lead: A Duerden Exec Lead: P 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 e-PR) 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. Workshop 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

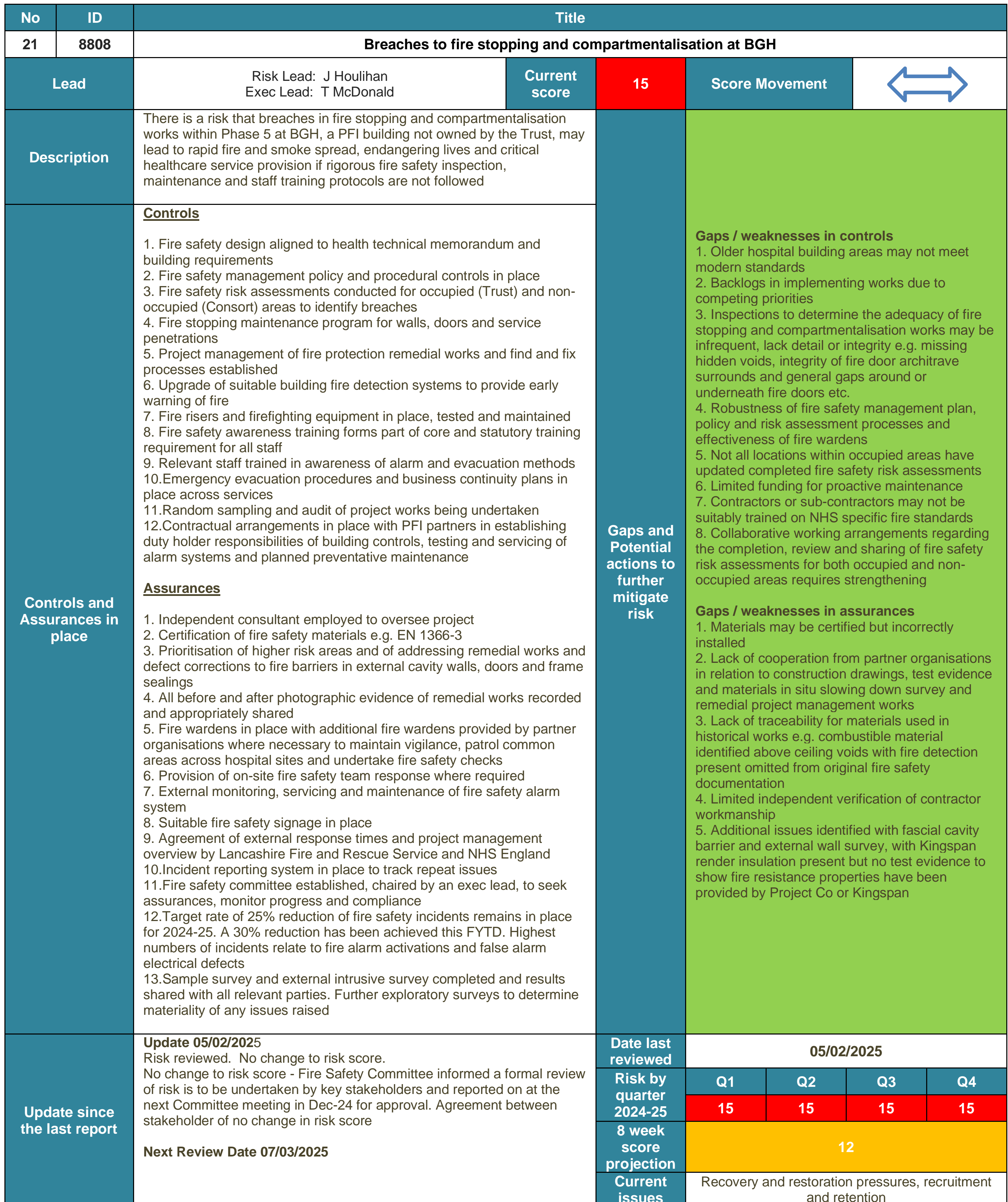
Update since the last report

Update 05/02/2025
Risk reviewed. No change to risk score.
Falls summit undertaken and actions agreed. No falls with lapses in care with catastrophic consequences since Jan-24. Also data showing reduced number of falls generally since Apr-24 which will support a reduced risk score should no further catastrophic harm be seen.

Next Review Date 05/03/2025

Date last reviewed	03/02/2025			
Risk by quarter 2024-25	Q1	Q2	Q3	Q4
		15	15	15
8 week score projection	12			
Current issues	System wide influences			

Safe | Personal | Effective



No	ID	Title
21	8808	**Breaches to fire stopping and compartmentalisation at BGH**

Lead	Risk Lead: J Houlihan Exec Lead: T McDonald	Current score	15	Score Movement	⇔

Description	There is a risk that breaches in fire stopping and compartmentalisation works within Phase 5 at BGH, a PFI building not owned by the Trust, may lead to rapid fire and smoke spread, endangering lives and critical healthcare service provision if rigorous fire safety inspection, maintenance and staff training protocols are not followed
Controls and Assurances in place	**Controls** 1. Fire safety design aligned to health technical memorandum and building requirements 2. Fire safety management policy and procedural controls in place 3. Fire safety risk assessments conducted for occupied (Trust) and non-occupied (Consort) areas to identify breaches 4. Fire stopping maintenance program for walls, doors and service penetrations 5. Project management of fire protection remedial works and find and fix processes established 6. Upgrade of suitable building fire detection systems to provide early warning of fire 7. Fire risers and firefighting equipment in place, tested and maintained 8. Fire safety awareness training forms part of core and statutory training requirement for all staff 9. Relevant staff trained in awareness of alarm and evacuation methods 10.Emergency evacuation procedures and business continuity plans in place across services 11.Random sampling and audit of project works being undertaken 12.Contractual arrangements in place with PFI partners in establishing duty holder responsibilities of building controls, testing and servicing of alarm systems and planned preventative maintenance **Assurances** 1. Independent consultant employed to oversee project 2. Certification of fire safety materials e.g. EN 1366-3 3. Prioritisation of higher risk areas and of addressing remedial works and defect corrections to fire barriers in external cavity walls, doors and frame sealings 4. All before and after photographic evidence of remedial works recorded and appropriately shared 5. Fire wardens in place with additional fire wardens provided by partner organisations where necessary to maintain vigilance, patrol common areas across hospital sites and undertake fire safety checks 6. Provision of on-site fire safety team response where required 7. External monitoring, servicing and maintenance of fire safety alarm system 8. Suitable fire safety signage in place 9. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England 10.Incident reporting system in place to track repeat issues 11.Fire safety committee established, chaired by an exec lead, to seek assurances, monitor progress and compliance 12.Target rate of 25% reduction of fire safety incidents remains in place for 2024-25. A 30% reduction has been achieved this FYTD. Highest numbers of incidents relate to fire alarm activations and false alarm electrical defects 13.Sample survey and external intrusive survey completed and results shared with all relevant parties. Further exploratory surveys to determine materiality of any issues raised
Gaps and Potential actions to further mitigate risk	**Gaps / weaknesses in controls** 1. Older hospital building areas may not meet modern standards 2. Backlogs in implementing works due to competing priorities 3. Inspections to determine the adequacy of fire stopping and compartmentalisation works may be infrequent, lack detail or integrity e.g. missing hidden voids, integrity of fire door architrave surrounds and general gaps around or underneath fire doors etc. 4. Robustness of fire safety management plan, policy and risk assessment processes and effectiveness of fire wardens 5. Not all locations within occupied areas have updated completed fire safety risk assessments 6. Limited funding for proactive maintenance 7. Contractors or sub-contractors may not be suitably trained on NHS specific fire standards 8. Collaborative working arrangements regarding the completion, review and sharing of fire safety risk assessments for both occupied and non-occupied areas requires strengthening **Gaps / weaknesses in assurances** 1. Materials may be certified but incorrectly installed 2. Lack of cooperation from partner organisations in relation to construction drawings, test evidence and materials in situ slowing down survey and remedial project management works 3. Lack of traceability for materials used in historical works e.g. combustible material identified above ceiling voids with fire detection present omitted from original fire safety documentation 4. Limited independent verification of contractor workmanship 5. Additional issues identified with fascial cavity barrier and external wall survey, with Kingspan render insulation present but no test evidence to show fire resistance properties have been provided by Project Co or Kingspan
Update since the last report	**Update 05/02/2025** Risk reviewed. No change to risk score. No change to risk score - Fire Safety Committee informed a formal review of risk is to be undertaken by key stakeholders and reported on at the next Committee meeting in Dec-24 for approval. Agreement between stakeholder of no change in risk score **Next Review Date 07/03/2025**

Date last reviewed	05/02/2025			
Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	15	15	15	15
8 week score projection	12			
Current issues	Recovery and restoration pressures, recruitment and retention			

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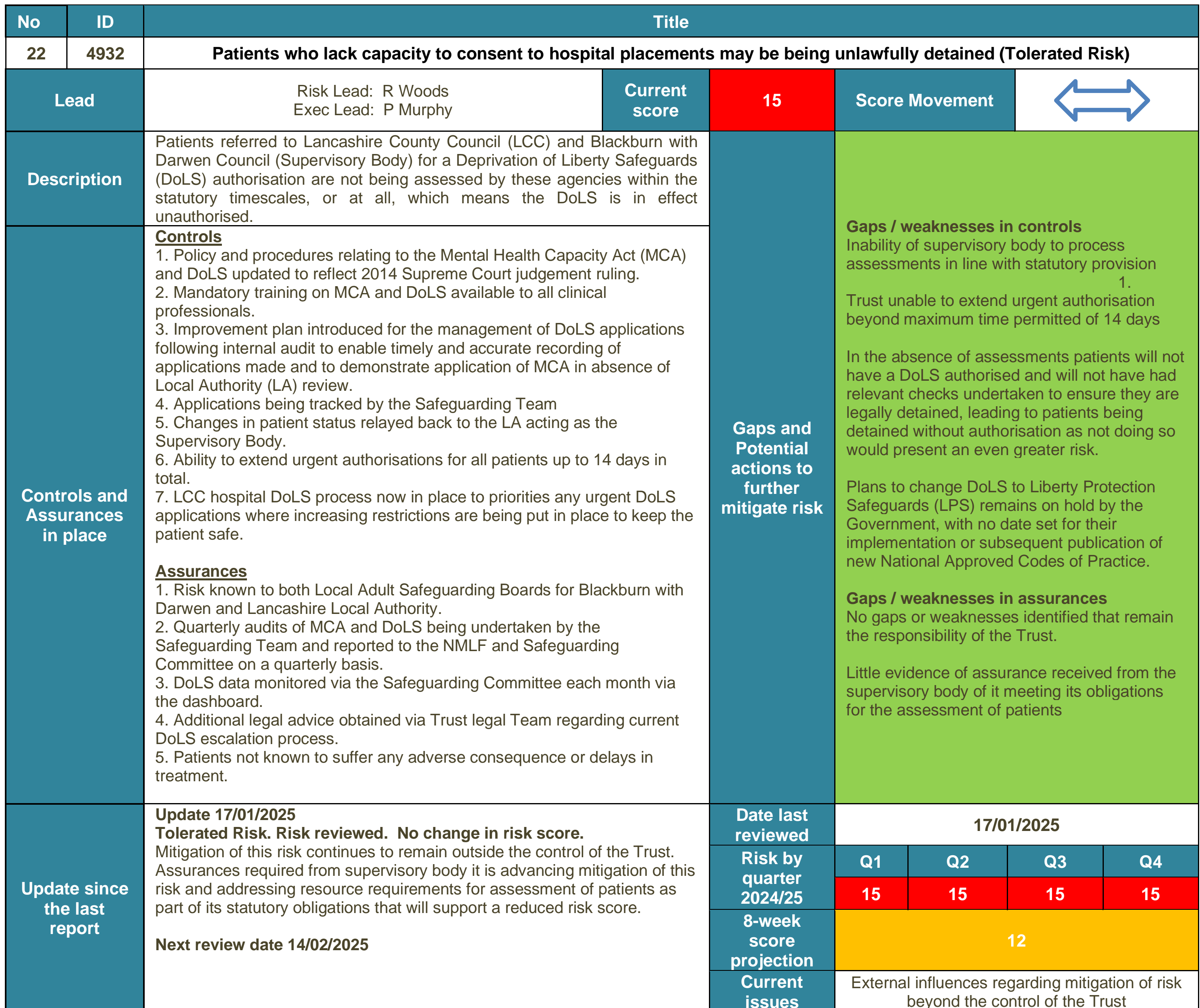
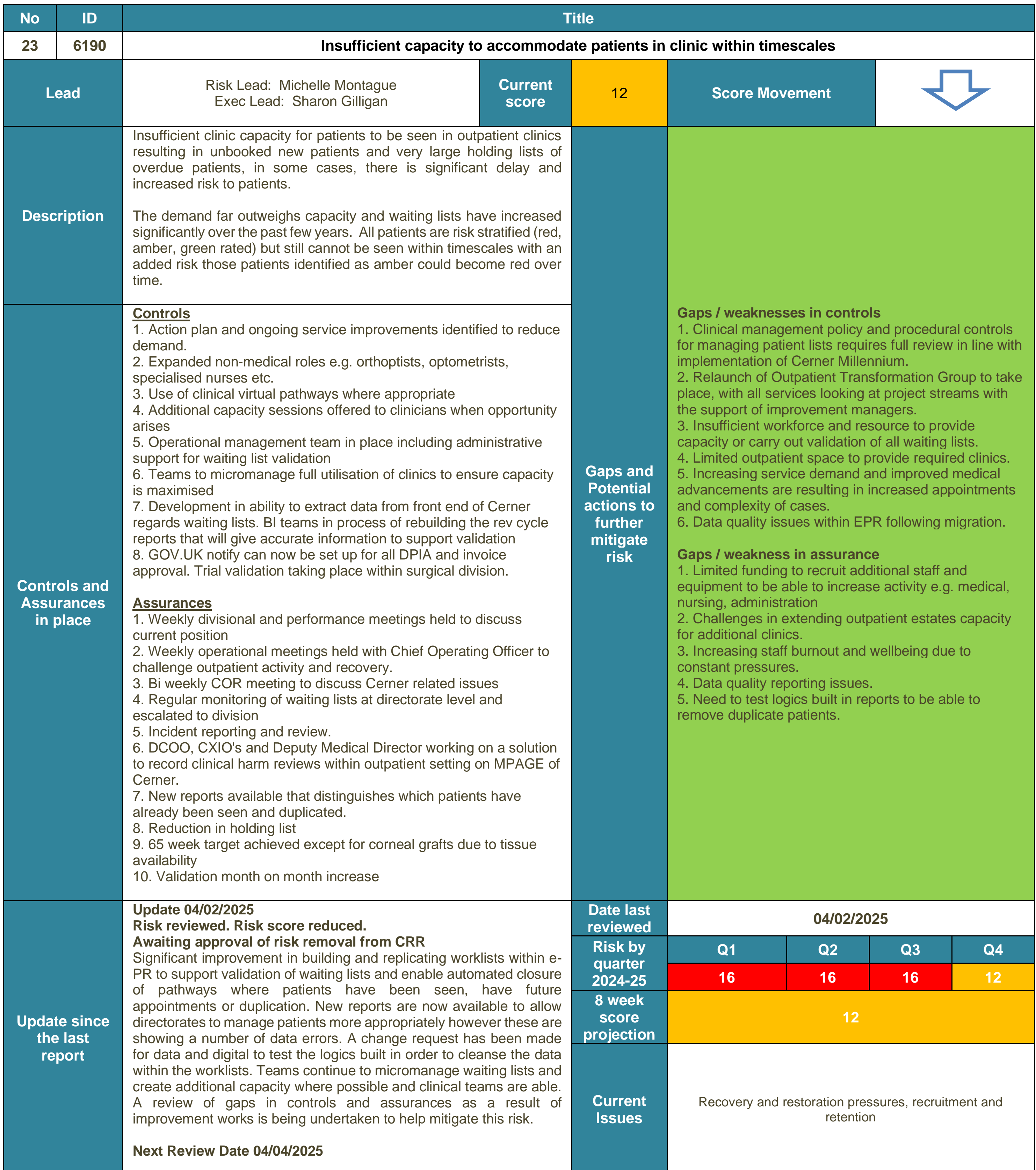


No	ID	Title					
22	4932	**Patients who lack capacity to consent to hospital placements may be being unlawfully detained (Tolerated Risk)**					
Lead		Risk Lead: R Woods Exec Lead: P Murphy	**Current score**	15	**Score Movement**	⇔	
Description		Patients referred to Lancashire County Council (LCC) and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DoLS) authorisation are not being assessed by these agencies within the statutory timescales, or at all, which means the DoLS is in effect unauthorised.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** Inability of supervisory body to process assessments in line with statutory provision 1. Trust unable to extend urgent authorisation beyond maximum time permitted of 14 days 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. Plans to change DoLS to Liberty Protection Safeguards (LPS) remains on hold by the Government, with no date set for their implementation or subsequent publication of new National Approved Codes of Practice. **Gaps / weaknesses in assurances** No gaps or weaknesses identified that remain the responsibility of the Trust. Little evidence of assurance received from the supervisory body of it meeting its obligations for the assessment of patients			
Controls and Assurances in place		**Controls** 1. Policy and procedures relating to the Mental Health Capacity Act (MCA) and DoLS updated to reflect 2014 Supreme Court judgement ruling. 2. Mandatory training on 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 LA acting as the Supervisory Body. 6. Ability to extend urgent authorisations for all patients up to 14 days in total. 7. LCC hospital DoLS process now in place to priorities any urgent DoLS applications where increasing restrictions are being put in place to keep the patient safe. **Assurances** 1. Risk known to both Local Adult Safeguarding Boards for Blackburn with Darwen and Lancashire Local Authority. 2. Quarterly audits of MCA and DoLS being undertaken by the Safeguarding Team and reported to the NMLF and Safeguarding Committee on a quarterly basis. 3. DoLS data monitored via the Safeguarding Committee each month via the dashboard. 4. Additional legal advice obtained via Trust legal Team regarding current DoLS escalation process. 5. Patients not known to suffer any adverse consequence or delays in treatment.					
Update since the last report		**Update 17/01/2025** **Tolerated Risk. Risk reviewed. No change in risk score.** Mitigation of this risk continues to remain outside the control of the Trust. Assurances required from supervisory body it is advancing mitigation of this risk and addressing resource requirements for assessment of patients as part of its statutory obligations that will support a reduced risk score. **Next review date 14/02/2025**	**Date last reviewed**	17/01/2025			
			Risk by quarter 2024/25	Q1	Q2	Q3	Q4
				15	15	15	15
			8-week score projection	12			
			Current issues	External influences regarding mitigation of risk beyond the control of the Trust			



No	ID	Title
23	6190	**Insufficient capacity to accommodate patients in clinic within timescales**

Lead	Risk Lead: Michelle Montague Exec Lead: Sharon Gilligan	Current score	12	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. 6. Data quality issues within EPR following migration. **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 for additional clinics. 3. Increasing staff burnout and wellbeing due to constant pressures. 4. Data quality reporting issues. 5. Need to test logics built in reports to be able to remove duplicate patients.
Controls and Assurances in place	<u>**Controls**</u> 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 6. Teams to micromanage full utilisation of clinics to ensure capacity is maximised 7. Development in ability to extract data from front end of Cerner regards waiting lists. BI teams in process of rebuilding the rev cycle reports that will give accurate information to support validation 8. GOV.UK notify can now be set up for all DPIA and invoice approval. Trial validation taking place within surgical division. <u>**Assurances**</u> 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 COR meeting to discuss Cerner related issues 4. Regular monitoring of waiting lists at directorate level and escalated to division 5. Incident reporting and review. 6. DCOO, CXIO's and Deputy Medical Director working on a solution to record clinical harm reviews within outpatient setting on MPAGE of Cerner. 7. New reports available that distinguishes which patients have already been seen and duplicated. 8. Reduction in holding list 9. 65 week target achieved except for corneal grafts due to tissue availability 10. Validation month on month increase		

Update since the last report	**Update 04/02/2025** **Risk reviewed. Risk score reduced.** **Awaiting approval of risk removal from CRR** Significant improvement in building and replicating worklists within e-PR to support validation of waiting lists and enable automated closure of pathways where patients have been seen, have future appointments or duplication. New reports are now available to allow directorates to manage patients more appropriately however these are showing a number of data errors. A change request has been made for data and digital to test the logics built in order to cleanse the data within the worklists. Teams continue to micromanage waiting lists and create additional capacity where possible and clinical teams are able. A review of gaps in controls and assurances as a result of improvement works is being undertaken to help mitigate this risk. **Next Review Date 04/04/2025**	**Date last reviewed**	04/02/2025			
		Risk by quarter 2024-25	Q1	Q2	Q3	Q4
			16	16	16	12
		8 week score projection	12			
		Current Issues	Recovery and restoration pressures, recruitment and retention			

TRUST BOARD REPORT

12 March 2025

Item	**39**
Purpose	Information Decision

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: No formal Committee

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust

Patient Safety Incident Response Framework Report

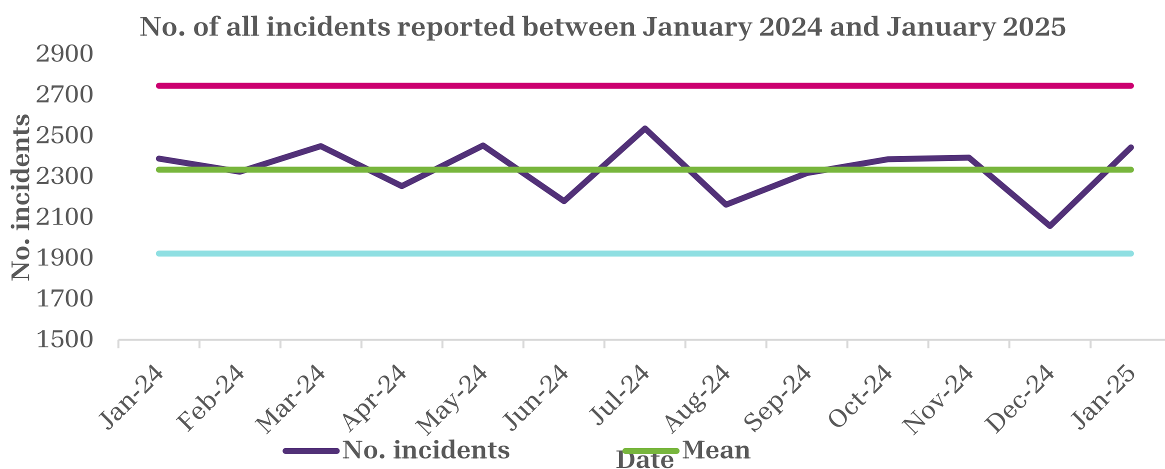
Reporting Period:		December 2024 to January 2025
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group, however, this was stood down in January but information was shared and discussed at the Trust Wide Quality Governance Part B meeting in January and February 2025.
1a.	**Alert**	The Trust has reported its third Never Event within the reporting period of April 2024 to March 2025. The Never Event was reported under the criteria of misplaced naso-gastric tube, which a small amount of fluid was passed down prior to confirmation of correct placements, the impact to the patients was low. A timeline of events leading up to the incident has been completed and a full PSII investigation is now taking place.
1b.	**Advise**	In January 2025 there has been a large increase in the number of reported staffing issue, over 50% of which were related to Nurse staffing incidents rather than harm to patients. A review of the information contained within the incident description of the nurse staffing incidents, suggests themes of staffing shortages (nurses and HCAs), and high acuity related increased one to once and enhanced care levels. The data suggests that actions are put in place with escalation to senior staff and actions taken to mitigate any risks such as reallocation of staff. Regular safety huddles are taking place highlight and respond to any staffing concerns. There has been an increase in the number of incidents awaiting final quality checks on DATIX. At the end of January 2025, there were 764 incidents awaiting final approval. Of which 137 cannot be closed, leaving 627 awaiting, against a target of 500. This has been due to a period of increased leave within the incident and policy team, meaning their focus has been on priority daily tasks.
1c.	**Assure**	This report now provides a breakdown of the Trust policies and SOPs by corporate services and divisions. To enable better oversight and assurance a list of all overdue policies and SOPs have been provided within eh report, these are all continually monitored and chased by the incident and policy team. To further support the timely reviews of policies and SOPs the incident and policy team are currently working on updating the committee lists so they can ask for assurance on policies and SOPs they hold accountability for.

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.

1.2 The reduction in reporting from December 2024 has not been sustained into January 2025.

Figure 1: Incidents reported over last 12 months.



1.3 **4499** reported incidents were triaged within 2 working days of being reported in **December 2024 and January 2025**, which equates to **99.95%** of all incidents reported within this period.

1.4 At the end of **January 2024** there were **764** incidents awaiting final approval. Of these **137** cannot be finally approved due to open S42 incidents awaiting Local Authority outcome, incidents awaiting information from Divisions, and outstanding Infection Control reviews included within cluster reviews, leaving 627 against a target of 500.

1.5 Following the initial change in harm grading that resulted in the increase in the number of moderate harms reported, the number now appears to be settling into a consistent pattern over the last 4 months. (appendix A)

1.6 After an increase in September and October 2024, the number of severe harm incidents reported has seen a reduction since November 2024. (appendix A)

1.7 The three fatal incidents reported in December 2024 and January 2025: (appendix A)

1.7.1 One is being investigated as a PSII and is related to issues with anticoagulant medication and monitoring.

1.7.2 One is being investigated as a PSII and is related to a potential poor management of a course of antibiotics.

1.7.3 One has been recorded as Fatal but is related to an incident that has occurred outside of the Trust regarding dispensing error by an outside pharmacy, currently being investigated.

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 has been an overall decrease in **December 2024** in IR2 completion in all but two divisions, this has reported by the divisions as due to annual leave over the Christmas break.

3.3 Corporate Services has seen a significant increase of IR2s actioned with 30 days from 28.95% to 62.50%, the incident and policy team will continue to work with corporate services to make further improvements.

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 has been an overall slight increase in the number of open PSRs and the number of those that have been open more than 90 calendar days.

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

5.1 In **December 2024** and **January 2025**, the Complex Case meeting reviewed **5** new incidents and reported **6** incidents meeting the PSIRF Priorities and require a PSII, these have been allocated to lead investigators within the Patient Safety Team.

5.2 The Trust reported its 3rd Never Event within the reporting period of April 2024 to March 2025. The Never Event was reported under the criteria of misplaced naso-gastric tube within the Family Care Division: a small amount of fluid was passed down the tube prior to confirmation of correct placements, the impact to the patients was low. A timeline of events leading up to the incident has been completed and a full PSII investigation is now taking place.

5.3 A KPI dashboard of PSIIs is provided is appendix D. At the end of **January 2025**, the Trust had **23** open PSII incidents of which **9** were being investigated by MNSI.

5.4 At the end of **January 2025** there were **4** PSIIs which had been open longer than 6 months and **4** MNSI reports.

5.4.1 The **4** MNSI reports that are overdue are outside of the control of trust. The reasons for the PSIIs being overdue are as follows:

- 1 PSII has been delayed due to missing clinical records in Cerner (now found by IT and the investigation ongoing). Investigation completed and report being drafted.
- 1 PSII report has been approved by PSIRI within the timeframe however, the family requested two months to be able to review the draft and have now requested some amendments and asked further questions. Report will be represented at PSIRI in March 2025.
- 1 PSII report has been approved at PSIRI but still awaiting Divisional safety improvement plan before it can be closed.
- 1 PSII delayed due to lead investigator having a family bereavement and then attending jury service. Report has been presented at PSIRI but requires some amendments and divisional safety improvement plan.

5.5 In **December 2024** and **January 2025**, **6** PSII reports have been approved by PSIRI with learning and closed.

6 PSIRI Panel Approval and Learning from Reports

6.1 During **December 2024** and **January 2025, 9** reports were reviewed, of these there were 4 new PSII reports. See appendix E for the detail of these reports and the review outcome.

7 Mandatory National Patient Safety Syllabus Training Modules

7.1 At the end of **November 2024**, the Trust has achieved **95.4%** Level 1a, **87.30%** Level 1b and **92.7%** Level 2 for National Patient Safety Training since making it mandatory for all staff to complete within the Trust.

7.2 Table 1: Patient Safety Syllabus Training (as of end of **January 2025**)

National Patient Safety Training	Target	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec24	Jan 25
Level 1a	95%	91.4%	92.30%	93.30%	93.60%	93. 80%	93.30%	94.10%	94.30%	94.90%	94.80%	95.20%	95.40%
Level 1b		76.6%	81.0%	83.50%	84.40%	83.50%	84.20%	84.70%	85.10%	85.90%	85.60%	86.00%	87.30%
Level 2		85.6%	87.0%	88.30%	88.80%	89.90%	90.10%	90.90%	91.10%	92.10%	92.00%	92.10%	92.70%

8 Trust Wide Policies and SOPs

8.1 At the end of **January 2025**, there were **8** Trust wide SOPs out of **144** overdue their review date, and **15** out of **298** policies are currently overdue their review date.

8.2 The report now provides a breakdown of overdue policies and SOPs as requested by Trust Board and a full list is provided in appendix F.

8.3 Of the 3 overdue policies for Quality Governance

8.3.1 New and Expectant Mother's Risk Assessment Procedure has now been ratified and approved on 24th Feb 2025

Figure 2: Trust wide policies and SOPs overdue by Directorate

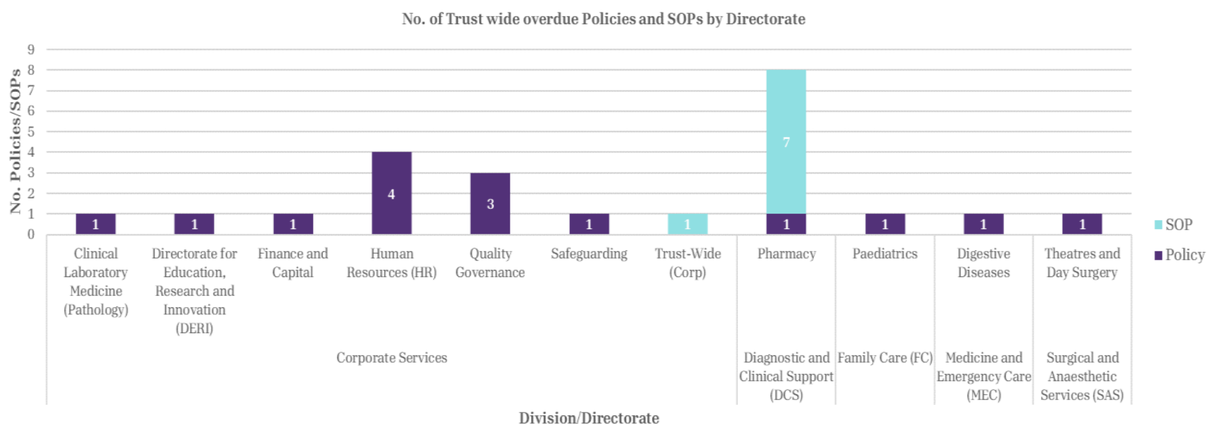


Table 2: Trust wide polices and SOPs within review date:

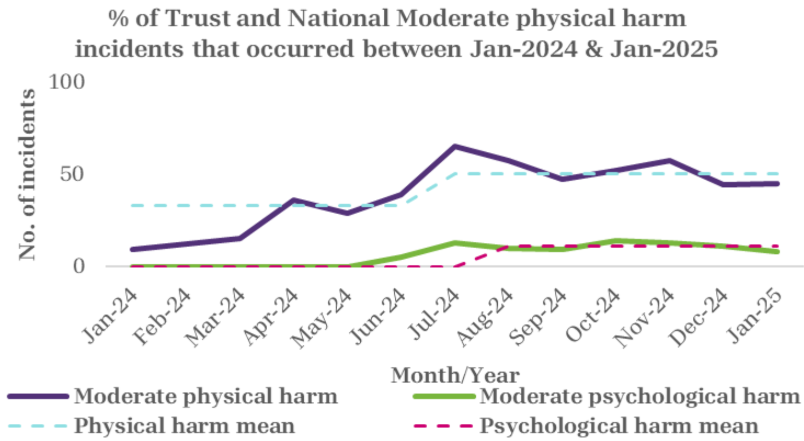
Policies / SOPs	Target	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Trust wide Policies	90%	90.88%	88.15%	86.11%	84.83%	83.10%	88.97%	88.70%	93.20%	94.56%	95.56%	95.58%	94.28%
Trust wide SOPs		90.78%	93.06%	93.75%	95.86%	93.75%	88.37%	86.90%	100%	98.63%	100%	97.92%	94.44%

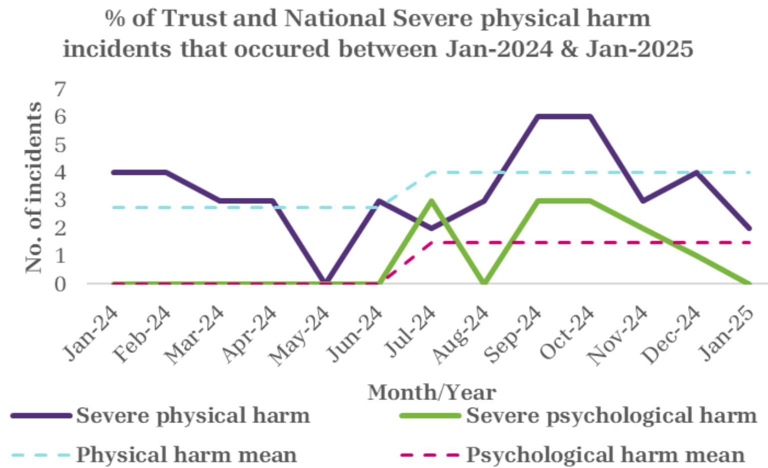
9 Maternity specific serious incident reporting in line with Ockenden recommendations

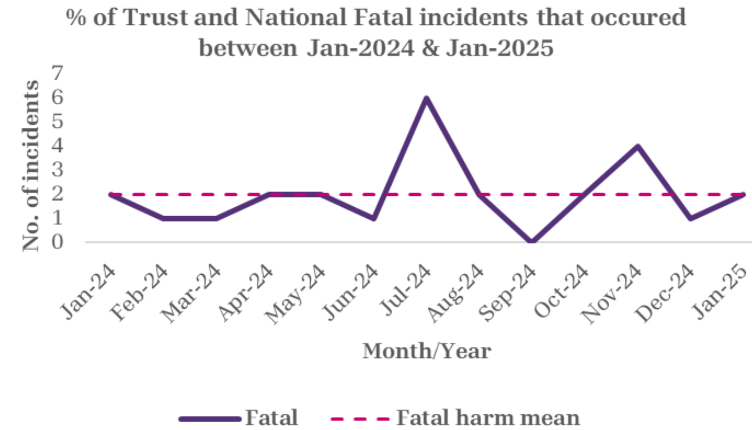
9.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 **75** maternity related incidents have been reported on StEIS of which:

- **46** have been approved and closed
- **15** have been agreed for de-escalation from StEIS
- **3** have had closure on StEIS requested
- 10 are currently being investigated by MNSI
- **1** is being undertaken via the PMRT process

Appendix A: ELHT Incidents by Moderate harm and above







Appendix B: KPI Dashboard for IR2s

Division	Number of SIRs (IR2s) by Month Trust Target 90%	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Trend
CIC	Total IR2 reported	410	378	341	315	360	344	471	375	398	444	405	405	↓
	(total number investigated) % complete within 30 calendar days	(354) 86.34%	(333) 88.10%	(300) 87.98%	(281) 89.21%	(323) 89.72%	(289) 84.01%	(424) 90.02%	(316) 84.27%	(344) 86.43%	(388) 87.39%	(373) 92.10%	(356) 87.90%	
DCS	Total IR2 reported	138	129	110	112	136	103	149	125	116	164	189	118	↓
	(total number investigated) % complete within 30 calendar days	(101) 73.19%	(90) 69.77%	(85) 77.27%	(93) 83.04%	(91) 66.91%	(75) 72.82%	(103) 69.13%	(77) 61.60%	(82) 70.69%	(124) 75.61%	(154) 81.48%	(85) 72.03%	
FC	Total IR2 reported	237	221	284	283	314	239	272	232	259	235	268	210	↑
	(total number investigated) % complete within 30 calendar days	(177) 74.68%	(185) 83.71%	(222) 78.17%	(228) 80.57%	(240) 76.43%	(189) 79.08%	(198) 72.79%	(169) 72.84%	(228) 88.03%	(179) 76.17%	(224) 83.58%	(187) 89.05%	
MEC	Total IR2 reported	947	915	992	903	899	873	936	849	945	936	921	778	↓
	(total number investigated) % complete within 30 calendar days	(823) 86.91%	(762) 83.28%	(863) 87.00%	(762) 84.39%	(752) 83.65%	(742) 84.99%	(804) 85.90%	(694) 81.74%	(768) 81.27%	(758) 80.98%	(707) 76.76%	(495) 63.62%	
SAS	Total IR2 reported	415	397	434	344	426	371	393	346	347	341	357	326	↓
	(total number investigated) % complete within 30 calendar days	(304) 73.25%	(335) 84.38%	(291) 67.05%	(276) 80.23%	(362) 84.98%	(291) 78.44%	(315) 80.15%	(304) 87.86%	(312) 89.91%	(298) 87.39%	(310) 86.83%	(248) 76.07%	
Corp	Total IR2 reported	82	89	83	87	97	85	82	52	67	74	76	32	↑
	(total number investigated) % complete within 30 calendar days	(40) 48.78%	(44) 49.44%	(37) 44.58%	(47) 54.02%	(63) 64.95%	(33) 38.82%	(45) 54.88%	(24) 46.15%	(35) 52.24%	(30) 40.54%	(22) 28.95%	(20) 62.50%	
Trust Total	Total IR2 reported	2229	2129	2244	2044	2232	2015	2303	1979	2132	2194	2216	1869	↓
	(total number investigated) % complete within 30 calendar days	(1799) 80.71%	(1749) 82.15%	(1798) 80.12%	(1687) 82.53%	(1831) 64.95%	(1619) 80.35%	(1889) 82.02%	(1584) 80.04%	(1769) 82.97%	(1777) 80.99%	(1790) 80.78%	(1391) 74.72%	

Total number of IR2s open on DATIX over 30 calendar days old						
Division	CIC	DCS	FC	MEC	SAS	Corp
No. open	23	127	12	261	83	232

Appendix C: KPI Dashboards for PSRs

Division	Number of PSRs open	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Trend >90
CIC	No. open	29	39	55	40	44	61	56	51	52	72	83	52	
	No. open more than 90 calendar days	5	7	5	5	9	8	2	1	3	5	5	2	
DCS	No. open	21	7	9	8	9	22	14	24	12	13	9	9	
	No. open more than 90 calendar days	5	2	1	0	1	2	1	2	0	0	0	0	
FC	No. open	47	40	53	54	51	55	54	37	39	39	38	45	
	No. open more than 90 calendar days	16	9	11	17	14	11	14	7	6	4	5	5	
MEC	No. open	125	94	124	115	88	102	96	93	60	61	71	82	
	No. open more than 90 calendar days	15	16	18	24	25	28	27	32	13	7	9	15	
SAS	No. open	60	56	51	50	31	47	34	37	35	41	28	48	
	No. open more than 90 calendar days	15	16	13	17	17	16	12	10	5	6	7	7	
Trust	No. open			292	277	223	287	254	242	198	226	232	236	
	No. open more than 90 calendar days			48	66	66	65	56	52	27	22	26	29	

Appendix D: KPI Dashboards for PSIIs

PSII reports (including HSIB/PMRT)	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Trend
No. incidents at Complex case	32	41	23	3	5	2	2	7	2	3	3	2	
No. incidents agreed as PSII including (MNSI was HSIB)	3	5	5	2	5	2	4	3	2	3	4	2	
No. over 6 months	6(5)	6(4)	5(3)	3(2)	3(3)	2(1)	3(1)	5(2)	7(3)	10(4)	11(4)	8(4)	↓
Total No. of PSIIs Open including (MNSI was HSIB)	23(6)	23(4)	25(4)	24(4)	27(10)	23(8)	26(7)	27(5)	24(7)	23(10)	24(8)	23(9)	↓
No. approved/closed by PSIRI including (MNSI was HSIB)	4	5	5	5	3	5	1	2	4	4	3	3	

Appendix E: Summary of PSII reports reviewed by PSIRI and the outcome

During December 2024 One new PSII reports were presented at the Trusts PSIRI panel. (there was only one meeting of PSIRI panel in December due to Christmas break).

- Incident resulting in death (eIR1275683) – The report was not approved and required re submission to the panel with an additional paragraph included and the improvement plan. The investigation identified the following safety recommendations:
    - The Trust to cascade to all ward staff the importance of the completion of gastrointestinal charts and testing for infection following one episode of unexplained diarrhoea to due to potential C.Diff infection.
    - Patients who test positive for C.Diff infection at peripheral sites should be discussed with a medical ST3+ on-call to ensure appropriate treatment and management.
    - C.Diff infection patients should be assessed at the bedside by a senior doctor (ST3+) within 48 hours of diagnosis.
    - Update the C.Diff guidelines on Eolas in view of the investigation findings.

- Consider submitting a change request for Cerner to highlight C.Diff infection patients and support staff in ensuring timely management to assess C.Diff infection severity.
- Disseminate guidance and information around the significance of C.Diff infection patients and how to treat.
- Consider what change requests are needed to ensure daily C.Diff infection reviews are undertaken and for timely C.Diff management to be embedded in patient care.
- Raise awareness about ensuing alternative antibiotics are administered to C.Diff infection patents where appropriate.

Two reports that were previously reviewed by the panel were returned for approval of the improvement plan; one report was approved however the improvement plan was not approved; the other report was approved.

During January 2025 three new PSII reports were presented at the Trusts PSIRI panel.

- Incident resulting in death (eIR1289888) – The report was a PSR and was not approved, the report required re submission to the panel with some additional information to be added. Below is a summary of safety recommendations identified in the report:
    - Share the dermatology team education video around 'skin conditions (rashes)' which highlights the difference between a skin rash and a low platelet rash with medical staff within UCC.

- Incident resulting in death (eIR1283620) – The report was not approved and required a discussion to take place outside of the meeting to agree the amendments required. Below is a summary of safety recommendations identified in the report:
    - The safety recommendations focus on implementing and educating staff about the updated Headache Pathway, developing a monitoring process for patients identified for the Intensive Home Support Service outside working hours, and ensuring effective monitoring of end-of-life care decisions in Ward B2.

- Maternal death (eIR1279248) – The report was produced by MNSI and was approved by the panel. The investigation did not identify any safety recommendations.

Four reports that were previously reviewed by the panel were returned for approval:

- Three required a review of the safety improvement plans and were approved.
- One required a review of amendments to the PSII report. the report was approved however the divisional safety improvement still requires submission to the panel.

Appendix F: Overdue Trust wide Policies/SOPs

Division/Directorate	Ref	Title	Review Date
Corporate Services			
Clinical Laboratory Medicine (Pathology)	IC08	Severe Acute Respiratory Illness Policy including MERSSARS Avian Influenza	29/11/2024
Finance and Capital	F05	Travel & Vehicle Expenses Policy	30/09/2022
Human Resources (HR)	HR58 HR62 HR31 HR01	Policy on the Development of Professional Roles Staff Bank and Agency Worker Policy Alcohol, Drugs and Substance Misuse Pre & Post Employment Checks and the Recruitment of People with a Criminal Record (Including Profess	31/12/2024 31/07/2024 30/08/2024 30/08/2024
Quality Governance	C006 C157 C147	Complaints / Concerns Policy and Procedure (Patient Experience) Chaperones Accompanying Patients During an Intimate Procedure / Treatment (Patient Experience) New and Expectant Mother's Risk Assessment Procedure (Health & Safety) Ratified and approved 24th Feb 2025	28/06/2024 30/04/2024 31/01/2025
Safeguarding	CP30	Care of the Dying patient	31/01/2025
Corporate Nursing	SOP081	Nursing Bedside Handovers	31/01/2025
Diagnostic and Clinical Support (DCS)			
Pharmacy	MM02 SOP048 SOP051 SOP053 SOP054 SOP059 SOP061 SOP069	Policy for Supply and / or Administration Of Prescription Only Medicines Under Patient Group Directive Receipt, storage, transfer of medicines and cold chain medicines on Wards and Departments Short stay medicines discharge procedure Handover of medicines to patients-carers at hospital discharge Management of medicines-related errors and near misses Procedure for general administration of medication Prescription ordering and security Procedure for Vaccination of At-Risk Inpatients with Influenza Vaccine	31/12/2024 31/12/2024 31/01/2025 31/01/2025 31/01/2025 31/01/2025 31/12/2024 31/12/2024
Family Care			
Paediatrics	C172	Infant Feeding and Relationship Building	31/01/2025
Medicine and Emergency Care			
Digestive Diseases	CP51	Low Risk Upper GI Bleeding Pathway	31/01/2025
Surgical and Anaesthetic Services			
Theatres and Day Surgery	C089	Latex Policy	31/01/2025

TRUST BOARD REPORT	**Item**	**40**
12 March 2025	**Purpose**	Approval Assurance Information

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

Summary: The purpose of this report is to provide:
1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Perinatal Safety Ambitions, specific 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 recommendations and maternity/ Neonatal Three-year delivery 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 (Bimonthly report presented at trust wide quality committee) with celebrations noted.

Recommendation: The Board of Directors are asked to.

