Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

East Lancashire Hospitals NHS Trust Board Meeting

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NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD MEETING (OPEN SESSION) AGENDA

15 JANUARY 2025, 12.30

BOARDROOM, BIRCH HOUSE

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

OPENING MATTERS				
TB/2025/001	**Chairman's Welcome**	Chairman	v	
TB/2025/002	**Apologies** To note apologies.	Chairman	v	
TB/2025/003	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	
TB/2025/004	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 20 November 2024.	Chairman	d✓	Approval
TB/2025/005	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2025/006	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2025/007	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2025/008	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information/ Approval
QUALITY AND SAFETY				
TB/2025/009	**Staff / Patient Story** To receive and consider the learning from a patient/staff story.	Deputy Chief Nurse	p	Information/ Assurance
TB/2025/010	**Corporate Risk Register Report** To receive an update on the Corporate Risk Register and approve revisions based on the Executive Risk Assurance Group, Committees' and Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Executive Medical Director	d✓	Assurance/ Approval
TB/2025/011	**Board Assurance Framework** To receive an update on the annual review of the Board Assurance Framework and risk appetite and approve the revisions based on the Executive Risk Assurance Group, Committees' and the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Executive Director of Service Development and Improvement	d ✓	Assurance/ Approval
TB/2025/012	**Patient Safety Incident Response Assurance Report** To receive the paper as a summary update on the incidents reported under the new Patient Safety Incident	Executive Medical Director	d✓	Information/ Assurance

	Response Plan (PSIRP). This report also includes information on maternity specific serious incidents reporting as required by Ockenden recommendations.			
STRATEGIC ISSUES				
TB/2025/013	**Maternity and Neonatal Services Update** *T Thompson to attend for this item.*	Deputy Chief Nurse / Divisional Director of Midwifery and Nursing	d✓	Information/ Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2025/014	**Financial Reporting**	Executive Director of Finance	d✓	Information/ Assurance
TB/2025/015	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: **15.15** a) Introduction (Chief Executive) **15.20** b) Safe (Executive Medical Director and Chief Nurse) **15.25** c) Caring (Chief Nurse) **15.30** d) Effective (Executive Medical Director) **15.35** e) Responsive (Chief Operating Officer) **15.40** f) Well-Led (Director of People and Culture and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2025/016	**Care Quality Commission Urgent and Emergency Care Survey Results 2024**	Deputy Chief Nurse	d✓	Information/ Assurance
TB/2025/017	**Freedom to Speak Up Report** *J Butcher to attend for this item.*	Executive Director of People and Culture	d✓	Information/ Assurance
GOVERNANCE				
TB/2025/018	**ELHT&Me Annual Report and Accounts 2023-24** (The Board is meeting as Corporate Trustee for this item)	Executive Director of Finance	d✓	Approval
FOR INFORMATION				
TB/2025/019	**Triple A Reports from People and Culture Committee** To note the matters considered by the Committee in discharging its duties. a) November 2024 b) December 2024	Committee Chair	 v v	Information
TB/2025/020	**Triple A Reports from Finance and Performance Committee**	Committee Chair		Information

	To note the matters considered by the Committee in discharging its duties. a) November 2024 b) December 2024		d✓ d✓	
TB/2025/021	**Triple A Reports from Quality Committee** To note the matters considered by the Committee in discharging its duties. a) December 2024	Committee Chair	d✓	Information
TB/2025/022	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2025/023	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
CLOSING ITEMS				
TB/2025/024	**Any Other Business**	Chairman	v	
TB/2025/025	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2025/026	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: 1. Have we, as the Board, via the agenda and our discussions fulfilled our objective of supporting our: a. Communities b. Staff c. Stakeholders 2. Have we, as the Board fulfilled our statutory obligations.	Chairman	v	
TB/2025/027	**Date and Time of Next Meeting** Wednesday 12 March 2025, 12.30pm, Boardroom, Birch House	Chairman	v	

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

15 January 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	27 December 2024

Summary: The minutes of the previous Trust Board meeting held on 20 November 2024 are presented for approval or amendment as appropriate.