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

Report linkages

Related Trust Goal	Deliver safe, high-quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse, and highly motivated people Drive sustainability
	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South

Related to key risks identified on Board Assurance Framework	Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust is unable to fully deliver on safe, personal, and effective care in line with the requirements of the NHS Constitution, relevant legislation, and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) because of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture. 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor (None)
Related to recommendations from audit reports	Audit Report Title and Recommendation/s (None)
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to Maternity incentive Scheme (MIS) Year 5.
Related to ICB (Integrated Care Board) Strategic Objective	State which ICB Strategic Objective the paper relates to continue to deliver on the National Maternity and Neonatology Safety Ambition.

Impact

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

Previously considered by:

1. INTRODUCTION

The purpose of this report is to provide:

1. An overview of ELHT maternity and neonatal quality and safety programmes resulting from national policy and Maternity and Neonatology safety ambitions. The Secretary of State's ambition to halve the number of stillbirths, neonatal deaths, maternal deaths, and brain injuries by 2025 is a key focus. This will also include a reduction of the pre-term birth rate from 8%-6% by 2025.

2. A monthly progress summary with any exceptions will be evidenced at ELHT trust boards with clear plans specifically relating to the ten CNST maternity safety actions included in year six of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. **(Appendix 1)**

3. Regular updates with schedules regarding ELHT maternity and neonatology services in response to the NHS England/Improvement (NHSE) Ockenden review- immediate and essential actions, Three Year maternity and neonatology Delivery Plan, all party parliamentary group (APPG) birth trauma report 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

Blue indicates complete

Green indicates progressing without concern

Orange indicates barriers/ risk to compliance identified

Red indicates non-compliance identified

Safety Action	Progress	Assurance/Exceptions
1. Perinatal Mortality Review Tool (PMRT)		• **Non-compliance declared** – For four reviews there was a shortfall within the 2-month deadline for answering all technical guidance/Factual Questions (FQs). This places current compliance at 88%. Overall Target for the reporting period is 95%. Non-compliance for CNST Year 6 has therefore been declared. Steps taken to mitigate this risk for CNST Year 7 are detailed in the report below. • The quarter 3 PMRT report covering October-December cases is attached for submission (**Appendix 1**).
2. Maternity Services Data Set (MSDS)		• **Compliant** – July data submitted, and all areas passed. • **Ongoing surveillance** – Continued monthly reviews of scorecard. Latest dashboard (December) included below.
3. Transitional Care (TC)		• **Compliant** – All quarterly audits fir CNST Year 6 have been submitted to Trust Board. • **Ongoing surveillance** - For CNST Year 7 the service will move to an annual audit, which will be submitted to Trust Board in January 2026. The temperature management QI registered as part of this Safety Action will continue to be monitored and progress reported to the LMNS.
4. Clinical Workforce		• **Compliant** – workforce action plans complete and submitted previously, consultant attendance audits complete and the quarter 3 audit is attached for assurance (**Appendix 2**), Locum Standard Operating Procedures (SOP) in place. • **Ongoing surveillance** – Neonatal nursing workforce action plan aligned to BAPM standards to continue to be monitored.
5. Midwifery Workforce		• **Compliant** – Bi-annual staffing reports submitted to Trust Board included detail and assurance of all CNST Year 6 asks. • **Ongoing surveillance** – Birthrate+ business case has been completed. Current funded midwifery establishment does not reflect Birthrate+ recommendations. Birthrate+ acuity app continues to monitor 1:1 care and supernumerary and midwifery red flags each month. Birthrate+ exercise due for renewal this year.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		• **Compliant** - ELHT are currently at 91% overall implementation following the LMNS assurance visit in January 2025. This implementation progress has been sufficient for sign off for this safety action.

		• **Ongoing surveillance** - Further progress and sustainability of current implementation plan with associated actions continues with close oversight from Obstetrics Clinical Director/Perinatal Quadrumvirate.
7.User Feedback		• **Compliant** – Maternity and Neonatal Voices Partnership (MNVP) meetings and workplan in place. Engagement Lead is now in post and has commenced attending engagement sessions. Patient experience group for Maternity and Neonatology continues to develop actions from CQC Maternity Survey results. • **Ongoing surveillance** – MNVP programme continues with oversight by the Assistant Director of Midwifery and the Maternity and Neonatal Transformation Team. A schedule of works is being planned to meet the asks of Safety Action 7 for CNST Year 7.
8. Training		• **Compliant -** All required thresholds for training have been met by the end of the reporting period (30th November 2024). • **Ongoing surveillance** – Training compliance continues to be monitored by the Maternity Training Team and the Neonatal Training Lead.
9. Board Assurance		• **Compliant** – PQSM in place with minimum data set monthly, safety champions in place with reporting structure available to staff, triangulation of incidents complaints and claims meetings took place, and culture improvement plan is in place. • **Ongoing surveillance** - PQSM minimum data set continues to be reviewed monthly, and safety champion and executive walk rounds continue. A follow up meeting for the triangulation of incidents complaints and claims is due to take place on the 14th of March 2025. The culture improvement plan continues to be monitored with culture coaches in place.
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		• **Compliant** – All required reporting complete for CNST Year 6. Quarter 3 report is attached for submission (**Appendix 3**) • **Ongoing surveillance** – Governance leads continue to monitor to ensure that all requirements are met for MNSI reporting.

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?

The Quarter 3 PMRT Report is attached as an appendix to this report (**Appendix 1**).

Table 1 Perinatal Mortality Review Tool – Dashboard of PMRT Cases

* Indicates that the cases in this month have not yet met deadline dates for this step of the process. The dashboard will automatically populate compliance figures once the deadline month has been reached.

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

CNST - PMRT

[All measures reported against month of death]

* = Data not relevant for month
n/a = Data not available at time of report

		Reporting Measure	Threshold	###	###	###	###	###	###	Jul-	###	###	###	###	###	Monthly Trend
SAFETY ACTION 1	PMRT01 a	Total Number of Stillbirths (= 24 weeks)		1	1	1	2	3	0	1	1	2	4	1	2	
	PMRT01 b	Number of Neonatal Deaths		0	1	1	3	3	3	3	0	0	0	1	1	
	PMRT01 c	Number of late fetal loss between 22+0 and 23+6 weeks		0	1	0	0	0	0	1	0	0	0	0	1	
		Total Eligible Cases		1	3	2	5	6	3	5	1	2	4	2	4	
	PMRT0 2a	a) i Number of cases reported to MBRRACE		1	3	2	5	6	3	5	1	2	4	2	4	
			100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	PMRT06a	c) i Number PMRT tool started 2 months		1	3	2	5	5	2	5	1	2	2	0	2	
			95%	100.0%	100.0%	100.0%	100.0%	83.3%	66.7%	100.0%	100.0%	100.0%	50.0%	-	-	
	PMRT06a	c) ii Number PMRT published reports by 6 months		1	2	2	3	6	3	0	0	0	0	0	0	
			60%	100.0%	66.7%	100.0%	60.0%	100.0%	100.0%	-	-	-	-	-	-	
	PMRT05 e	Number PMRT published reports not due		0	0	0	0	0	0	5	1	2	4	2	4	

As demonstrated via the above Perinatal Mortality Review Tool (PMRT) dashboard, the required time limits for reporting to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) within 7 days (a) and PMRT published reports by 6 months (cii) have been met to the required compliance thresholds within the reporting period. For 4 of the 35 cases eligible for PMRT review, the review was started within the required 2-month period (ci), however it was identified that some Factual Questions (FQs) were unanswered, putting the measure at 88.57% compliance.

The target threshold as per CNST guidelines is 95%. 2 of these cases had received antenatal care externally and therefore part of the review was reassigned to be completed by external Trusts, meaning that this caused a delay in completion of FQs.

A deep dive into these cases was completed by the PMRT team and maternity safety champions. As such, guidance from MBRRACE-UK was sought. The Divisional Director of Midwifery, Clinical Director for Obstetrics and perinatal transformation lead met with a representative from MBRRACE-UK and were advised to submit an action plan outlining the mitigations taken, and to declare non-compliance with the safety action one at submission

point. A further review of the mitigations will be considered by MIS as the external validators for the safety action with an update to ELHT in due course.

As an immediate response to this, the maternity safety champions have further reviewed all failsafe processes, to ensure that all criteria are met for PMRT reviews. The Quality and Safety team complete a weekly check of compliance with all timescales for reviews.
A summary report is submitted to the perinatal transformation team, Divisional Director of Midwifery, Assistant Director of Midwifery, Clinical Director, and Deputy Clinical Director for assurance with all aspects of governance aligned with CNST requirements. A weekly meeting is also in place every Thursday for any exceptions for PMRT and timescales.

Furthermore, a team of 3 PMRT midwives has been put in place scheduled into already funded administration time with additional training to support timely commencement and completion of reviews. The PMRT midwives have protected time away from the clinical setting to complete all reviews within the strict timescales. This will mitigate shortfalls to ensure that no FQs are missed for future cases.

Of the 4 reviews that failed requirement ci (review started), 3 met the target for cii (report published). We were therefore able to rectify the delay in review. The remaining review was published within 7 months.

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: December 2024

NHS England

Notes: The final results for the CNST MIS Y6 SA2 assessment, using July 2024 data, are available in this scorecard.

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	415			Passed
CQIMDQ14	465	475	97.9		Passed
CQIMDQ15	455	455	100.0		Passed
CQIMDQ16	420	455	92.3		Passed
CQIMDQ24	415	420	98.8		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	335	460	72.8	Passed
CQIMDQ08	460	475	96.8	Passed
CQIMDQ09	465	475	97.9	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	465	475	97.9		Passed
CQIMDQ11	190	465	40.9		Passed
CQIMDQ12	20	465	4.3		Passed
CQIMPPH	15	465		32	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	465	475	97.9		Passed
CQIMDQ22	455	455	100.0		Passed
CQIMDQ23	420	455	92.3		Passed
CQIMPreterm	35	455		79	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	465	475	97.9		Passed
CQIMDQ15	455	455	100.0		Passed
CQIMDQ16	420	455	92.3		Passed
CQIMDQ18	260	455	57.1		Passed
CQIMDQ20	5	240	2.1		Passed
CQIMTears	5	240			Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	465	475	97.9	Passed
CQIMDQ15	455	455	100.0	Passed
CQIMDQ16	420	455	92.3	Passed
CQIMDQ18	260	455	57.1	Passed
CQIMDQ26	455	455	100.0	Passed
CQIMDQ27	555	555	100.0	Passed
CQIMDQ28	255	555	45.9	Passed
CQIMVBAC	10	40	25.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	465	475	97.9	Passed
CQIMDQ31	475	475	100.0	Passed
CQIMDQ32	425	475	89.5	Passed
CQIMDQ33	475	475	100.0	Passed
CQIMDQ34	260	475	54.7	Passed
CQIMDQ36	465	465	100.0	Passed
CQIMDQ37	190	465	40.9	Passed
CQIMDQ38	475	475	100.0	Passed
CQIMDQ39	460	465	98.9	Passed
CQIMRobson01	5	60	8.3	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	60	90	66.7	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	65	80	81.2	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	555	475	116.8	Passed
CQIMDQ04	555	555	100.0	Passed
CQIMDQ05	50	555	9.0	Passed
CQIMSmokingBooking	50	555	9.0	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	455	465	97.8	Passed
CQIMSmokingDelivery	30	455	6.6	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	530	555	95.5	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 is the month submitted into CNST Year 6 evidence to evidence compliance for this reporting year. The July 2024 dashboard, showing all metrics as passed, was submitted to November Trust Board, and the Safety Action was signed off as complete by the LMNS. The above dashboard shows December 2024 data, evidencing continued compliance with this ask.

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?

The most recent TC audit, covering October-November data was submitted to the January Trust Board. The service is now moving towards an annual TC audit, covering the CNST Year, meaning that the next audit will be submitted to Trust Board in January 2026.

As per the CNST requirement, a temperature management quality improvement (QI) has been registered. The QI will focus on midwife education around temperature management on Postnatal Ward, which has been identified as a target area by the QI lead. A cycle of education will be undertaken on the ward in 2025. An update on progress with this was provided at Floor to Board on the 27th of November 2024.

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

The elements for ongoing surveillance outside of the CNST reporting year for this safety action include the following:

Consultant attendance audit – the quarter 3 report is attached for submission (**Appendix 2**). Exceptions were discussed at Perinatal Governance Board and will be discussed at Floor to Board on the 4th of March 2025.

Neonatal Nursing Workforce action plan – as submitted to September 2024 Trust Board and presented at January Trust Board. This continues to be monitored with oversight by the senior nursing team.

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

The second bi-annual midwifery staffing report for the period 1st of July to 31st of December 2024 was submitted to January 2025 Trust Board. This covers all actions taken to meet safety action 5.
A business/ improvement case has been completed in March 2023 following the birth are plus assessment in September 2022 for the deficit in funding to meet the midwifery staffing establishment as set out in the Birthrate+ report.

The Birthrate+ exercise was completed in 2022 and must be repeated every 3 years, meaning this is due for renewal in 2025. A meeting is scheduled on the 1st of April to plan for 2025 birth rate plus assessment. This is a CNST and Ockenden ask to all trusts.

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 (July-September) of the 6 elements of Saving Babies' Lives (SBL) was conducted on the 8th of January 2024. Compliance has increased to 64/70 interventions implemented overall, which equates to 91%. A breakdown of elements is provided below.

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	8/10 interventions implemented and evidenced **(80%)**
Element 2 - Fetal Growth Restriction	19/20 interventions implemented and evidenced **(95%)**
Element 3 - Reduced Fetal Movement	2/2 interventions implemented and evidenced **(100%)** [1 intervention contains 4 asks]
Element 4 - Effective fetal monitoring during labour	5/5 interventions implemented and evidenced **(100%)**
Element 5 - Reducing preterm births and optimising perinatal care	24/27 interventions implemented and evidenced **(89%)**
Element 6 - Management of Diabetes in Pregnancy	6/6 interventions implemented and evidenced **(100%)**

Meetings with the LMNS have been diarised throughout the CNST Y7 reporting period as below, this provides the forum to meet the ask '*continued quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to*

demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle.'

- 19th June 2025
- 23rd September 2025 – CNST Y7 Q1
- 4th November 2025 – CNST Y7 Q2
- 13th January 2025 – CNST Y7 Q3 (sign off)

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

Evidence of MNVP engagement with the community, including 15 steps reports from exercises carried out in October, and feedback from sessions, has been reviewed and approved by the LMNS. The CQC Action Plan based on the 2023 CQC Maternity Survey results has been monitored through the Maternity and Neonatal patient experience group, with further feedback to support the action planning collected by ELHT midwives.

A new CQC Maternity Survey action plan based on the 2024 results will be completed and submitted to May Trust Board, in preparation for CNST Year 7.

Following a demand and capacity review of the MNVP Lead role in partnership with Healthwatch, and Engagement Lead was appointed to support the MNVP tasks within Safety Action 7. The Engagement Lead is now in post and has commenced feedback collection in the community. The MNVP lead continues to support with feedback collection to inform further Transformation projects, such as a Translation Services QI and digital communications improvements.

The Divisional Director of Midwifery, Assistant Director of Midwifery, and Maternity and Neonatal Transformation Team continue to work alongside the MNVP leads and newly appointed MNVP Project Lead at Healthwatch to coordinate feedback collection efforts.
An MNVP Update Day is taking place on the 14th of March at which ELHT, MNVP, and Healthwatch colleagues will meet to plan for the next year of activity. Actions such as updating current feedback methods and processes will be discussed at this meeting to ensure that feedback is received in a timely manner to inform actions within the service. A focus will also

be on obtaining feedback from those at risk of experiencing the 'worst outcomes' as per CNST requirements.

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

As reported to the January Trust Board, all training elements monitored for CNST Year 6 - Fetal monitoring and surveillance training, Maternity emergencies, and multi-professional training (PROMPT), and Neonatal basic life support – met the required 90% compliance threshold for all staff groups by the end of the reporting period.

The Maternity Training team and Neonatal Training Lead continue to monitor compliance with all training in preparation for CNST Year 7. The training for midwives equates to a staff roster KPI of 26%, the annual review of time allocations aligned with mandatory requirements is taking place in March 2025, pre-birth rate plus assessment to inform accurately.

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?

Safety Champions are continuing to meet with the perinatal leadership team at a minimum of bi-monthly at Floor to Board meetings. The next meeting is scheduled for the 4th of March 2025.

Perinatal Quality Surveillance Model (PQSM) Minimum Data Set November and December 2024 data:

Perinatal Quality Surveillance Dataset

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

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

Perinatal Data

Metric	Standard	Sept 24	Oct 24	Nov 24	Dec 24
1:1 care in labour	100%	100%	100%	100%	100%
Stillbirth rate	<4.4/1000	6.02	7.83	2.01	2.14
Term admissions to NICU	<7%	6.73%	7.77%	7.93%	6.69%
Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	4.44%	4.16%	2.85%	3.70%
3rd/4th degree perineal tear	<5%	3.27%	2.80%	4.39%	2.38%

Staffing/Training

Metric	Standard	Sept 24	Oct 24	Nov 24	Dec 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	<1.28	<1.28	<1.28	<1.28
Midwife to birth ratio (in post)	<1.28	<1.28	<1.28	<1.28	<1.28
Training compliance for all staff groups (CNST)	>90%	>90%	>90%	>90%	>90%

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 has been 1 stillbirth in November – this was an intrapartum stillbirth and is being investigated by MNSI, and 1 stillbirth in December – this was an antepartum stillbirth.

Term admission to NICU:
Term admission to NICU rates SPC chart included on slide 3. All these admissions have been reviewed and 2 are having a further review to ensure they were not avoidable, and 5 have had fetal monitoring reviews. All the others are unavoidable. Any incidental learning is identified and shared with the teams.

3rd/4th degree perineal tears
The number of 3rd/4th degree tears has remained stable for the last 3 months below 5%.

Dedicated obstetric consultant presence on labour ward
from January 2025 the 90-hour consultant presence on labour ward will not be met following job plan changes. This will now be 72 hour presence.

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

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

Feedback

Metric	Standard	Sept 24	Oct 24	Nov 24	Dec 24
Service user feedback (MNVP)		1 sessions attended	0 sessions attended	0 sessions attended	1 sessions attended
FFT satisfaction rated as good	>90%	88.13%	84.03%	91.19%	90.53
Number of level 4 complaints	-	2	2	2	2
Executive safety walkaround	Bi-Monthly	1	1	1	1
Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly				

External Reporting

Metric	Sept 24	Oct 24	Nov 24	Dec 24
Maternity incidents graded moderate or above	2	3	4	4
Cases referred to MNSI	1	3	1	2
Cases referred to coroner	1	0	0	0
Coroner reg 28 made directly to the Trust	0	0	0	0
HSIB/CQC with a concern or request for action	0	0	0	0

CNST

Metric	Sept 24	Oct 24	Nov 24	Dec 24
Progress with CNST 10 safety action compliance	●	●	●	●

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

MNVP Service User Feedback:
MNVP meetings held in December. Ongoing work planning engagement events for 2025.

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 have been 2 level 4 complaints in both November and December.

Executive Safety Walkarounds:
An executive and non-executive walkaround took place in Antenatal Clinic and Blackburn Birth centre in this time period– feedback awaiting from this walkaround.

Moderate or above incidents:
There have been 8 reported incidents in November and December – these include a never event – retained vaginal pack; an intrapartum stillbirth and 2 cooled babies referred to MNSI.

Coroner referral:
0 cases have been referred to the Coroner in November and December.

MNSI referral:
There has been 3 cases referred to MNSI in November and December – these are 1 intrpartum stillbirth and 2 cooled babies – the cooled baby cases have been rejected due to normal MRI scans and no concerns with care.

CNST:
The reporting period for this period ended on December 8th. The final assurance visit by the LMNS is planned for January. The Trust is reporting compliance with all standards except Standard 1 – this has been escalated to the LMNS and will be escalated to Trust Board at the next meeting.

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

The next meeting of the task and finish group working on the triangulation of claims, incidents and complaints is scheduled for the 14th of March 2025.

This group is attended by the Board and Maternity Safety Champions, the Quality and Safety Team, and the Transformation Team. At this meeting, an update will be provided on the ongoing actions resulting from the triangulation exercise in 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 Safety, Communication, Operational, Reliability and Engagement (SCORE) culture survey is monitored and lead by the Maternity and Neonatal Quadrumvirate (Quad), who meet monthly with a direct focus on safety and culture listed within the agenda.

The Perinatal 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. The podcast is due to be recorded on the 19th of March 2025.

Following on from 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 completed initial training and are due to attend follow up sessions. They have also held the first cultural conversation in February and will feedback to the Quad on the findings of this session. All four ELHT culture coached attended a training day on Friday 28th February to further educate and inform the ELHT culture improvement plan.

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. The 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 quarterly reports produced by the Quality and Safety Lead. The quarter 3 report is attached as an appendix for submission (**Appendix 4**)

3. MATERNITY AND NEONATAL 3 YEAR DELIVERY PLAN

The Maternity and Neonatal three-year delivery plan was published by NHS England in March 2023 (**Appendix 5**) and sets out responsibilities for Trusts based on four high level themes:

- Listening to and working with women and families with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care

The latest update on the ELHT Maternity and Neonatal position with regards to the 3-year plan is included as an appendix (**Appendix 6**). Work is ongoing within the division to benchmark the current position and understand actions that need to be taken to meet the requirements within the 3-year period. A meeting is scheduled on the 19th of March 2025 to complete this exercise with the multidisciplinary perinatal team, including all safety champions facilitated by the Maternity and Neonatal Transformation Team.

The NHS England Regional Maternity and Neonatal team has scheduled an assurance site visit on the 30th of April 2025. This visit will include a series of presentations to highlight the ongoing work within the directorates to meet the requirements of the 3-year plan, workshops facilitated by the NHS England team, and a tour of the unit.

An update on the outcome of the benchmarking exercise and the NHS England site visit will be provided at the May Trust Board.

4. CONCLUSION

On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board is the final submission to inform progress of the ten CNST maternity safety

actions throughout the year 6 reporting period. The next Trust Board submission will include updates based on the new CNST Year 7 guidance, due to be published in April 2025.

Any other matters of patient safety concerns point prevalent will continue to be reported through the bimonthly maternity and neonatology safety champions floor to board agendas and reflected within trust board papers for wider discussions and escalation 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
March 2025

Appendix 1 – CNST-MIS Y6 Guidance

MIS-Year-6-guidance.pdf

Appendix 2 – PMRT Quarter 3 Report

Quarterly PMRT report Q3 24.docx

Appendix 3 – Consultant Attendance Quarter 3 Audit

Consultant attendance audits 2

Appendix 4 – MNSI Quarter 3 Report

CNST SA 10 Year 6 Jan 25 update.docx

Appendix 5 – Maternity and Neonatal 3 Year Delivery Plan

three-year-delivery-plan-for-maternity-a

Appendix 6 – ELHT MPOP Quarter 3

ELHT-MPOP Q3 Feb 2025.xlsx

NHS Resolution

Maternity (and perinatal) Incentive Scheme

Year Six v1.1

Conditions of the scheme

Ten maternity safety actions

Additional guidance

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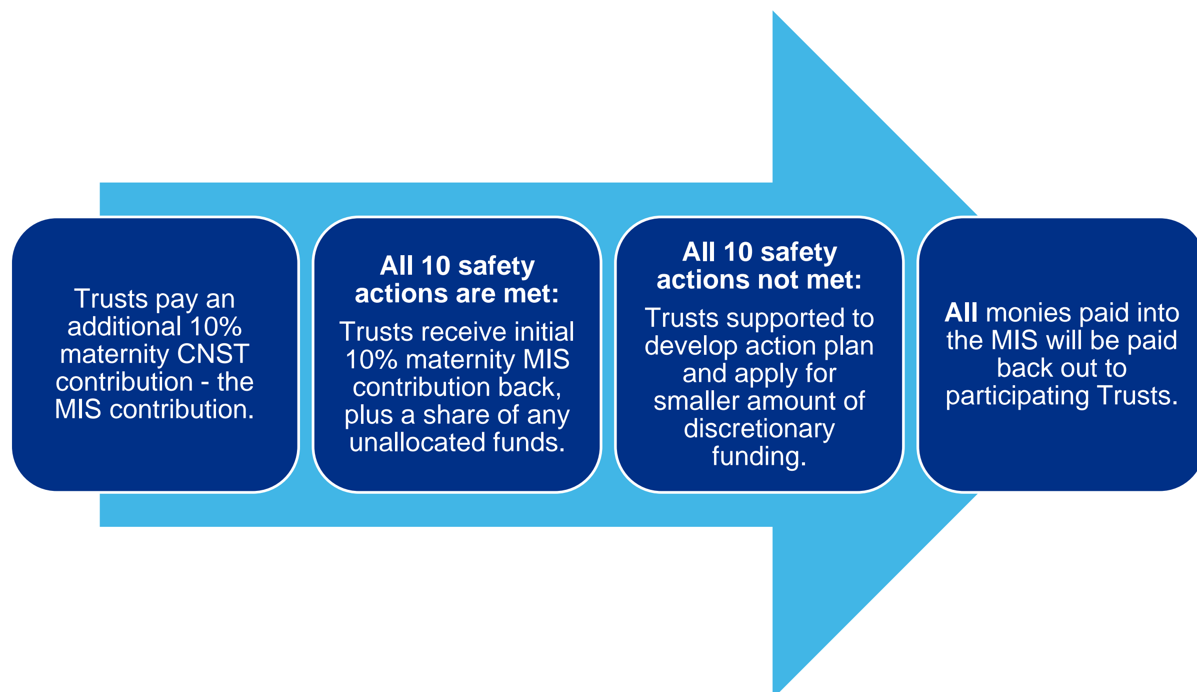
Introduction

Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

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



The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigation Programme (MNSI).

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution.

MIS year six: conditions

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon** on **3 March 2025** and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the director of midwifery/head of midwifery and clinical director for maternity services.
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- The Trust's CEO must sign to confirm that:

  - ☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
  - ☑ There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2025.
  - ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates from Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the MIS results. See 'Reverification'.

NHS Resolution will publish the outcomes of the MIS verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

External verification

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c).

NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

National Neonatal Research Database (NNRD), MNSI and **NHS Resolution** for the number of qualifying incidents reportable (safety action 10, standard a).

Trust submissions will also be sense checked with the **CQC**, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year.

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided internally in the Trust to support the Trust Board decision only. This will not be reviewed by NHS Resolution unless requested. See 'Reverification'.
- On the Board Declaration form Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.

Safety action No. 2
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	N/A
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	

- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by **12 noon 3 March 2025** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.

- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by AO of Clinical Commissioning Group/Integrated Care System.
- The Board declaration form will be made available on the MIS webpage during the MIS reporting period.

'What Good Looks Like'

Trusts are reminded to retain all evidence used to support their compliance position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described below) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net prior to the 3 March 2025.
- The Board declaration form must be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.
- Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
  - Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation.
  - Technical errors outside the Trust's control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- The NHS Resolution MIS clinical team will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Appeals must be made in writing to NHS Resolution on the agreed template within two weeks of the final notification of results. Information on how to do this

will also be communicated to all Trusts when the confirmed MIS results are sent out.

Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a smaller amount of funding to support progress. To apply for funding, such Trusts must submit a completed action plan together with their completed Board declaration form by 12 noon on 3 March 2025 to NHS Resolution nhsr.mis@nhs.net.

Action plans submitted must be:

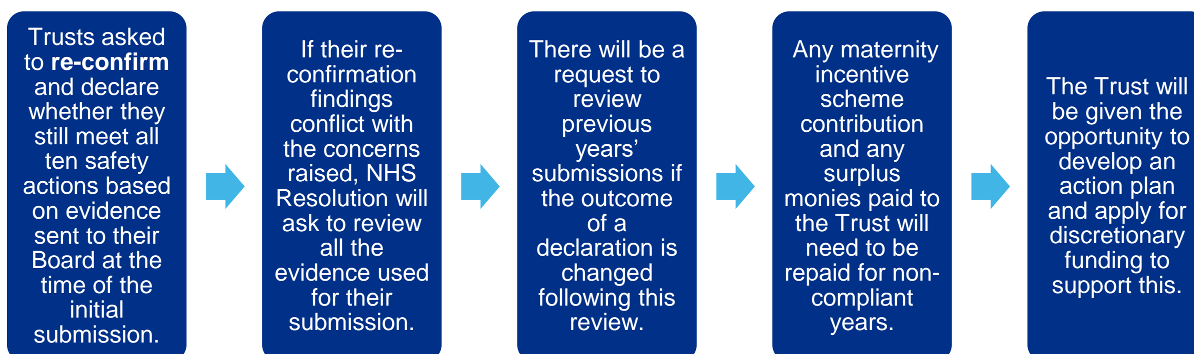
- Submitted on the action plan template in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and will enable the financial calculation of the funding requested.
- Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE).
- Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
- Action plans should not be submitted for achieved safety actions.

Ruth May, NHS England Chief Nursing Officer wrote to NHS Trusts on 8th April 2021 confirming that commissioners must ensure that any funding awarded to implement the agreed action plan for improvement is ringfenced for the maternity service to support the delivery of the action plan.

Reverification

Reverification is initiated if a concern is raised that a Trust Board may have incorrectly declared compliance with one or more of the ten safety actions' sub-requirements within the MIS. This may be identified through whistleblowing or following a CQC report that may call into question the original declaration. This concern may relate to any completed year of the MIS.

In the first instance, Trusts are asked to complete their own internal review of the evidence that was used to support their compliance for the relevant year at the time of submission. This must be the same evidence that was used to inform the Trust Board at the point of declaration. Trusts will be given the opportunity to downgrade their position at this point.



If following their own internal review, the Trust remains confident that their compliance declaration was correct, the Trust will be asked to provide all of their supporting evidence to NHS Resolution. A full review of the relevant evidence will then be undertaken by two members of the MIS clinical team.

Following this review, any Trusts found to have mis-declared compliance will be notified and will be required to repay the funds originally awarded to them for that MIS year. They will be asked to develop an action plan to introduce safety improvements and work towards full compliance, and they will be advised to bid for discretionary funding to support this action plan. Any discretionary funds agreed must be spent on the improvements in the agreed plan. Any amount of discretionary funding agreed will be deducted from the total MIS rebate amount repayable to NHS Resolution.

If a mis-declaration has been identified (as above), reverification of the previous MIS year will automatically be initiated. When a further mis-declaration is identified, this process will then be repeated for the previous year. This process will be limited to impact the current MIS year, and the two preceding historical MIS years only.

Any funds retrieved from non-compliant Trusts will be redistributed to all Trusts that achieved compliance for the applicable MIS year. This redistribution must take place within the same financial year that NHS Resolution receives the funds.

Need Help?

If you have any queries or concerns regarding any aspect of the MIS, please contact the MIS clinical team on nhsr.mis@nhs.net. There is a new FutureNHS MIS workspace where queries can be submitted and additional information and resources will be provided.

To ensure you receive all correspondence relating to the MIS, please add your name to the MIS contacts list.

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

Required Standard
a) **Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. b) **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards. c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months. d) **Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.
Minimum Evidence Requirement for Trust Board
Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical guidance regarding the introduction of the NHS Submit a Perinatal Event Notification system - SPEN). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process
Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications. MBRRACE-UK/PMRT will take the data extract for verification on 1 February 2025.
Relevant Time period
From 8 December 2023 to 30 November 2024

Link to technical guidance

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

Required Standard
This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 MSDS-only (see technical guidance) Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. Final data for July 2024 will be published during October 2024. 2. July 2024 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).
Minimum Evidence Requirement for Trust Board
The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard
a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice Or Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards. b) Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.
Minimum Evidence Requirement for Trust Board
Evidence for standard a) to include: **For units with TC pathways** • Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04. **For units working towards TC pathways** • An action plan signed off by Trust and LMNS Board for a move towards the TC pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.
Evidence for standard b) to include: 1. By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team. 2. By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard
a) Obstetric medical workforce
1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility (CEL) to undertake short-term locums. 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.** rcog-guidance-on-compensatory-rest.pdf 4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

c) Neonatal medical workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing.

or

the standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

or

The standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal ODN.

Minimum Evidence Requirement for Trust Board

Obstetric medical workforce

1) Trusts/organisations should audit their compliance via Medical Human Resources.

   Information on the CEL for short term locums is available here: www.rcog.org.uk/cel

   This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk)

   A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk

2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance.

3) Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that consultants/senior SAS

doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and senior SAS doctors about their ability to take appropriate compensatory rest in such situations.
NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG

4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.

Anaesthetic medical workforce

The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota.

Neonatal medical workforce

The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce.

If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.

A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Neonatal nursing workforce

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020).
For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.
A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN.

Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.

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

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

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

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

Minimum Evidence Requirement for Trust Board

The midwifery staffing report submitted will comprise evidence to support a, b, c and d progress or achievement.

It should include:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.
- Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

- The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.

  - The midwife to birth ratio.

  - The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.

Relevant Time period

From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard
Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.
Minimum Evidence Requirement for Trust Board
Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. *The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard
1. Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting: a) Engagement and listening to families. b) Strategic influence and decision-making. c) Infrastructure. 2. Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.
Minimum Evidence Requirement for Trust Board
1. a) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan. b) Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member, (Trusts should work towards the MNVP Lead being a quorate member), such **as:** • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee c) Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare costs

- If evidence of funding support at expected level is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.

2. Evidence of review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as an action plan.

Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard
90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.
Minimum Evidence Requirement for Trust Board
*See technical guidance for details of training requirements and evidence.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 1 December 2023 to 30 November 2024

Link to technical guidance

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Required Standard
a) All Trust requirements of the PQSM must be fully embedded. b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings. c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.
Minimum Evidence Requirement for Trust Board
Evidence for point a) and b) • Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice. • Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the **perinatal** leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback. • Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM. • Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action

and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.

- Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.

Evidence for point c):

Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:

- Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.

- Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Required Standard
a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024. b) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024. c) For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum Evidence Requirement for Trust Board
Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. Trusts' reporting will be cross-referenced against the MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard A) and B) have been met in the relevant reporting period. In addition, for standard B and C(i) there is a requirement to complete field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
Relevant Time period
From 8 December 2023 to 30 November 2024

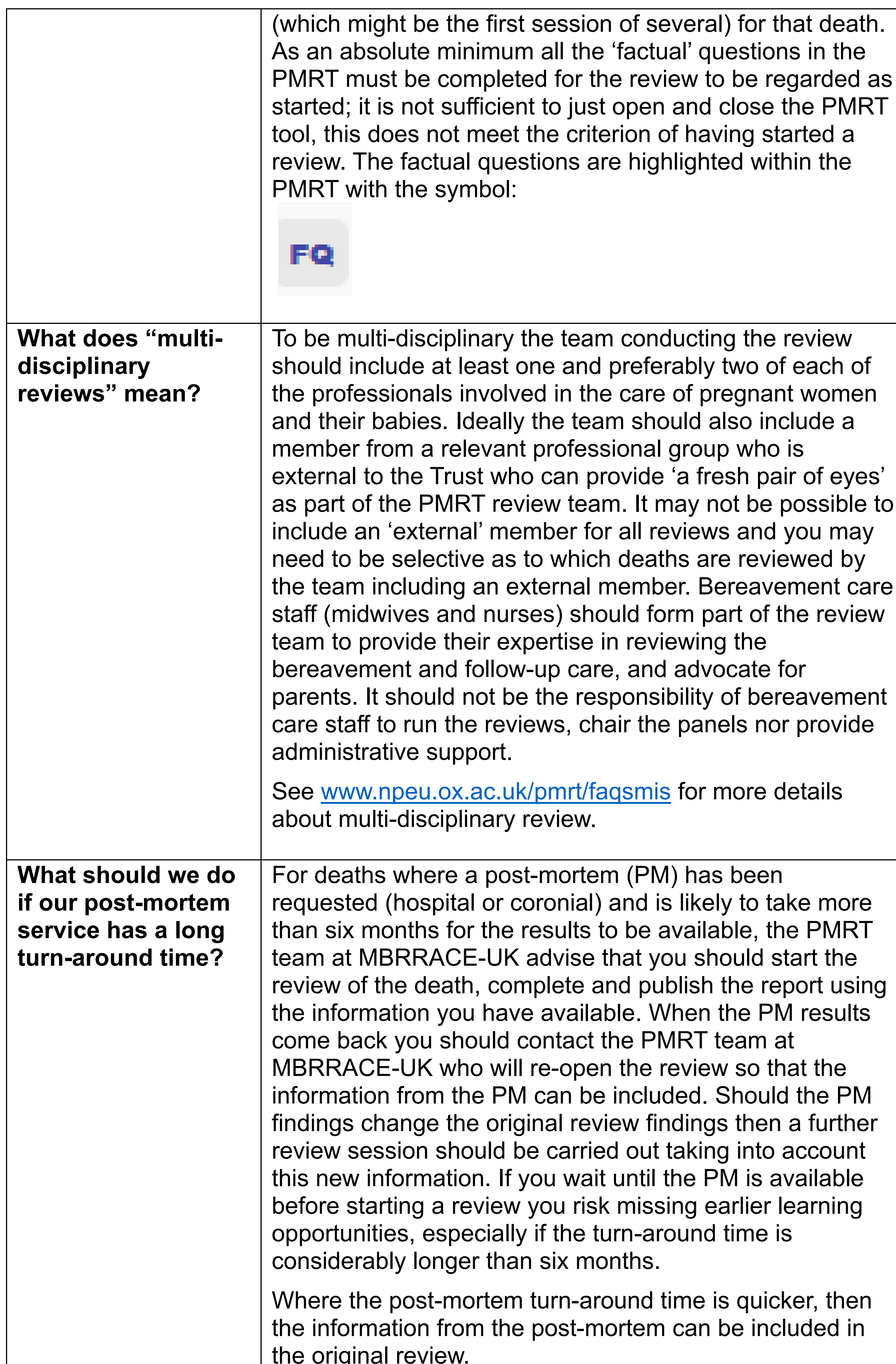
Link to technical guidance

Technical Guidance

Technical Guidance for Safety Action 1	
Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the MBRRACE-UK/PMRT system to track your notifications and reviews: www.npeu.ox.ac.uk/pmrt/faqsmis; these FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk.	
SA 1(a) – Notify all eligible deaths	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal deaths must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that the Submit a Perinatal Event Notification system (SPEN) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through SPEN and this information will be passed to MBRRACE-UK. It will still then be necessary for reporters to log into the MBRRACE-UK/PMRT system to provide the surveillance information and to use the PMRT.
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK must be notified to MBRRACE-UK within seven working days.
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route

	of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission to CDOP. This will also be the required route for providing additional information about the death required by both CDOPs and the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in 2024.
SA 1(b) – Seek parents' view of care	
We have informed parents that a local review will take place and they have been asked if they have any feedback or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' feedback, perspectives, and any questions can be considered during the review, this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' feedback and perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
We have contacted the parents of a baby who has died, and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their feedback and raise any questions and/or concerns they may subsequently have about their care.

	Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.
Parents have not responded to our messages and therefore we are unable to discuss their feedback at the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
SA 1(c) – Review the death and complete the review	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: d) Late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) e) Stillbirths (from 24+0 weeks' gestation) f) Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) up to 28 days after birth While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.
What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session



	(which might be the first session of several) for that death. As an absolute minimum all the ‘factual’ questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: FQ
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

Q3|October - December 2024

Title	**Family Care Division Quarterly PMRT Report (October -December 2024)**
Author	Helen Collier, 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

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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 Q2

1. Deaths notified to MBRRACE within 7 working days (target 100%)
   a. **100% (n=7) notified within target time**
2. Parents given opportunities to provide feedback or raise questions/concerns (target 95%)
   a. **100% (n=7) of parents had their input sought**
3. A review of the death should be commenced within 2 months (target 95%)
   a. **100% (n=7) had a PMRT review commenced within target time**
4. A multi-disciplinary review should be completed and published by 6 months (target 60%)
   a. **100% (n=3) 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 (Q3)			
	October	**November**	**December**	**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**

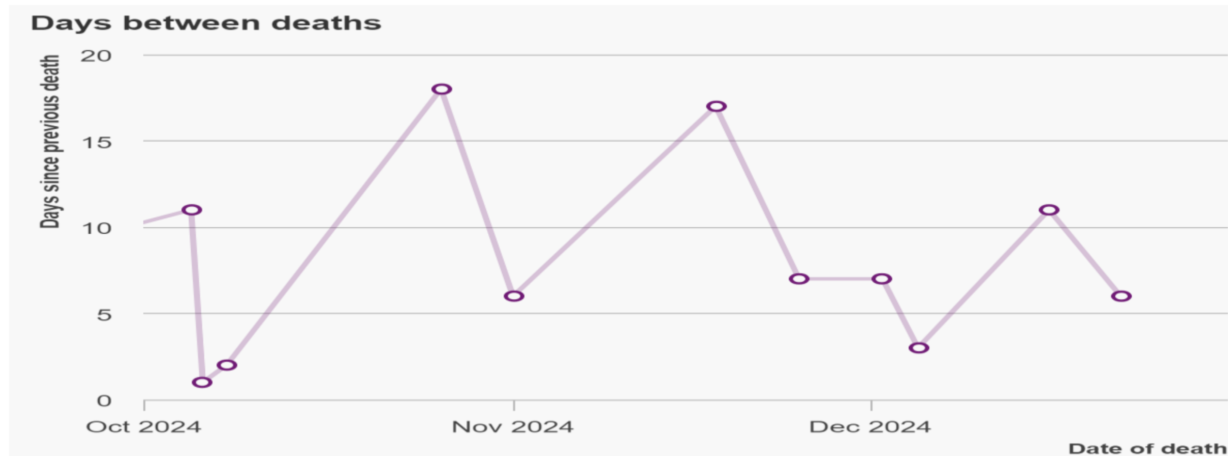
Grading of care – Neonatal deaths & Late fetal losses

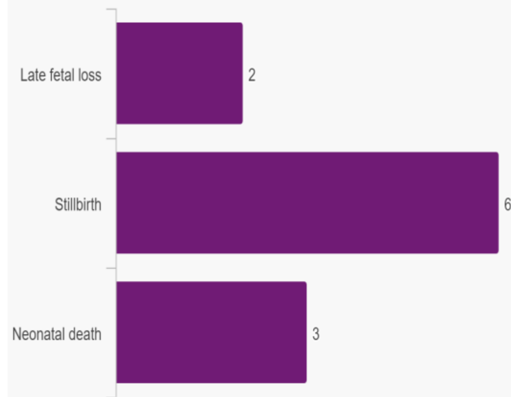
	Meeting Month (Q3)			
	October	**November**	**December**	**Total**
Number of cases discussed	**3**	**4**	**3**	**10**
Grading (up to birth of baby)				
A	**2**	**2**	**0**	**4**
B	**0**	**1**	**3**	**4**
C	**1**	**0**	**0**	**1**
D	**0**	**0**	**0**	**0**
Grading (from birth of baby until death)				
A	**2**	**0**	**0**	**2**
B	**1**	**4**	**0**	**5**
C	**0**	**0**	**0**	**0**
D	**0**	**0**	**0**	**0**
Grading (following death of baby)				
A	**3**	**2**	**0**	**5**
B	**0**	**0**	**0**	**0**
C	**0**	**0**	**0**	**0**
D	**0**	**0**	**0**	**0**

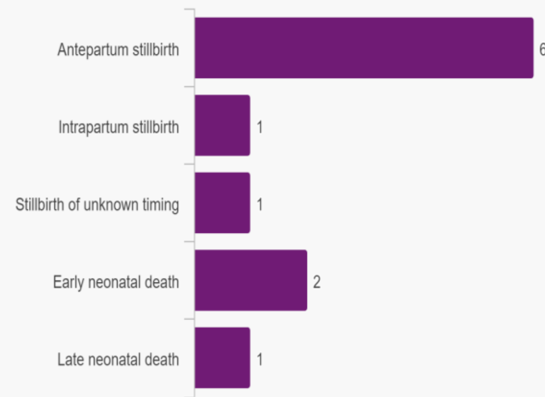
Clinical summary of new cases eligible for PMRT review occurring during Q4

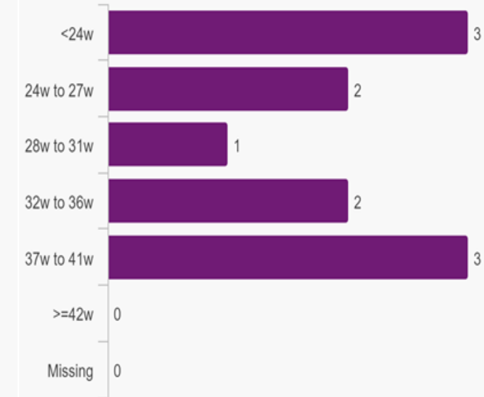
MBBRACE ID	Type of case	Gestation at birth	Date of death	Clinical summary
95465	Stillbirth	28+3	06/10/24	Attended 28/40 MW appointment – no FH. Fetal weight 0 centile.
95527	Stillbirth	26+2	08/10/24	IUD - suspect mother took mife/miso illegally
95876	NND	36+6	01/11/24	Expected NND - anencephaly
96316	Stillbirth	34+4	02/12/24	Previous bariatric surgery. Attended with RFMs – no FH. Normal growth at 33/40.
96429	Stillbirth	22+1	05/12/24	Attended with PV bleeding, preterm birth
96514	Late Fetal Loss	22+6	16/12/24	No FH detected at second attempt at anomaly scan.
96543	NND	24+3	22/12/24	PPROM from 21/40. Recurrent small antepartum haemorrhage, preterm birth.