Report linkages

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

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

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

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 13:00, 20 NOVEMBER 2024

MINUTES

PRESENT

Mr S Sarwar	Chairman	Chair
Mr M Hodgson	Chief Executive / Accountable Officer	
Mrs P Anderson	Non-Executive Director	
Professor G Baldwin	Non-Executive Director	
Mrs 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 L Sedgley	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	
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience	
Mrs K Quinn	Executive Director of People and Culture	
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)	

IN ATTENDANCE

Mr D Byrne	Corporate Governance Officer	Minutes
Mr S Islam	Deputy Medical Director (Performance)	
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 P Murphy	Chief Nurse
Mr R Smyth	Non-Executive Director

TB/2024/143 CHAIRMAN'S WELCOME

Mr Sarwar welcomed directors and members of the public to the meeting. He extended an additional welcome to Mrs Simpson to her first meeting as Executive Director of Finance and noted that Mrs Pemberton was in attendance in place of Mr Murphy.

TB/2024/144 APOLOGIES

Apologies were received as recorded above.

TB/2024/145 DECLARATIONS OF INTEREST

The Directors Register of Interests was presented for approval.

Mrs Atkinson advised that her role as a parent governor at Blacko Primary School had come to an end and requested that this was removed from the Register.

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

TB/2024/146 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 11 September 2024 were approved as a true and accurate record.

TB/2024/147 MATTERS ARISING

There were no matters arising.

TB/2024/148 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/2024/066: Corporate Risk Register and Risk Performance Report – Mr McDonald reminded directors that a revised process for the submission of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents had been implemented in October 2024 to improve the Trust's compliance in this area. He advised that an additional mapping event had been scheduled for the 12 December to review incident reporting and investigation processes to further improve compliance. Mr McDonald explained that, in order to allow these improvements to be embedded, it was now proposed to include RIDDOR in the Trust's internal audit plan for 2025-26.

TB/2024/129: Integrated Performance Report - Well-led – Mr Sarwar acknowledged that summaries of the Trust's sickness and absence levels had been circulated and emphasised that they were still higher than they should be.

Mrs Quinn explained that a new dashboard was currently in development that would assist in setting targets for reductions across a range of metrics, including sickness levels. She indicated that updates would continue to be provided via the People and Culture Committee once this dashboard was in place.

RESOLVED: Directors noted the position of the action matrix.

TB/2024/149 CHAIRMAN'S REPORT

Mr Sarwar provided a summary of his activities since the previous meeting of the Board. He reported that there had been a robust response to the Trust's recent Non-Executive Director (NED) recruitment campaign and confirmed that an appointment had successfully been made.

Mr Sarwar advised that the Board had recently taken part in a cyber security development session and noted that this had been particularly timely. He highlighted that the Trust had recently held a summit to launch its formal anti-racism campaign and to celebrate winning a bronze award from the North West Black, Asian and Minority Ethnic (BAME) Assembly and indicated that this event had been well attended by external stakeholders.

Mr Sarwar went on to inform directors that he, alongside Mr Hodgson, had recently had the opportunity to meet with the Labour Member of Parliament for Burnley, Oliver Ryan. He reported that it had been a good opportunity to share the challenges facing the Trust but also to hear back regarding the challenges facing constituents.

Mr Sarwar highlighted that the Board had taken part in a briefing session hosted by colleagues from Strasys Consulting regarding the clinical reconfiguration work being done across Lancashire and South Cumbria (LSC). He added that although this session had been quite detailed, there were still a number of questions in terms of the efficiencies and practicalities of this work that would need to be answered over the coming months.

Mr Sarwar went on to provide directors with an overview of his activities at a system level, including a recent session held by the Integrated Care Board (ICB) that he had attended with Mr Hodgson. He added that he had also had the opportunity to meet with the newly appointed chair of the ICB, Emma Woollett, and that her enthusiasm around collaboration had been clear.

Mr Sarwar concluded his update by informing directors that he had recently met with the Chief Executive Officer (CEO) or NHS Providers, Sir Julian Hartley, and noted that he would be stepping down in the near future to take up a new role at the Care Quality Commission (CQC).

RESOLVED: Directors received and noted the update provided.

TB/2024/150 CHIEF EXECUTIVE'S REPORT

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

Mr Hodgson referred to the recent announcement of the autumn budget and noted that an extra £22.7 billion had been pledged for the NHS over the current year and the next. He added that there had been other announcements around the provision of additional capital and stated that this was also welcome, particularly in light of the findings from the Darzi Review that had identified a range of issues in the NHS following decades of capital underinvestment. Mr Hodgson explained that it was likely that these funding pledges would be tied to a renewed focus on reducing waiting lists and informed directors that the Trust was one of 20 organisations that had been selected to be part of a new 'Further Faster 20' initiative that was intended to provide additional support to providers who serviced challenged local populations. He highlighted that the Trust was already productive on a number of the key metrics associated with this initiative.