MBRRACE Real time data 1st October – 31st December









PMRT Action Tracker (as of 31st December 2024 – completed actions excluded)

ISSUE	AGREED ACTION	PROGRESS	ACTION UPDATE	LEAD	DEADLINE	STATUS	COMPLETED DATE
History of previous thrombophilia with future care plan agreed, this was not acessed or followed inthis pregnancy, mother had a secong stillbirth.	Pathway of care for women who have had a previous pregnancy loss to be reviewed.	Ongoing - no issues	Rainbow CLinic guideline and pathway is under review	H Collier	01/2/25	Rainbow clinic model being reviewed	01/2/25
Review team felt that a skin laceration during birth could have been the source of infection - awareness of this could be improved.	Set up a Skin Care champion in NICU	Ongoing - no issues		J Murali		Ongoing	31/12/2024

Consultant Attendance audit

25th October to 31st Dec 2024

Fiona Clarke

Findings 26th Oct to 31st Dec 2024

Obstetrics Condition	No. of Patients	Consultant Attendance	Comments
Caesarean birth for major placenta praevia / abnormally invasive placenta	1	0	ST 6 and SCF, posterior placenta praevia just covering the os, EBL under 1 l, was performed in weekday when consultant was on CBS, cons presence not documented
Caesarean birth for women with a BMI >50	2	2	
Caesarean birth <28/40	3	3	
Premature twins (<30/40)	0	0	
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	4	3	St3 and St5 , total EBL 2.1, bleeding settled as reached theatre. was performed in weekday when consultant was on CBS, cons presence not documented
Gynaecology			
Any laparotomy			Currently unable to identify cases after introduction of CERNER

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

CNST Year 6 SA 10 update /Jan 25

Name	Incident	MNSI consent	MNSI DOC letter sent	NHSR leaflet given	Referred to MNSI	Case accepted	Reported to NHSR	Claims Reporting Wizard	Date ref. NHSR
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	8/05/24 Inc. date; 26/04/24
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	17/07/24 Inc date; 30/05/24 Delay in MNSI accepting case due to language
Mahmood	Cooled baby	Yes	Yes	Yes	Yes	Yes	Yes	Yes M24CT645/034	09/07/24 Inc. date; 07/06/24
Imran	Maternal death	Yes	Yes	N/A	Yes	Yes	N/A	N/A	
Giordano	Cooled baby	Yes	Yes	Yes	Yes	Yes		Yes Awaiting Id number	22/10/24 Inc. date; 26/09/24 Declined by NHSR
Ainekar	Intrapartum Stillbirth	Yes	Yes	N/A	Yes	Yes	N/A	N/A	
Mulla	Cooled Baby	No	Yes	Yes	No *MNSI informed of cooled baby but no consent from family	N/A	N/A	N/A	
Imdad	Intrapartum stillbirth	Yes	Yes	N/A	Yes	N/A	N/A	N/A	
Parkinson	Intrapartum stillbirth	Yes	Yes	N/A	Yes	Yes	N/A	N/A	
Cocker	Cooled Baby	Yes	Yes	Yes	Yes	In triage			
McClelland	Cooled Baby	Yes	Yes	Yes	Yes	In triage			

Dabiello - Britton	Cooled Baby	Yes	Yes	Yes	Yes	In triage			

NHS England

Three year delivery plan for maternity and neonatal services

March 2023

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Summary

With this plan we aim to make care safer, more personalised, and more equitable, by:

Listening to women and families with compassion which promotes safer care.

- All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
- During 2023/24, Integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
- From 2023/24, Integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

Supporting our workforce to develop their skills and capacity to provide high-quality care.

- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Developing and sustaining a culture of safety to benefit everyone.

- Throughout 2023, effectively implement the NHS-wide “PSIRF” approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Meeting and improving standards and structures that underpin our national ambition.

- Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new “MEWS” and “NEWTT-2” tools by 2025.
- In 2023, NHS England’s new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
- By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

Introduction

1. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. We are grateful to the many people and organisations that have shared what needs to be done including NHS staff, Donna Ockenden, Dr Bill Kirkup, and organisations representing families. Most importantly, we would like to thank those using maternity and neonatal services for informing this plan. While the birth of a baby represents the happiest moment of many people's lives, some families have experienced unacceptable care, trauma, and loss, and with incredible bravery have rightly challenged the NHS to improve.

2. The summary above sets out the benefits we expect to deliver for families through this plan. This will continue to require the dedication of everyone working in NHS maternity and neonatal services in England, who work tirelessly to support families and improve care. Most women have a positive experience of NHS maternity and neonatal services, and outcomes have improved with over 900 more families welcoming a healthy baby each year compared to 2010.

3. But we must acknowledge that there are times when the care we provide is not as good as we want it to be. Recent independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford and by Dr Bill Kirkup on maternity and neonatal services in East Kent, and previously Morecambe Bay, set out many examples of poor care over years. We know that families from some groups, especially ethnic minorities, have had particularly poor experiences. We must work together to change this, and this plan sets out how we will do this.

4. In preparing this plan we have listened to what you have to say. We know all staff want women and babies to be at the centre of care, and with so many improvement initiatives it can be difficult to know what to prioritise. We know gaps in staffing mean those who provide care do not always have time to learn and improve, and on occasion, struggle to provide care to the highest standards. We have heard that some people feel disempowered by negative team cultures and a lack of strong leadership.

5. For the next three years, we are asking services to concentrate on **four high level themes**. Please take some time to consider these themes, what they mean to you and to the women and babies you care for. Working together, we can make a real difference.

Responsibilities

6. This plan sets out what we need to have in place, and responsibilities for each part of the NHS:

   - Trusts are the main operational unit of maternity services in the NHS and the employer of most staff. Trust boards have a statutory duty to ensure the safety of care, including ensuring staff have the resources they need.
   - Integrated care boards (ICBs) commission most maternity services. Each ICB will be a partner in an integrated care system (ICS). ICSs are a partnership of organisations that plan and deliver joined up health and care services. The local maternity and neonatal system (LMNS) is the maternity and neonatal arm of the ICS. ICBs commission maternity and neonatal voices partnerships (MNVPs) which are designed to facilitate participation by women and families in local decision-making.
   - NHS England provides national leadership for the NHS in England. NHS England operates through regional teams which are responsible for relationships with individual ICBs. NHS England has statutory responsibility for commissioning neonatal services, through regional specialised commissioning teams and operational delivery networks (ODNs).

7. It is everyone's responsibility to provide or support high quality care. That includes a responsibility at each level of the NHS to understand the quality of care and identify, address, and escalate concerns. We have sought to improve our approach to quality surveillance at trust, ICS, regional, and national level. This involves bringing together all relevant partners at each level to facilitate robust understanding and action, informed by shared and accurate information. Some trusts need additional support to improve – this is provided through the Maternity Safety Support Programme (MSSP), which aligns with the overall NHS Oversight Framework and tiered support, so that support for maternity and neonatal care forms part of a wider response where needed.

What you told us

8. We could not develop this delivery plan without talking to people who use, work in, lead, or have an interest in these services. We want to thank everyone who shared their views to inform this plan. We held 50 meetings reaching over 1,000 attendees, including 191 service users, 419 workforce members, 329 leaders of services, systems, and regions, and 106 stakeholders. We additionally received 2,128 responses to our survey from 782 service users, 1,133 workforce members, 105 leaders, and 108 stakeholders.

9. While most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. Intersex, transgender, and non-binary people experiencing pregnancy and birth can experience particular health inequalities including poorer access and a lack of information and support in relation to their specific clinical and care needs within maternity services. The information in this plan also applies to these individuals; particularly the principles described in Theme 1.

10. While each of the groups who helped inform this plan had different areas they gave greatest importance to, there was clear agreement on what the plan's focus should be. This consensus has shaped the four themes, and the objectives within each of these.

11. The most consistent priority among those using and providing services was safe care. Delivering safe care remains central to this delivery plan.

    "Safe, compassionate care, which allows you the confidence to speak up and be listened to if something is not right." (Service user)

    "We need to take action and make a pledge to improve the safety of every maternity service in England." (Leader)

12. You told us how important improving equity and equality is. We have a dedicated objective on improving equity.

    "Those that are most vulnerable should be enabled to have a strong voice within maternity care provision." (Stakeholder)

13. You told us that we need to be clear about who is responsible for doing what, and to bring the asks of services and systems into one place. This delivery plan sets out clear responsibilities and measures of success across services and systems.

    "One clear plan that looks to encompasses the recommendations from various reports such as Better Births, Ockenden, Kirkup." (Workforce member)

Listening to and working with women and families with compassion

14. You told us that personalised care supports safety, makes women feel valued, and avoids families needing to re-tell their story – who they are or what they need. You told us it is important to join up care across maternity and neonatal pathways.

    "To be treated as an individual human being." (Service user)

    "Consistency! I saw so many different people I had to tell them my 'story' every time." (Service user)

    "Being fully informed without judgement on pros and cons of all care offered." (Service user)

    "Listening to the families using the care and embedding their voices along all pathway." (Leader)

    "Supporting parents to be actively involved in the care of their baby on the neonatal unit (family integrated care)." (Service users)

Growing, retaining, and supporting our workforce

15. You told us that there needs to be enough staff in services, with the time and training to support their effectiveness as well as to protect their wellbeing.

    "Safe staffing that will then provide safe and personalised care." (Leader)

    "Enough staffing to feel supported, safe and provide care when it is needed." (Service user)

    "Adequate staff with the appropriate training working in the right environment. Having the time and resources to listen to women and their families." (Workforce member)

Developing and sustaining a culture of safety, learning, and support

16. You told us that there needs to be a positive culture and leadership in services. Staff need to be free to speak up, in an environment that learns from experiences and incidents and does so with compassion.

    "Listening, learning and facing up to failings." (Stakeholder)

"Confidence in the care provider, trust, integrity and honesty if mistakes occur." (Leader)

"Leadership training to enable managers to better manage teams and support them." (Workforce member)

"Psychological safety at work and teams that work together with a shared vision and a foundation of kindness." (Stakeholder)

Standards and structures that underpin safer, more personalised, and more equitable care

17. You told us that we need to improve our data collection to help oversight and improvement, among other important standards and infrastructure. Our fourth theme focuses on these crucial elements that support the other themes.

"Notes to be available to all staff when required rather than just to one person." (Service user)

"Delivering high quality, evidence-based care in a local environment for service users." (Workforce member)

"Improved data collection and IT systems - joined up maternity and neonatal electronic patient record systems which are user friendly and accessible." (Workforce member)

"Organisational transparency and providing in depth data to provide meaningful data that can be used to prevent as well as respond to trends and themes." (Leader)

Theme 1: Listening to and working with women and families with compassion

1.1 Listening and responding to all women and families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services and helps address health inequalities. Better Births identified that "women wanted to be listened to about what they want for themselves and their baby, and to be taken seriously when they raise concerns". The Ockenden report into maternity services at Shrewsbury and Telford described how families who raised concerns "were brushed aside, ignored and not listened to". This section sets out actions for personalised care, improving equity, and working with service users.

1.2 Key commitments for women and families include:

Empowering staff to ensure that all women are offered personalised care and support plans as part of their care.

Ensuring pregnant women and new mothers have access to pelvic health services in every area of England by 2024 to identify, prevent, and treat common pelvic floor problems.

Rolling out perinatal mental health services to improve the availability of this specialist care.

Investing to ensure the availability of bereavement services 7 days a week by the end of 2023/24 for women and families who sadly experience loss.

Funding to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.

Implementing local plans to reduce inequalities in experience and outcomes for women and babies, including neonatal and maternal mortality.

Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support.

Objective 1: Care that is personalised

1.3 Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs. This information can be included in each personalised care and support plan to help ensure that service users do not have to repeat their story. While many women and babies experience excellent personalised care (CQC, 2023), it is clear from independent reports that not all do.

1.4 Our ambition is:

- Women experience care that is always kind and compassionate. They are listened and responded to.
- Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected.
- All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.
- Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination.
- Women have clear choices, supported by unbiased information and evidence-based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Re:Birth report, and is co-produced.
- All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and fetal medicine networks, and neonatal care, when needed.
- Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8

weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies.

- Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.
- Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units.

How we will make this happen

1.5 It is the responsibility of trusts to:

- Empower maternity and neonatal staff to deliver personalised care by providing the time, training, tools, and information, to deliver the ambitions above.
- Monitor the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings.
- Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022.
- Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.

1.6 It is the responsibility of integrated care boards (ICBs) to:

- Commission for and monitor implementation of personalised care for every woman.
- Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers.
- Commission and implement community perinatal mental health services including maternal mental health services, in line with national service specifications, to improve the availability of mental health care.

1.7 NHS England will:

- Work with service users and other partners to produce standardised information to aid decision-making, focusing on priorities identified by service users: intrapartum interventions, mode of birth, induction of labour, and pain relief.

- Extend the national support offer to the 38 maternity services yet to achieve UNICEF BFI accreditation or an equivalent initiative.
- Publish national postnatal care guidance by the end of 2023, setting out the fundamental components of high-quality postnatal care, to support ICSs with their local improvement initiatives. Information for GPs on the 6-8 week postnatal check will be published in spring 2023.
- In Spring 2023, publish a national service specification for perinatal pelvic health services alongside associated implementation guidance.
- Create a patient reported experience measure (PREM) by 2025 to help trusts and ICBs monitor and improve personalised care.
- By March 2024, act on findings from the evaluation of independent senior advocate pilots as set out in the interim Ockenden report.
- Invest to ensure availability of bereavement services 7 days a week by the end of 2023/24. This will help trusts to provide high quality bereavement care including appropriate post-mortem consent and follow-up.

Objective 2: Improve equity for mothers and babies

1.8 Significant health inequalities exist in maternity and neonatal care in England. For example, outcomes for women and babies from minority ethnic groups are worse than for white women, and outcomes for those living in the most deprived areas are worse than for those in the least deprived (MBRRACE-UK, 2022). Though we know NHS staff want to provide the best care to every woman and baby, a National Institute for Health and Care Research funded study found that "multiple structural and other biases exist in UK maternity care". (Knight, M et al, 2021).

The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived areas.

1.9 Our ambition is:

- To reduce inequalities for all in access, experience, and outcomes.
- Targeted support where health inequalities exist in line with the principles of proportionate universalism.
- Services listen to and work with women from all backgrounds to improve access, plan, and deliver personalised care. Maternity and neonatal voice partnerships

ensure all groups are heard, including those most at risk of experiencing health inequalities.

- The NHS collaborates with local authority services, other public sector organisations, and a wide range of private and voluntary sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022).

How we will make this happen:

1.10 It is the responsibility of trusts to:

- Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.
- Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. This data should be used to make changes to services and pathways to address any inequity or inequalities identified, to improve care.

1.11 It is the responsibility of ICBs to:

- During 2023/24, continue to publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, working across organisational boundaries.
- Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.

1.12 NHS England will:

- Provide regional and national support for the implementation of LMNS equity and equality action plans.
- Pilot and evaluate new service models designed to reduce inequalities, including enhanced midwifery continuity of carer, and from 2023, culturally sensitive genetics services for couples practising close relative marriage in high need areas.
- Continue to work with the Maternity Disparities Taskforce to explore disparities in maternity care and identify how to improve outcomes.

- In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services.

Objective 3: Work with service users to improve care

1.18 Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations representing service users.

1.19 Our ambition is:

- MNVPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.
- MNVPs have strategic influence and are embedded in decision-making.
- MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.

1.20 In addition, neonatal parental advisory groups represent service user experience as part of operational delivery networks.

How we will make this happen:

1.21 It is the responsibility of trusts to:

- Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.

1.22 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.
- Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.
- Ensure service user representatives are members of the local maternity and neonatal system board.

1.23 NHS England will:

- Co-produce national policy and quality improvement initiatives with national and regional service user representatives and MNVP leads.
- Through operational delivery networks, support parent representation in the governance of neonatal services.
- Provide funding for clinical leadership and programme management of ICBs, which includes funding to support service user involvement.

Determining success for Theme 1

1.24 We will determine overall success by listening to women and their families:

- Our outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey. They will be aggregated at trust, ICB, and national levels and at national level analysed by ethnicity and deprivation.
- We will use these progress measures:
  - Perinatal pelvic health services and perinatal mental health services are in place.
  - The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard.
  - The proportion of maternity and neonatal services with UNICEF BFI accreditation.
- Evidence which ICBs can use includes:
  - Feedback on personalised care gathered via MNVPs from a wide range of service users.
  - Local evidence of working with women and families to improve services, including co-production.
- Relevant regulation and incentivisation includes:
  - The CQC will continue to consider compassionate and personalised care as key lines of enquiry during inspections.
  - The NHS Resolution CNST Maternity incentive scheme which encourages the use of MNVPs.

Case Study: Seeking Sanctuary Clinic - to enhance the maternity care of anyone seeking sanctuary

The Seeking Sanctuary Clinic, hosted in Berkshire West, is a specialist maternity clinic developed in 2021 from co-production between Royal Berkshire NHS Foundation Trust maternity team, and Berkshire West public health team, to enhance the maternity care of anyone seeking sanctuary such as refugees, asylum seekers, those fleeing conflict, undocumented migrants and people who have been trafficked.

This is a 'one stop shop' style clinic held in a children's centre, delivered in two-hour sessions held every two months, aimed specifically for these families, in addition to their usual antenatal and postnatal care. The barriers to access and inequalities that these families may be experiencing are removed where possible. For example, women are able to bring their partners and children with them, there are interpreters booked for every language in attendance, refreshments are provided and transport is available to support people to get to the clinic.

There are many health care professionals and voluntary organisations that come together at the clinic including midwifery and obstetrics. There is also accessible antenatal education with New Directions, sexual health, health visiting, a tuberculosis service, health in pregnancy advisors, Compass Recovery College (mental health and wellbeing support), Reading Refugee Support and Reading Voluntary Action.

The clinic is ever evolving, and additional professionals and organisations are invited to sessions to meet the bespoke needs of the group. Local charity The Cowshed donated to the clinic enabling each family that attends to be provided a ready-made birth bag to assist them on their journey.

The local Maternity Voices Partnership also attends to offer feedback sessions for these groups. While the project is in an initial evaluation phase, feedback so far has been very positive from service users, with more than fifty families supported so far, predominantly from Afghanistan, Syria, and Ukraine.

Theme 2: Growing, retaining, and supporting our workforce

2.1 The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability. However, despite significant investment leading to increases in the midwifery, obstetric, and neonatal establishment, NHS maternity and neonatal services do not currently have the number of midwives, neonatal nurses, doctors, and other healthcare professionals they need. This means existing staff are often under significant pressure to provide the standard of care that they want to. We need to change that. The plan is informed by the best available evidence, including the QMNC framework which underpins the NMC midwifery standards. This theme sets out three areas of action for maternity and neonatal staffing: continuing to grow our workforce; valuing and retaining our workforce; and investing in skills.

2.2 Key commitments for women and families include:

> NHS services will ensure the right numbers of the right staff are available to provide the best care for women and babies through regular local workforce planning, including trusts meeting staffing establishment levels and achieving fill rates by 2027/28 for midwifery.
>
> Implementing staff retention improvement action plans to identify and address local retention issues. During 2023/24, retention midwives will be funded in every maternity unit.
>
> Supporting the retention and recruitment of staff caring for babies in neonatal units by continuing to invest in education and workforce leads.
>
> Providing a core competency framework that will inform local mandatory training programmes to ensure that the skills relevant to staff's roles are kept up to date.

Objective 4: Grow our workforce

2.3 The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and

psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements.

2.4 Established midwifery posts have increased by over 2,000 WTE since March 2021, with obstetric consultant posts and maternity support worker posts each increasing by around 400 WTE since April 2021. For neonatal services, we have invested to establish over 550 new neonatal nurses, care-coordinators, and workforce and education leads, and have committed to funding 130 WTE new allied health professional and over 40 WTE new psychologist posts.

2.5 Our ambition is for:

- Workforce capacity to grow as quickly as possible to meet local needs.
- Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training, absence, and leave.
- Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning.

How we will make this happen

2.6 It is the responsibility of trusts to:

- Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.
- Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.
- Provide administrative support to free up pressured clinical time.

2.7 It is the responsibility of ICBs to:

- Commission and fund safe staffing across their system.
- Agree staffing levels with trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels (for example, guidelines for the provision of anaesthesia services for an obstetric population and implementing the recommendations of the neonatal critical care transformation review).

- Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity. It is expected that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.
- Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and quality of clinical placements.

2.8 NHS England will:

- Assist trusts and regions with their workforce growth plans by providing direct support, including through operational delivery networks for neonatal staffing.
- Boost midwifery workforce supply across undergraduate training, apprenticeships, postgraduate conversion, return to midwifery programmes, and international recruitment.
- Increase medical training places across obstetrics and gynaecology and anaesthetics, to expand the consultant workforce in maternity services.
- Collaborate with the Royal College of Obstetricians and Gynaecologists (RCOG) to support their work developing an obstetric workforce planning tool, to be published in 2023/24. This initiative will help establish the staffing levels required to appropriately resource clinical leadership and intrapartum care.

Objective 5: Value and retain our workforce

2.9 Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. A growing number of staff who leave are aged under 55 and do so for reasons other than retirement. Some staff groups, including ethnic minority staff, are more likely to report negative experiences of working in NHS maternity and neonatal services. We need to do more to improve the experience of all our staff, to retain them within the NHS.

2.10 Our ambition is:

- Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.
- All staff are included and have equality of opportunity.

- A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination.

How we will make this happen

2.11 The NHS Long Term Plan and NHS People Plan set out how improving the experience of our NHS people will encourage them to stay with us for longer.

2.12 It is the responsibility of trusts to:

- Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.
- Implement equity and equality plan actions to reduce workforce inequalities.
- Create an anti-racist workplace, including for example, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource.
- Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey.
- Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.
- Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.

2.13 It is the responsibility of ICBs to:

- Share best practice for retention and staff support.
- Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach.

2.14 NHS England will:

- Support retention with funding to continue a retention midwife in every maternity unit during 2023/24, with ICBs maintaining the focus on retention thereafter.
- Continue to invest in neonatal operational delivery network (ODN) education and workforce leads to support the recruitment and retention of neonatal staff.
- In 2023/24, provide funding to establish neonatal nurse quality and governance roles within trusts, to support cot-side clinical training and clinical governance.

- In 2023/24, strengthen neonatal clinical leadership with a national clinical director for neonatal and national neonatal nurse lead.
- Continue to address workforce inequalities through the Workforce Race Equality Standard.
- Provide national guidance for implementation of the A-Equip model and for the professional midwifery advocate role to provide restorative clinical supervision in local services.
- By July 2023, develop a safe clinical learning environment charter for trusts; by April 2024, develop models for coaching; and, by October 2024, embed a framework to support the standards of supervision and assessment for midwifery students. These initiatives will help to ensure high quality clinical placements for those training to be midwives.

Objective 6: Invest in skills

2.15 Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and career development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to improve outcomes, yet unwarranted variation in training and competency assessment currently exists, especially for temporary staff (for example, Stulberg et al, 2020, McCulloch et al, 2008).

2.16 Our ambition is:

- All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development.
- All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards.
- Training is multi-disciplinary wherever practical to optimise teamworking.

How we will make this happen

2.17 It is the responsibility of trusts to:

- Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.

- Ensure junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.
- Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.

2.18 NHS England will:

- Refresh the curriculum for maternity support workers (MSWs) by June 2023.
- Provide tools to support implementation of the MSW competency, education, and career development framework by September 2023.
- Work with RCOG to develop leadership role descriptors for obstetricians by summer 2023 to support job planning, leadership, and development.
- Establish a sustainable national route for the training of obstetric physicians, to support the development of maternal medicine networks.
- Work with royal colleges and professional organisations to understand and address the challenges involved in recruiting and training the future neonatal medical workforce.
- Through action set out above to grow the workforce, help to address pressures on backfill for training.

Determining success for Theme 2

2.19 We will determine overall success by listening to staff:

- Our outcome measures for this theme will be the NHS Staff Survey, the National Education and Training Survey, and the GMC national training survey.
- Our progress measures will be:
  - Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data.
  - In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups. This will facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists.

- To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale.

- Evidence that ICBs can use includes:
  - Progress against workforce, retention, succession, and training plans.
  - Local staff feedback mechanisms.
  - Progress against the nursing and midwifery high impact retention interventions.
- Relevant regulation and incentivisation includes:
  - The CQC inspection criteria includes key lines of enquiry around staff skills, knowledge, experience, and opportunities for development.
  - The NHS Resolution CNST maternity incentive scheme incentivises trusts to evidence that training in accordance with the core competency framework is in place.

Case study: One stop obstetric ambulatory service

The Chelsea and Westminster Hospital NHS Foundation Trust cares for approximately 5,500 maternity patients per year. The maternity team identified common themes in complaints about their service, including delays in receiving care and long waits for obstetric or scan reviews. The team felt they could improve triage management, patient experience and care, through a truly multidisciplinary approach so set up a 'one stop' service since January 2021.

The team recognised a key cause of delay within the department was delays in obstetric reviews. They were able to increase consultant presence and recruit a clinical fellow with obstetric ultrasound training to work solely in the triage department for five mornings a week, to deliver a 'see and treat' set up, comparable to the way emergency departments are run.

The triage team also includes midwives and maternity support workers, who greet attendees, perform initial observations and a dedicated receptionist who enables clinicians to focus on care rather than administrative tasks. Some midwives have developed professionally to perform tasks that are usually undertaken by obstetricians, such as prescribing and performing presentation scans.

From October 2022 to February 2023 the service has had on average 850 visits per month, with around 100 ultrasound scans performed. The department answers approximately 2,500 phone calls per month, with one midwife allocated to answer phone calls each day to triage and support women.

Improvements in the new obstetric ambulatory service triage system mean the department works more efficiently and safely with staff feeling better supported. Waiting times have been reduced, with 80-95% of women seen within 15 minutes of arrival which exceeds the national KPI (within 30 minutes) for maternity triage services. Feedback from women has also been increasingly positive. The team are exploring future opportunities to expand the service hours and increase the scope of midwifery and maternity support workers, supporting the team's development and dynamic skillset.

Theme 3: Developing and sustaining a culture of safety, learning, and support

3.1 An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive. We want everyone to experience the positive culture that exists in many services – poor cultures need to be challenged and addressed. The failures in care identified in the Kirkup report stemmed from weaknesses in culture throughout the organisation, including a lack of teamworking, professionalism, compassion, listening, and learning. This theme sets out actions in three areas: developing and sustaining a positive safety culture for everyone; learning and improving; and support and oversight.

3.2 Key commitments for women and families include:

> Supporting staff to work with professionalism, kindness, compassion, and respect. Leaders will empower their teams to do this, with practical guidance and training through the perinatal culture and leadership programme by 2024.
>
> Implementing an NHS-wide approach in 2023 for all incidents to support families with a compassionate response, and to ensure learning.
>
> Listening and acting upon issues raised by staff or service users through Freedom to Speak Up (FTSU) Guardians, the complaints process, or maternity and neonatal voices partnerships (MNVPs).

Objective 7: Develop a positive safety culture

3.3 Culture is everyone's responsibility and key to enabling cultural change is compassionate, diverse, and inclusive leadership in maternity and neonatal services and beyond.

3.4 Our ambition is:

- All staff working in and overseeing maternity and neonatal services:
  - Are supported to work with professionalism, kindness, compassion, and respect.

  - Are psychologically safe to voice their thoughts and are open to constructive challenge.
  - Receive constructive appraisals and support with their development.
  - Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.
- Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.
- There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'.
- Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.
- Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.
- Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief.

How we will make this happen

3.5 It is the responsibility of trusts to:

- Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. This includes time to engage stakeholders, including MNVP leads.
- Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.
- At board level, regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy.
- Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.
- Ensure all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.

3.6 It is the responsibility of ICBs to:

- Monitor the impact of work to improve culture and provide additional support when needed.
- Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other.

3.7 NHS England will:

- By April 2024, offer the perinatal culture and leadership programme to all maternity and neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads. This includes a diagnosis of local culture and practical support to nurture culture and leadership.

Objective 8: Learning and improving

3.8 Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and improvement approach, from teams to ICBs.

3.9 Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services.

3.10 The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria. The responsibilities for trusts and ICBs set out below, also apply to these, or any other external investigations.

How we will make this happen

3.11 It is the responsibility of trusts to:

- Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of duty of candour and a single point of contact for ongoing dialogue with the trust.
- Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.
- Respond effectively and openly to patient safety incidents using PSIRF.

- Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.
- Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.
- Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).

3.12 It is the responsibility of ICBs to:

- Share learning and good practice across all trusts in the ICS.
- Oversee implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place.

3.13 NHS England will:

- Throughout 2023, support the transition to PSIRF through national learning events.
- Through regional teams, share insights between organisations to improve patient safety incident response systems and improvement activity.

Objective 9: Support and oversight

3.14 While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise.

3.15 Our ambition is:

- Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate.
- Well led services, with additional resources channelled to where they are most needed.
- Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.

How we will make this happen

3.16 It is the responsibility of trusts to:

- Maintain an ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.
- Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard.
- Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.
- Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.
- At board level, listen to and act on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the FTSU guide and improvement tool.

3.17 It is the responsibility of ICBs to:

- Commission services that enable safe, equitable, and personalised maternity care for the local population.
- Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives.
- Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.

3.18 NHS England will:

- Through our regional teams, listen to the local NHS and through our national governance listen to frontline staff voices and continue to work RCOG, RCM, BAPM, and others.
- Continue to work closely with national bodies, ICBs, and trusts to address issues escalated to national level.
- Provide nationally consistent support for trusts that need it through the Maternity Safety Support Programme (MSSP).
- Work to align the MSSP with the NHS oversight framework, improve alignment with the recovery support programme, and evaluate the programme by March 2024.
- During 2023/24, test the extent to which the PQSM has been effectively implemented.

- By March 2024, provide targeted delivery of the maternity and neonatal board safety champions continuation programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.

Determining success for Theme 3

3.19 Achieving meaningful changes in culture will take time and progress measures are difficult to identify and can have unintended consequences. We will primarily determine overall success by listening to the people who use and work in frontline services.

3.20 Our outcome measures for this theme are midwives' and obstetrics and gynaecology specialists' experience using the results of the NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey. We will explore how to better understand the experiences of other staff groups.

- The evidence ICBs can use across maternity and neonatal services includes:
  - Assurance from trust boards that they are using an appreciative enquiry approach to support progress with plans to improve culture.
  - Whether trust boards regularly share and act on learning.
  - Staff feedback on how incidents and issues of concern are managed.
- Relevant regulation includes:
  - The CQC will continue to consider whether a trust has a learning and responsive culture, strong leadership, and robust governance.

Case study: NFaST - Neonatal Families and Staff Together, supporting neonatal units to become more emotionally supportive environments

In 2021, the North West Neonatal Operational Delivery Network commissioned Spoons, a Greater Manchester-based charity specialising in neonatal family support, to research how their neonatal units could become more emotionally supportive environments for service users and staff.

The project worked with 13 neonatal units and a 28-family focus group, collecting data from more than 260 parents and 250 staff members, exploring their emotional needs. The project identified that the experience of neonatal care has a profound long-term impact on parents and their infants. In turn, the experience of working on a neonatal unit is emotionally challenging and can have significant impact on a staff member's individual wellbeing.

Volunteer peer supporters, who had personal experience of neonatal care, were trained for the units. Psychological training was provided to 100 staff across four neonatal units, including doctors, nurses, and support staff. Reflective practice group sessions were led by a clinical psychologist, to help the teams collaborate and understand each other and the needs of their babies and families better.

The pool of volunteer peer supporters continues to grow, and additional peer support training has been commissioned, with a model of ongoing supervision in development. This project demonstrates the power of true collaboration between the NHS, service users and third sector partners.

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

4.1 To deliver the ambition set out in this plan, maternity and neonatal teams need to be supported by clear standards and structures. This includes being enabled to implement best clinical practice for all families, having high quality data to inform the decisions of clinicians and leaders, and having digital tools that enable information to flow. In many areas this is already in place; this plan does not seek to introduce new standards, extra reporting, or change structures, but to ensure that these enablers are consistently implemented to support care.

4.2 Key commitments for women and families include:

Making care safer by consistently implementing best practice, including:

- By 2024, an updated version of the updated Saving Babies Lives Care Bundle – a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- By 2025, the national maternity early warning score and updated newborn early warning trigger and track tools to improve the care of unwell mothers and babies, enabling timely escalation where needed.

In 2023, NHS England's new taskforce will report on how data can be used as an early warning system to detect safety issues within maternity and neonatal services, enabling action to address any issues sooner.

By 2024, the NHS will publish refreshed data and recording standards that allow us to collect more meaningful standardised data that can then be used to improve care.

Supporting the roll out electronic patient records to enable women to access their records and interacting with their digital plans and information to support informed decision-making.

Objective 10: Standards to ensure best practice

4.3 Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. However, the Ockenden report found that many women cared for at the trust were not offered care in line with best clinical practice. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care. Additionally, the Kirkup report highlighted the detrimental effect that sub-optimal estates have on the provision and experience of care.

4.4 Nationally defined best practice already exists, including:

- The Saving Babies Lives Care Bundle, a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- The national maternity early warning score (MEWS)and updated newborn early warning trigger and track (NEWTT-2) tools to improve the detection and care of unwell mothers and babies, enabling timely escalation of care.
- NICE guidance, which sets out the evidence based best practice in maternity and neonatal care.

4.5 Our ambition is:

- Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities.
- Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice care.
- Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance.
- Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines.
- Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies.

How we will make this happen

4.6 It is the responsibility of trusts to:

- Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.
- Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.
- Ensure staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance.
- Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.

4.7 It is the responsibility of ICBs to:

- Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle.
- Oversee and be assured of trusts' declarations to NHS Resolution for the maternity incentive scheme.
- Monitor and support trusts to implement national standards.
- Commission care with due regard to NICE guidelines.

4.8 NHS England will:

- Keep best practice up to date through version 3 of the Saving Babies Lives Care Bundle and the MEWS and NEWTT-2 tools, as well as developing tools to improve the detection and response to suspected intrapartum fetal deterioration.
- Support the integration of MEWS, NEWTT-2, and other clinical tools into existing digital maternity information systems by autumn 2024.
- Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.
- Over the next 3 years, undertake a national maternity and neonatal unit infrastructure compliance survey and report, to determine the level of investment needed for an environmentally sustainable development of the maternity and neonatal estate across England.
- Continue to learn from research and evaluation as set out in the National Maternity Research Plan available on the FutureNHS platform.

Objective 11: Data to inform learning

4.9 The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects.

4.10 Our ambition is:

- Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.
- Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports.
- The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work.

How we will make this happen

4.11 It is the responsibility of trusts to:

- Review available data to draw out themes and trends and identify and promptly address areas of concern including consideration of the impact of inequalities.
- Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.

4.12 It is the responsibility of ICBs to:

- Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.

4.13 NHS England will:

- At a regional level, understand any variation in outcomes and support local providers to address identified issues.
- Convene a taskforce to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services, reporting by autumn 2023.

- Create a single notification portal by summer 2024 to make it easier to notify national organisations of specific incidents.

Objective 12: Make better use of digital technology in maternity and neonatal services

4.14 Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR). Most neonatal units use the same electronic product, which is designed for neonatal data capture, though some trusts and neonatal units are considering how to improve neonatal alignment with maternity and paediatrics as part of their EPR roll out.

4.15 Our ambition is:

- Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them.
- All clinicians are supported to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, secure networks, and training.
- Organisations enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices.

How we will make this happen

4.16 It is the responsibility of trusts to:

- Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England what good looks like framework.
- Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the digital maternity record standard and the maternity services data set and can be updated to meet maternity and neonatal module specifications as they develop.

- Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.

4.17 It is the responsibility of ICBs to:

- Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.
- Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.
- Support regional digital maternity leadership networks.

4.18 NHS England will:

- Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024.
- Publish a refreshed digital maternity record standard and maternity services data set standard by March 2024.
- Grow the digital leaders' national community, providing resources, training, and development opportunities to support local digital leadership.
- Incorporate pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app.
- Develop facets of a digital personal child health record with service user-facing tools to support neonatal and early years health by March 2025.

Determining success for Theme 4

4.19 We will determine overall success by focusing on clinical outcomes:

- Outcome measures for this theme are those of our existing safety ambition: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births. We will monitor these measures nationally by ethnicity and deprivation.
- The progress measures we will use are:
  - Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool.
  - Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care.

  - The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme.
  - A periodic digital maturity assessment of trusts, enabling maternity services to have an overview of progress in this area.
- The evidence that ICBs can use includes:
  - Clinical audits of implementation of shared standards. A standardised tool will be provided for assuring version 3 of the Saving Babies' Lives Care Bundle.
  - An ICB-wide dashboard to support benchmarking and improvement. The national maternity dashboard contains LMNS benchmarking on metrics where possible.
  - Progress against locally planned improvements.
- Relevant regulation and incentivisation includes:
  - The NHS Resolution CNST maternity incentive scheme supports trusts to provide safer maternity services through incentivising compliance with 10 safety actions.
  - The CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance.

Case Study: Ask A Midwife - using social media to communicate with service users

Ask A Midwife (AAM) is a social media messaging service managed by midwives, which empowers service users to make timely and informed decisions about their maternity care. AAM is coordinated centrally to ensure consistency of delivery and messaging by the Humber and North Yorkshire local maternity and neonatal system (LMNS), and four acute trusts are now working collaboratively to offer the service via Facebook, Instagram, and email.

The service is staffed by trust midwives who have a dual role in supporting the AAM service on a part-time basis alongside their clinical work. Questions from women and families range from pregnancy, birthing options, appointments, and the care of a new-born baby.

More than 94% of queries can be answered immediately and midwives can refer women to other health professionals and support organisations where required. The service routinely averages 800 queries per month, with more than 8,500 queries answered overall in 2022 and 508 onward referrals to health professionals, maternity units, NHS 111, and pharmacies. Patient confidentiality is conducted in the same way as telephone queries would be in a hospital, but the usual ways of contacting the hospital maternity team, such as by phone, are also available.

The service also allows the LMNS to cascade timely public health updates for pregnant women, including communications around vaccinations, perinatal mental health, postnatal care, and infant feeding. For example, when the AAM team saw an increase in messages around winter viruses they responded by posting self-help information.

AAM is promoted through Maternity Voices Partnership groups, with printed postcards and posters distributed in maternity settings, Children’s Centres, through direct referral by midwives, and attendance at community outreach events, such as one in Spring 2023 specifically for people from the Romanian and Polish community.

Support available to staff, trusts, and systems

The maternity hub on the FutureNHS platform has relevant material for each theme.

Theme 1: Listening to and working with women and families with compassion

- Personalised care and support planning guidance and the Personalised Care Institute
- Equity and Equality guidance for Local Maternity and Neonatal Systems
- NHS statutory guidance for working in partnership with people & communities
- National maternity voices partnership toolkit
- Service specification for care of pregnant and post-natal women in detained settings
- Delivering Midwifery Continuity of Carer at full scale
- Maternal medicine network national service specification

Theme 2: Growing, retaining, and supporting our workforce

- Nursing and midwifery retention self-assessment tool
- National preceptorship framework
- Advanced Clinical Practice: capability framework for midwifery
- RCOG advice and guidance on workforce planning and flexibility
- A 'how to' guide and templates to reflect the Core Competency Framework

Theme 3: Developing and sustaining a culture of safety, learning, and support

- Maternity and Neonatal Safety Champions toolkit
- NHS national freedom to speak up policy and guidance

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

- Support for quality improvement through patient safety collaboratives
- The Maternity self-assessment tool
- The recommendations register
- NICE guidance
- Saving Babies Lives Care Bundle
- An MSDS guidance hub
- For digital health there is Digital Maternity Leaders training course and the Shuri Network brings together women from minority ethnic groups

Acknowledgements

This plan has been developed with contributions from clinical leaders within NHS England and a wide range of partners, including but not limited to:

- The Independent Working Group, chaired by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists. Members include:
  - British Association of Perinatal Medicine
  - Royal College of Paediatrics and Child Health
  - Royal College of Anaesthetists
  - Obstetric Anaesthetists Association
  - Society of Radiographers
  - Care Quality Commission
  - The Department of Health and Social Care
  - Health Education England
  - Service user voice representatives.
- Hearing from around 3,000 people via events and a survey. This included:
  - People who use maternity and neonatal services
  - National and regional service user voice representatives
  - Frontline professionals, including midwives, obstetricians, and neonatal colleagues
  - Integrated care boards
  - NHS England regional teams
  - Voluntary, community, and social enterprise organisations
  - National Guardian's Office
  - National stakeholders.

We remain committed to working closely with partners as we deliver this plan. Thank you to all the individuals and organisations who have shared their time, expertise, and experience so far.

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

This publication can be made available in a number of alternative formats on request.

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TRUST BOARD REPORT | **Item** 41

12 March 2025 | **Purpose** Information

Title	Financial Performance Report Month 10 2024-25
Report Author	Ms C Henson, Deputy Director of Finance
Executive sponsor	Mrs S Simpson, Executive Director of Finance
Date Paper Approved by Executive Sponsor	6 March 2025

Summary: The Trust is reporting a deficit of £47.3m, against a planned deficit of £5.6m for the 2024-25 financial year to date. £41.7m behind the revised plan. A deficit of £5.8m in month, an improvement of £3.5m in month (M9 £9.3m).

Recommendation: To note the content.

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	Risk ID: Risk Descriptor. 10082 – Failure to meet internal and external financial targets for the 2024-25 financial year
Related to recommendations from audit reports	Assurance Framework Key Financial Controls Risk Management Core Controls
Related to Key Delivery Programmes	Finance Strategy and Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience, and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Finance and Performance Committee

Lancashire and South Cumbria Provider Collaborative

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Executive Summary

1. At M10, the Trust is reporting a deficit of £47.3m, against a planned deficit of £5.6m for the 2024-25 financial year to date. £41.7m behind the revised plan. A deficit of £5.8m in month, an improvement of £3.5m in month (M9 £9.3m).

2. Funding for the 2024-25 capital programme has increased by £2.2m to £36.0m for four additional externally funded schemes with forecast expenditure now £0.3m below plan, which the Trust expects to be able to manage.

3. The cash balance on 31st January 2025 was £2.1m, a reduction of £8.0m compared to the previous month, largely due to the Trust withholding £7.0m received to fund the 2024-25 pay award payment made in November at the end of the previous month, which the ICB deducted from the core contract payment.

Recommendation

4. The Trust Board is asked to:

   - Note the contents of this report.
   - Discuss the financial performance for 2024-25.

East Lancashire Hospitals
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Financial Update

Trust Board – Part 1

Wednesday, March 12, 2025

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Month 10 Financial Position

Month 10 Key Headlines

- The Trust is reporting a deficit of £47.3m, against a planned deficit of £5.6m for the 2024-25 financial year to date; £41.7m behind the revised breakeven plan. A deficit of £5.8m in month, an improvement of £3.5m in month (M9 £9.3m).
- The Trust had an agreed deficit financial plan of £21.9m, and a result of the allocation of the deficit support funding (DSF), all of which was received and recognised at month 6, the Trust's revised annual financial plan is to deliver a breakeven plan. This is a non-recurrent benefit in year.
- Due to the phasing of the Deficit Support Funding (DSF) the year-to-date position of £47.3m is understated by £3.6m so would be a deficit of £51.0m.
- Excluding the DSF, the year-to-date deficit is £69.2m.

Month 10 Key Headlines

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	NHSE Plan	In month			Cumulative		
		Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000
Operating Income							
Operating Income from Patient Care Activities	715,127	58,110	58,432	322	605,217	611,472	6,255
Other Operating Income	40,800	4,568	4,283	(285)	37,141	38,938	1,797
Employee expenses	(526,530)	(43,713)	(47,126)	(3,413)	(436,935)	(477,156)	(40,221)
Operating expenses excluding employee expenses	(206,916)	(14,119)	(19,214)	(5,095)	(192,327)	(202,382)	(10,055)
Operating (Deficit)	**22,481**	**4,846**	**(3,625)**	**(8,471)**	**13,096**	**(29,128)**	**(42,224)**
Net Finance Costs	(34,556)	(521)	(819)	(298)	(33,509)	(32,776)	733
Gains/(Losses) on disposal of assets	0	0	(2)	(2)	0	64	64
(Deficit) for the period/year	**(12,075)**	**4,325**	**(4,446)**	**(8,771)**	**(20,413)**	**(61,840)**	**(41,427)**
Remove impairments	0	0	0	0	0	0	0
Remove impact of PFI liability remeasurement	12,102	(1,350)	(1,378)	(28)	14,799	14,509	(290)
Remove capital donations/grants I&E impact	(27)	(9)	36	45	(14)	(17)	(3)
Breakeven duty financial performance (deficit)	**0**	**2,966**	**(5,788)**	**(8,754)**	**(5,628)**	**(47,348)**	**(41,720)**
Less Non-Recurrent Deficit Funding	(21,886)	0	0	0	(21,886)	(21,886)	0
Breakeven duty financial performance (deficit) excluding Non-Recurrent Deficit Funding	**(21,886)**	**2,966**	**(5,788)**	**(8,754)**	**(27,514)**	**(69,234)**	**(41,720)**

- Excluding the DSF, the year-to-date deficit is £69.2m.
- £1.5m of the improvement relates to pay costs, specifically a reduction of £1.1m in the usage of bank, £729k to the reduction in the usage of agency, offset by substantive costs increasing by £426k.
- £1.4m relates to an increase non-patient care related income, £0.8m relates to system depreciation income with £0.6m relating to DERI income

Month 10 Key Headlines

NHS
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	NHSE Plan	In month			Cumulative		
		Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000
Clinical Divisions							
Medicine & Emergency Care		(9,523)	(10,804)	(1,281)	(103,957)	(116,037)	(12,080)
Surgery and Anaesthetic Services		(3,616)	(5,854)	(2,239)	(46,710)	(62,609)	(15,899)
Community & Intermediate Care		(4,241)	(4,396)	(155)	(40,183)	(43,286)	(3,103)
Diagnostic and Clinical Support		(8,211)	(8,993)	(782)	(83,043)	(88,889)	(5,846)
Family Care Division		(5,323)	(5,603)	(280)	(54,621)	(58,746)	(4,125)
Sub Total		**(30,913)**	**(35,650.96)**	**(4,738)**	**(328,515)**	**(369,568)**	**(41,053)**
Non-Clinical Divisions							
Estates and Facilities		(5,019)	(5,319)	(300)	(50,045)	(53,807)	(3,762)
Corporate Services		(4,182)	(4,616)	(434)	(43,048)	(45,475)	(2,427)
Central Services & Income		46,075	43,460	(2,615)	456,282	458,891	2,609
Education, Research & Innovation		920	454	(466)	(1,242)	923	2,165
EBITDA : Earnings before interest, taxation, depreciation and amortisation	**46,893**	**6,880**	**(1,672)**	**(8,552)**	**33,433**	**(9,036)**	**(42,468)**
Depreciation	(20,984)	(1,748)	(1,619)	129	(17,480)	(16,379)	1,101
Amortisation	(3,428)	(286)	(335)	(49)	(2,857)	(3,713)	(857)
Impairments	0	0	0	0	0	0	0
Operating Surplus/(Deficit)	**22,481**	**4,846**	**(3,625)**	**(8,472)**	**13,096**	**(29,128)**	**(42,224)**
Finance Income	1,203	101	160	60	1,005	1,675	670
Finance Expense	(35,474)	(598)	(644)	(46)	(34,276)	(34,116)	160
PDC dividends payable/refundable	(285)	(24)	(335)	(311)	(238)	(335)	(98)
Net Finance Costs	**(34,556)**	**(521)**	**(818)**	**(298)**	**(33,509)**	**(32,776)**	**733**
Other gains/(losses)	0	0	(2)	(2)	0	64	64
	(12,075)	**4,326**	**(4,446)**	**(8,771)**	**(20,413)**	**(61,840)**	**(41,427)**
- remove impact of PFI liability remeasurement	12,102	(1,350)	(1,378)	(28)	14,799	14,509	(290)
- capital donations/grants I&E impact	(27)	(9)	36	45	(14)	(17)	(2)
Breakeven duty financial performance (deficit)	**0**	**2,966**	**(5,788)**	**(8,754)**	**(5,628)**	**(47,348)**	**(41,720)**
Less Non-Recurrent Deficit Funding	(21,886)	0	0	0	(21,886)	(21,886)	0
Breakeven duty financial performance (deficit) excluding Non-Recurrent Deficit Funding	**(21,886)**	**2,966**	**(5,788)**	**(8,754)**	**(27,514)**	**(69,234)**	**(41,720)**

Month 10 In-month

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- There has been a favourable movement of £3.5m from the month 9 position of £9.3m, to £5.8m in month 10
- Key movements to note between month 9 and month 10, are:
  - **Income** has increased by £3.1m month-on-month, largely due to retrospective negative income adjustments in the previous month relating to ERF (£2.5m) and Depreciation Funding (£1.1m), although the latter has been revised at Month 10 due to developments within the system. Other variances relate to reduced pass-through income for Drugs and Devices, and monies received relating to Community Diagnostics Centre activity,
  - Total Pay movement has improved by £0.5m, with significant improvement in bank **(£0.9m)**
  - Total non-pay actuals improved by **£0.2m,** relating to a reduction in endoscopy insourcing costs, theatre Lifecyle works and energy costs offset by pressures from increased blood products costs and external testing.

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Waste Reduction and Financial Improvement Performance

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WRP/ CIP Performance to date

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Division	WR & FIP Annual Target 2024/25	YTD Performance					Recurrent Actuals	
		2425 Annual Delivered	YTD Delivered	YTD Target Plan	Variance	% Varr.	Recurrent YTD Act. (2425)	Recurrent YTD Act.
MEC	11,620	£5,695	£5,360	£7,747	-£2,387	-31%	£5,570	£5,256
SAS	11,649	£1,993	£1,774	£7,766	-£5,993	-77%	£1,245	£1,133
FC	6,686	£1,687	£1,412	£4,457	-£3,046	-68%	£1,606	£1,331
DCS	8,485	£1,919	£1,567	£5,657	-£4,090	-72%	£1,168	£986
CIC	3,619	£1,250	£1,235	£2,413	-£1,178	-49%	£236	£220
Corp.	2,956	£1,810	£1,550	£1,971	-£421	-21%	£1,234	£973
Est.	4,498	£1,007	£994	£2,999	-£2,005	-67%	£523	£518
DERI	1,175	£1,175	£1,036	£783	£252	32%	£1,175	£1,036
Central	8,991	£2,513	£2,498	£5,994	-£3,496	-58%	£2,513	£2,498
ELHT Total	**59,679**	**£19,049**	**£17,425**	**£39,787**	**-£22,362**	**-56%**	**£15,270**	**£13,951**

- **£17.4m** has been delivered in 2024-25 to date, **£22.4m** behind plan at M10. In-month delivery has increased by **£1.1m.**
- WR & FIP for the year has increased to **£19m**, up by **£500k** from £18.5m at M9
- There is ongoing work to review the **non-recurrent schemes (£3.8m)** to be able to convert these into recurrent savings, as scoping around the workforce transformation needed continues. The non-recurrent schemes remain a pressure into 25/26 that will need addressing recurrently.
- **242 QIRAs** completed for M10, with all schemes transacted having an approved QIRA in place. All schemes require a QIRA before they can be transacted and become level 4 schemes.

WRP/ CIP Performance to date

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	Delivery Status					
Division	Delivered YTD	Fully developed / in delivery	Plans in Progress	Opportunity	Unidentified	TOTAL
MEC	£5,360	£335	£176	£252	£5,497	£11,620
SAS	£1,774	£219	£0	£120	£9,537	£11,649
FC	£1,412	£275	£41	£22	£4,936	£6,686
DCS	£1,567	£352	£0	£30	£6,536	£8,485
CIC	£1,235	£15	£709	£30	£1,630	£3,619
Corp.	£1,550	£260	£205	£95	£846	£2,956
Est.	£994	£13	£79	£150	£3,262	£4,498
DERI	£1,036	£139	£0	£10	£0	£1,185
Central	£2,498	£15	£0	£0	£6,468	£8,981
ELHT Total	**£17,425**	**£1,624**	**£1,209**	**£709**	**£38,712**	**£59,679**

- Unidentified across all areas is £38.7m. Divisional discussions suggest there will not be any further material schemes identified for this financial year, with all schemes that have been mobilised in the last months captured in plans in progress or opportunity.
- Plans in progress has some significant schemes relating to ward closures and additional opportunities to improve the forecast outturn position and improve the £19m, with work continuing to progress these plans into delivered schemes.

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Cash

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Statement of Cash Flows 31st January 2025

Cash Flow Statement	As at 31st March 2024 £000	As at 31st January 2025 £000	Prior month £000
Operating Activities			
Operating Surplus/(Deficit)	(16,883)	(29,128)	(25,502)
Depreciation and amortisation	22,831	20,092	18,138
Impairments and reversals	19,385	0	0
Donated assets received credited to revenue but non cash	(173)	(377)	(377)
(Increase)/decrease in trade and other receivables	11,976	(13,442)	(15,509)
(Increase)/decrease in inventories	(759)	128	(113)
Increase/(decrease) in trade and other payables	(23,797)	19,859	17,068
Increase/(decrease) in other liabilities: deferred income	(5,875)	1,801	10,959
Increase/(decrease) in provisions	(511)	(210)	(175)
Net cash inflow from Operating Activities	**6,194**	**(1,277)**	**4,489**
Cash Flows from Investing Activities			
Interest received	2,051	1,665	1,518
(Payments) for property, plant and equipment	(42,483)	(10,974)	(10,094)
Proceeds from disposal of property, plant and equipment	9	528	530
(Payments) for intangible assets	0	0	0
Net cash outflow from Investing Activities	**(40,423)**	**(8,781)**	**(8,046)**
Net cash inflow before Financing	**(34,229)**	**(10,058)**	**(3,557)**
Cash Flows from Financing Activities			
Public dividend capital received	31,250	19,428	18,581
Loans from Department of Health - repaid	(200)	(100)	(100)
Capital element of lease payments	(5,927)	(6,233)	(5,658)
Capital element of PFI payments	(12,276)	(11,627)	(10,464)
Interest paid	(479)	(462)	(354)
Interest element of PFI obligations	(5,982)	(5,303)	(4,773)
PDC dividend (paid)/refunded	(5,464)	4,924	4,924
Net cash outflow from Financing Activites	**922**	**627**	**2,156**
Decrease in cash	**(33,307)**	**(9,431)**	**(1,401)**
Cash at the beginning of the year	**44,882**	**11,575**	**11,575**
Cash at the end of the financial period	**11,575**	**2,144**	**10,174**

Cash position

- The PDC application for a further £20.0m of revenue support was submitted, as approved by the Board, and the outcome is expected 6/7 March 2025.
- The cash balance on 31st January was £2.1m, a reduction of £8.0m compared to the previous month, largely due to the Trust withholding £7.0m received to fund the 2024-25 pay award payment made in November at the end of the previous month, which the ICB deducted from the core contract payment.
- The value of aged payables as at 31 January 2025 had risen to £27.2m and with the Trust having to prioritise non-NHS suppliers.

BPPC

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	Number	£000s
Non-NHS payables		
Total non-NHS trade invoices paid in the year	64,923	367,187
Total non-NHS trade invoices paid within target	48,770	336,428
Percentage of non-NHS invoices paid within target	**75.1%**	**91.6%**
NHS payables		
Total NHS trade invoices paid in the year	1,629	29,430
Total NHS trade invoices paid within target	1,341	28,083
Percentage of NHS invoices paid within target	**82.3%**	**95.4%**

- As a result of the continued effect of the Trust having to withhold payments to suppliers due to its cash position, Better Payment Practice Code (BPPC) performance remains well below target in January.
- While the Trust continues to only meet the target to pay 95% of invoices on time for the financial year to date by value for NHS invoices.
- Performance against the remaining BPPC measures is also now expected to remain below target for 2024-25.

Statement of Financial Position

- All stocktakes are arranged for the end of the financial year.
- The valuation of the estate is arranged for March 2025
- A £2.2m reduction in receivables and a £3.5m increase in payables are the main factors which offset the impact of the £4.4m in month deficit before technical adjustments on the cash position.

	As at 31st March 2024 £000	As at 31st January 2025 £000	Year to date movement £000	Prior month £000	In-month movement £000
Non-Current Assets:					
Intangible assets	25,257	22,957	(2,300)	23,081	(124)
Property, plant and equipment (PFI)	97,553	96,266	(1,287)	96,103	163
Property, plant and equipment (other)	166,079	163,857	(2,222)	163,749	108
Right of use assets	19,060	31,657	12,597	32,278	(621)
Receivables	675	675	0	675	0
Total non-current assets	**308,624**	**315,412**	**6,788**	**315,886**	**(474)**
Current assets:					
Inventories	9,969	9,841	(128)	10,082	(241)
Receivables (NHS)	24,031	25,543	1,512	27,829	(2,286)
Receivables (non-NHS)	17,109	23,984	6,875	23,893	91
Assets held for sale	475	0	(475)	0	0
Cash and cash equivalents (GBS/NLF)	11,562	2,126	(9,436)	10,156	(8,030)
Cash and cash equivalents (other)	13	18	5	18	0
Total current assets	**63,159**	**61,512**	**(1,647)**	**71,978**	**(10,466)**
Total assets	**371,783**	**376,924**	**5,141**	**387,864**	**(10,940)**
Current liabilities:					
Trade and other payables (capital)	(7,254)	(3,816)	3,438	(3,216)	(600)
Trade and other payables (non-capital)	(60,849)	(80,901)	(20,052)	(77,918)	(2,983)
Borrowings / DHSC loan	(6,500)	(11,162)	(4,662)	(6,837)	(4,325)
Other financial liabilities (PFI)	(12,586)	(14,018)	(1,432)	(13,875)	(143)
Provisions for liabilities and charges	(609)	(554)	55	(573)	19
Other liabilities: deferred income	(1,522)	(3,323)	(1,801)	(12,481)	9,158
Total current liabilities	**(89,320)**	**(113,774)**	**(24,454)**	**(114,900)**	**1,126**
Net current assets/(liabilities)	**(26,161)**	**(52,262)**	**(26,101)**	**(42,922)**	**(9,340)**
Total assets less current liabilities	**282,463**	**263,150**	**(19,313)**	**272,964**	**(9,814)**
Non-current liabilities					
Borrowings / DHSC loan	(13,015)	(20,986)	(7,971)	(25,886)	4,900
Other financial liabilities (PFI)	(220,032)	(235,273)	(15,241)	(236,579)	1,306
Provisions for liabilities and charges	(2,912)	(2,807)	105	(2,819)	12
Total non-current liabilities	**(235,959)**	**(259,066)**	**(23,107)**	**(265,284)**	**6,218**
Total assets employed	**46,504**	**4,084**	**(42,420)**	**7,680**	**(3,596)**
Financed by taxpayers equity					
Public dividend capital	309,890	329,318	19,428	328,471	847
Revaluation reserve	19,225	18,748	(477)	18,748	0
Income and expenditure reserve	(282,611)	(343,982)	(61,371)	(339,536)	(4,446)
Total taxpayers equity	**46,504**	**4,084**	**(42,420)**	**7,683**	**(3,599)**

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Capital

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Capital

- Funding for the 2024-25 capital programme has increased by £2.2m to £36.0m for four additional externally funded schemes with forecast expenditure now £0.3m below plan, which the Trust expects to be able to manage. The new PDC funded schemes are:- £0.9m of funding for LED lighting, £0.5m of funding for PFI PACS legal costs, £0.5m of funding for RAAC related design costs and £0.4m of digital funding.

- At £26.9m, the year-to-date position is £16.4m ahead of plan, largely due to the Trust recognising £17.3m of right of use asset related expenditure for six Community Health Partnerships properties used by the Trust where the existing lease expired in December 2024, but related expenditure had been planned for March 2025.

- The £7.9m of year-to-date capital spend, excluding the CHP lease renewals, represents 60% of the forecast £13.1m of remaining capital funding, excluding the £2.2m of additional externally funded schemes, which compares favourably with the position for previous years. It is not expected at this stage that the cash position of the Trust will impact on the delivery of this year's capital programme.

	YTD actuals	Forecast
	£m	£m
Total funding available		**36.0**
IFRS 16 Right of use assets	19.0	20.7
Externally funded schemes	1.5	4.7
Estates	2.6	5.0
Information technology	1.5	2.6
PFI lifecycle	1.8	2.1
Medical equipment	0.1	0.1
Donated	0.4	0.5
Total capital expenditure	**26.9**	**35.7**
Forecast underspend		**0.3**

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2024-25 Workforce vs Plan

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YTD Workforce vs Plan to update

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	YTD Plan	YTD Actuals	
	Jan-25	Jan-25	Movement
Staff Type	**wte**	**wte**	**wte**
Total Substantive	9,385.27	9,680.23	294.96
Total Bank	561.79	606.01	44.22
Total Agency	87.05	71.32	-15.73
Total	**10,034.11**	**10,357.56**	**323.45**

	YTD Plan	YTD Actuals	
	Jan-25	Jan-25	Movement
Staff Group	**wte**	**wte**	**wte**
Regst'D Nurses & Others	3,174.30	3,246.00	71.70
Medics	1,061.44	1,122.11	60.67
Hcare Scients & Others	1,080.16	1,129.37	49.21
Support Clinical Staff	2,031.67	2,159.40	127.73
Nhs Infrastructure Supp	2,686.54	2,709.33	22.79
Other Staff Costs	0.00	-8.65	-8.65
Total	**10,034.11**	**10,357.56**	**323.45**

- Compared to the submitted workforce plan for 2024-25, the Trust is 323.45 wte above the plan for January 2025.
- This is an increase of 30 wte from March 2024 and includes 122 wte related to service transfers so a net reduction of 92 wte

YTD Workforce Movement M9 to M10

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- Workforce reported externally, is **'Contracted wte** 'for substantive staff, and **'Worked wte**' for bank and agency staff.
- The actual WTE has decreased by **131.44 wte** from the previous month overall, with reductions in bank and agency but an increase in substantive.
- There has been a reductions in all staff groups in January 2025.

	Actuals	Actuals	
	Dec-24	Jan-25	Movement
Staff Type	**wte**	**wte**	**wte**
Total Substantive	9,665.51	9,680.23	14.72
Total Bank	749.34	606.01	-143.33
Total Agency	74.15	71.32	-2.83
Total	**10,489.00**	**10,357.56**	**-131.44**

	Actuals	Actuals	
	Dec-24	Jan-25	Movement
Staff Group	**wte**	**wte**	**wte**
Regst'D Nurses & Others	3,300.28	3,246.00	-54.28
Medics	1,138.14	1,122.11	-16.03
Hcare Scients & Others	1,129.99	1,129.37	-0.62
Support Clinical Staff	2,187.77	2,159.40	-28.37
Nhs Infrastructure Supp	2,742.47	2,709.33	-33.14
Other Staff Costs	-9.65	-8.65	1.00
Total Workforce	**10,489.00**	**10,357.56**	**-131.44**

YTD Workforce Movement M9 to M10

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- The actual WTE has decreased **174.86 wte** (*worked for all staff types*) from the previous month across all staff types and staff groups

	Actuals	Actuals		Actuals	Actuals	
	Dec-24	Jan-25	Movement	Dec-24	Jan-25	Movement
Staff Type	wte	wte	wte	£000	£000	£000
Total Substantive	9,363.28	9,334.58	-28.70	42,711	43,059	348
Total Bank	749.34	606.01	-143.33	4,296	3,412	-884
Total Agency	74.15	71.32	-2.83	623	655	32
Total	10,186.77	10,011.91	-174.86	47,629	47,126	-503

	Actuals	Actuals		Actuals	Actuals	
	Dec-24	Jan-25	Movement	Dec-24	Jan-25	Movement
Staff Group	wte	wte	wte	£000	£000	£000
Regst'D Nurses & Others	3,142.05	3,084.77	-57.28	14,450	14,380	-69
Medics	1,175.35	1,144.02	-31.33	12,683	12,257	-427
Hcare Scients & Others	1,084.28	1,078.58	-5.70	5,190	5,195	5
Support Clinical Staff	2,125.26	2,076.53	-48.73	6,340	6,312	-28
Nhs Infrastructure Supp	2,668.88	2,636.06	-32.82	8,857	8,786	-71
Other Staff Costs	-9.05	-8.05	1.00	110	195	86
Total	10,186.77	10,011.91	-174.86	47,629	47,126	-503

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Thank You

Any further questions or comments?

Lancashire and South Cumbria Provider Collaborative

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TRUST BOARD REPORT | **Item** 42

12 March 2025 | **Purpose** Assurance

Title	Integrated Performance Report
Report Author	Mr D Hallen, Director - Data and Digital
Executive sponsor	Mrs S Gilligan, Chief Operating Officer
Date Paper Approved By Executive Sponsor	

Summary: This paper presents the corporate performance data at January 2025

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 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	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes *(Delete as appropriate)*	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 *(Delete as appropriate)*	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 *(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:

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

Integrated Performance Report

Published: February 2025

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How to read an SPC Chart

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart

The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits

In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse– blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.
The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

Summary

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The matrix provides a summary of performance metrics included in this report. It highlights where metrics are showing assurance and variation.
18.6% of our metrics are consistently achieving target
37.3% of our metrics are inconsistently achieving target
8.5% of our metrics are not achieving target, however 2 of these are showing special cause improvement.
35.6% of our metrics do not have a target currently set.

Assurance / **Variation**

	Achieving target	Inconsistently achieving target	Not achieving target	No target set
Special cause improvement	Appraisal (consultant)	31d cancer	VTE, Appraisal (AFC)	RN/MW agency spend, >62d urgent cancer GP referral
Common cause	Fill (RN/MW night & care staff day), Inpatient and Outpatient F&F, Complaints, Appraisal (other medical), Safeguarding children training, Turnover	MRSA, Staffing red flags, Wards <80%, Community and Maternity F&F, A&E 4hr, Cancer 28d and 62d, Vacancy, BPPC NHS value invoices, Variance to capital programme	A&E F&F, Information governance training	C. diff, E.coli, P.aeruginosa, RN/MW bank spend, Crude mortality rate, Beds occupied by patients 7+, 14+, 21+, Income run rate, Other operating expenses
Special cause concern	Fill (RN/MW day and care staff night)	Wards <80% fill, CHPPD, Maternity F&F, Handovers >60 mins, BPPC NHS no invoices, BPPS Non NHS no and value invoices, Liquidity days, Variance to planned financial performance, WRP	SHMI, Operations cancelled on the day	Klebsiella, In hospital deaths, A&E attends, Avg arrival to handover, Handovers >30 mins, Bed occupancy, Over 12hr TiD, Employee expenses run rate, Emergency average LOS

SAFE - Summary Scorecard

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METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
AVERAGE FILL RATE REGISTERED CARE STAFF (DAY)	JAN 25	0.95	0.90		
AVERAGE FILL RATE REGISTERED CARE STAFF (NIGHT)	JAN 25	1.05	0.90		
AVERAGE FILL RATE REGISTERED NURSES (DAY)	JAN 25	0.90	0.90		
AVERAGE FILL RATE REGISTERED NURSES (NIGHT)	JAN 25	0.97	0.90		
MRSA	JAN 25	0.00	0.00		
PATIENTS RISK ASSESSED FOR VENOUS THROMBOEMBOLISM	JAN 25	0.86	0.95		
NATIONAL NURSING RED FLAGS	JAN 25	0.00	0.00		
WARDS <80% REGISTERED NURSE (DAY) FILL RATE	JAN 25	4.00	0.00		
CARE HOURS PER PATIENT DAY (CHPPD)	JAN 25	7.76	8.00		

METRIC	LATEST DATE	VALUE	VARIATION
C DIFF PER 100000 RATE	JAN 25	20.45	
ECOLI PER 100000 RATE	JAN 25	27.27	
KLEBSIELLA PER 100000 RATE	JAN 25	34.09	
PSUEDOMONAS PER 100000 RATE	JAN 25	3.41	
REGISTERED NURSE AGENCY SPEND	JAN 25	243146.58	
REGISTERED NURSE BANK SPEND	JAN 25	866304.24	

Alert

We have seen increasing numbers of positive Klebsiella blood stream infections in January 7 HOHA, 3 COHA cases, a full review of the cases ongoing to identify any themes and trends.

During January 2025 there remained challenges with Nurse staffing. This was due to unexpected unavailability, and redeploying staff to support patients in the Emergency Department. 4 wards were below the fill rate % of 80% for the month of January. This was due to unexpected unavailability, and redeploying staff to support patients in the Emergency Department. All staffing gaps were mitigated and covered by internal moves across Directorates and Divisions.

There has been an increase in the number of incidents being reported from 45 in December 2024 to 79 in January 25. The ED department experienced high attendances of complex and high acuity patients resulting in long waits within the ED department, following a decision to admit, despite increasing the bed base across the inpatient sites. However since 1 April 2024, 537 pressure damage have been reported under the care of ELHT with 86 confirmed lapses in care (16%) – these figures continue to demonstrate a significant improvement on the 2023-2024 position.

Advise

We are still seeing cases of Influenza although now on a downward trend, masks are still required in the entry point areas, this will be reviewed at the end of February.

Nurse staffing continues to be monitored twice daily in a trust wide staffing meeting. Midwifery staffing continues to be monitored four times a day. Where pressure are increased, the calls are then attended by each Divisional Director of Nursing and 1 Deputy Chief Nurse. The ICB have now agreed a new pathway for management of pressure damage that develop on residents within the Regulated Care Sector. Which will reduce the number of investigations being undertaken by Community Services. This is planned to go live from April 2025. January achieved 48% compliance in the Pressure Damage Quality Indicator (target 65-80%) which is a decrease from 57% in Q2. The data and key messages have been shared with DDNs and Pressure Damage Leads with the Trust.

Assurance

The NICU outbreak is under control there has been no further cases.

There were no red flags reported in relation to safer nurse/midwifery staffing. The overall percentage fill rate for RNs for days and nights was above 90%. The overall percentage fill rate for CSW for days and nights was above 97%.

Compliance with the pressure damage and moisture associated damage e-learning in Dec has reduced to 90.38% and 90.47% respectively which will be addressed by the Pressure Damage Steering Group

1 CAS Alert overdue. NatPSA/2023/010/MHRA (bed rails) action plan in place, work on going to meet requirements of alert.

SAFE - Infection Control

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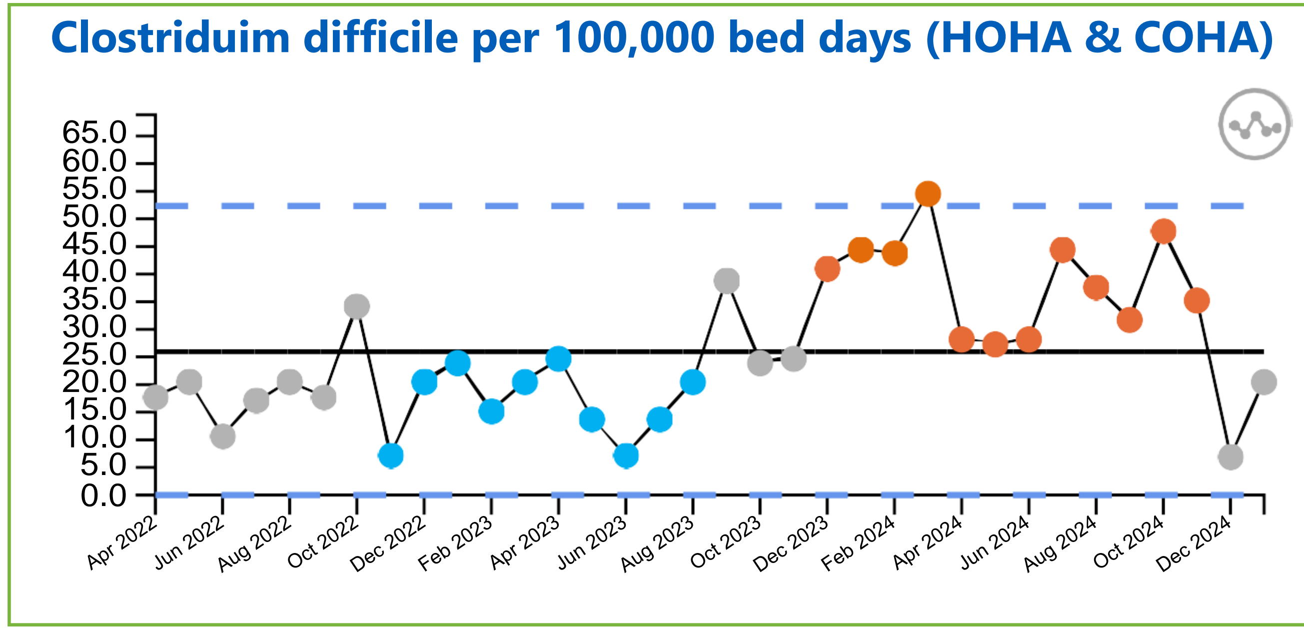
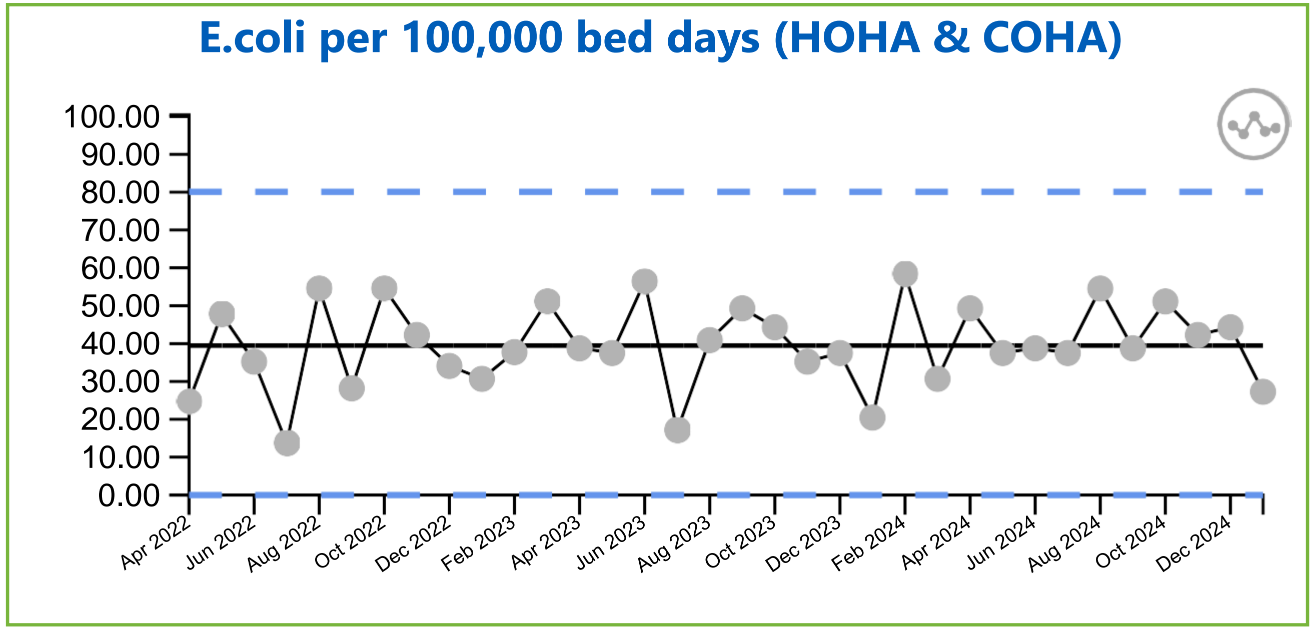
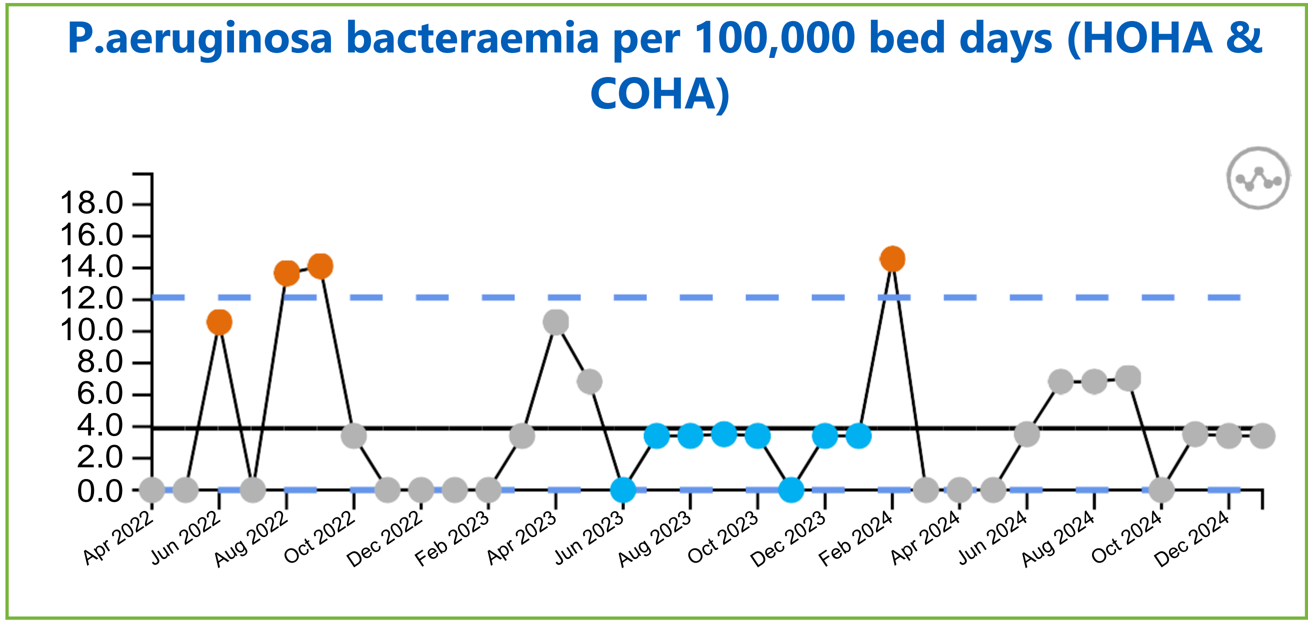
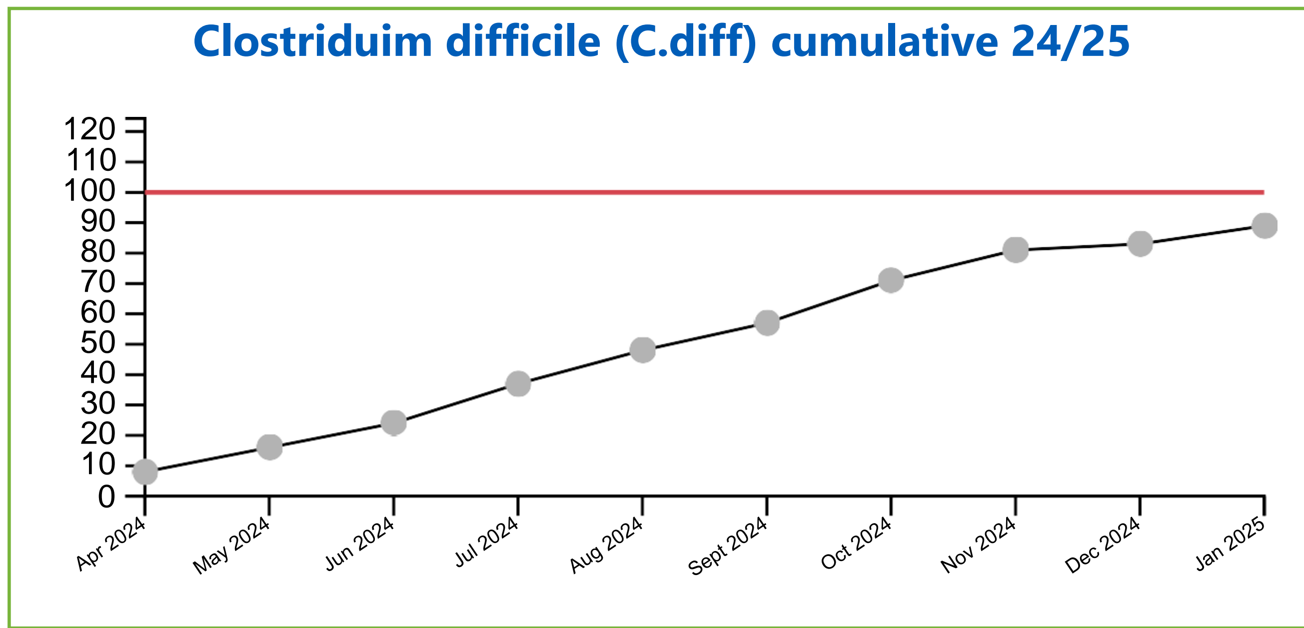
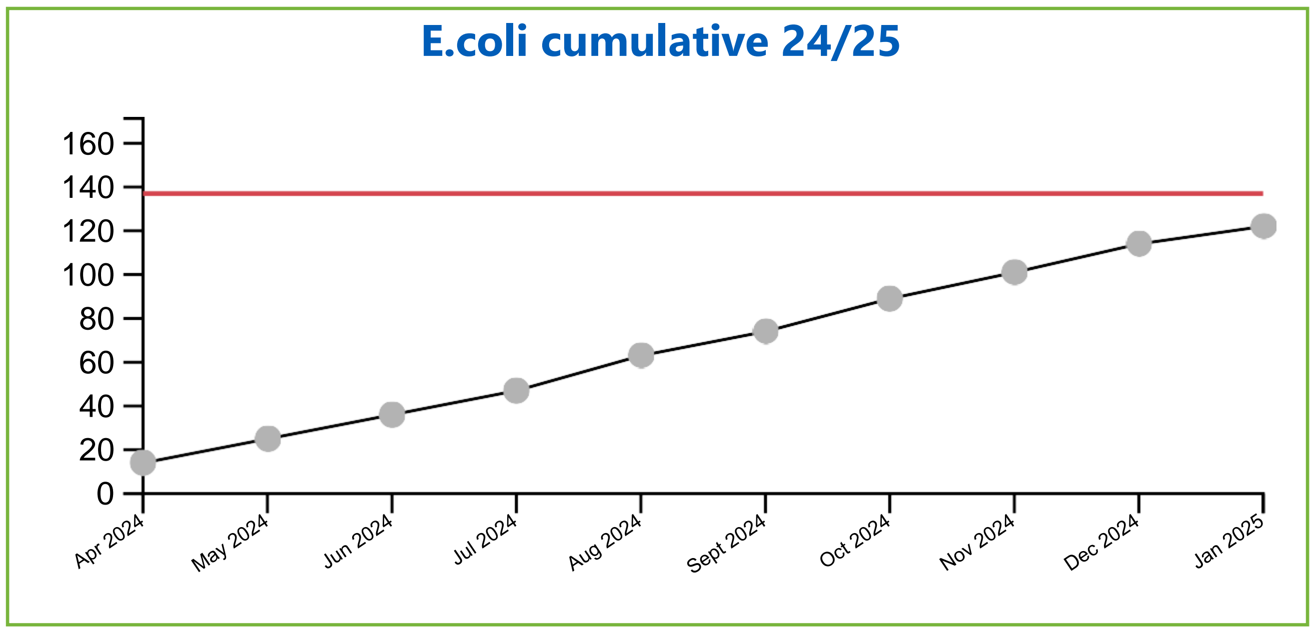
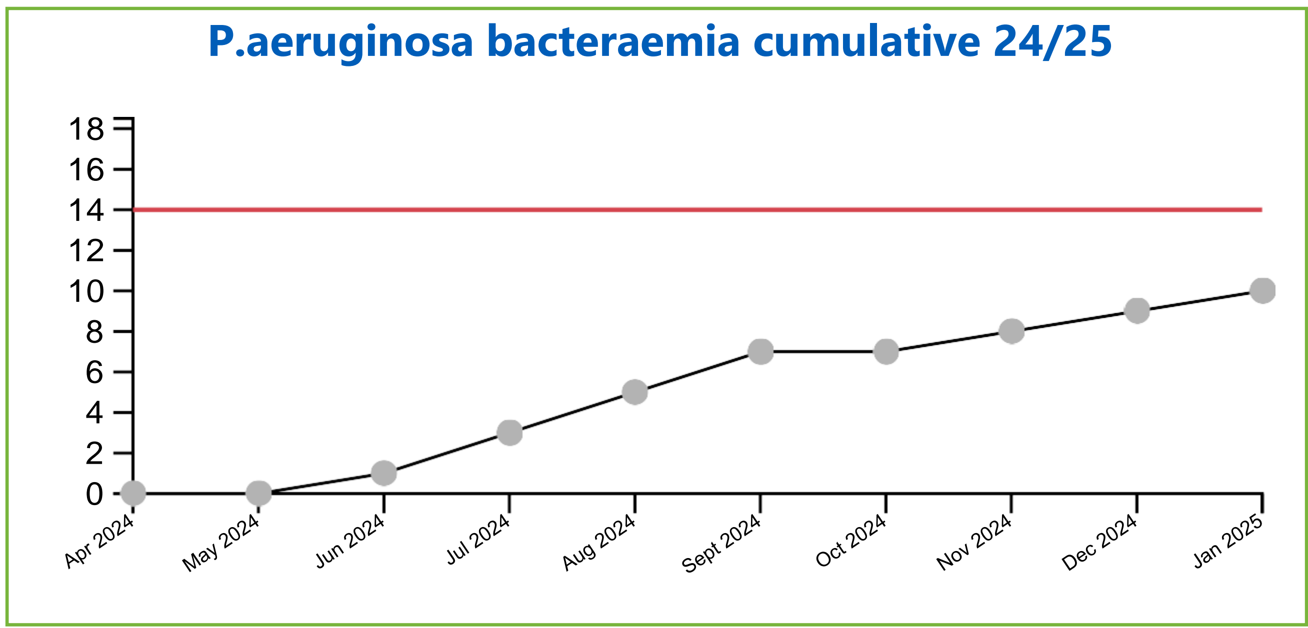