Mr Hodgson informed members that he had attended the most recent annual NHS Providers Conference and that keynote speeches had been delivered by the Secretary of State for

Health and Social Care, Wes Streeting MP, and the Chief Executive of NHS England (NHSE), Amanda Pritchard. He reported that Mr Streeting had alluded to three significant shifts that would be taking place around the NHS 10-Year Plan, specifically the shift from hospital to community care, the move from analogue to digital services and increasing work being done around sickness prevention. Mr Hodgson informed members that these announcements coincided with the recent launch of a national public consultation process to inform the development of the 10-Year Plan and that the first regional event had taken place the previous week. He highlighted that Mrs Pritchard's speech had referenced the evolution of the current NHS operating model, including clarifying the roles of NHSE, ICS bodies and a shift in the wider oversight model. Directors noted that Mrs Pritchard had also laid out five key tasks for the NHS: living within its financial means, embedding improvement, maintaining quality and safety, working better with primary care colleagues, and making the most of opportunities around data and digital, including the increased use of federated data platforms and the NHS app.

Mr Hodgson emphasised that the winter period was likely to be extremely challenging and reported that there were already signs of increasing activity in urgent and emergency care (UEC) pathways. He advised that the results of a recent patient survey undertaken by the Care Quality Commission (CQC) in UEC areas had been published and acknowledged that there were several tough messages for the Trust within these. Mr Hodgson confirmed that the vaccination programmes for flu and COVID-19 for the current year were well underway.

Mr Hodgson highlighted that it had recently been confirmed that the current Chair of NHSE, Richard Meddings, would be stepping down from this role in March 2025.He added that Mr Meddings' successor had not yet been confirmed.

Mr Hodgson informed directors that several developments had taken place at a Lancashire and South Cumbria (LSC) system level. He reported that system working was becoming more established and highlighted that the One LSC programme had successfully launched on the 1 November as planned. Mr Hodgson reminded directors that the Trust was the host organisation for One LSC and that emphasised that a significant amount of work had been done recent weeks to ensure that staff were safely transferred and still received their pay. He indicated that the focus would not shift to a more improvement and transformation focused agenda around the services that were part of One LSC to ensure that they were as efficient as they could be.

Mr Hodgson made reference to the LSC clinical reconfiguration work being done by Strasys Consulting and confirmed that a range of sessions had been held with ICB colleagues around this. He explained that further clarity around the practical aspects of the high-level recommendations being put forward by Strasys, and the associated business models for this work, would be needed over the coming months.

Mr Hodgson went on to provide a summary of other developments taking place at Trust level, including the recent appointment of Mrs Simpson to the Board as Executive Director of Finance following Michelle Brown's retirement. He added that Mr Husain had given indication that he would also be stepping down from his role as Executive Medical Director at the end of the current financial year.

Mr Hodgson stated that difficult decisions continued to be made in the Trust to ensure that it was able to continue meet its statutory obligations, including the recent closure of Accrington Victoria Hospital (AVH) and the relocation of a number of key clinical services to alternative premises across Accrington. He acknowledged that this had been a difficult process and praised Miss Wright and her colleagues for developing a robust communications programme to allay the concerns expressed by staff and members of the public. Mr Hodgson acknowledged that keeping clinical services in Accrington had impacted on where they could be provided and praised colleagues for the good work being done in developing a practical plan to address any related issues. He confirmed that further engagement work with patients and their families was also planned.

Mr Hodgson went on to highlight that the Trust had been the only organisation in LSC to achieve the nationally mandated target of eliminating all patients 65 weeks or more for treatment from its waiting lists by the end of September 2024. He noted that this target had been revised to be achieved by the end of December 2024 for the organisations that had not managed to achieve the first.

Mr Hodgson emphasised that the Trust had redoubled its efforts over recent weeks to reduce its spend and ensure that it was living within its means. He explained that this was being done in conjunction with colleagues from PA Consultancy and through regular internal finance cell meetings. Mr Hodgson confirmed that a substantial number of actions had been put in place around authorising processes, reducing variable pay and implementing a recruitment firebreak. He informed directors that the Trust had recently received a visit from the NHSE Nominated Lead for Investigation and Intervention for the North West, Simon Worthington, to assess its financial performance and had received a formal report of his findings.