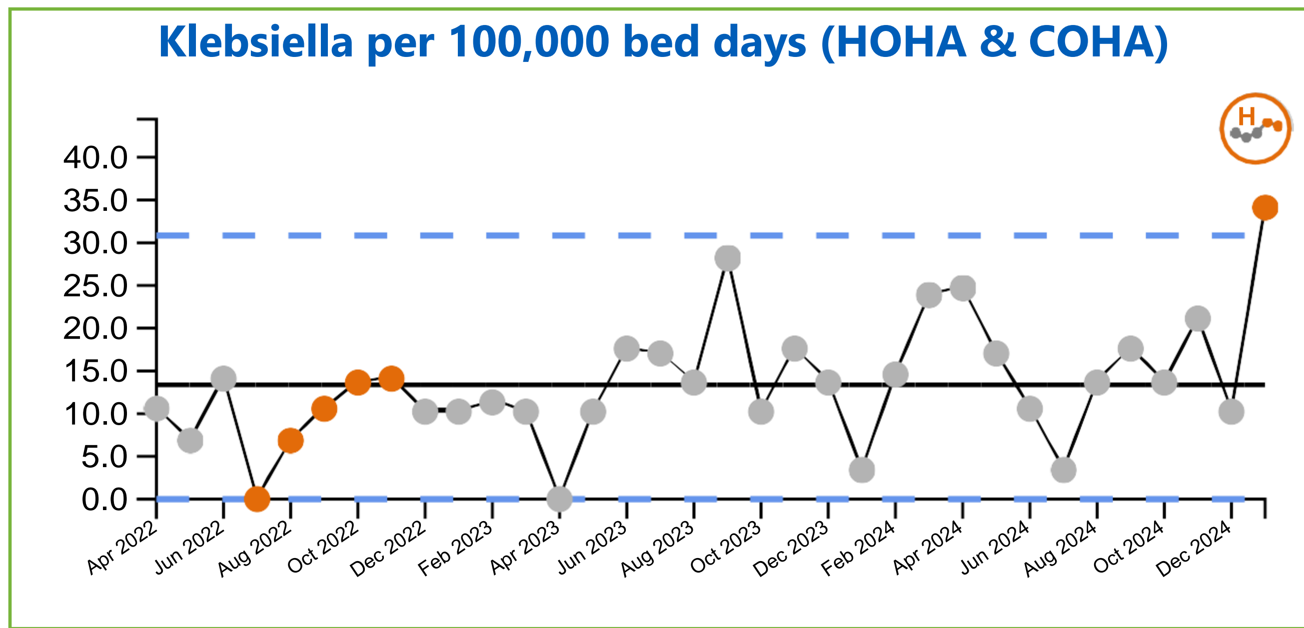


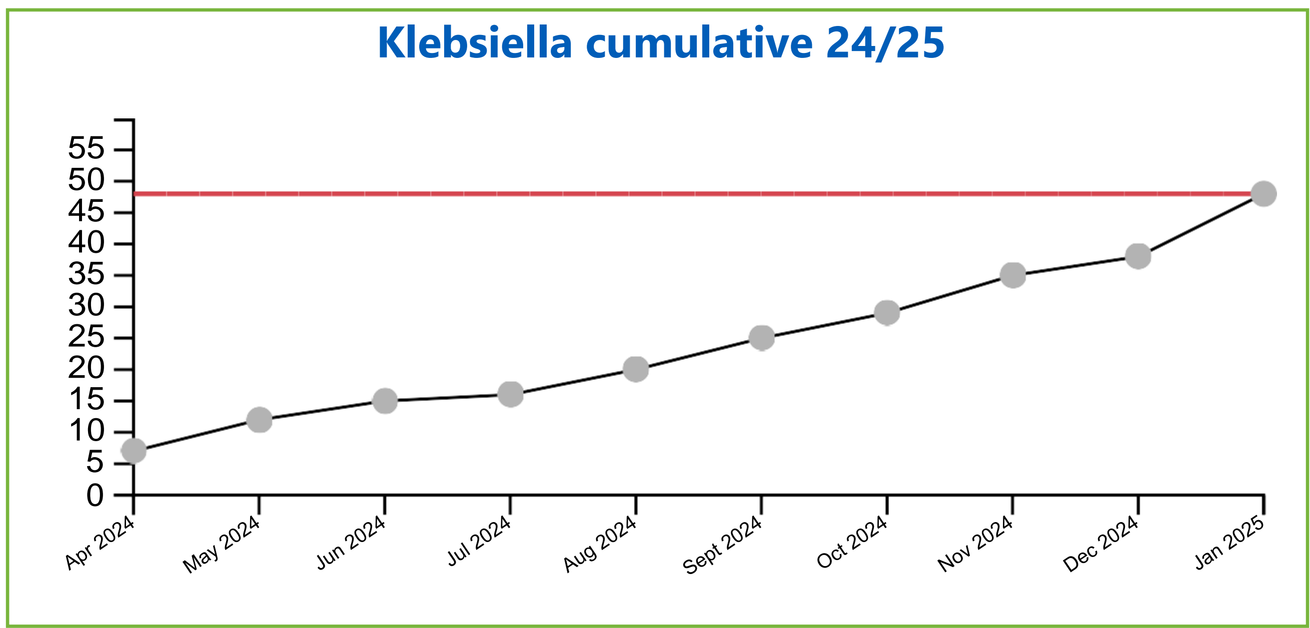


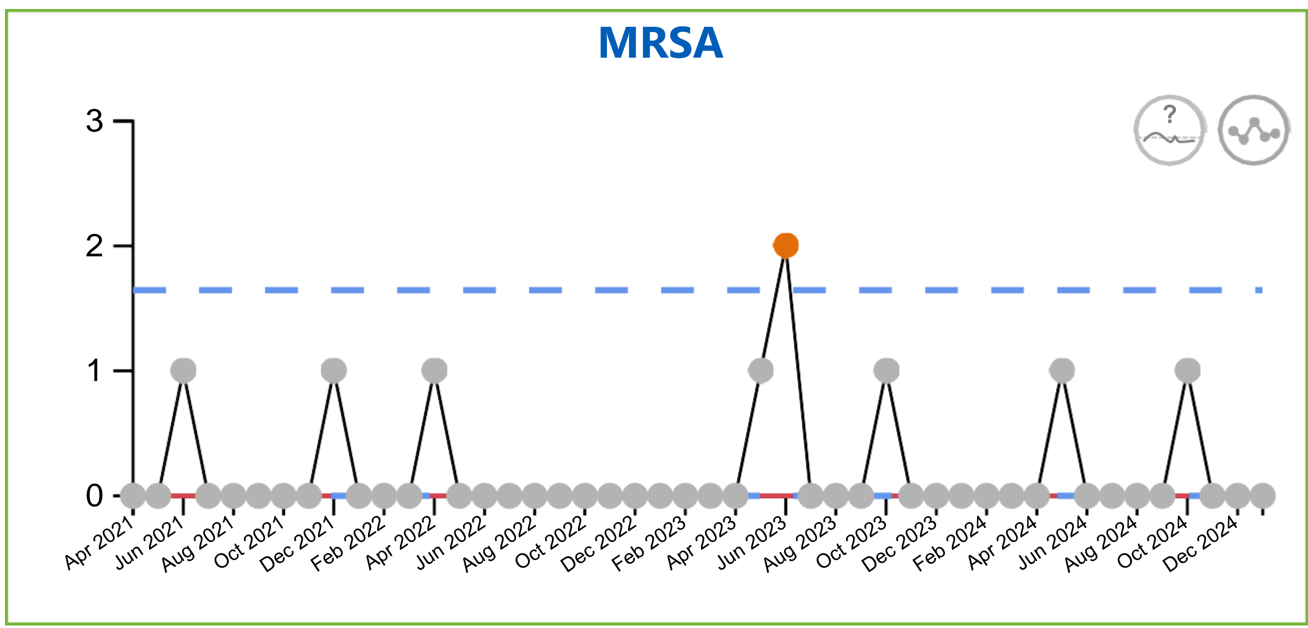








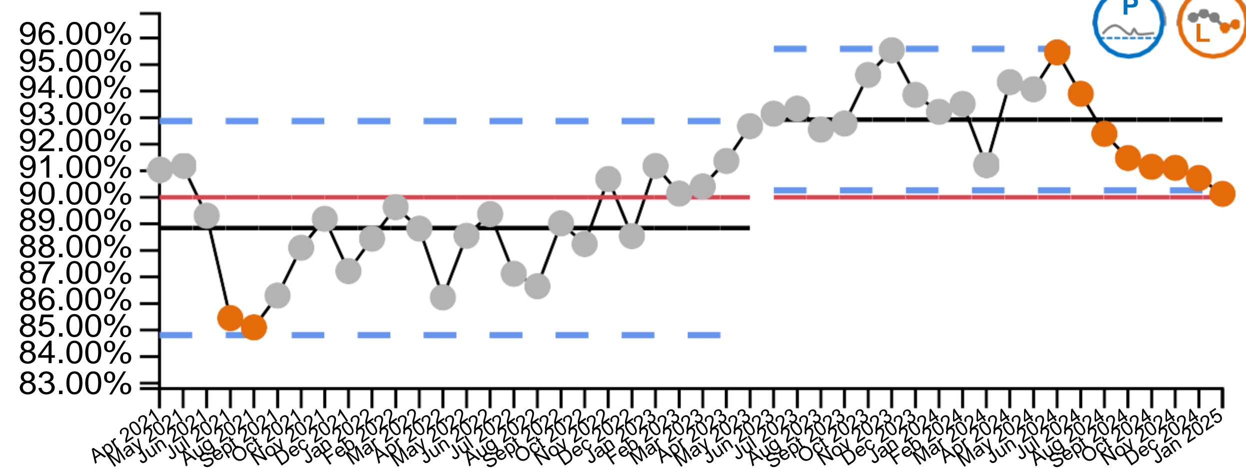




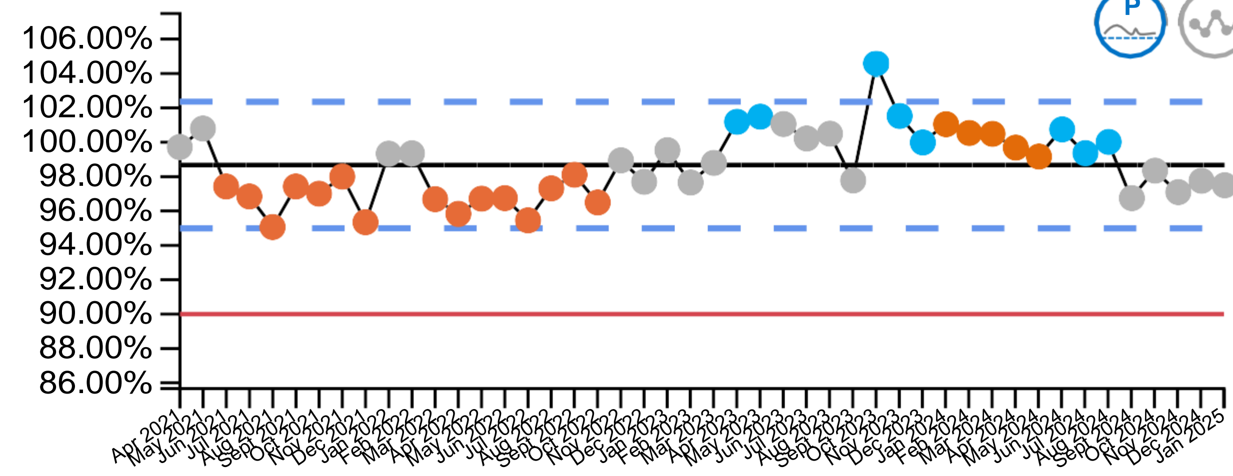
SAFE - Staffing

East Lancashire Hospitals NHS Trust
A University Teaching Trust

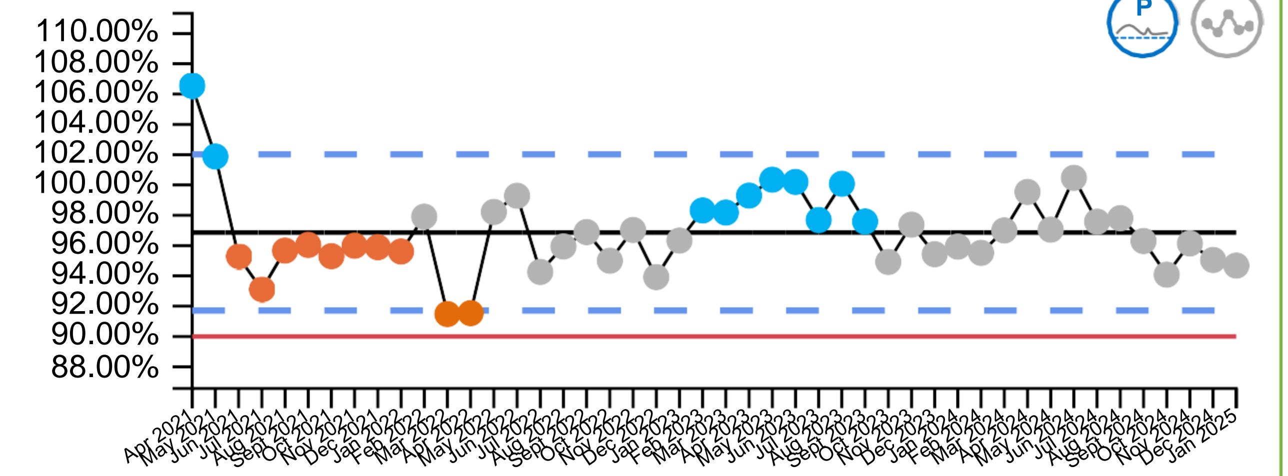
Average fill rate - registered nurses/midwives (day)



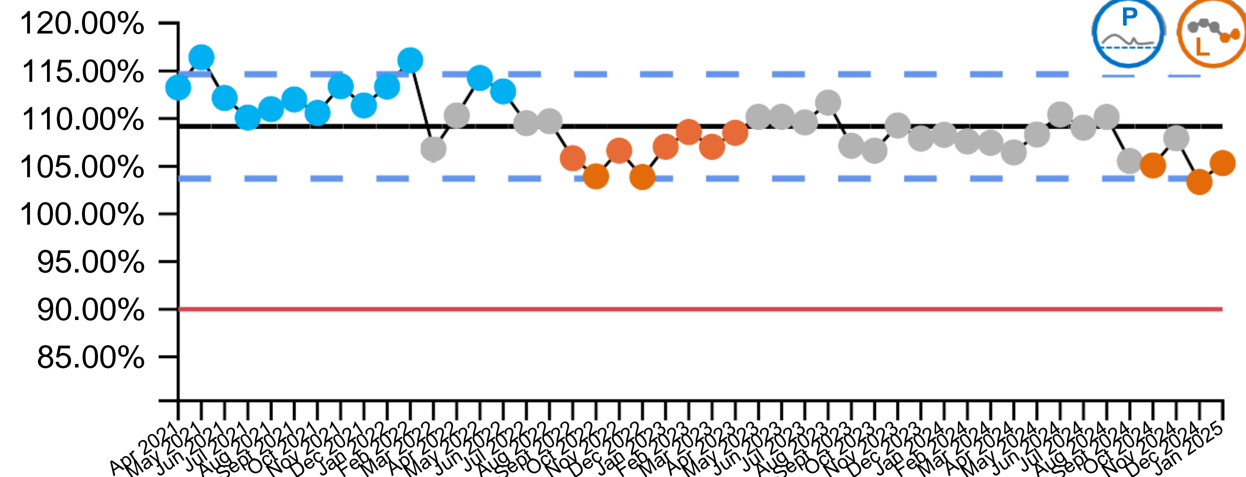
Average fill rate - registered nurses/midwives (night)



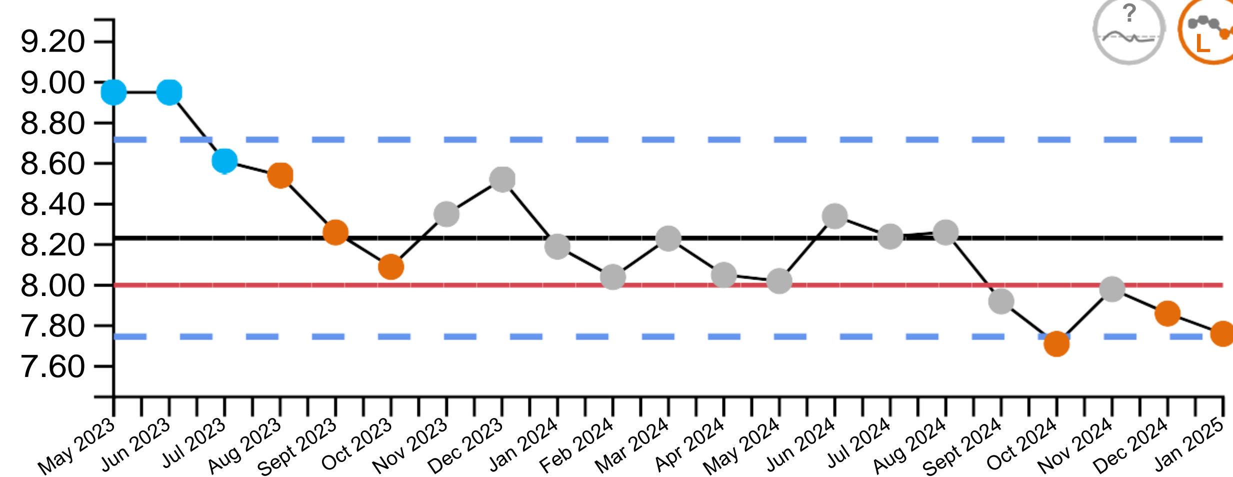
Average fill rate - care staff (day)



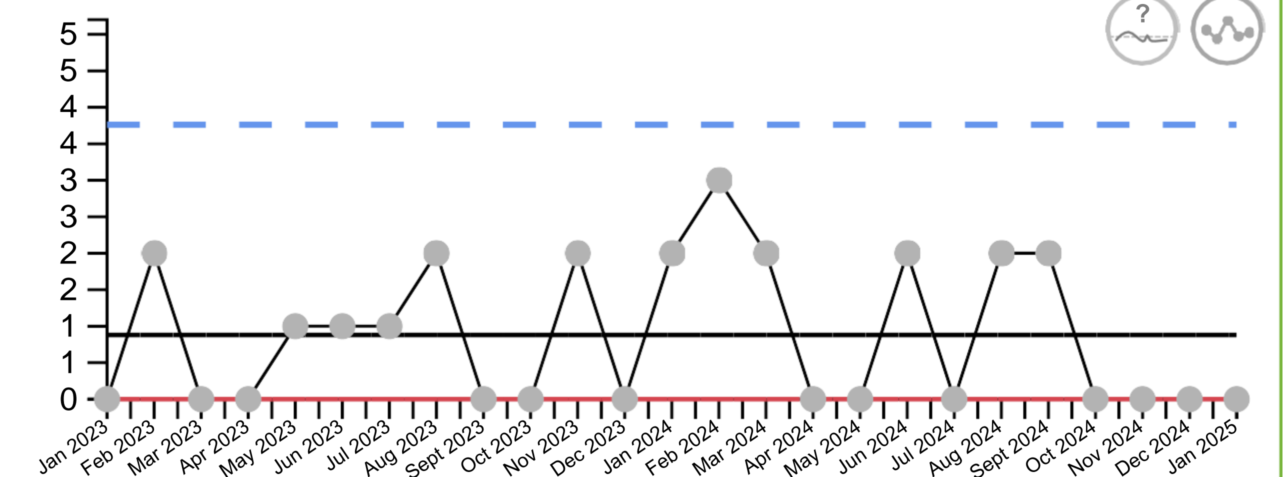
Average fill rate - care staff (night)



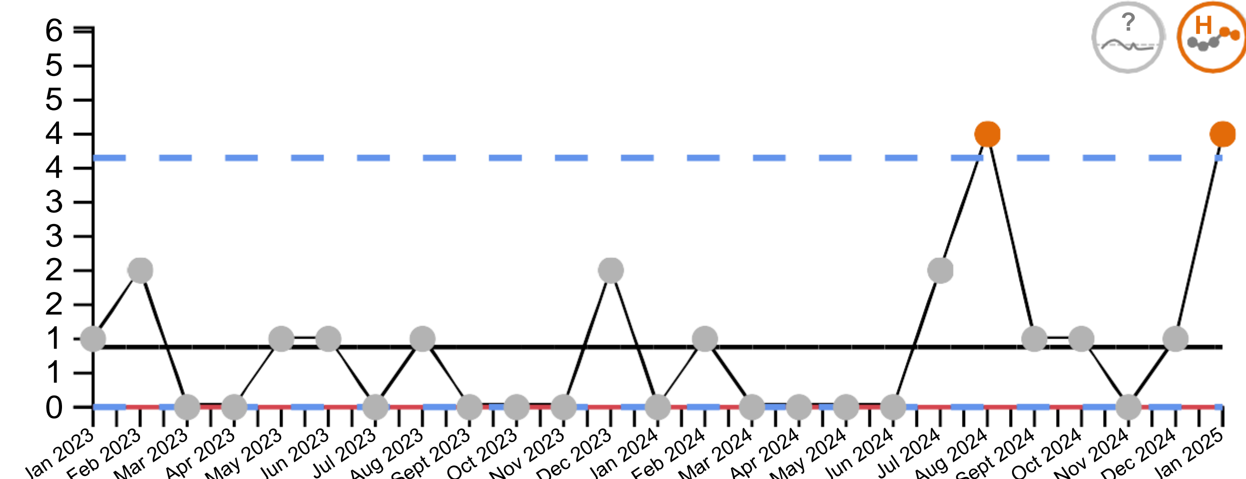
Care hours per patient day (CHPPD)



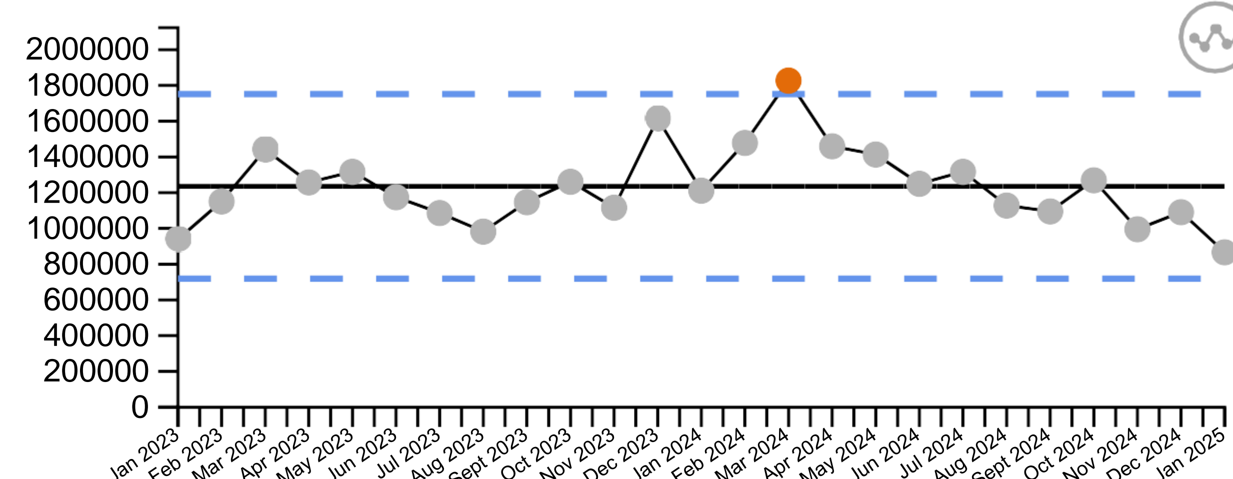
National nursing and midwifery red flags



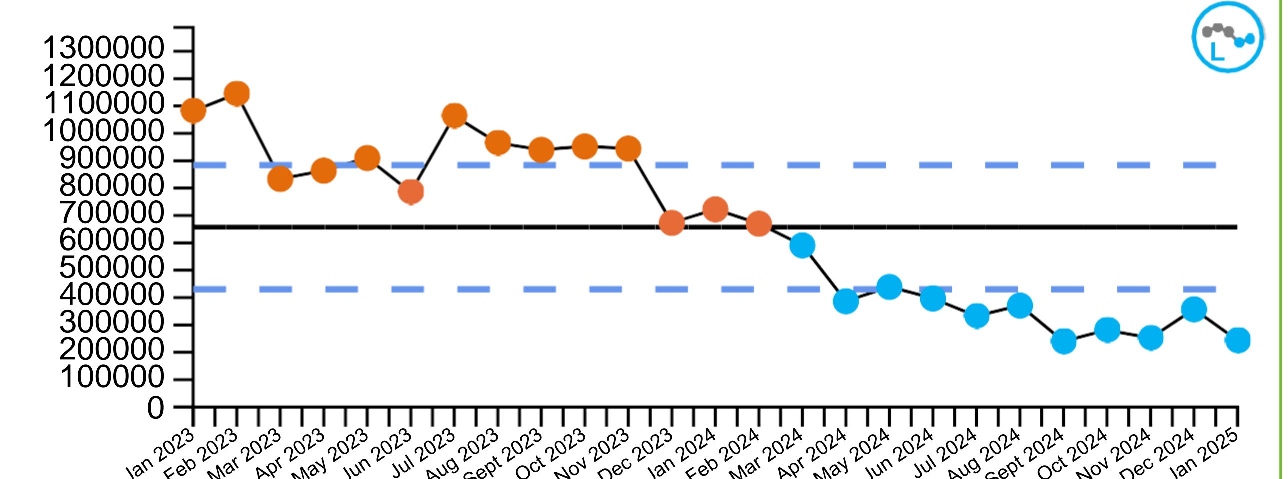
Wards <80% registered nurse (day) fill rate



Registered nurse and midwifery bank spend



Registered nurse and midwifery agency spend

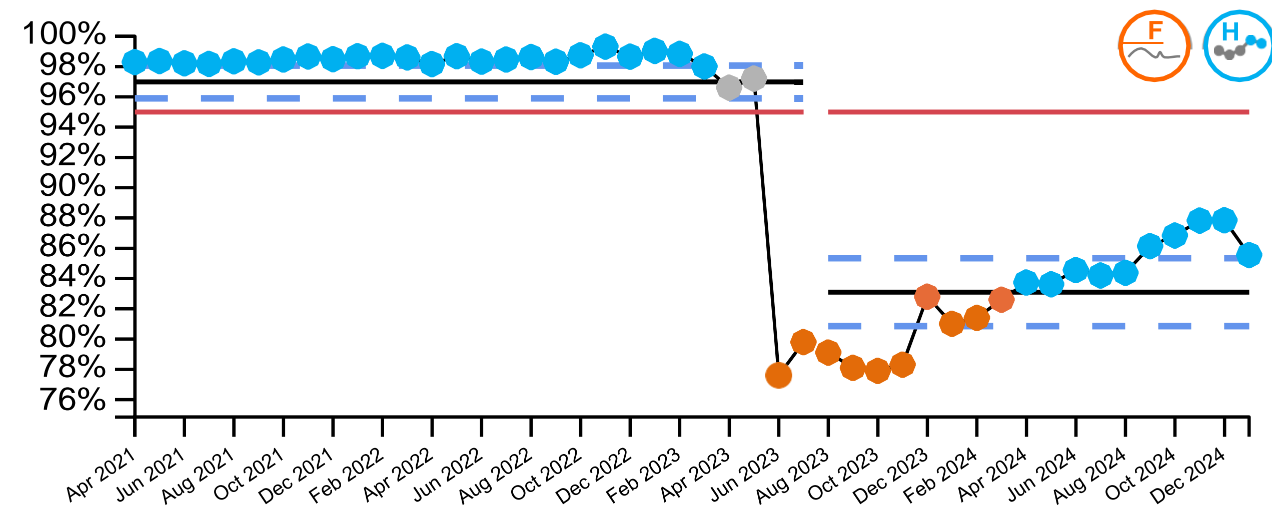


SAFE - Incidents and Pressure Ulcers

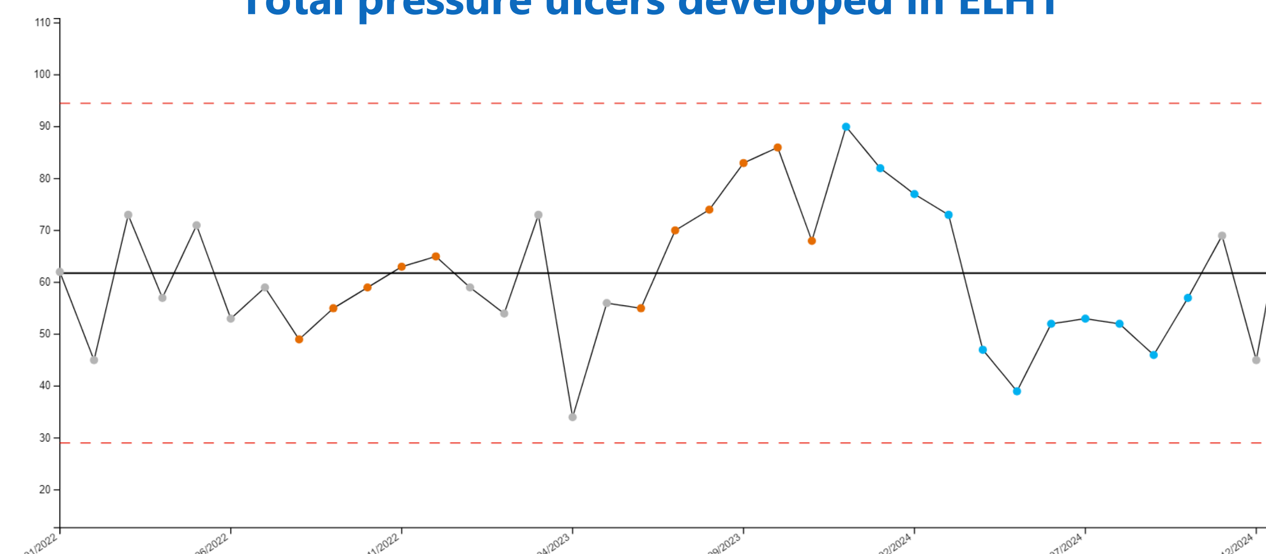
In month Never events	Year to date Never events	In month Medication errors serious/fatal harm	Year to date Medication errors serious/fatal harm	In month CAS alerts - Non-compliance	Year to date CAS alerts - Non-compliance
0	2	1	5	1	10

In month Serious incidents	Year to date Serious incidents	In month Slips trips falls serious/fatal harm	Year to date Slips trips falls serious/fatal harm
2	36	4	8

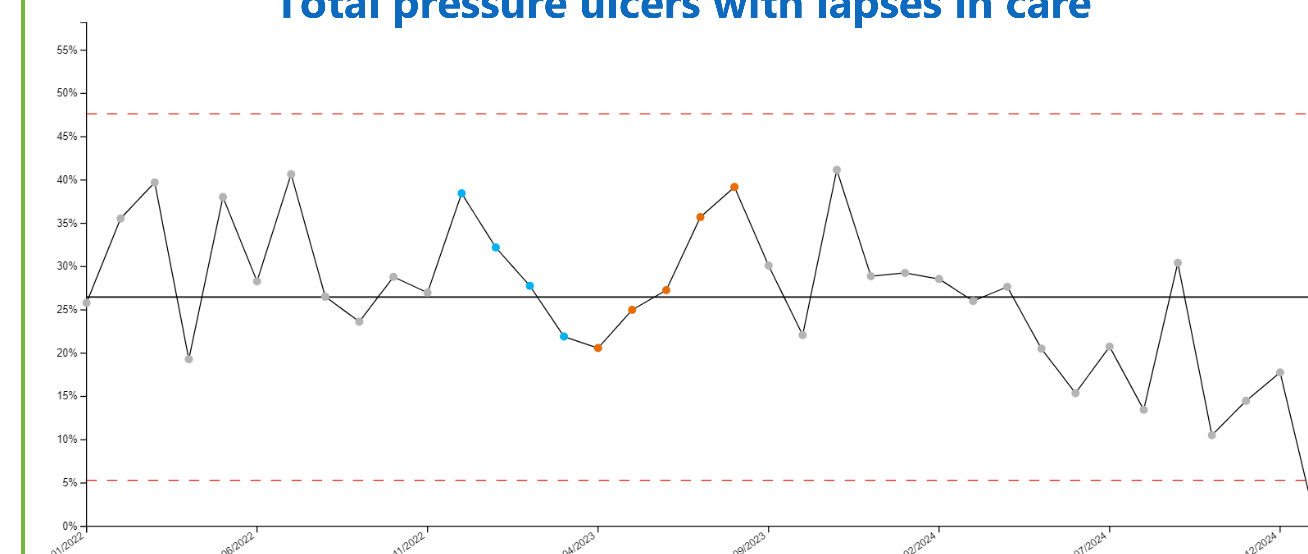
Patients risk assessed for venous thromboembolism



Total pressure ulcers developed in ELHT



Total pressure ulcers with lapses in care



A number of pressure ulcers in recent months remain currently under investigation. New reporting definitions were also introduced from April 2024.

CARING - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
A&E FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 25	0.66	0.90		F
COMMUNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 25	0.94	0.90		?
COMPLAINTS RATE PER 1000 CONTACTS	JAN 25	0.18	0.40		P
INPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 25	0.96	0.90		P
MATERNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 25	0.94	0.90		?
OUTPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 25	0.94	0.90		P

Alert

Our A&E Friends and Family Test (FFT) recommendation rate is 68%, down 1% from the last report. Given the extremely high demand on our A&E services, maintaining a recommendation rate in the upper 60s is a testament to the staff's dedication, even though it is below the national average of 76%. The A&E senior leadership team and Execs are working to mitigate factors impacting patient experience, but acknowledge that challenges persist for patients, their families, and staff.

Advise

Maternity Friends and Family Test (FFT) recommendation improved from 87% to 93% in January. Work is ongoing to address the identified concerns in postnatal care.

Assurance

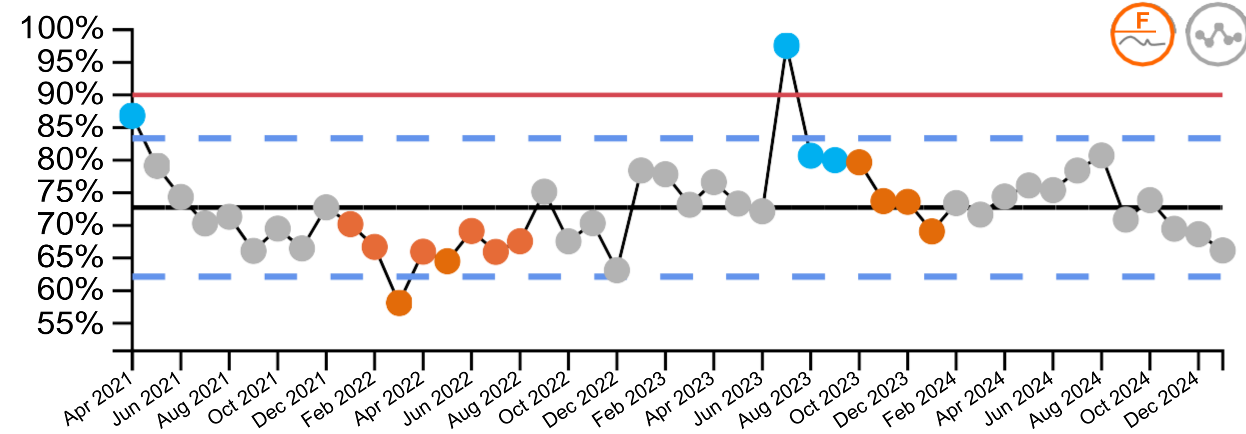
The percentage of patients recommending our inpatient, outpatient, and community services through the Friends and Family Test remains at or above the national average.

The Trust currently has 67 open complaints. The average time to close a complaint has slightly increased from 57 days in December to 57 days February. The formal complaints rate per 1,000 contacts remains within the expected range.

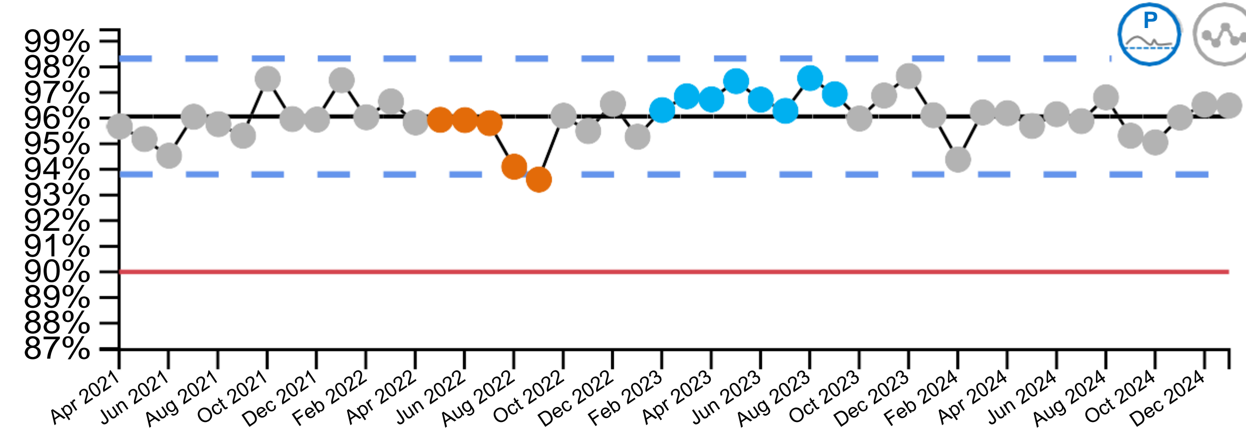
CARING - Feedback

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

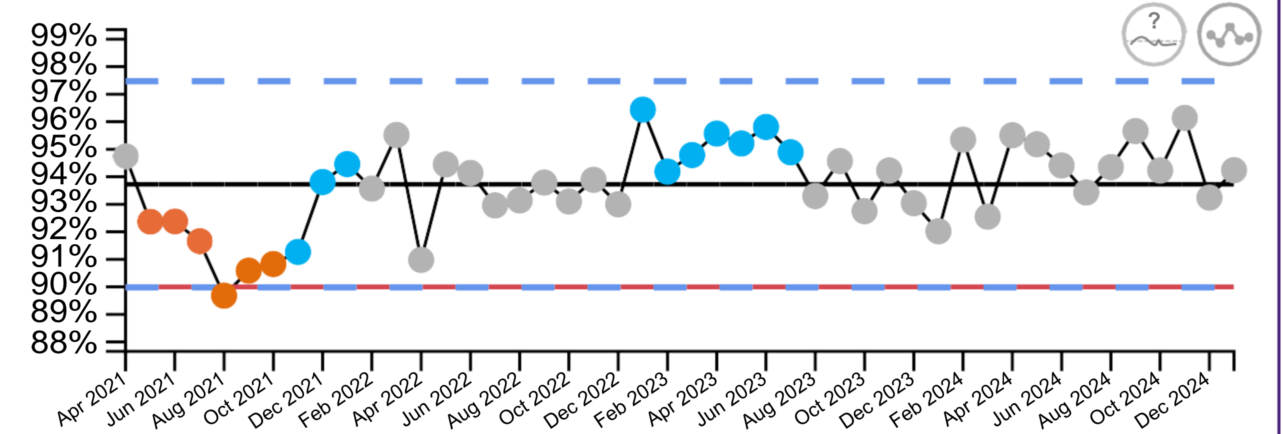
A&E FFT - % describing their experience as good or very good



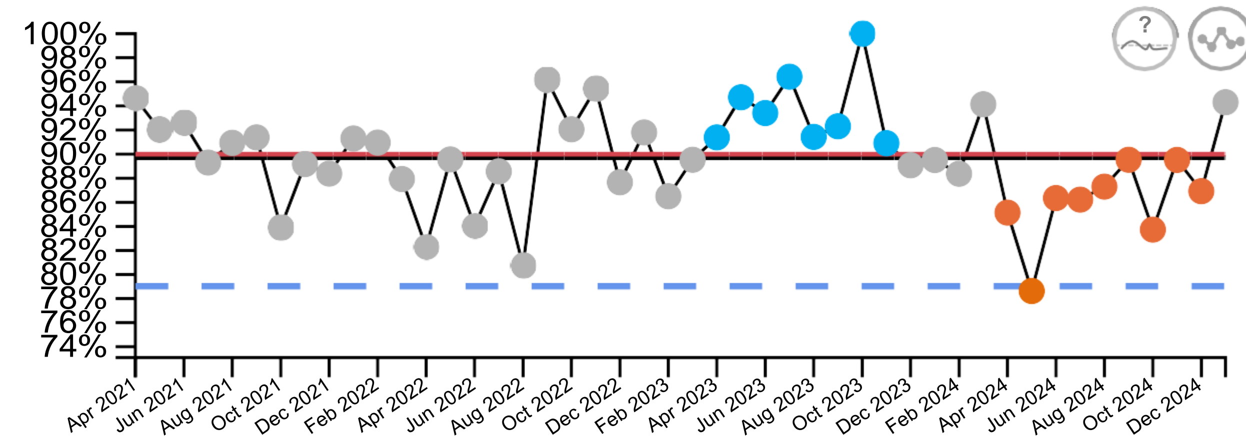
Inpatient FFT - % describing their experience as good or very good



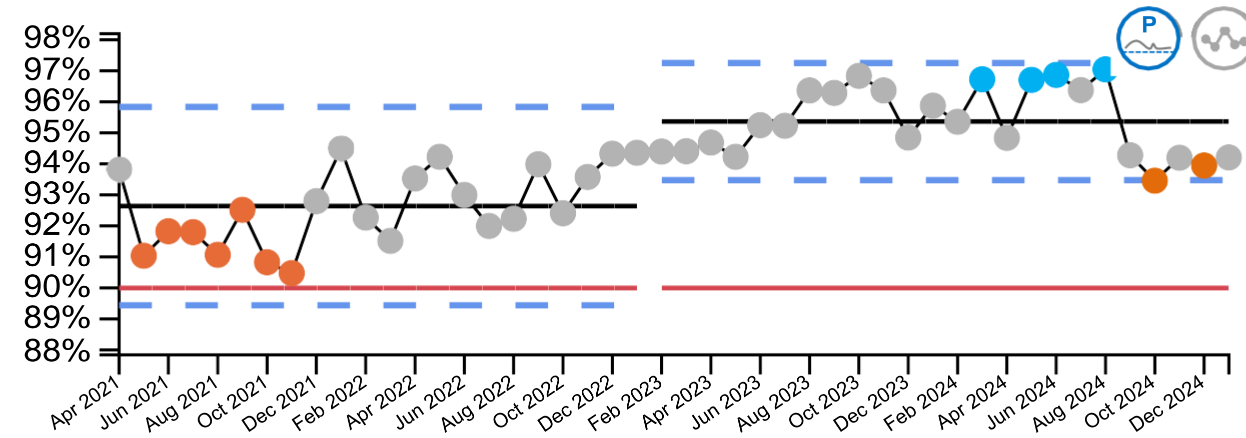
Community FFT - % describing their experience as good or very good



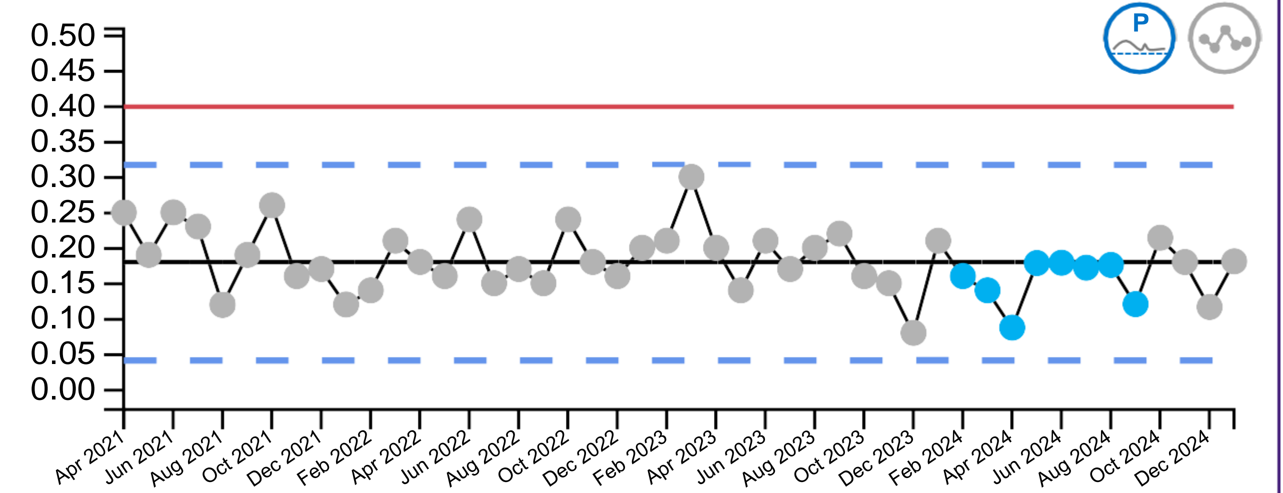
Maternity FFT - % describing their experience as good or very good



Outpatient FFT - % describing their experience as good or very good



Complaints rate per 1000 contacts



EFFECTIVE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	VARIATION
CRUDE DEATHS	JAN 25	184.00	
CRUDE MORTALITY RATE	JAN 25	0.04	
SHMI	JAN 25	1.32	

Alert

The Trust remains unable to provide assurance in relation to the HSMR and SHMI mortality indicators due to issues with data submission. Unfortunately, indications are that there are ongoing issues with reporting which means that the hoped for early access data will not be available for a further period.

HSMR is not currently calculated but has historically been above expected. SHMI is published and remains very high, although has plateaued (1.32), but confidence remains low. The data published nationally does contain a caveat that our data contains a high percentage of invalid diagnosis codes and also notes that the trusts that have removed SDEC activity are reporting higher SHMI.

Crude mortality has shown a further increase in January from December, although remains within process limits, and is not seasonally adjusted. There has been a significant increase in deaths in ED.

The post responsible for managing Doctors revalidation reports and the SJR process has been vacant since 30 June 24. The post has been recruited to and will commence work 4 March.

Advise

4 of the stillbirths were anticipated due to foetal anomalies. One was unexpected and is subject to the PMRT process.

Assurance

Some assurance with respect to trust mortality is provided by close monitoring of the crude mortality rate. This currently stands at 3.93% which shows an increase in this month, although this does not exceed control limits.

There are issues impacting the SHMI 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 alerting groups.

Latest month SHMI banding

Higher than expected

Stage 1 SJR Reviews

Completed in most recent month

Reviews	Total
Number complete	6
Backlog	> 100
5 - Excellent Care	0
4 - Good Care	6
3 - Adequate Care	0
2 - Poor Care	0
1 - Very Poor Care	0

Stage 2 SJR Reviews

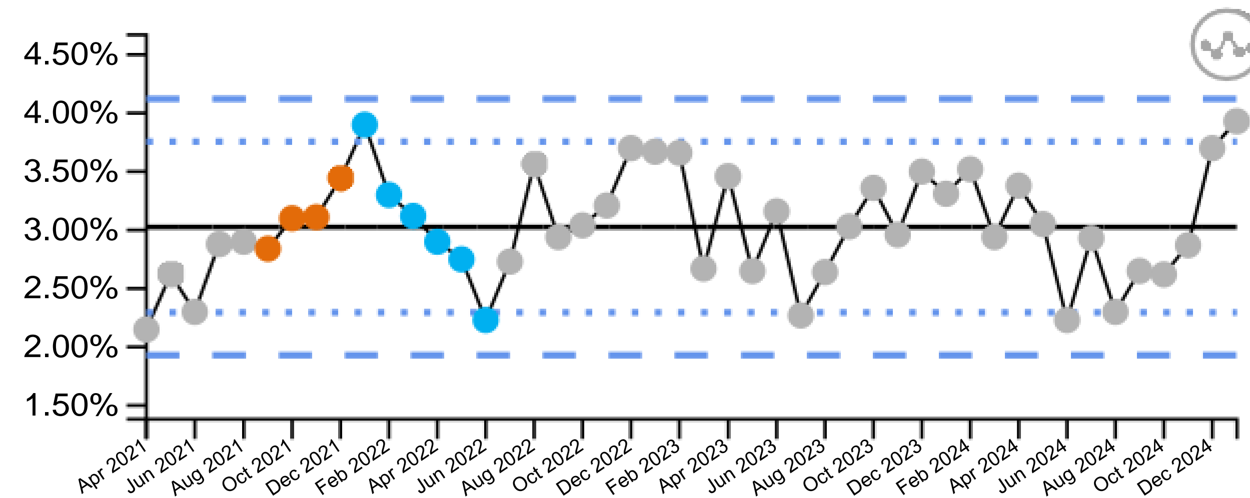
Completed in most recent month

Reviews	Total
Number complete	0
Backlog	0
5 - Excellent Care	0
4 - Good Care	0
3 - Adequate Care	0
2 - Poor Care	0
1 - Very Poor Care	0

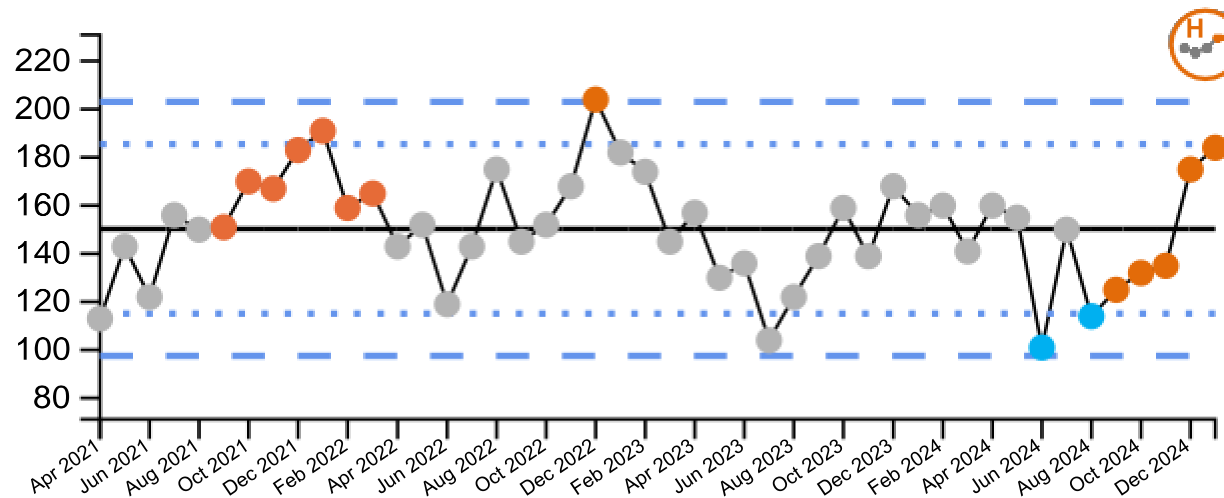
Learning Disability Mortality Reviews

- No update provided

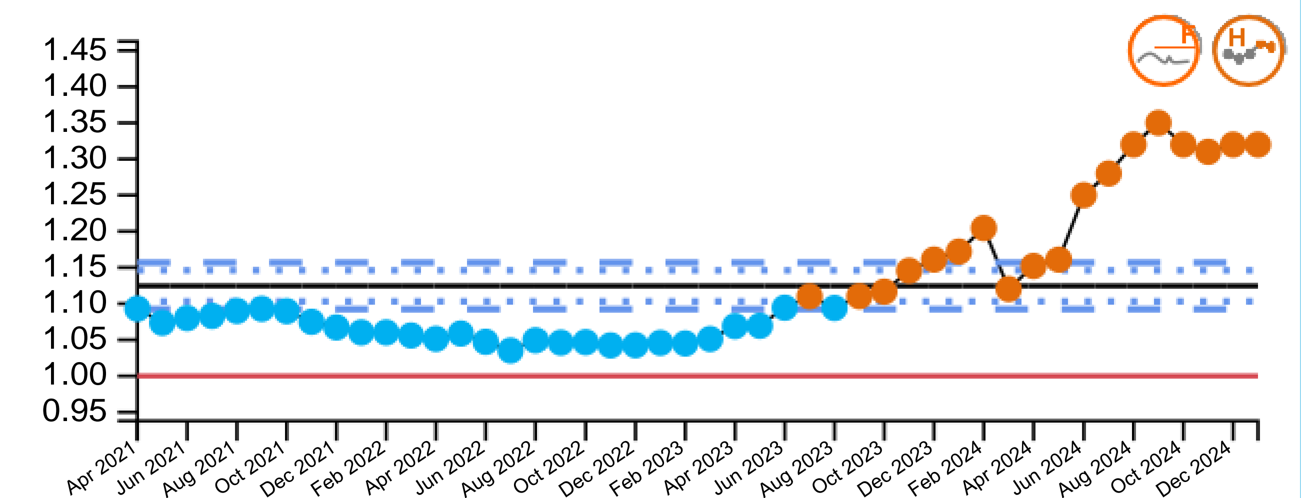
Crude Mortality Rate



In Hospital Deaths



Summary Hospital-level Mortality Indicator (SHMI)



Stillbirths	Year to date stillbirths
5	25

Maternal deaths	Year to date maternal deaths
0	1

RESPONSIVE - Summary Scorecard

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
A&E 4HR PERFORMANCE (TRUST)	JAN 25	0.74	0.78		
AMBULANCE HANDOVERS >60 MINUTES	JAN 25	438.00	0.00		
CANCELLED ON DAY OPERATIONS	JAN 25	75.00	0.00		
NOT TREATED WITHIN 28 DAYS OF LAST MINUTE CANC	JAN 25	6.00	0.00		
PATIENTS WAITING OVER 6 WEEKS FOR A DIAGNOSTIC TEST	JAN 25	0.10	0.05		
28D GENERAL FDS	DEC 24	0.80	0.75		
31D GENERAL TREATMENT STANDARD	DEC 24	0.96	0.96		
62D GENERAL STANDARD	DEC 24	0.75	0.70		

METRIC	LATEST DATE	VALUE	VARIATION
% HANDOVERS > 30 MINUTES	JAN 25	0.44	
A&E ATTENDANCES	JAN 25	22091.00	
BED OCCUPANCY G&A	JAN 25	0.95	
EMERGENCY AVERAGE LENGTH OF STAY (EXCL 0 AND 1 DAYS)	JAN 25	10.93	
OVER 12 HOURS IN DEPARTMENT	JAN 25	2575.00	
AVERAGE ARRIVAL TO HANDOVER	JAN 25	0.79	
MAX ARRIVAL TO HANDOVER TIME	DEC 24	12.18	
PATIENTS OVER 62 DAYS (URGENT GP REFERRAL)	JAN 25	193.00	

METRIC	LATEST DATE	VALUE
RTT ONGOING	JAN 25	63180.00
RTT OVER 52 WEEKS	JAN 25	2557.00
RTT OVER 65 WEEKS	JAN 25	9.00
RTT OVER 78 WEEKS	JAN 25	0.00

Alert

Ambulance Handover Data: This has not been verified due to the NWAS data not being confirmed and validated at the time of reporting.

Emergency Department: (ED) 4-Hour Performance: January performance was 73.65%, with 22,091 attendances. National average performance was 73%. Improvement efforts continue, focusing on alternative pathways, deflection, and same-day emergency care to enhance ED performance.

12-Hour Waits (All Types): In December, 2,613 patients waited over 12 hours in the department. In January, this slightly reduced to 2,575. Of the 22,091 January attendances, 88% of patients spent less than 12 hours in the department. Improvement work is on-going, supported by a dedicated PMO lead with clinical and operational support to reduce the time spent in the department.

Advise

DM01 Performance: Continued improvement in January, reducing to 9.89%, progressing towards the national ambition of 5% by March 2025.
Cancelled On-the-Day Operations: Reduced to 75 (above the average of 65). Ongoing efforts focused on enhancing pre-operative pathways to reduce cancellations further.

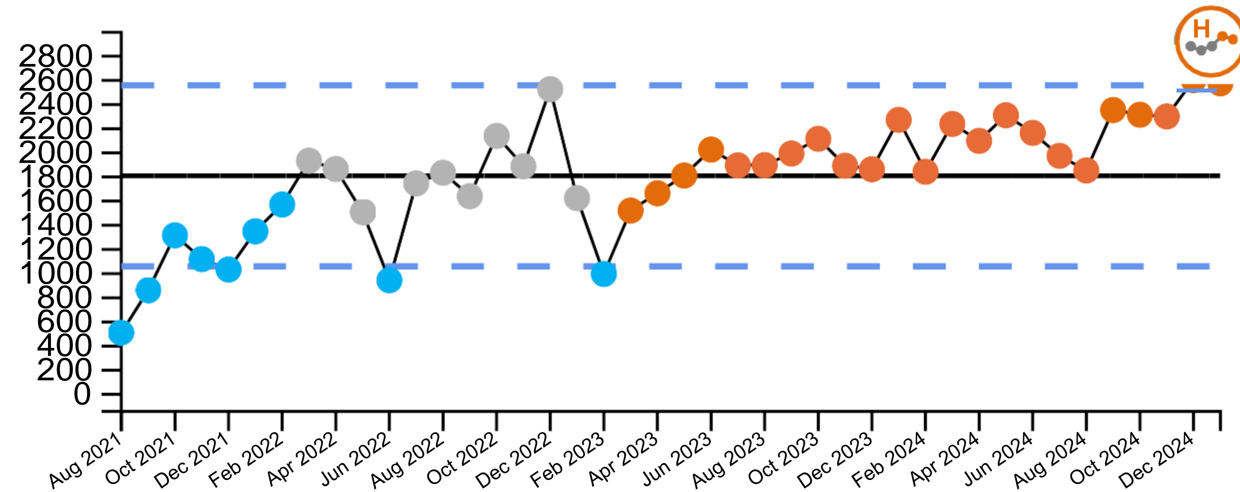
Assurance

Cancer Performance: FDS, 31-day, and 62-day targets all exceeded national ambition.
RTT Waits: 9 Opthalmology breaches at 65 weeks due to limited tissue availability.
Theatre Utilisation: Maintains top quartile national performance.
Daily Discharge Dashboard: Fully operational, supporting improvements in safe and timely patient discharge.

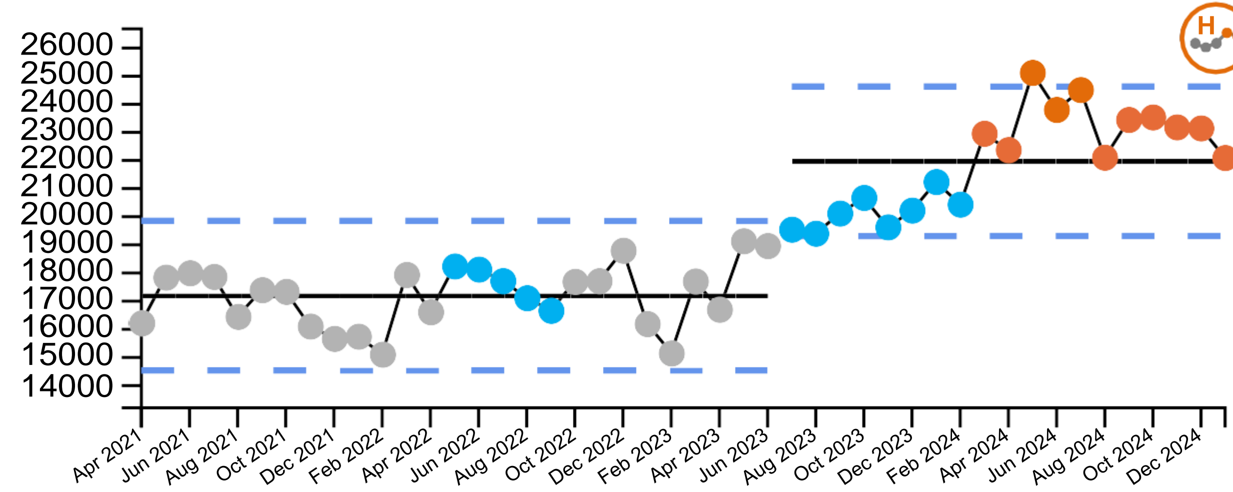
RESPONSIVE - A&E

East Lancashire Hospitals NHS Trust
A University Teaching Trust

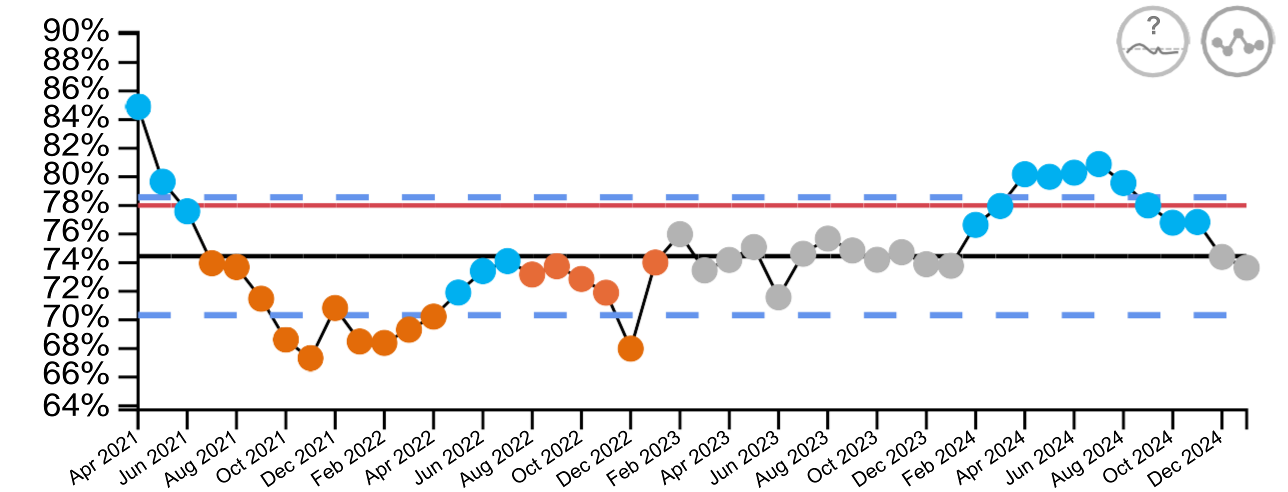
Over 12 hours in department



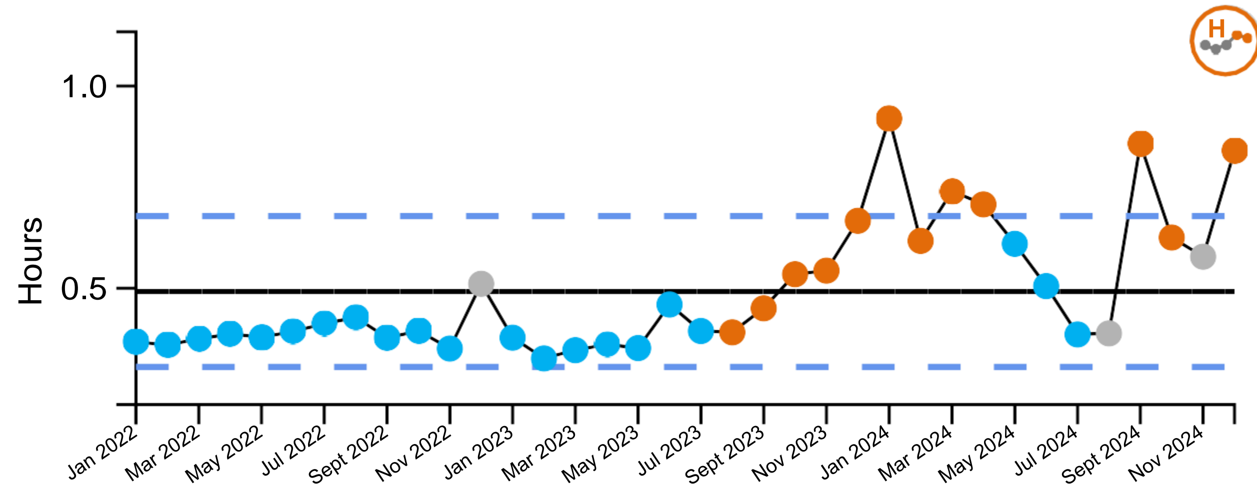
A&E attendances



A&E 4hr performance (Trust)



Average arrival to handover time



Average arrival to handover time h:mm (latest month)

(Blank)

Maximum arrival to handover time h:mm (latest month)

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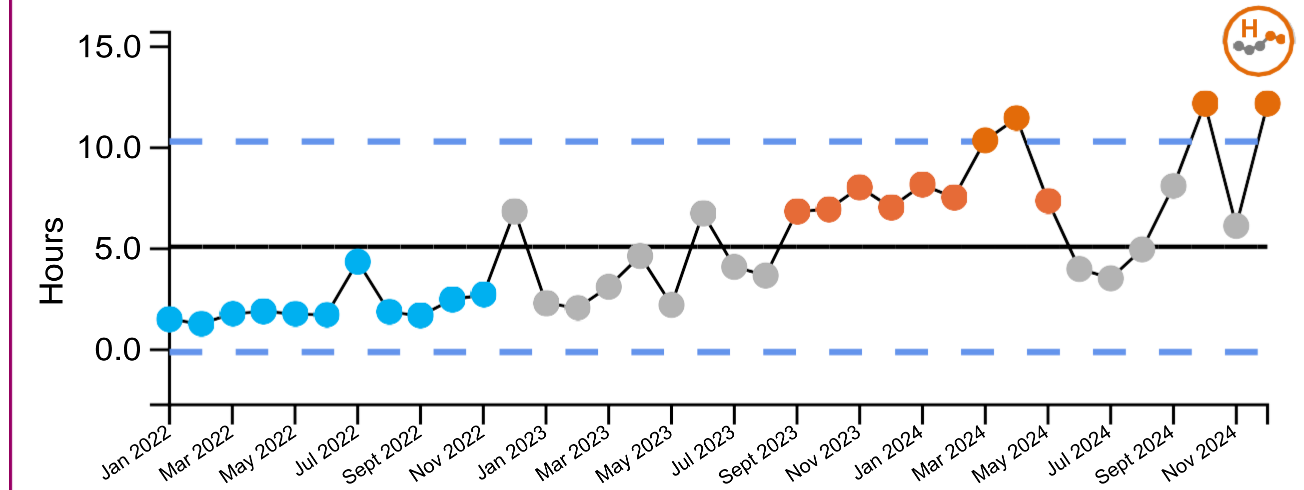
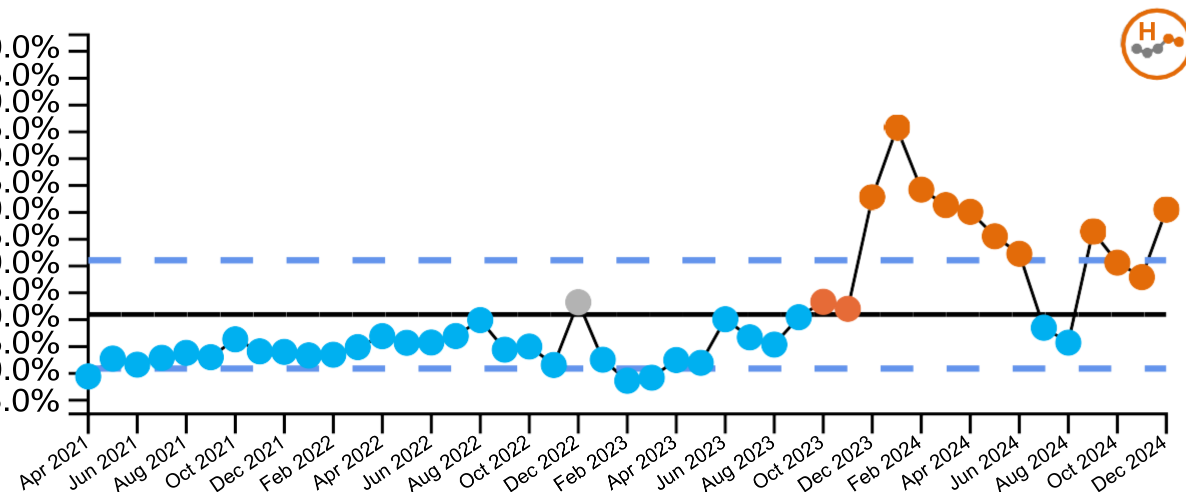
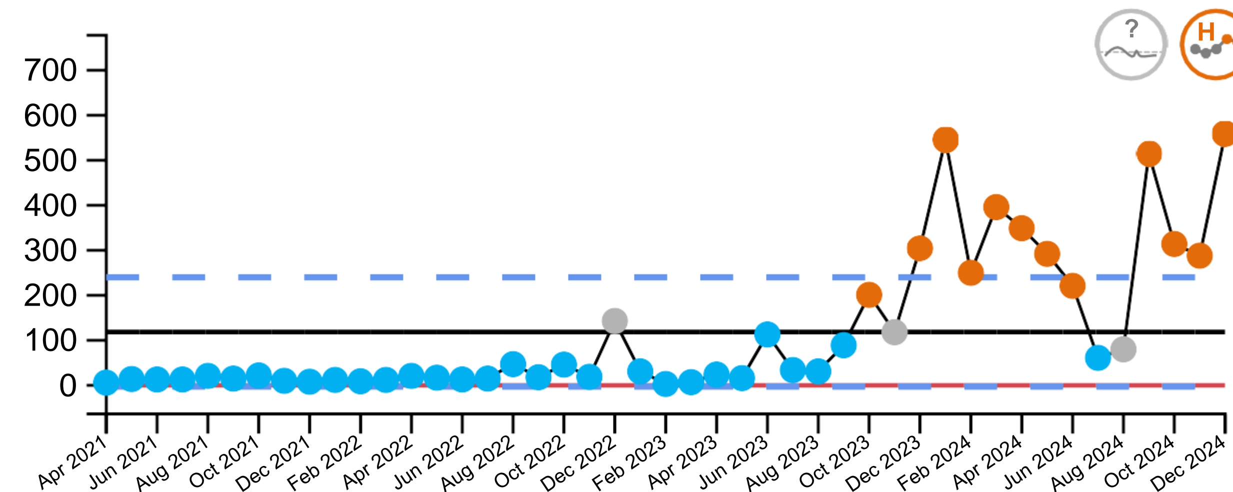
Maximum arrival to handover time



% handovers > 30 minutes

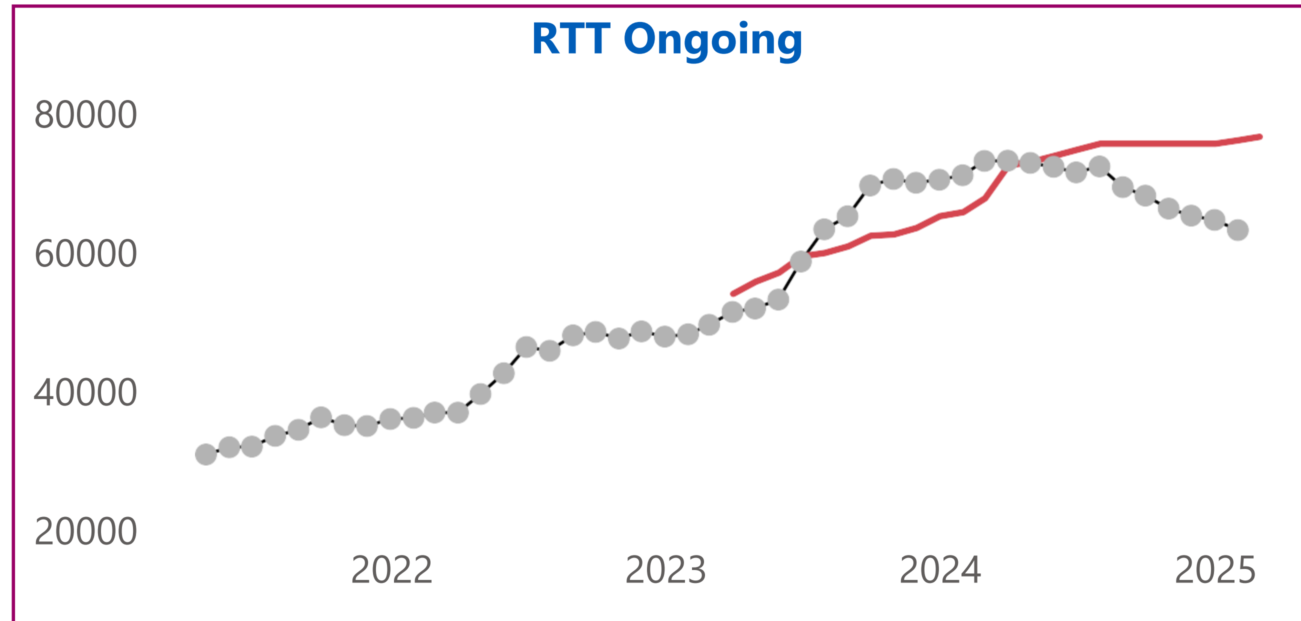


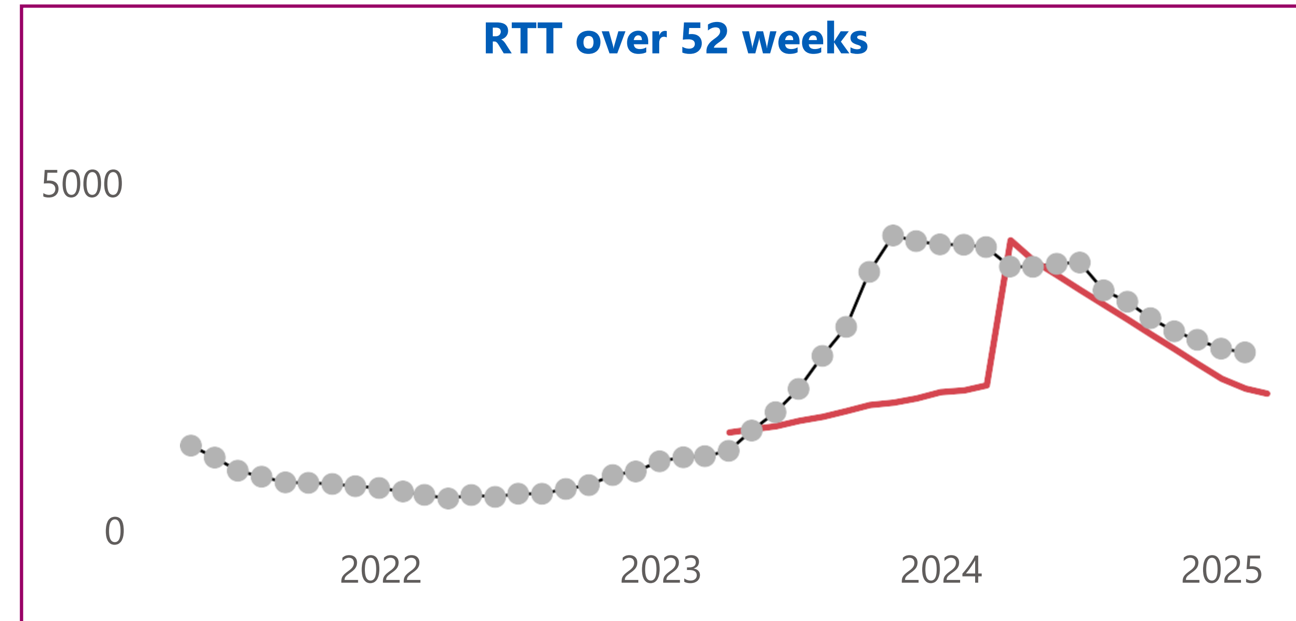
Ambulance handovers >60 minutes

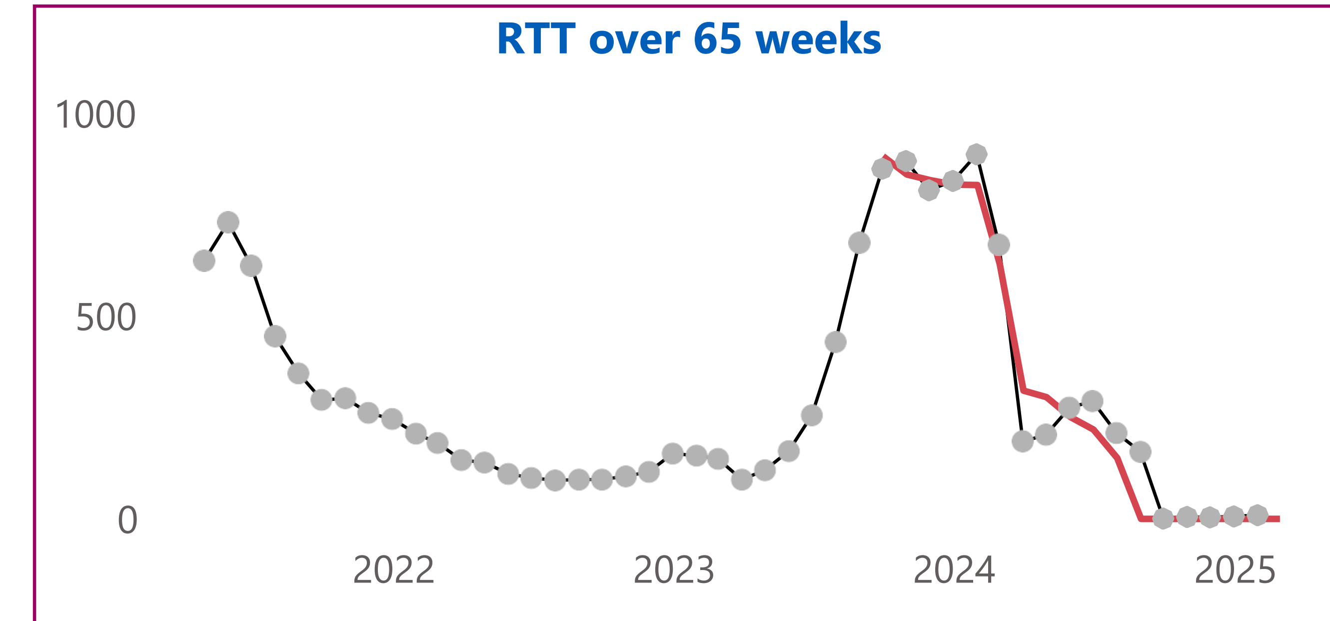


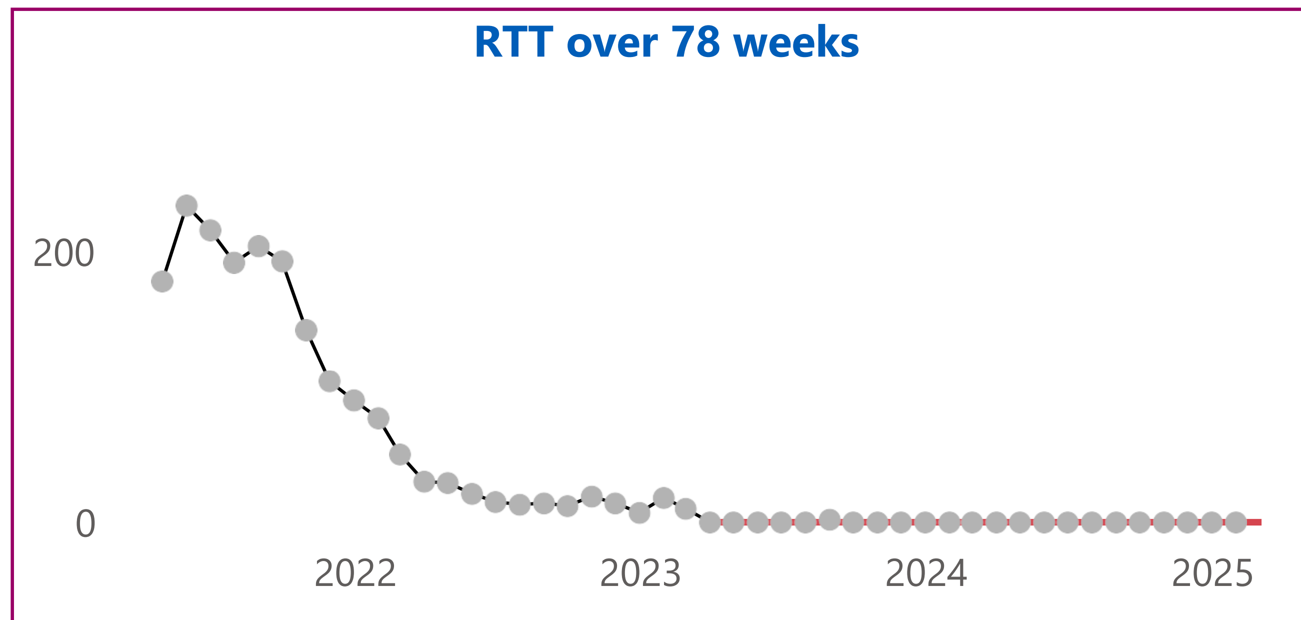
RESPONSIVE - RTT and Diagnostics

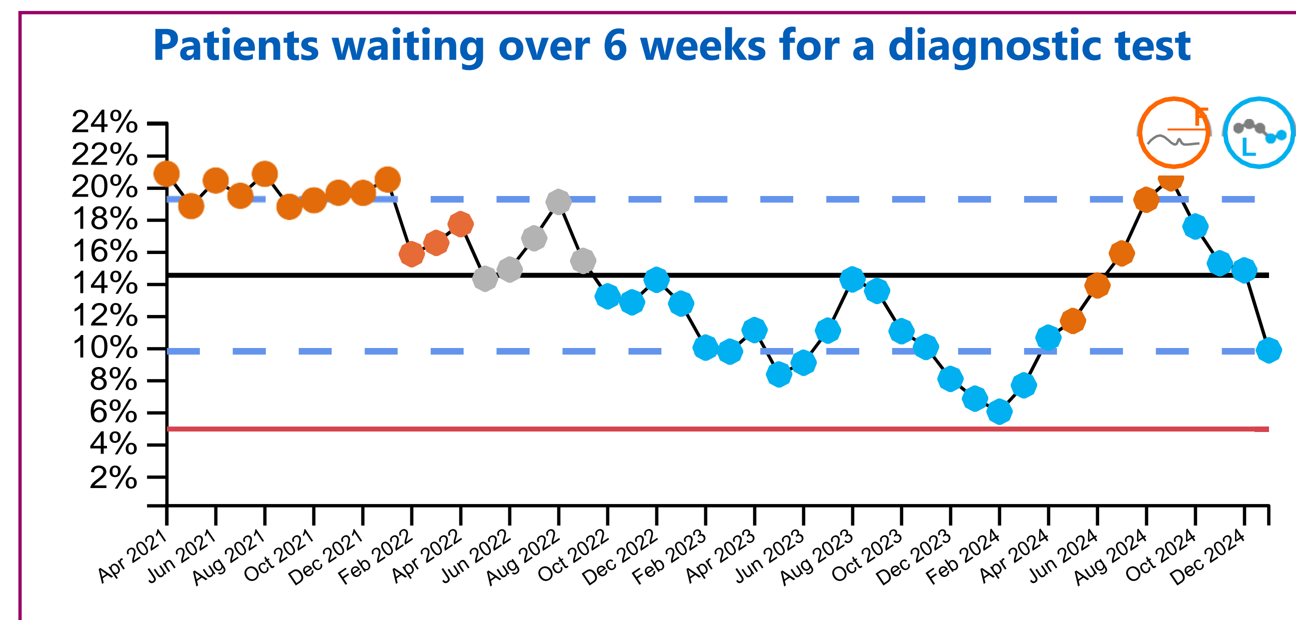
East Lancashire Hospitals NHS Trust
A University Teaching Trust







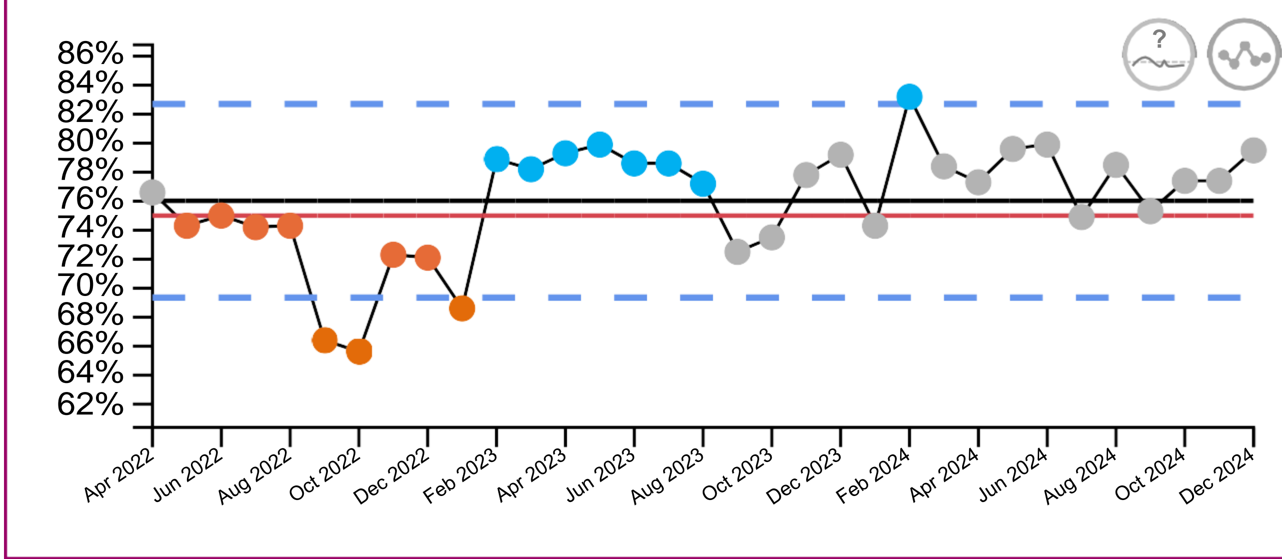




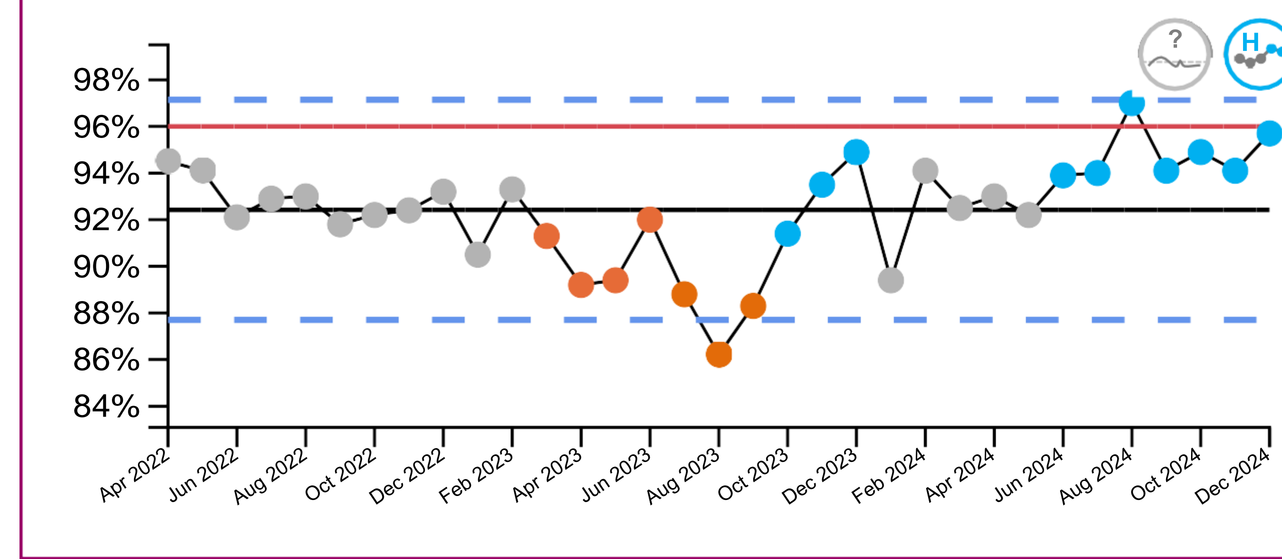
RESPONSIVE - Cancer

East Lancashire Hospitals NHS Trust
A University Teaching Trust

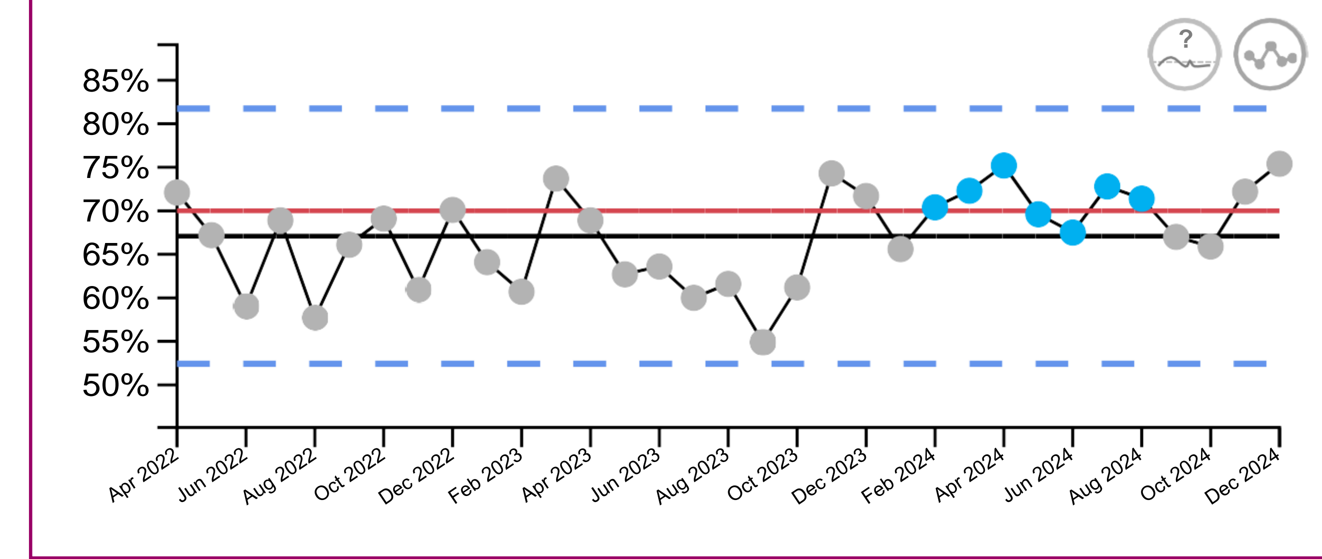
Cancer 28d general FDS



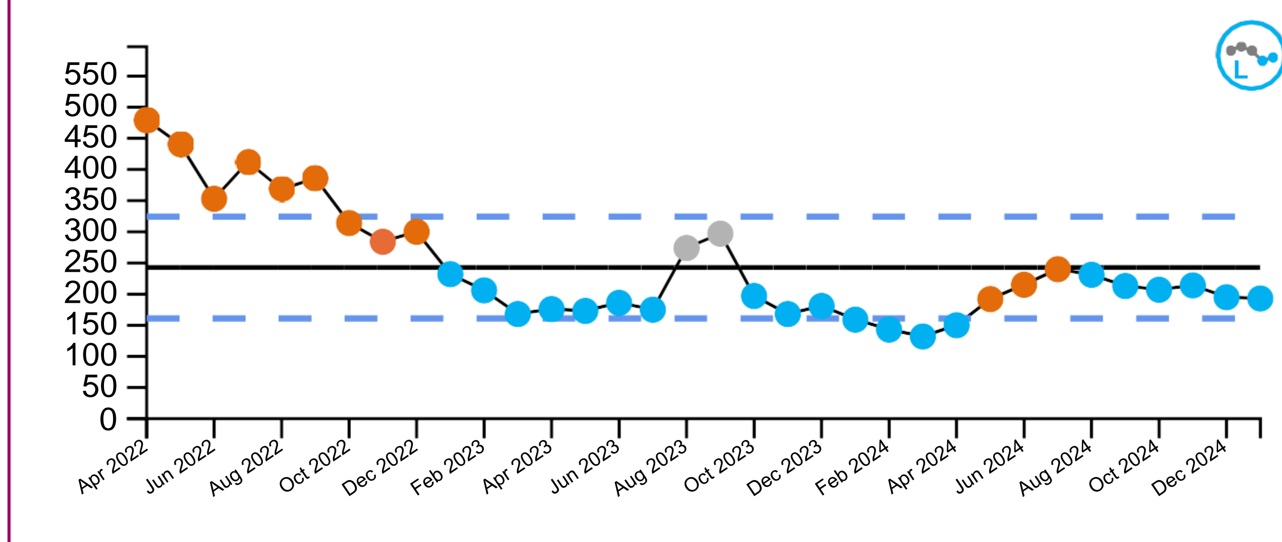
Cancer 31 day general treatment standard



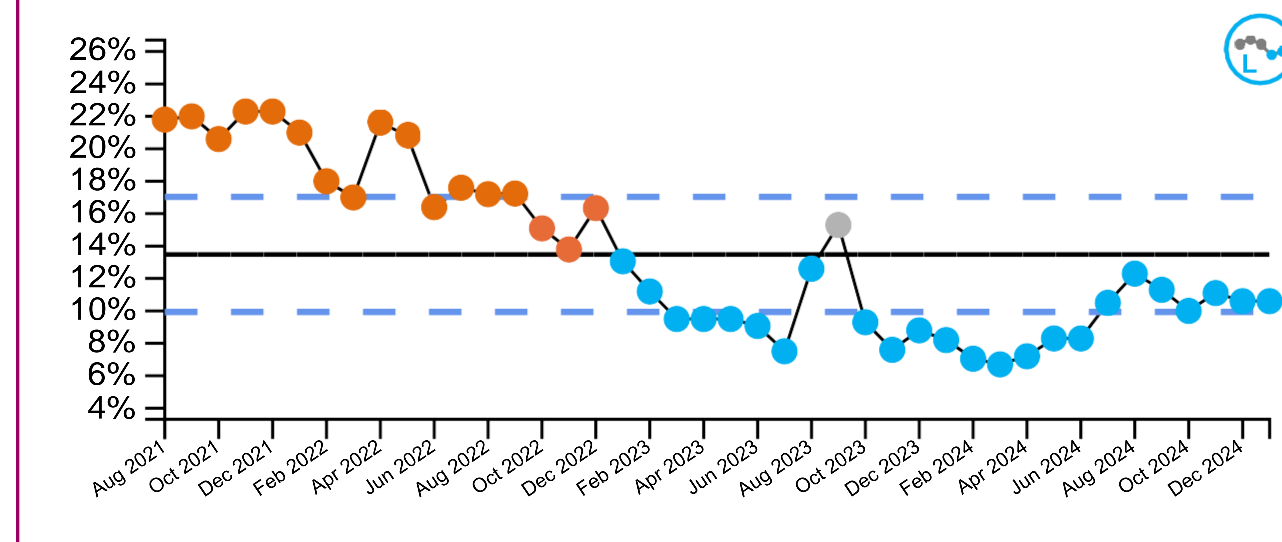
Cancer 62 day general standard



Patients over 62 days (urgent GP referral)