Mr Hodgson went on to provide a summary of other key developments that had taken place in the Trust over recent, including the opening of a new state of the art chemotherapy unit, the provision of new cancer diagnosis and endoscopy equipment funded by one of the Trust's charitable donor organisations, Labels for Cares, and the opening of a new Heart Care Unit at the Royal Blackburn Teaching Hospital (RBTH) site. He also highlighted that the latest national staff survey was now underway and indicated that a significant amount of work was taking place to secure as many responses as possible.

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: Rossendale West and Pendle West District Nurses, Ophthalmology Day Case, Wards 22 and C18b, the Rakehead Rehabilitation Unit, Endoscopy Unit A, and the Neonatal Intensive Care Unit (NICU).

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

Mrs Sedgley noted that there was a significant amount of concern being expressed nationally around the potential impact on privately owned care homes following the announced rise in national insurance contributions and enquired if any local organisations had indicated that they may be affected.
Mr Hodgson explained that similar concerns had been raised by GP practices and pointed out that the finer details of the changes to national insurance contributions were still being worked through.
Mr McDonald clarified that discussions were ongoing through national sector bodies to raise any related concerns. He advised that the Government had confirmed that the changes to national insurance would apply to care sector organisations and that around £600m would be allocated to support and address their concerns. Responding to a further query from Mrs Sedgley regarding the amount of private and council owned care homes across East Lancashire (EL), Mr McDonald explained that there was no specific information available regarding private care homes but confirmed that the Trust worked closely with adult social care colleagues and local authority colleagues around this.

Mr Sarwar suggested undertaking a baseline analysis in this area to better ascertain the potential impact on the Trust and to get a better sense of the current position of local providers and any actions they may be undertaking in response.

Mr McDonald provided assurances that the Trust engaged with providers on a daily basis and that no indication had been given regarding any imminent changes to the provision of their services. He added that there had also been no concerns raised around any additional issues or risks.

Mr Sarwar requested that a report was provided either to a future Board meeting or to the Finance and Performance Committee to facilitate a better understanding of this area and the position of providers.

Mr Sarwar went on to make reference to the CQC patient survey mentioned by Mr Hodgson in his report and requested that a related report, summarising the survey findings and any actions taken as a result, was provided both at the next meeting of the Quality Committee and at the Trust Board meeting due to take place in January 2025.

Mr Hodgson agreed that this was a sensible suggestion, particularly as the pressures in UEC pathways remained the most significant challenge for the Trust. He acknowledged that the results in this survey had indicated that more thought was needed around quality and safety, the wellbeing of staff working in pressured areas and the role of place colleagues.

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

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.

TB/2024/151 STAFF / PATIENT STORY

Mrs Pemberton provided a brief introduction to the patient story. She explained that it had been provided by a member of the public, Tim Clokey, and detailed the experiences of his wife who had been recently cared for by the Trust during the final stages of her life.

Mr Sarwar reiterated his suggestions made at previous meetings that consideration be given to enabling patients to attend future meetings of the Board to present their experiences in person. He requested that this was progressed outside of the meeting.

Miss Wright pointed out that while some patients would appreciate the opportunity to attend meetings in person to present their stories, others may not, and that this proposal may narrow down the range of stories that were received.

Mrs Randall commented that there was an ongoing lack of diversity in the stories being presented and urged more consideration to be given to expanding this going forward.

Mrs Sedgley advised that at a previous organisation she had worked at, live link sessions had been arranged with patients for them to present their stories rather than requiring them to be in the room.

Mrs Pemberton confirmed that she would pass on the suggestions made back to the Patient Experience Group for further consideration.

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

Mr Razaq joined the meeting at this time.

Mr Sarwar commented that the story had been an emotional one and requested that the condolences of the Board were passed on to Mr Clokey on the passing of his wife. He observed that the story had referenced the importance of good communication and acknowledged that this had been previously identified as an area of challenge for the Trust. Mr Sarwar stated that colleagues working on the ward where Mr Clokey's wife had been cared for had acted in all of the right ways and requested that the formal thanks of the Board were passed on to them.

Mrs Sedgley noted that Mr Clokey had made several references to staff outside of ward level and that this had emphasised the importance of all staff to the experience of patients, not just frontline colleagues.

Mr McDonald commented that the story was a good example of the importance of making every patient contact count and in getting the basics of care right, particularly communication.