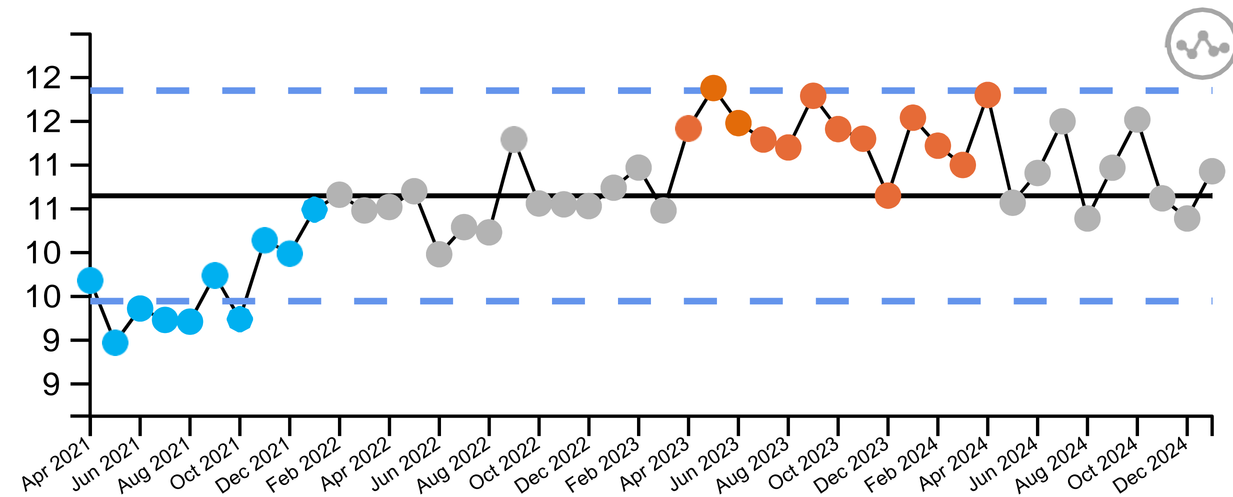
Percentage waiting over 62 days (urgent GP referral)



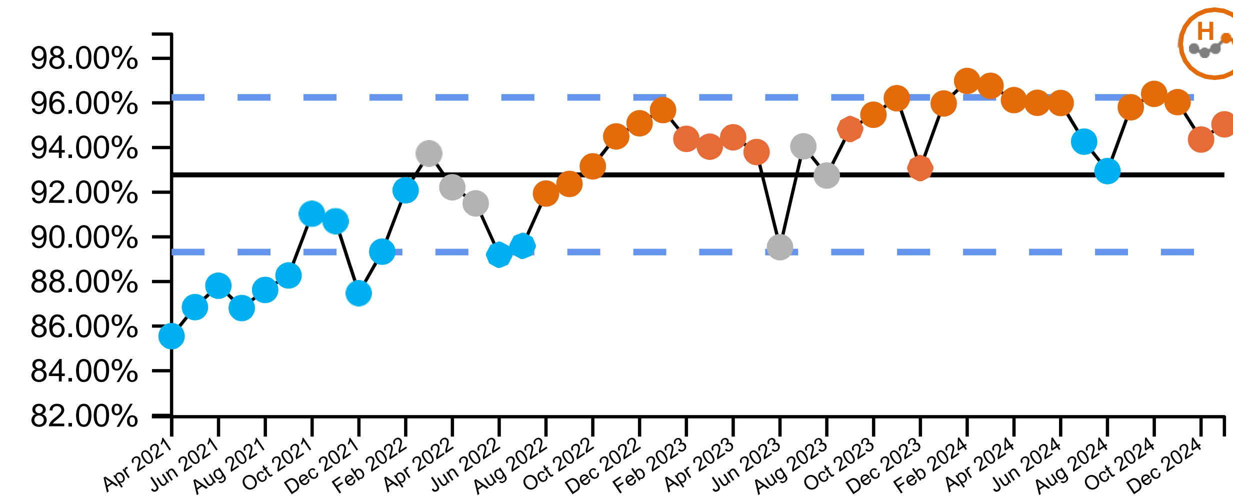
RESPONSIVE - Length of Stay and Bed Occupancy

East Lancashire Hospitals NHS Trust
A University Teaching Trust

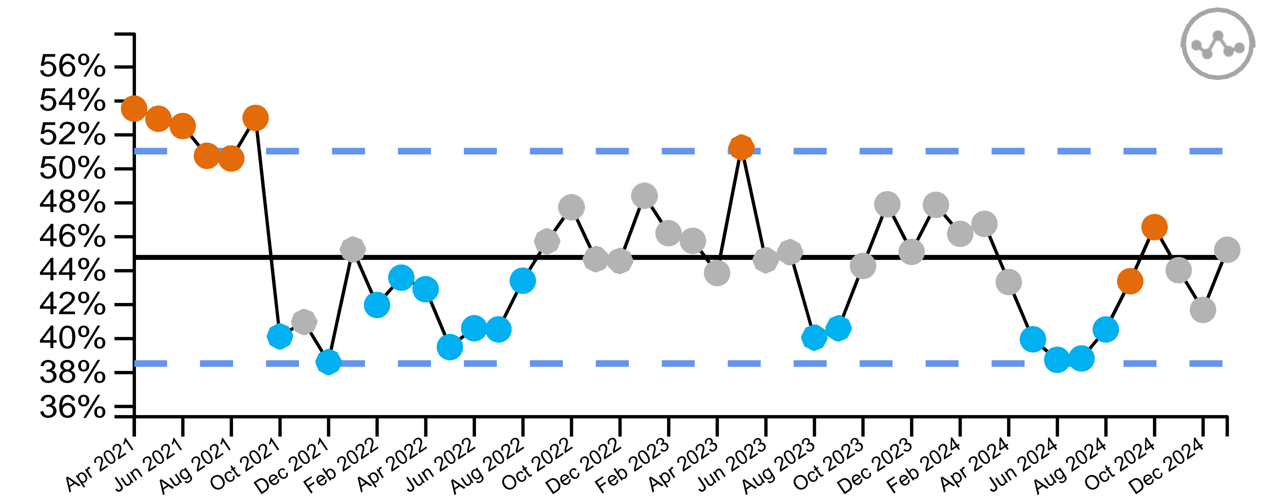
Emergency average length of stay (excluding 0 and 1 days)



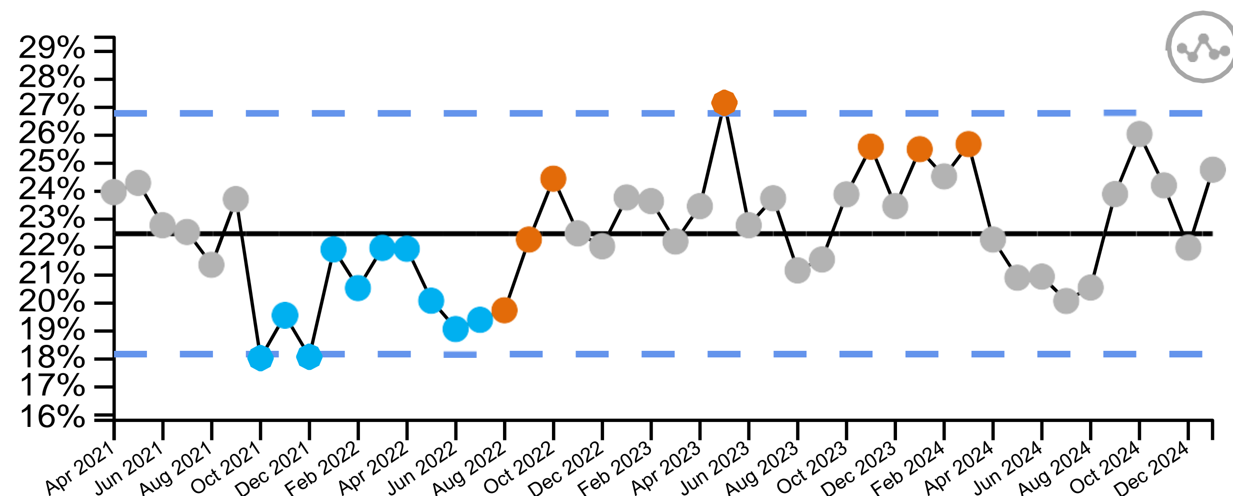
Bed occupancy G&A



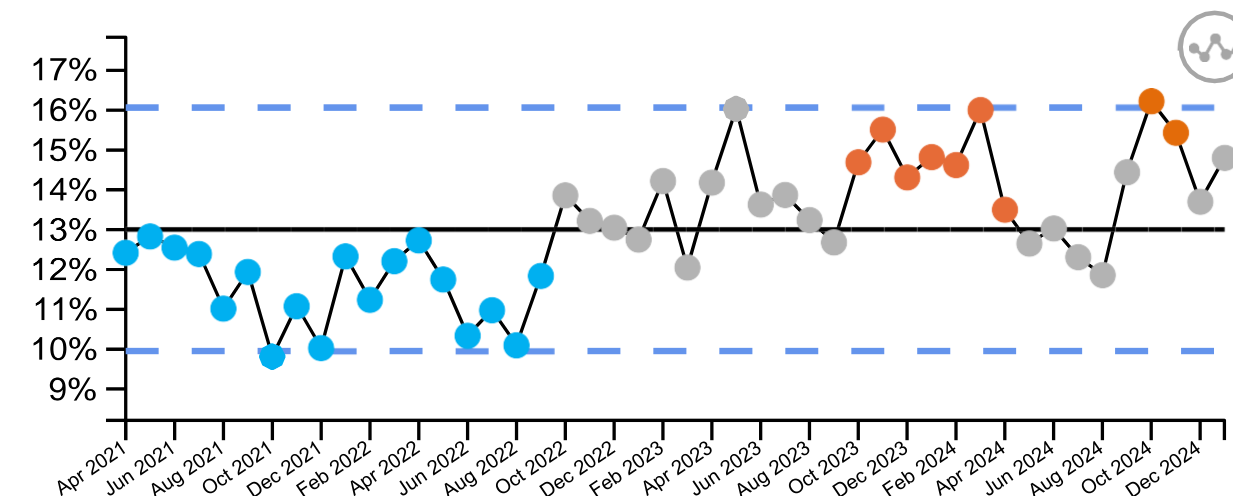
% Beds occupied by Long-Stay Patients 7+ days



% Beds occupied by Long-stay patients: 14+ days



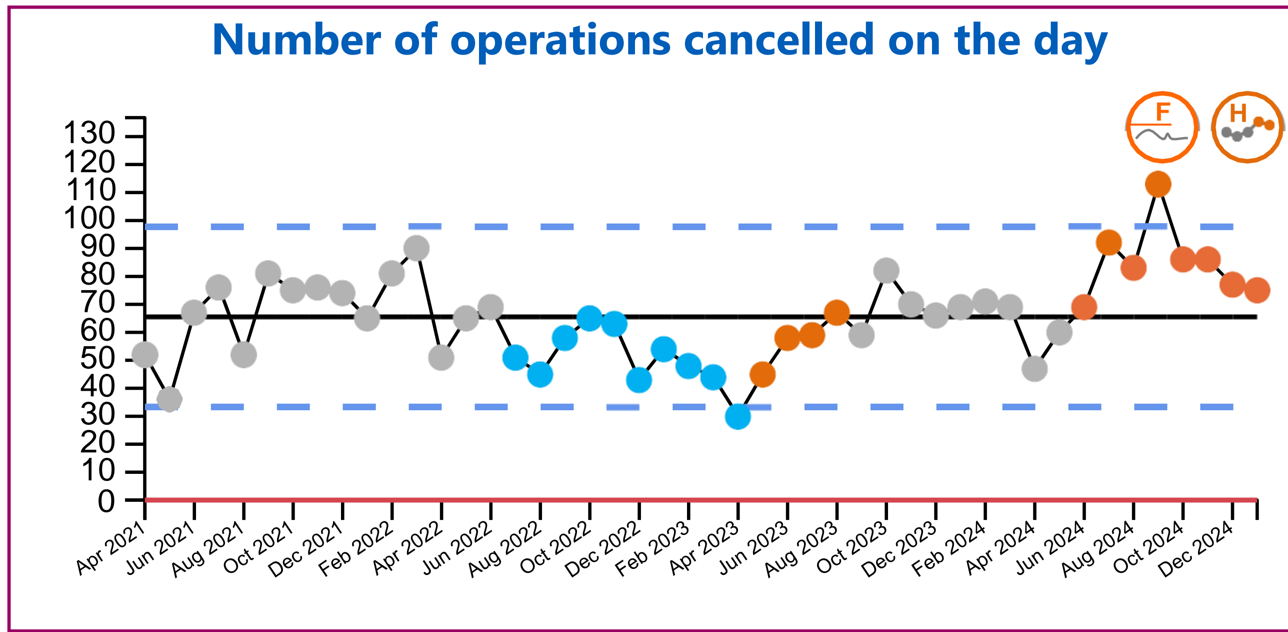
% Beds occupied by Long-stay patients 21+ days



RESPONSIVE - Cancellations and Utilisation

East Lancashire Hospitals NHS Trust
A University Teaching Trust

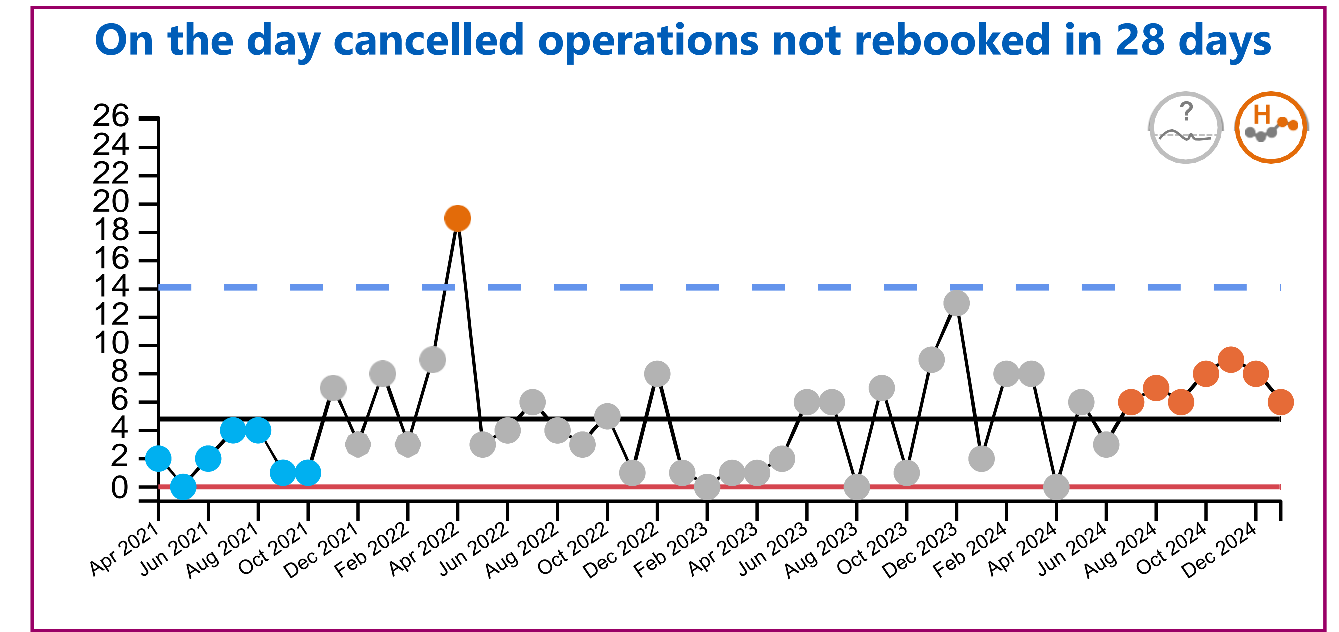
Number of operations cancelled on the day



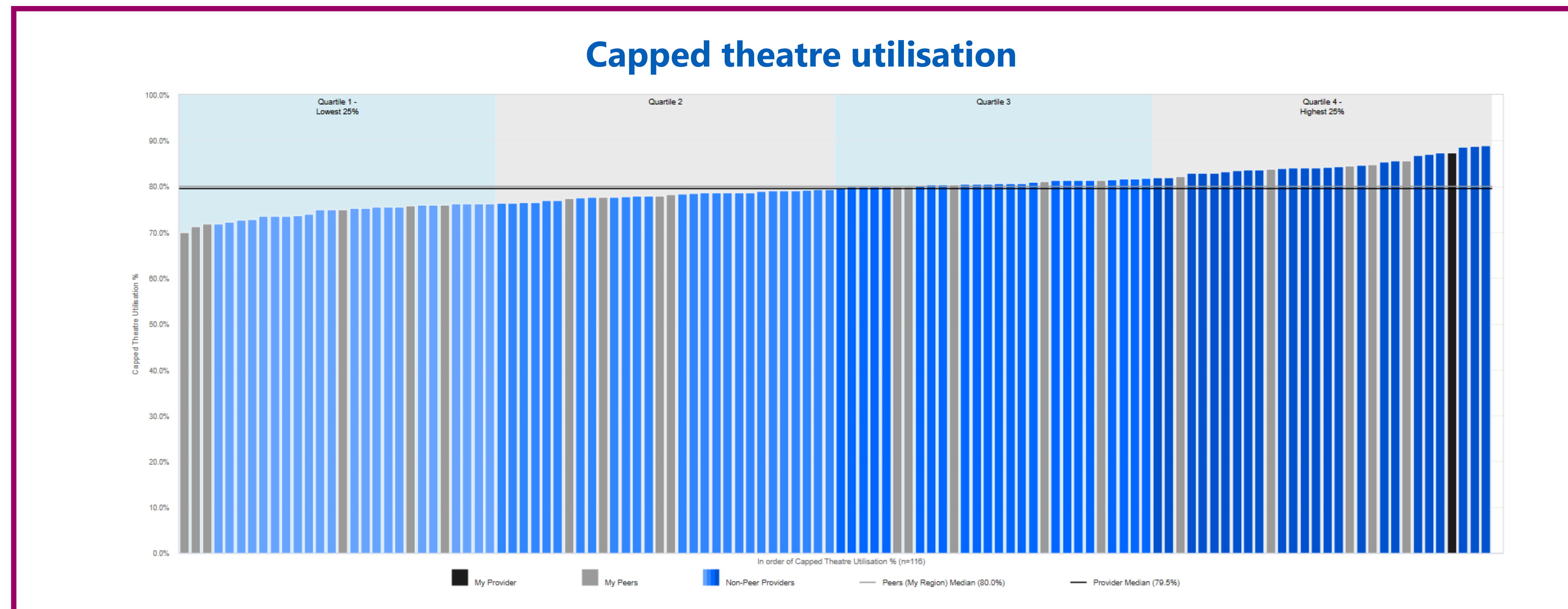
Urgent operations cancelled for 2nd time

0

On the day cancelled operations not rebooked in 28 days



Capped theatre utilisation



WELL LED - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
APPRAISAL (AGENDA FOR CHANGE)	JAN 25	0.83	0.90	H	F
APPRAISAL (CONSULTANT)	JAN 25	0.98	0.90	H	P
APPRIASAL (OTHER MEDICAL)	JAN 25	0.98	0.90		P
INFORMATION GOVERNANCE TRAINING	JAN 25	0.94	0.95		F
SAFEGUARDING CHILDREN L1	JAN 25	0.95	0.90		P
SICKNESS	DEC 24	0.07	0.00		F
TURNOVER	JAN 25	0.08	0.12		P
VACANCY	JAN 25	0.06	0.05		?

Alert

Non-medical appraisals remain below the 90% target, no movement from previous month at 83%. Slight improvements in Corporate Services and Family Care, offset by small declines in Community & Integrated Care, Surgery & Anaesthetics and DERI. Medicine & Emergency Care and Diagnostic & Clinical have not changed.

Information Governance training compliance has dropped to 88%, which is 7% off target. Individuals who are non-compliant are being contacted to complete the required training to push to the 95% target.

Advise

Sickness rate increased in January to 7.36%, up from 6.94% in December and significantly above the 4.5% national target. A review of all long-term sickness cases has been undertaken to confirm appropriate support and actions are in place. Specific posts being recruited to (redeployment opportunities) to support around reasonable adjustments, which has been identified as an area of improvement.

On average 53 concerns per quarter are raised, Q1 & Q2 were on par, however, Q3 saw an increase of 116%. The top concern remains perceived inappropriate attitudes and behaviours.

Assurance

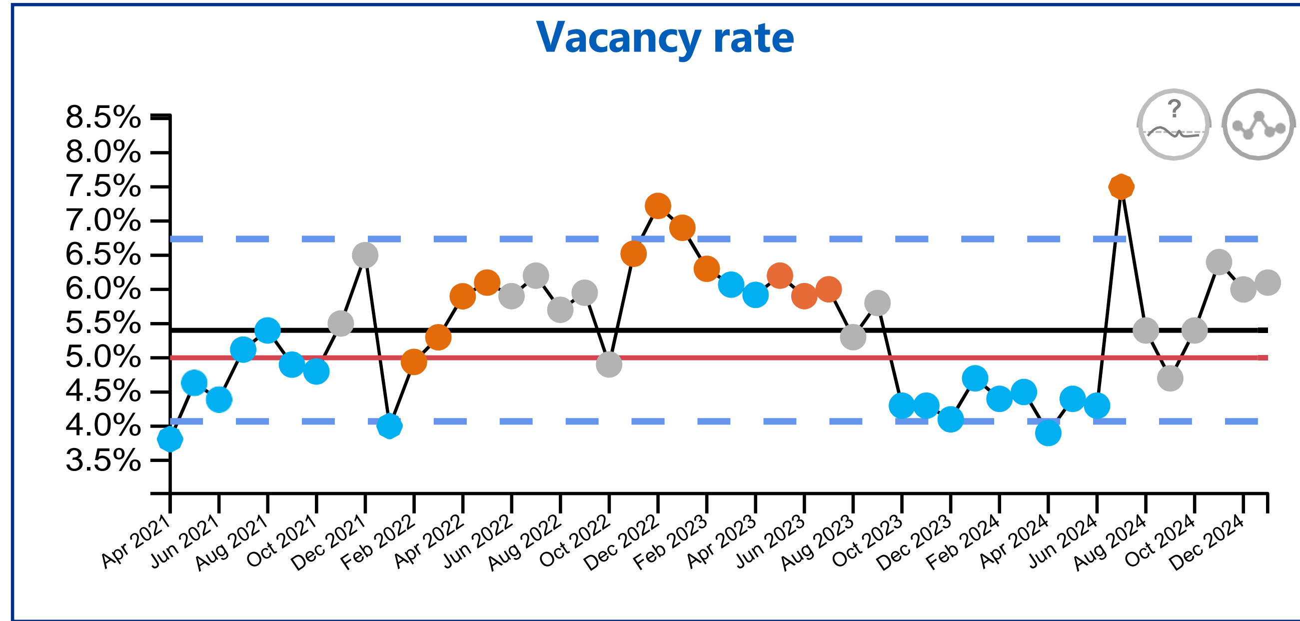
Medical appraisals compliance remains high and above target, with a slight improvement with non-Consultant grades.

Safeguarding training remain consistently above target.

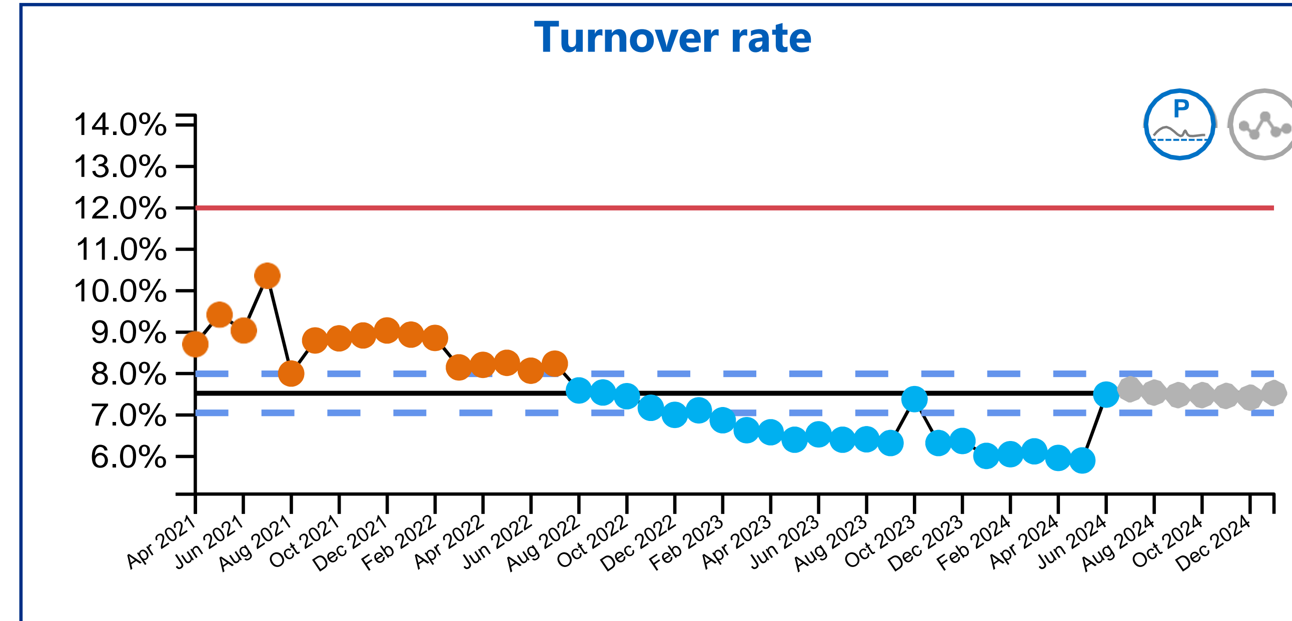
Turnover remains has dropped slightly since last month, well within Trust target.

Vacancies remain relatively low, but are seeing some increase linked to vacancy control measures.

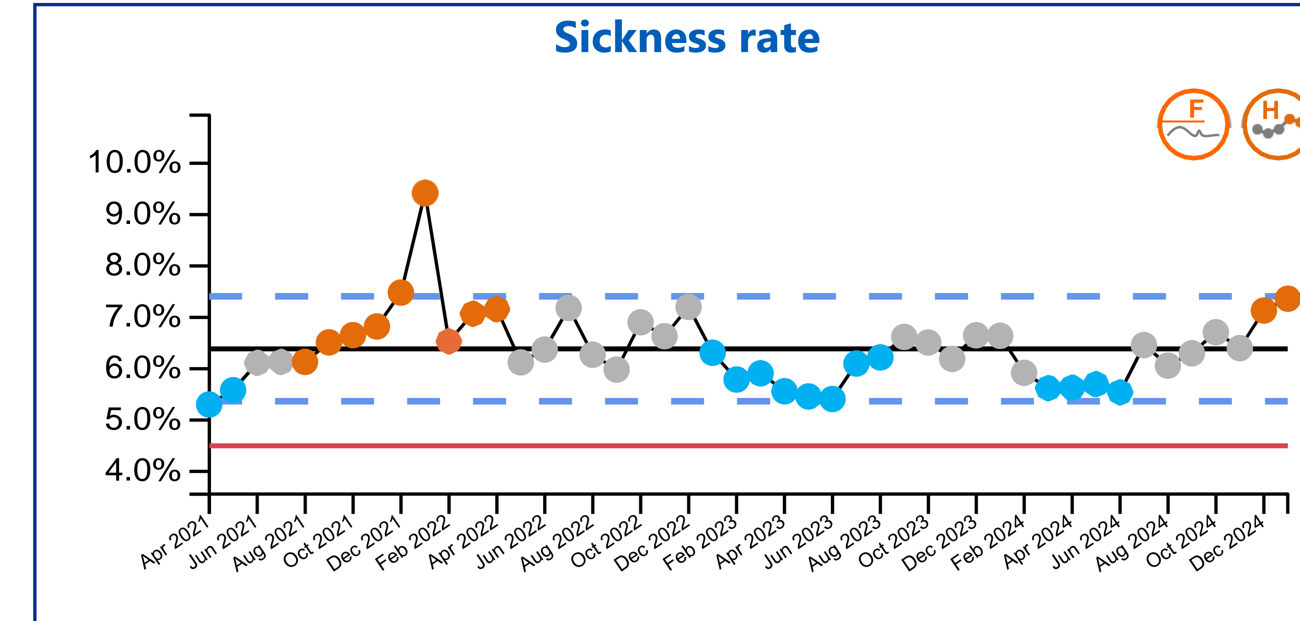
Vacancy rate



Turnover rate



Sickness rate



Freedom to Speak Up Cases by Elements

Reporting Period	Cases	Patient safety	Behaviour & attitudes	Bullying & harassment	Worker safety
Q1 24/25	40	3	21	11	18
Q2 24/25	61	0	35	16	34
Q3 24/25	115	4	29	7	22
Total	**216**	**7**	**85**	**34**	**74**

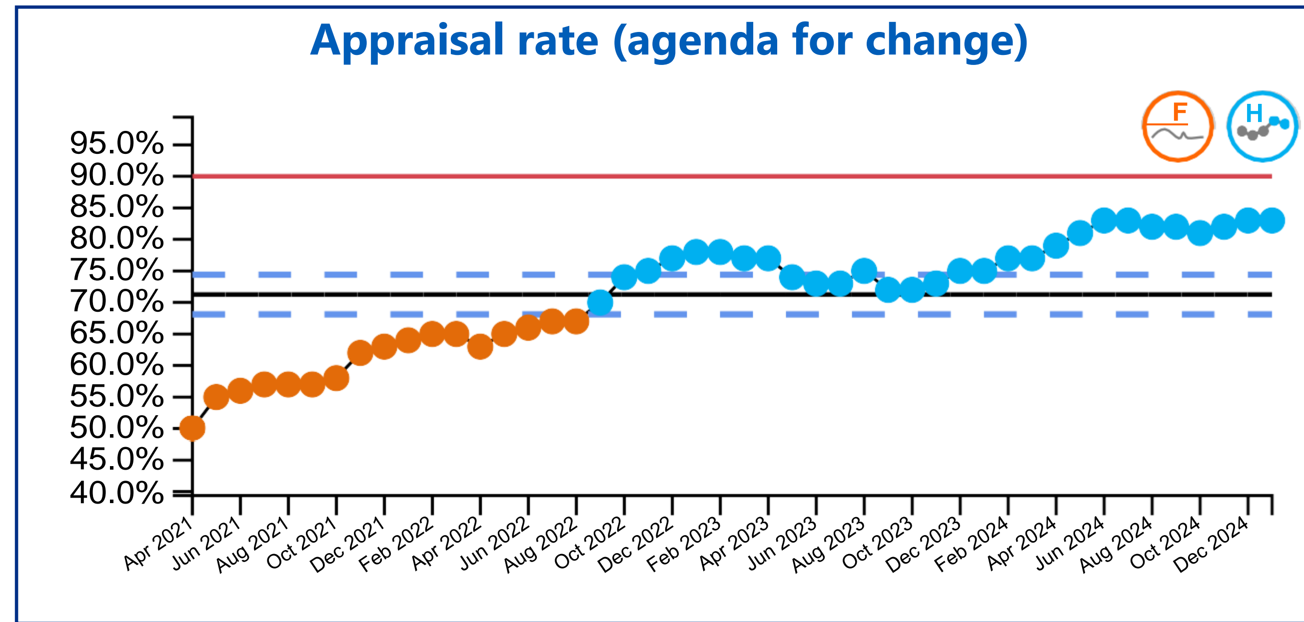
Job Plans

Stage	Consultants	Non consultants grades
Awaiting Signatures	138	24
Complete	60	17
Due Soon	52	26
In Progress	78	24
No Current Job Plan	13	8
Not Started	33	16
Referred Back	7	0
Uploaded	0	0
Total	**381**	**115**

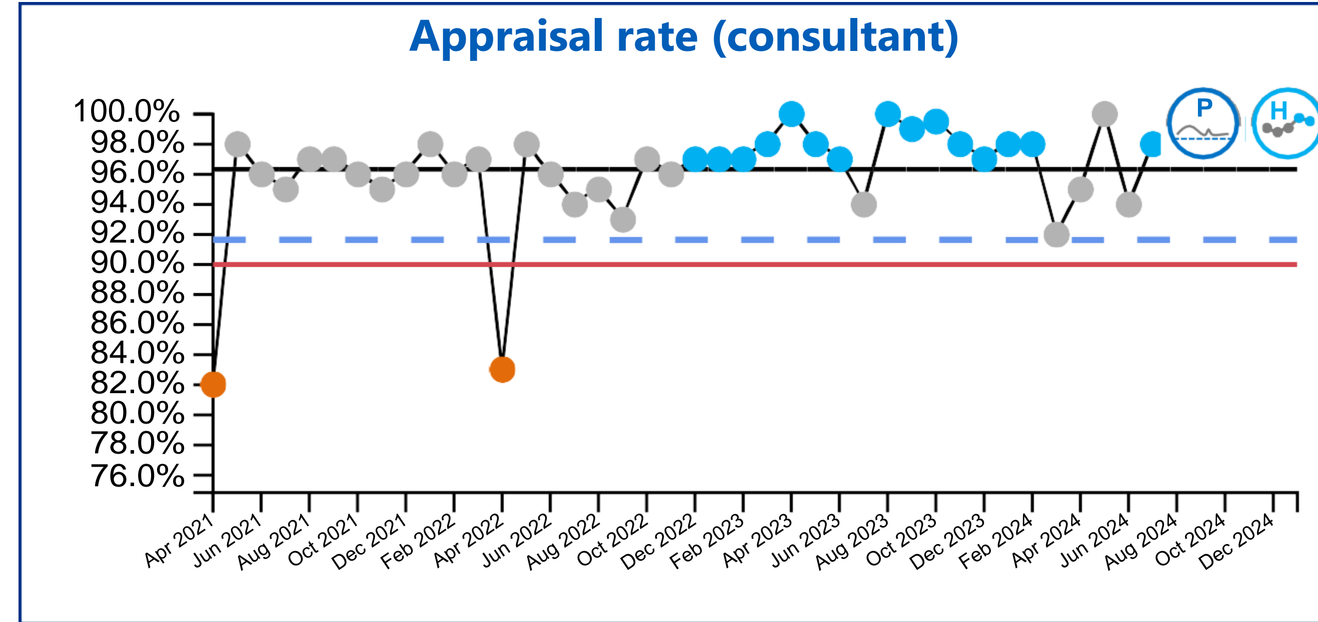
WELL LED - Learning and Development

East Lancashire Hospitals NHS Trust
A University Teaching Trust

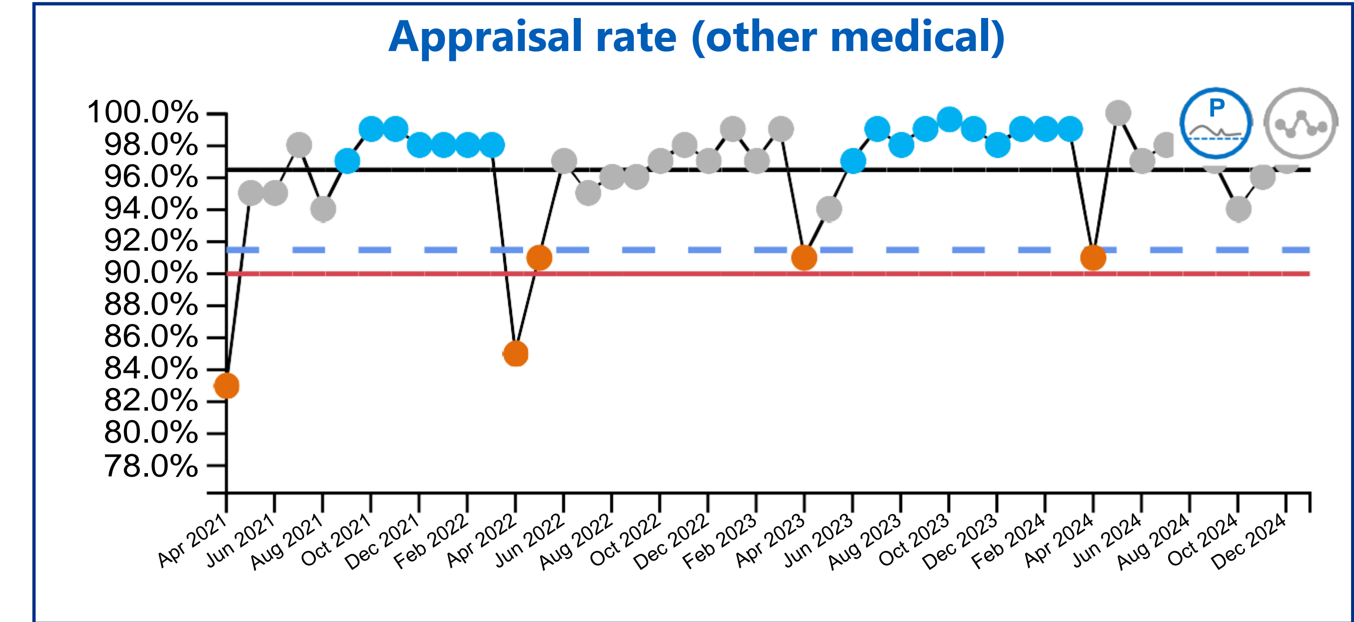
Appraisal rate (agenda for change)



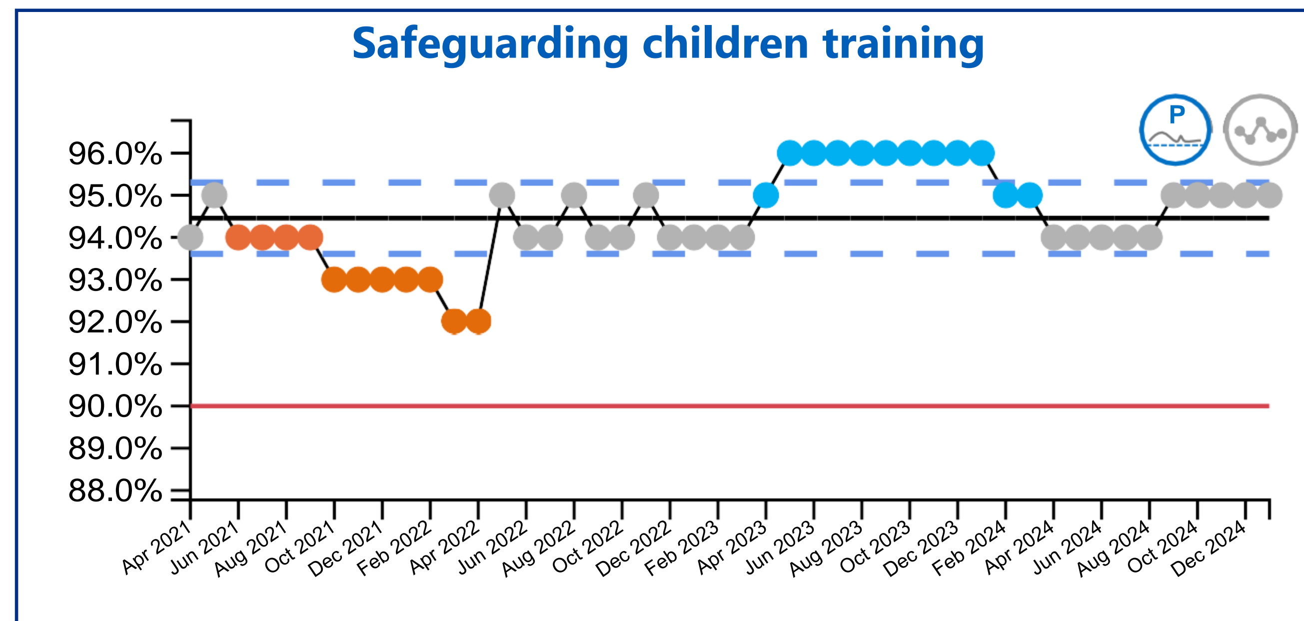
Appraisal rate (consultant)



Appraisal rate (other medical)



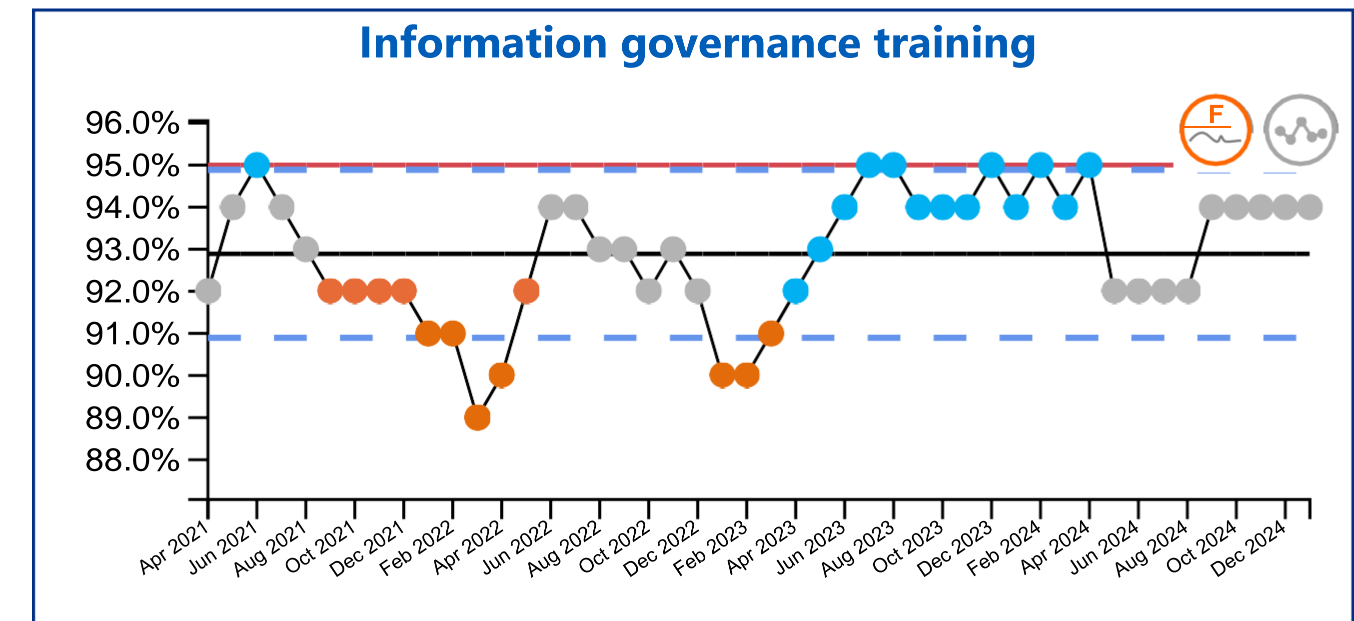
Safeguarding children training



Module	Target	Compliance
Basic Life Support	90.00	0.89
Conflict Resolution L1	90.00	0.97
Equality, Diversity and Human Rights	90.00	0.96
Health, Safety and Welfare	90.00	0.97
Infection Prevention L1	90.00	0.98
Infection Prevention L2	90.00	0.91
Prevent	90.00	0.96
Safeguarding Adults L1	90.00	0.96
Safeguarding Adults L2	90.00	0.97
Safeguarding Adults L3	90.00	0.86
Safeguarding Children L1	90.00	0.95
Safeguarding Children L2	90.00	0.96
Safeguarding Children L3	90.00	0.92
Safeguarding Children L4	90.00	1.00

Module	Target	Compliance
Fire Safety	95.00	0.96
Freedom to Speak Up	95.00	0.93
Information governance training	95.00	0.94
Safer Handling L1	95.00	0.96
Safer Handling L2 (Patient Handling)	95.00	0.90

Information governance training



WELL LED FINANCE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
BETTER PAYMENT PRACTICE CODE (BPPC) NHS NO OF INVOICES	JAN 25	0.74	0.95	L	?
BETTER PAYMENT PRACTICE CODE (BPPC) NHS VALUE OF INVOICES	JAN 25	0.95	0.95		?
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS NO OF INVOICES	JAN 25	0.72	0.95	L	?
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS VALUE OF INVOICES	JAN 25	0.90	0.95	L	?
LIQUIDITY DAYS	JAN 25	-28.80	-14.30	L	?
VARIANCE TO PLANNED FINANCIAL PERFORMANCE (DEFICIT) (£M)	JAN 25	-8.80	0.00	L	?
WRP ACHIEVED - VARIANCE TO PLAN (£M)	JAN 25	-8.90	0.00	L	?
VARIANCE TO CAPITAL PROGRAMME (£M)	JAN 25	0.40	0.00		?

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION
EMPLOYEE EXPENSES RUN RATE (£M)	JAN 25	47.10	0.00	H
INCOME RUN RATE (£M)	JAN 25	62.70	0.00	
OTHER OPERATING EXPENSES RUN RATE (£M)	JAN 25	19.20	0.00	

Alert

The Trust is reporting a deficit of £47.3m, against a planned deficit of £5.6m for the 2024-25 financial year to date, £41.7m behind the revised breakeven plan, an adverse movement of £5.8m in month.

Performance against the Better Payment Practice Code (BPPC) continues to be adversely affected by the Trust's financial position with only the measure relating to the value of NHS invoices paid on time not showing as a cause for concern.

Advise

While year to date capital expenditure is significantly ahead of plan, the Trust is not forecasting to overspend against its 2024-25 capital programme.

The main reason for the year to date variance continues to be due to the Trust recognising right of use assets for six Community Health Partnerships properties used by the Trust where the existing lease expired in December 2024 but related capital expenditure had been planned for March 2025.