Mrs Gilligan stated that the story had highlighted the difficult balance involved in caring for end-of-life care for patients and in ensuring that they were able to pass away in an area of their choosing.

Mr Hodgson agreed that staff in the Trust were typically managing a myriad of different agendas on a day-to-day basis and that there was often no single perfect solution to the issues that they experienced.

Mrs Pemberton pointed out that one of the key reasons for Mr Clokey and his wife's positive experience had been that both had been seen and treated as individuals. She added that there were often unintended consequences from the wider changes made to how staff worked, such as the recent move to 12-hour shifts, and that this had increased the importance of reinforcing the fundamentals of care, including communication.

Mrs Randall advised that Mr Clokey's story had also been presented at the most recent meeting of the Quality Committee. She suggested that it would be a particularly good story to be presented at staff inductions or similar venues, as it provided a clear picture of the values of the Trust and what was expected from staff.

Mr Husain added that the presentation of Mr Clokey's story at the Quality Committee had coincided with the presentation of the most recent results from the annual National Audit of Care at the End of Life (NACEL) which had showed that significant improvements had been made in the Trust over recent years, particularly in relation to communication.

Mrs Atkinson highlighted that a significant quality improvement programme had been in place around end-of-life care and explained that this had utilised the Trust's NACEL results to triangulate priorities and focus on areas that required the most improvement. She added that it was good to see that this work was now starting to bear fruit.

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

TB/2024/152 CORPORATE RISK REGISTER (CRR) AND RISK PERFORMANCE REPORT

Mr Husain referred Directors to the previously circulated report and provided a summary of key highlights. He reported that there were currently 20 risks on the CRR, with no additions or

removals since the previous meeting. Mr Husain highlighted there had been an increase in the score assigned to risk **8941** (**increased reporting time in histology due to increased activity outstripping resource)** up to 20, following a number of unexpected results from routine histopathology backlogs. He clarified that 10 cases were currently going through a clinical review and that there was expected to be one confirmed harm and four moderate or above harms as a result. Directors noted that duty of candour had been carried out for all of these cases.

Professor Baldwin joined the meeting at this time.

Mr Husain went on report that the majority of risks remained clinically based and highlighted that the number of open risks in the Trust had continued to reduce, as had the number of risks open for three years or more.

Mr Husain confirmed that issues around histopathology had been escalated to Integrated Care System (ICS) level and extended his thanks to colleagues at the University Hospitals of Morecambe Bay (UHMB) NHS Foundation Trust for the increase in mutual aid support that they had provided in this area. He acknowledged that the reduction in the Trust's backlog were still not at the level required and advised that he had raised the issue with senior colleagues in the LSC Pathology Collaborative. Mr Husain indicated that this had been accepted and assurances provided that the efforts to develop a more sustainable and systematic approach would be redoubled.

In response to a query from Mr Sarwar as to how any potential harm arising from this situation would be mitigated in the interim, Mr Husain explained that the backlog in question comprised mainly of routine samples rather than urgent or cancer specific samples and that the risk of these leading to malignancies was low. He added that the Trust would have to incur additional costs in order to full abolish its pathology backlog and that this had been clearly laid out in a business case paper produced by Diagnostic and Clinical Service colleagues. Directors noted that the amount of mutual aid being provided by UHMB had been recently increased from 300 to 400 samples as a result.

Mrs Gilligan informed directors that any cancer and urgent samples were being prioritised. She explained that work was also underway to try and agree common job plans across the

pathology network to ensure greater consistency. Mrs Gilligan reiterated that the risk associated with routine samples was generally low, and that the issues being seen were a result of the long wait times currently being seen.

Mr Rehman observed that there were a substantial number of controls in place in relation to risk **ID 8126 (poor records management due to sub optimal implementation of new ePR system)** and that these would need to cohere into a smart action plan going forward. He added that it was clear that a number of risks related to wider data and digital infrastructure issues which were likely to remain in place for some time.
Mr Husain confirmed that discussions were underway around revamping this risk now that a formal Data and Digital Board was in place.

Mrs Anderson expressed concern regarding the substantial pathology backlog, particularly as it had been confirmed that harm was being caused, although in low quantities.
Mrs Gilligan explained that there were a number of factors that had led to the issues around the Trust's backlog, including substantial increases in demand and patient acuity. She acknowledged that there were still questions around whether the Trust was as productive as it could be in this area and that recent changes in senior leadership would help to facilitate closer scrutiny around this going forward.