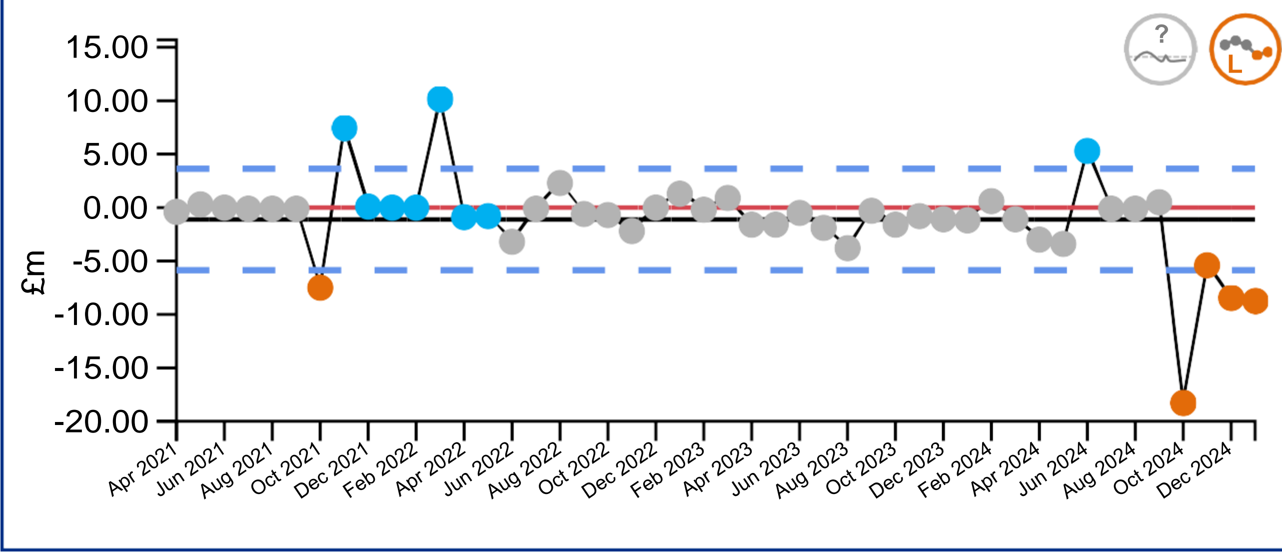
Assurance

Agency spend as a proportion of the total pay bill remains below the mean, with the target for 2024-25 of 2.9% being consistently achieved.

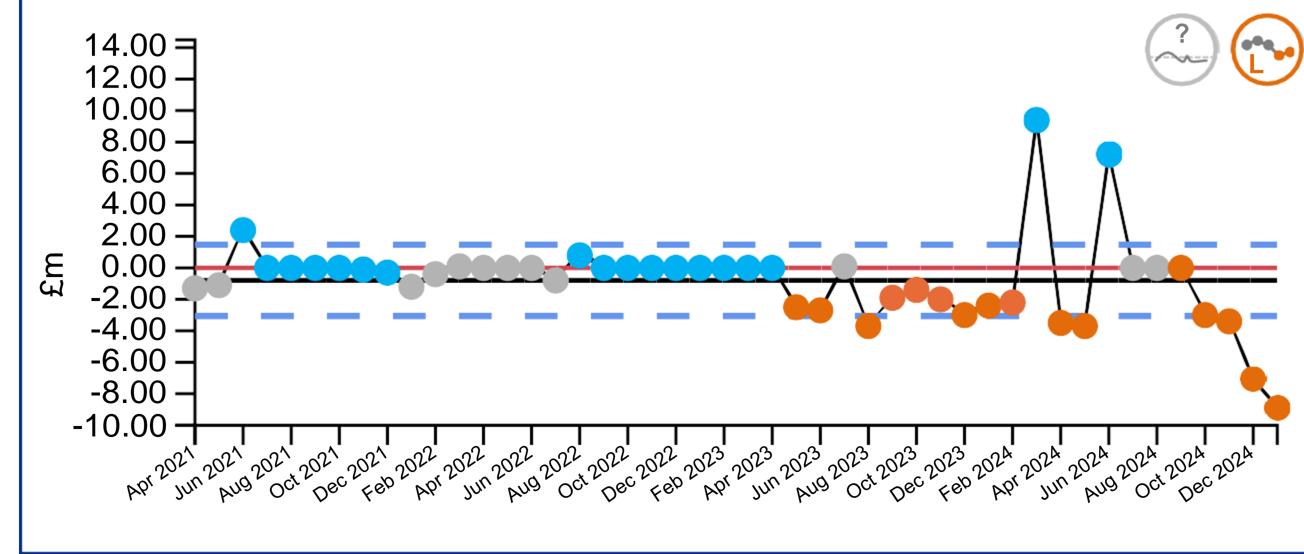
WELL LED - Finance

East Lancashire Hospitals NHS Trust
A University Teaching Trust

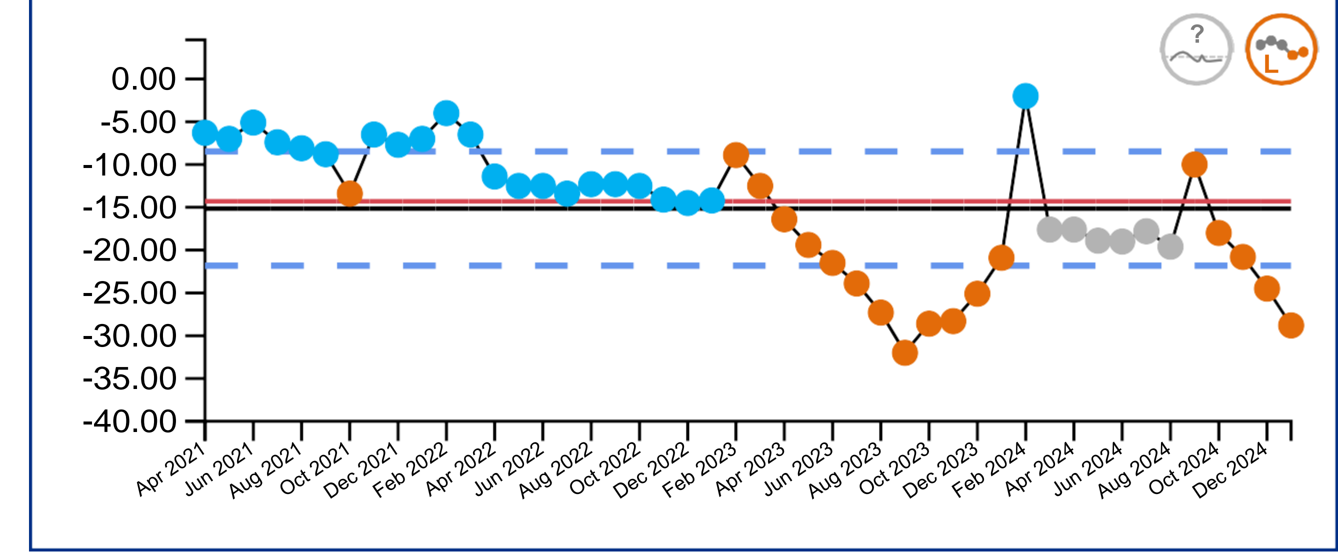
F1 - Variance to planned financial performance (deficit) (£m)



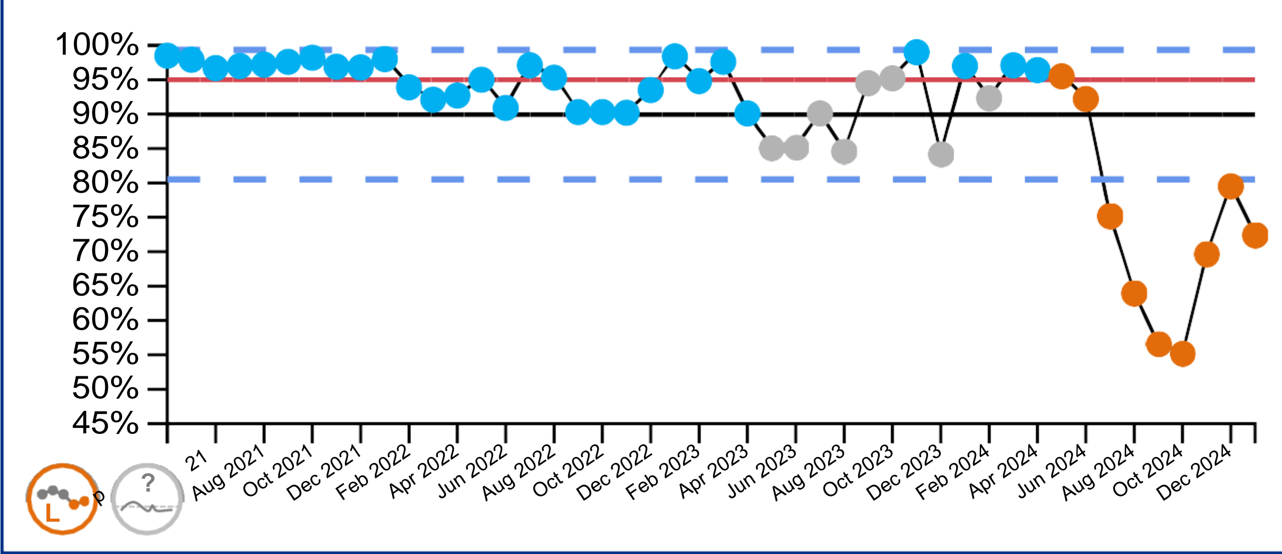
F2 - WRP achieved - variance to plan (£m)



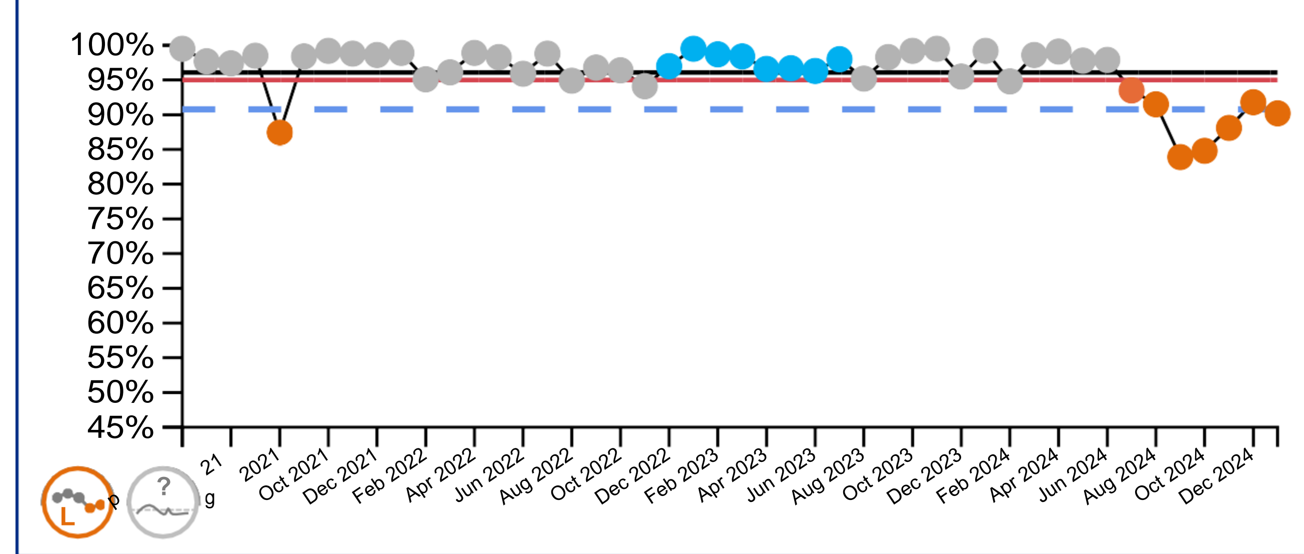
F3 - Liquidity days



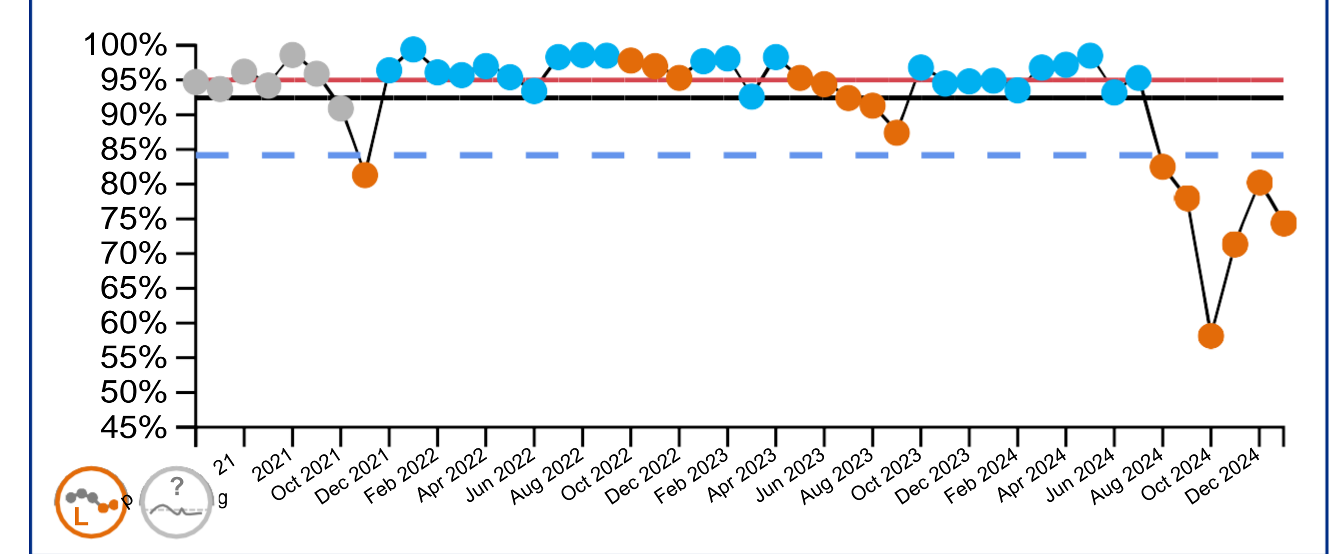
F12 - BPPC Non NHS no of invoices



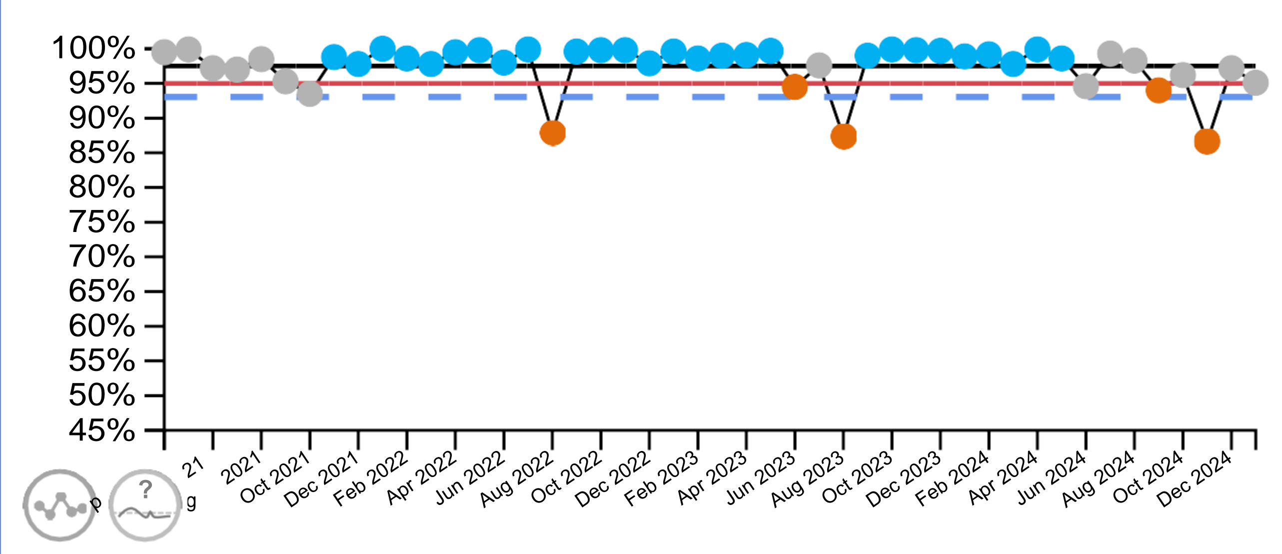
F13 - BPPC Non NHS value of invoices



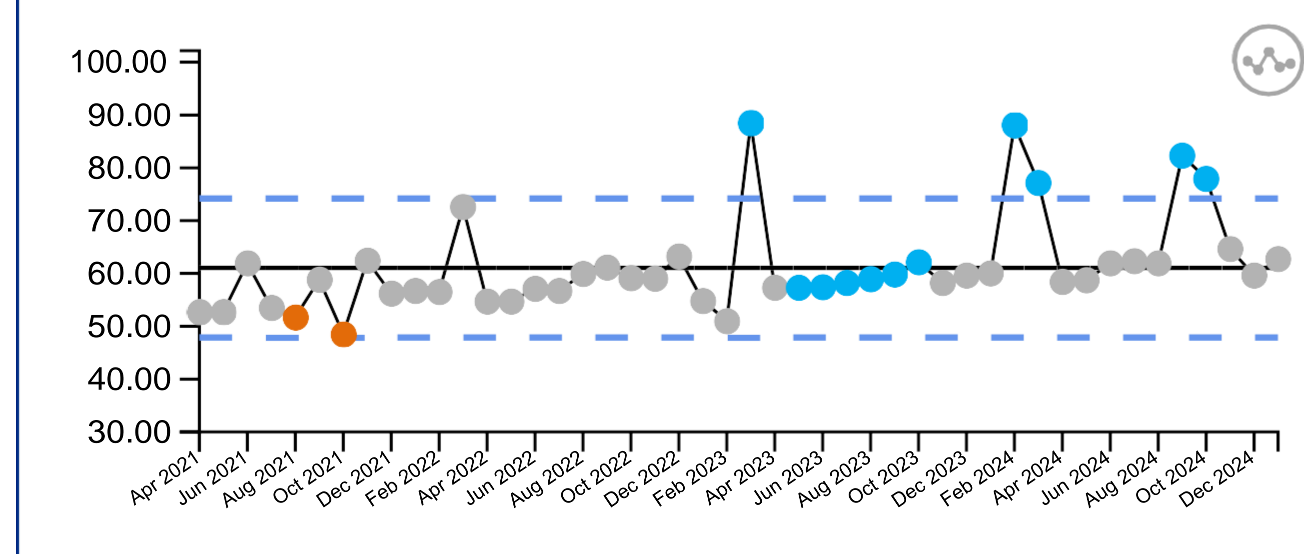
F14 - BPPC NHS no of invoices



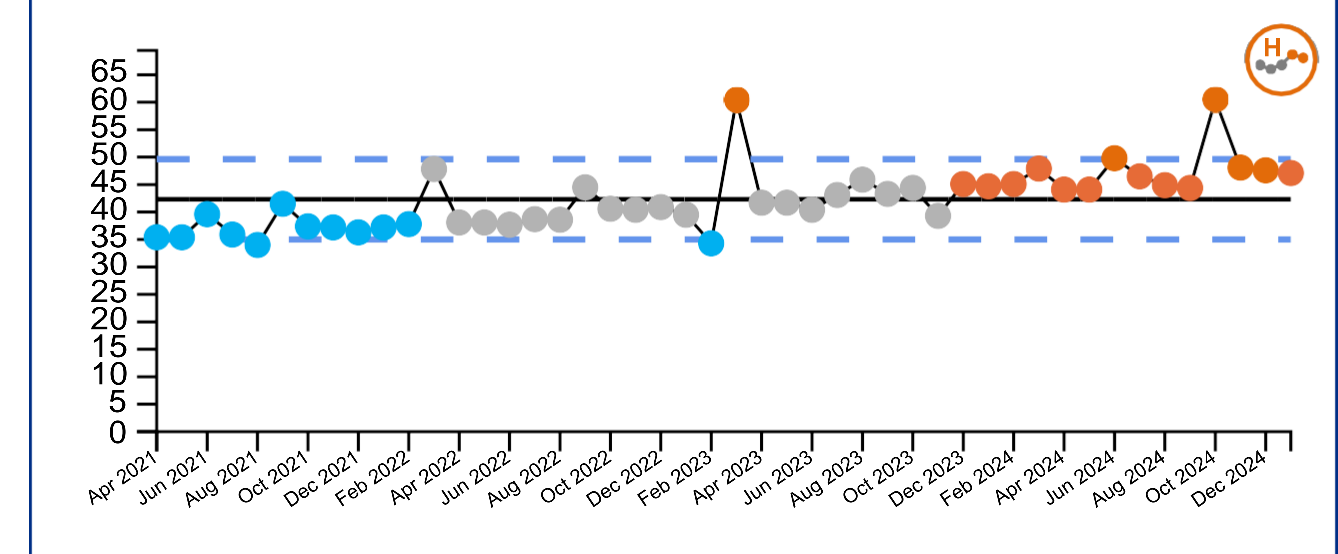
F15 - BPPC NHS value of invoices



Income run rate (£m)



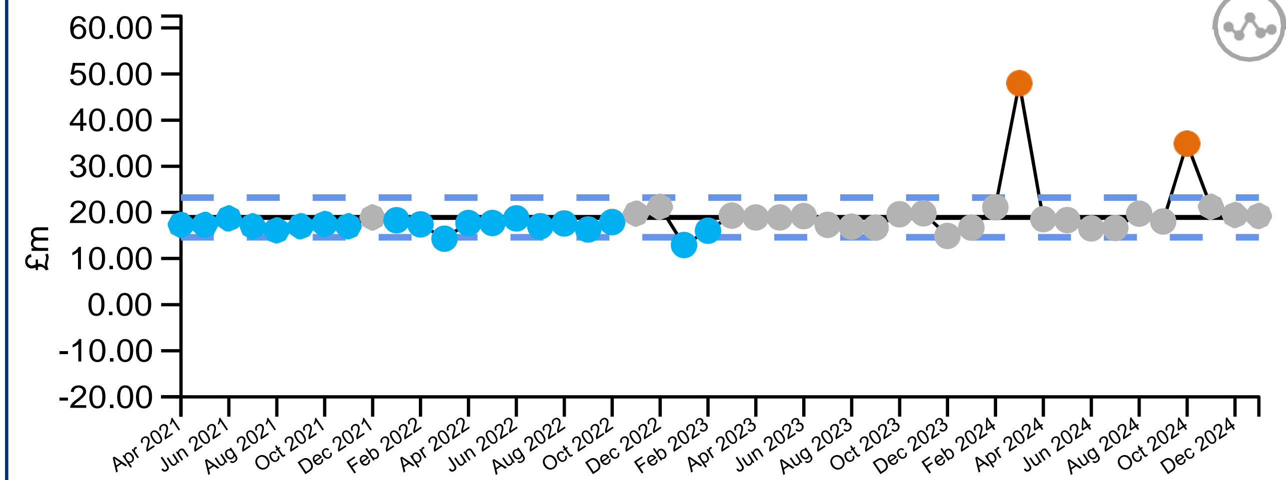
Employee expenses run rate (£m)



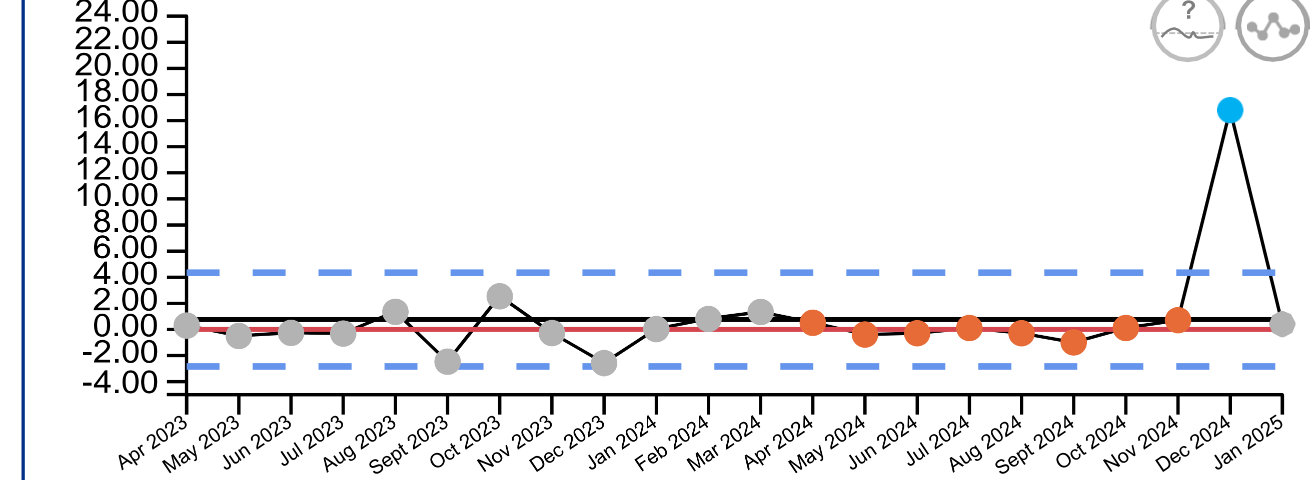
Employer contributions to NHS pensions paid by NHS E on behalf of the trust are removed from March figures.

WELL LED - Finance

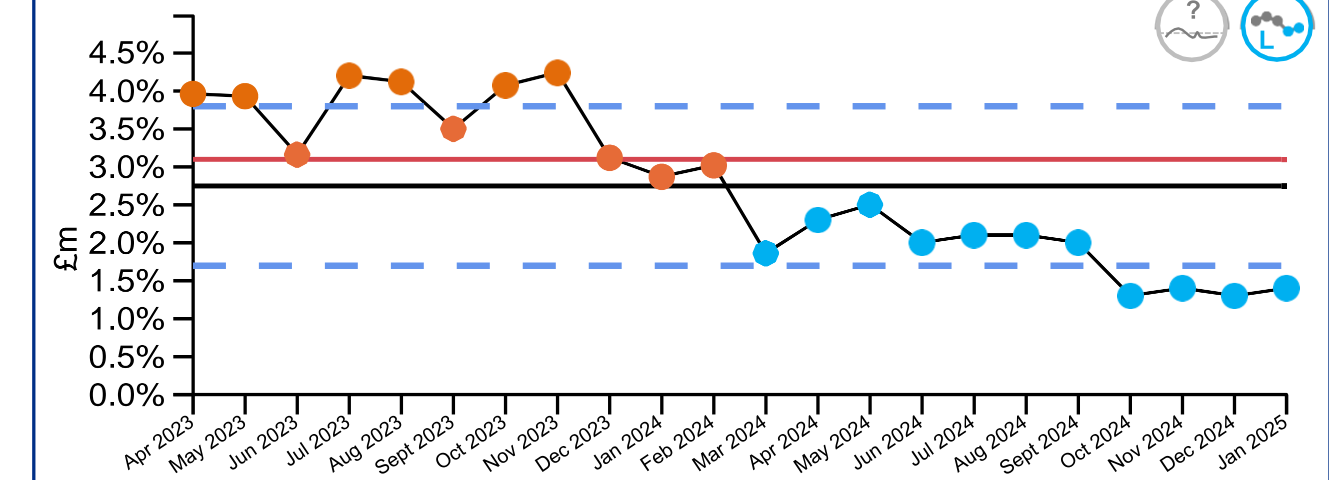
Other operating expenses run rate (£m)



Variance to capital programme (£m)



Agency spend as proportion of total pay bill (£m)



Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT	**Item**	**43b**
12 March 2025	**Purpose**	Information

Title	People and Culture Committee Summary Report
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mrs T Anderson, Committee Chair

Summary: This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 2 December 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	Compassionate and inclusive culture Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	4 — The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
Related to key risks identified on Corporate Risk Register	ID 9746: Inadequate funding model for research, development and innovation
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	People Plan Priorities
Related to ICB Strategic Objective	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Committee Name:	People and Culture Committee
Date of Meeting:	2 December 2024
Committee Chair:	Trish Anderson
Attendance:	Quorate
Key Items Discussed:	Staff Story
	People Promise Exemplar Progress Update
	Development for One LSC
	Professional Nurse Advocate Programme Update
	Senior Support and Share Update
	Core Skills Training Compliance Deep Dive
	Freedom to Speak Up Report
	Industrial Action Update
	Review of Committee Terms of Reference and Workplan
	Review of New Integrated Performance Report (IPR)

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. • Members received a Freedom to Speak Up Report which highlighted that a total of 101 concerns had been raised. It was noted that numbers had increased in this quarter and more were being raised anonymously. It was highlighted that at least 4 people had chosen to leave the Trust after raising concerns. • Concerns were also raised in terms of the teams capacity to manage the additional demand potentially arising from the transfer in of One LSC staff.
ASSURE
Please include items that have been discussed at the Committee that the Board can be gain assurance from. • Members received an update on the Senior Support and Share visits which occur on a weekly basis. Feedback is positive and of good quality • Minutes from the JNCC and JLNC were received for information.
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. • Members were advised of the successful launch of One LSC on 1 November as planned. There were few issues arising from the transfer of the staff into the Trust. • Members were updated on progress with the Professional Nurse Advocate Programme (PNA) programme. It was noted that as a result of significant operational pressures numbers receiving restorative clinical supervision had dropped. The Trust is unlikely to meet the 2025 deadline for PNS numbers.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT | **Item** | **43b**

12 March 2025 | **Purpose** | Information

Title	People and Culture Committee Summary Report
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mrs T Anderson, Committee Chair

Summary: This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 13 January 2025. 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	Compassionate and inclusive culture Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	4 — The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
Related to key risks identified on Corporate Risk Register	ID 9746: Inadequate funding model for research, development and innovation
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	People Plan Priorities
Related to ICB Strategic Objective	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

(43b) People and Culture Committee Summary Report

Committee Name: People and Culture Committee

Date of Meeting: 13 January 2025

Committee Chair: Trish Anderson

Attendance: Quorate

Key Items Discussed: Board Assurance Framework
Corporate Risk Register Report
Focus Spot: Staff Story
2024 Staff Survey Result Briefing
One LSC Update
People Promise Exemplar Progress Update
Update on Trust Financial Performance

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.

- Members received a report on core skills training within the Trust. Concerns had been expressed by a number of staff in relation to the volume of mandatory training required. There were concerns that the Trust was not compliant with the Information Governance (IG) training requirements which was closely linked to the level of cyber related risk to the organisation. A rise in incidents in the Trust of colleagues accessing inappropriately was also highlighted. A report on training compliance for One LSC staff will come to a future meeting.
- The Committee were alerted to some initial difficulties with regard to the transfer to One LSC. These covered interim arrangements leading to duplication, detrimental effect on staff due to additional pressures and some obstructive behaviours being exhibited as a result. It was highlighted that these areas needed to be addressed quickly to ensure transformation work can get underway. It was suggested that a formalised governance structure would be helpful to have in place.
- Findings from the latest staff survey were discussed. Overall response rate has deteriorated as in other LSC trusts which is against the national trends. The Trust is still above average in key areas such as Health and Well Being but had deteriorated

in 6 of the 9 People Promise themes. Members agreed a robust action plan was required and a 'heat map' would be of benefit.

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.

- An update on the People Promise Exemplar was received and the pressures that staff were feeling given the financial situation was noted.
- Members were updated on the Trusts financial performance and that there would be a significant focus on variable pay over the coming months. A Mutually Agreed Resignation Scheme had been launched prior to Christmas.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT | **Item** | **43c**

12 March 2025 | **Purpose** | Information

Title	People and Culture Committee Summary Report
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mrs T Anderson, Committee Chair

Summary: This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 3 February 2025. 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	Compassionate and inclusive culture Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	4 — The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
Related to key risks identified on Corporate Risk Register	ID 9746: Inadequate funding model for research, development and innovation
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	People Plan Priorities
Related to ICB Strategic Objective	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

(43c) People and Culture Committee Summary Report

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust

Committee Name: People and Culture Committee

Date of Meeting: 3 February 2025

Committee Chair: Trish Anderson

Attendance: Quorate

Key Items Discussed:
Staff Story
Workforce Update
One LSC Update
People Promise Exemplar Progress Update
Senior Support and Share Update
Staff Side Update
Staff Health and Wellbeing Report
Guardian of Safe Working Hours Report
People and Culture Performance Dashboard

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. • A workforce report was received which highlighted the challenge of reducing the workforce head count. A figure of 455 posts was highlighted as needed to go by the end of the year to meet the financial target. Focused work is taking place in each division through a reduction in staff roles and variable pay controls to meet this target. Complete service reviews are taking place in all divisions to determine what can be delivered within the financial framework and there is buy in and good engagement taking place with teams. Requests were made for detailed divisional information to come to the Committee. • A detailed report was received from the Guardian of Safe Working in relation to safe working hours. It was highlighted that there are increases in the number of exception reports submitted reflecting an increasing amount of pressure Medical colleagues were under particularly in MEC (ED) and SAS. Concerns were noted in relation to the difficulties in colleagues not being able to take rest breaks which have not yet been addressed. Further information was requested.

ASSURE
Please include items that have been discussed at the Committee that the Board can be gain assurance from. • A detailed paper on progress with One LSC was discussed. Each organisation is now operating under the One LSC umbrella. • Change is already evident through the sharing of good practice and an exploration of new ways of working are now being considered including the use of AI. • A Target Operational model has now been developed and it was noted that several fragile services had been identified during the exercise with future work to be done on those.

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 People Promise Exemplar progress update was received and noted. • A Senior Support and Share update report was received and noted. • A detailed staff side report was received highlighting issues around on-site facilities, car parking, and activities on social media channels around redundancies and carry forward of annual leave. • An update on work on the development of the People and Culture dashboard was provided.

TRUST BOARD REPORT	**Item**	**44a**
12 March 2025	**Purpose**	Assurance Information

Title	Triple A Report from Finance and Performance Committee
Report Author	Mrs L Sedgley, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 27 January 2025. 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:	Finance and Performance Committee
Date of Meeting:	27 January 2025
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting Cost Improvement Programme Update Planning 2025/26 Update Improvement Update One LSC Update Integrated Performance Report PFI PACS Contract Contracts over £1,000,000 Private Finance Initiative (PFI) Update Systems 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 notes the worsening financial position at Month 9 and also the ongoing challenges to improve the Forecast Outturn Position (FOT) for 24/25
- The Financial plan for 25/26 will be equally challenging given the lack of CIPs identified and enacted in 24/25 to reduce the Trust's run rate going into 25/26
- The Trust will face considerable challenge in managing its cashflow forecast if the application for additional PDS is delayed or the amount reduced.
- UEC attendances are still significantly higher than those across the ICS and the rest of the North West despite the continued focus on avoidance and treatment in alternative setting. This is driving significant financial, as well as operational pressures.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee had an update on the Trust's current and FOT cash position and the need to apply for a further £20m of Provider Revenue Support in order to meet liabilities and maintain the minimum cash balance. The committee supported this application and recommended that the Trust Board approves the application
- Work is being undertaken to appoint a Turnaround/ Recovery Director to support the Trust reduce the in-year run rate and also establish a PMO office to support the identification and implementation of CIPs in 25/26 and beyond in order to return the Trust to a position of financial stability
- The Committee heard about the work carried out at system level by Simon Worthington and team to ensure consistent planning across the ICS for 25/26 to align operational, workforce and financial plans
- The improvement team's update highlighted the start of the Variable Pay reviews was indicating that there would be significant opportunities to reduce variable pay in year. An update was given on the service reviews which have been completed to date and have identified 163 opportunities which are being scoped.
- Given the Trust's ongoing financial issues, it was recommended that the next Audit Committee has a discussion with the Trust's external auditors about Going concern, Value for Money rating and financial governance.

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 decline in the financial results for December, as the deficit for the month rose to £9.3m an increase of £3m on Month 8. The Trust is now £33m behind the revised breakeven plan.
- The increase in the deficit in the month is principally due to the removal of the forecast overachievement ERF income. This has been removed from the financial position as the additional income is not guaranteed and is high risk as the activity plan is phased towards the end of the financial year. There is also the impact on data capture and coding due to the implementation of Cerner, and work is underway with clinical and operational colleagues to evidence the activity undertaken.
- The CIP target for 24/25 was £59.7m of which only £16.2m has been delivered by month 9 against a plan of £29.8m.
- FOT at Month 9 is in the region of £88m worse case, excluding the £22.9m Deficit Support Funding. However, the committee was told that work will continue to improve this position.

- PwC is now providing support to the Trust and the LSC system, this meeting was observed by 3 members of the Trust's PwC team.
- The Chief Executive confirmed that LSC ICS is now in formal turnaround and that the second IAG meeting will take place on 29 January. He also outlined the significant decisions that the Trust had already made in order to address the financial deficit so far which include the transfer of service of services out of Accrington Victory Hospital, the cessation of the shuttle bus by ELHT and the closure of a community ward.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT	**Item**	**44b**
12 March 2025	**Purpose**	Assurance Information

Title	Triple A Report from Finance and Performance Committee
Report Author	Mrs L Sedgley, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 24 February 2025. 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:	Finance and Performance Committee
Date of Meeting:	24 February 2025
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting
	Planning 2025/26 Update
	Board Assurance Framework
	Corporate Risk Register
	Improvement Update
	One LSC Update
	Integrated Performance Report
	Private Finance Initiative (PFI) Update
	Scope of Work for the Turnaround Director
	Systems 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 Trust together with 3 other acute trusts and the ICS have now formally been placed in NOF 4, due to its financial position.
- The Committee were advised that due to the ongoing monthly deficits the cash position has worsted by £8m to £2.1m at M10. An application for further financial support of £20m has been submitted in February. The Trust is managing its cash position by prioritising supplier payments resulting in aged payables rising to £27.2m
- The Committee had an update on the 25/26 draft plan which shows 25/26 deficit after inflation of £112m. The waste reduction and financial improvement plan currently stands at £12m which is £3m risk adjusted. Again, all these schemes meet the 4 tests to ensure their viability.
- Work continues to review and identify opportunities for 25/26 and beyond and the activity and performance plans with be fully triangulated to workforce and finance plans to ensure alignment and delivery.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- It was noted that agency spend was down to 1.8% of gross pay costs at £8.7m which is £4.6m below target
- Capital expenditure for 24/25 is on track at £26.9m at M10 with total spend for 24/25 forecast at £35,7m just £0.3m below plan
- The Recovery support director Mark Friedman is now working in the Trust 3 days a week, he will be working closely with PWC and our Improvement team to establish a PMO office to support the Trust in working towards financial sustainability.
- The Committee heard about the changes made to improve reporting and governance arrangements in particular around CIPs and FIP reporting and that all CIPs are now only included in the tracker once they have passed the 4 tests established by Simon Worthington
- The Committee were pleased to note the improvement in the finance papers in particular with regards to the cash position and the divisional performance and it was agreed that the meeting be extended further to 3 hours from March.
- The Committee had a verbal update on the progress made on the fire safety work at RBH where the good progress was noted by LFRS. However, it was noted that more pace is needed at BGH due to delays and more extensive work is required.
- The Committee noted the continued delivery of the 6 week RTT standard and improvement in the DM01 position.

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 improvement in the financial results for January, as the deficit for the month reduced by £3.5m to £5.6m mainly due to £3.1m of income being included as its recoverability has now been established. The Trust is now £41.7m behind the revised breakeven plan, this is £69.2m YTD excluding the deficit support funding.
- The CIP for 24/25 was £59.7m of which only £17.4m has been delivered by month 10 and the FOT is expected to be £19m.
- Forecast Outturn position (FOT) was in Month 9 established at £85.9m, with the additional elective income of £4.6m and a run rate reduction of £1.3m from grip and control measures the FOT for 24/25 is now expected to be £79.4m. However, the committee was told that work will continue to improve this position

- The committee heard the results achieved by the Variable Pay Rapid Improvement weeks; this is using the successful methods used at Leeds Teaching Hospitals to reduce variable pay across the organisation by establishing a financial daily management process for teams to use.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT	**Item**	**44b**
12 March 2025	**Purpose**	Assurance Information

Title	Finance and Performance Committee Part 2 Summary
Report Author	Mrs L Sedgley, Non-Executive Director/Committee Chair

Summary: This report details the agenda items discussed in the Finance and Performance Committee Part 2 meeting held on 24 February 2025.

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

Lancashire and South Cumbria Provider Collaborative

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East Lancashire Hospitals NHS Trust
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Committee Name:	Finance and Performance Committee
Date of Meeting:	24 February 2025
Committee Chair:	Liz Sedgley
Attendance:	Quorate

ITEMS DISCUSSED

At the Finance and Performance Committee Part 2 meeting, held on 24 February 2025, the following matter was discussed in private:

a) Seagry Report Discussion

TRUST BOARD REPORT	**Item**	**45a**
12 March 2025	**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 29 January 2025. 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: 29 January 2025

Committee Chair: Catherine Randall

Attendance: Quorate

Key Items Discussed: Urgent and Emergency Care Update
Waiting Lists and Resultant Harms
Nursing Professional Judgement Review – January 2025
Electronic Patient Record Update
Quality Impact Risk Assessments
Trust Wide Quality Group AAA Reports
Patient Safety Incident Response Framework Report
Integrated Performance Report
CQC Update
AAA Report from the Safeguarding Committee
Minutes from the Mortality Steering Group

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.

- An update on the Trust's ongoing urgent and emergency care pressures was provided to the committee, including an update on the development of a new standard operating policy that was intended to improve the experience of patients being cared for on corridors.
- Members received an overview of the Trust's waiting lists and any resultant harms. It was explained that although there were only a small number of related incidents, it was likely that there were others which were being underreported. Members agreed for future updates to be provided on a six-monthly basis going forward.
- The committee was provided with an overview of the progress made with the implementation of the Trust's electronic patient record system. It was noted that there were a number of significant challenges still to be overcome, including the

ongoing need for financial investment to ensure that the system could receive the updates required to maintain full functionality.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- Members were informed that meaningful reductions were starting to be seen in the Trust's waiting lists and that there were no patients waiting 65 weeks or more for treatment.

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.

- Members were provided with an overview of the Trust's latest professional judgement reviews for nurse staffing levels. No concerns were raised.
- The Committee was provided with a patient story that summarised the experiences of an elderly patient who had ultimately passed away in the Trust's care. Members noted that a significant amount of learning and work had taken place in the interim period and that the patient's family had played an active role in the improvements made since. The Committee agreed that the story should be escalated to the attention of the board.

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TRUST BOARD REPORT | **Item** 45b

26 February 2025 | **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 26 February 2025. 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.

(45b) Triple A Report from Quality Committee

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:	26 February 2025
Committee Chair:	Catherine Randall
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update
	Annual Mortality Report
	Cancer Update
	Histopathology Update
	Admissions Avoidance and Health Inequalities
	Quality Impact Risk Assessments
	Nursing Assessment Performance Framework Update
	Nurse Staffing Exception Report
	Floor to Board Report for Maternity and Neonatology Services
	Trust Wide Quality Group AAA Reports
	Patient Safety Incident Response Framework Report
	Patient Participation Panel Report
	Board Assurance Framework
	Corporate Risk Register
	Integrated Performance Report
	CQC Update

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- Members were informed Never Event had occurred in the Trust involving a child in the community whose nasogastric tube had been misplaced, this was later replaced but protocol was not followed properly leading to issues with fluid ending up in the patient's lungs. No harm was caused to the patient, and it was confirmed that appropriate actions had been taken to avoid similar incidents occurring in the future.

- It was confirmed that colleagues from the Integrated Care Board would be visiting the Trust later in the week and that a visit from the Care Quality Commission was planned in the near future.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- An update on the work taking place in the Trust around its cancer performance was provided to members.
- The committee was informed that work was underway to inform stakeholders that the Trust was not commissioned to provide level two and three paediatric care.
- An update on the work taking place around the Trust's pathology backlog was provided to the committee. It was noted that positive progress had been made over recent weeks.

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 patient story was presented to the committee that detailed a patient's journey through the Trust's stroke pathway. It was confirmed that work was ongoing to secure more stories from patients from diverse backgrounds or with protected characteristics.
- Members were informed that the Trust's Alcohol Care Team would be wound down by the end of the current financial year and that affected staff would be redeployed to other positions in the organisation.

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TRUST BOARD REPORT		**Item**	**46**
12 March 2025		**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 23 January 2025 and 20 February 2025

Report linkages

Related Trust Goal	-
Related to key risks identified on assurance framework	-

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	Yes

(46) Remuneration Committee Summary Report

Meeting: **Remuneration Committee**

Date of Meeting: **23 January 2025**

Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 23 January 2025, the following matter was discussed in private:

a) Director of Communications and Engagement Arrangements
b) Proposed Recruitment and Remuneration Arrangements for Turnaround Director
c) Recruitment Process and Remuneration for the Executive Medical Director and arrangements for Interim Medical Director
d) Cessation of secondment of Executive Director of Integrated Care, Partnerships and Resilience
e) Ceasing arrangements for Interim Operational Director of Finance

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Meeting: **Remuneration Committee**

Date of Meeting: **20 February 2025**

Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 23 January 2025, the following matter was discussed in private:

a) Executive Director Contract Standard Template
b) Executive Director and VSM Succession Planning
c) Confirmation of Appointment of Turnaround Director and Remuneration
d) Confirmation of Interim Medical Director and Remuneration

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TRUST BOARD REPORT	**Item**	**47**
12 March 2025	**Purpose**	Information

Title	Trust Board (Closed Session) Summary Report
Report Author	Mr D Byrne, 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 15 January 2025.

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:

Lancashire and South Cumbria Provider Collaborative

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

Date of Meeting: **15 January 2025**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 20 November 2024 were approved as a true and accurate record.

ITEMS DISCUSSED

At the meeting of the Trust Board on 15 January 2025, the following matters were discussed in private:

a) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.
b) Round Table Discussion: Site Operational Pressures
c) Financial Reporting: Financial Performance
d) Financial Reporting: Formal Intervention
e) National Planning Guidance 2025-26
f) One LSC
g) Outpatient Pharmacy Project (Project Blue): Update and Decision Paper
h) Pathology Update
i) Microsoft Licence Contract
j) Data Security and Protection Toolkit: Non-Compliance with the 2023-24 Return
k) Communications Update and Horizon Scanning

ITEMS RECEIVED FOR INFORMATION

None.