Mr Sarwar stated that while it was important for the Trust to ensure its productivity was as a good as it could be with regard to pathology, it was equally as important for the wider system to take some responsibility in this area.
Mr Hodgson agreed and advised that this was one of the main reasons why a system wide meeting had recently been called to discuss the situation in more detail. He added that the matter also continued to be raised through regular meetings with ICB colleagues.

Mr McDonald observed that, of the 20 risks currently on the CRR, three were deemed to have inadequate controls, three to have adequate controls and 14 to have limited controls. He noted that there had been little to no change in these ratings for some time and stated that risks on the CRR should be more dynamic in general. Mr McDonald suggested that more work may be needed with risk owners to facilitate this or to enact a shift in the associated mindset and approach to the management of risks.

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

TB/2024/153 BOARD ASSURANCE FRAMEWORK (BAF)

Mrs Atkinson referred directors to the previously circulated report and confirmed that the BAF had been through the usual review process and presented to the Board's sub-committees for approval. She confirmed that the scores assigned to each risk remained unchanged.

Mrs Atkinson explained that BAF Risk 6 (One LSC) was the only risk to have received any significant updates since the previous meeting to reflect the fact that the programme had now gone live and highlighted that the majority of actions focused on the safe transfer of staff had been completed and closed. She added that this risk would now be revised to focus on the Trust's obligations as host and any associated risks.

Mrs Atkinson noted that it was a good time to consider a mid-year review of the BAF and confirmed that she would make the necessary arrangements for this to be done.

Mrs Simpson made reference to the actions for BAF Risk 5 (Financial Sustainability) and provided brief updates on the progress being made. She informed directors that the system meetings around an ICB workplan had been stood down and were due to be rearranged, that confirmation form the ICB regarding the system plan being accepted was still awaited and that the Trust had successfully signed and returned the contract for 2024-25 to the ICB.

Mrs Atkinson stated that it would be beneficial for the review of the BAF to be done earlier than it had been in previous years and suggested that the Trust should aim to do so in April 2025.

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

TB/2024/154 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 advised that there had been a recent reduction in incident reporting in the Surgical and Anaesthetics Division following the introduction of the Learning from Patient Safety Events (LfPSE) platform but confirmed that these had now returned to normal levels following the introduction of additional training. Mr Husain reported that there

had been an increase in the amount of severe physical harm and explained that this had been due to three patients that had suffered from fractured hips following a fall.
Mr Husain referred directors to the information provided in the report regarding the first Patient Safety Specialist Annual report that had recently been presented to the Trust Wide Quality Group and to the Quality Committee. He explained that there was currently only one Patient Safety Specialist in post at the Trust and confirmed that work was underway to spread this work out over a number of additional colleagues.

Mr Husain concluded his update by highlighting that compliance with the national Patient Safety Training had continued to improve, reaching 94%, 85% and 91% for the level 1a, level 1b and level 2 modules, respectively.
Mrs Quinn reported compliance for the Board at 86% in total, with a total of two individuals currently non-compliant and two not required to complete the training.
Mr Sarwar stated that he had made his position clear at previous meetings and reiterated his request for compliance to reach 95% as soon as possible.

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

TB/2024/155 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 two reviews had not met the two-month deadline for answering all technical guidance or factual questions, placing the Trust at 93.6% compliance. She confirmed that the actions taken to mitigate this risk were detailed further down in the report.

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 and that a new quality improvement programme temperature management had been registered with the central improvement team.

Safety Action 4 - Clinical Workforce: Miss Thompson confirmed that the Trust was on track to achieving this action and that a recent audit around short and long-term locum employment had shown full compliance with CNST requirements.

Safety Action 5 - Midwifery Workforce: Miss Thompson indicated that the Trust was on track with all associated asks with this action, including the production of a bi-annual staffing paper. She added that a draft report on birth rate+ staffing requirements had been presented to the Executive team and that a number of additional amendments had been requested prior to its presented to the Board in the future.

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 work was underway to triangulate against themes identified by the CQC and in the feedback provided through the Friends and Family Test (FFT). She informed directors that further improvements had been made following an exercise undertaken with the Trust's Maternity and Neonatal Voices Partnership (MNVP).

Safety Action 8 – Training: Miss Thompson confirmed that the Trust was making good progress in achieving compliance and confirmed that all non-compliant anaesthetists had been booked onto upcoming multi-disciplinary emergency training sessions in November 2024.

Safety Action 9 - Board Assurance: Miss Thompson confirmed that the Trust was fully compliant against this action, and it had been signed off as complete by the LMNS during their latest assurance visit earlier in the month.

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 reiterated that a full report on the birth rate+ staffing requirements would be provided to the Board at a future meeting and that this was another example of the balance that the Trust was having to maintain between saving money and ensuring patient safety. He noted that there had been a total of three stillbirths in September 2024 and requested a further update on this.

Miss Thompson provided assurances that the Trust was not deemed as an outlier in this area. She added that a 'deep dive' exercise had also been carried out into neonatal deaths, the findings of which would be presented to the meeting of the Trust Board in January 2025. Miss Thompson acknowledged that three stillbirths taking place in one month was a high number but explained that no gaps in care had been identified. Directors noted that all three cases would also go through the MNSI process.

In response to a query from Mr Sarwar regarding the prevalence of increased birth complications among specific communities, Miss Thompson confirmed that there was an increased risk among certain groups due to increased risk factors. She stressed that this did not necessarily mean that the outcomes would be any different but explained that there was a need to ensure that mothers in certain cultures understood that they should bring their babies into hospital if it was needed. Miss Thompson confirmed that work was being done through the interpretation services to address this.

Mr Razaq stated that the points raised around awareness in local communities was a valid one and that he and his colleagues would be happy to work with Miss Thompson to amplify any associated messaging if it would help. He informed directors that plans were underway to hold a North West Public Health Conference in May 2025 which would be focused on tackling racial health equity and that further details would be shared with the Board at a later date.

Responding to a suggestion from Mr Rehman, Mr Sarwar requested that patient names were redacted form future reports and that an additional ethnicity column was added instead.

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

TB/2024/156 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Mr Hodgson referred to the previously circulated report and confirmed that it covered the period up to the end of September 2024. He noted that reported provided a mixed picture overall, with areas of strong performance such as the four-hour A&E standard and cancer, contrasted with areas of more challenge around finance and sickness and absence levels.

b) Safe

Mr Husain highlighted that there had been 57 cases of Clostridium difficile (C. diff) reported against the Trust's trajectory of 100 for the year. He reported that there had been a national increase in C. diff cases of 18% in both hospital and community areas across quarter one, as well as a 28% increase in Methicillin-Resistant Staphylococcus Aureus (MRSA) during the same period. Mr Husain informed directors that there had been a total of 163 outbreaks of COVID-19 in the 2024-25, an increase from 142 in 2023-24 and explained that this was likely due to the increased proximity of patients to one another in the emergency department (ED) or on wards. He highlighted that venous thromboembolism (VTE) assessment compliance had risen to 90% following a dip earlier in the year and confirmed that a substantial amount of work was taking place to raise this to the 95% standard.

Mrs Pemberton reported that the Trust was within required parameters for safer staffing. She pointed out that there were a number of areas that would be rated red from a safer care point of view but explained that this was necessary to maintain safety across the Trust. Mrs Pemberton provided assurances that additional elements were implemented in such cases to ensure patient safety.

In response to an observation from Mr Sarwar that activity levels had seemingly not risen at the same pace as workforce numbers, Mrs Pemberton advised that a specific piece of work was underway with the ICB around this. She explained that the rise in workforce numbers was due in part due to the increased numbers of wards and community teams and a general rise in the size of clinical areas following the COVID-19 pandemic. Mrs Pemberton pointed out that it was important to consider the care being provided to patients as well as the numbers of staff on the ground and that there had been an increased throughput of patients in the nursing arena over recent months.

Mr Sarwar stressed that the Trust was likely to receive significant challenge around its staffing levels over the coming months and that it would be crucial to ensure that it was able to provide a robust, data driven narrative around this.

Mrs Atkinson confirmed that analysis around this was being facilitated through the Trust's finance cell meetings, including triangulation against activity levels.

Responding to a query from Mrs Sedgley regarding staff fill rates and whether patient volumes and acuity were being correctly recorded to ensure that income was correct, Mrs Pemberton

that any areas rated as red meant that the right number of staff were potentially not on duty and that this was why a full professional judgement process was carried out twice a year. She explained that discussions also took place throughout the year to compare staffing levels against accredited tools to ensure that the Trust had the right numbers in its establishments to deliver care and that thus far there had been no outliers identified.

Mrs Gilligan explained that it was not currently possible for the Trust to say with complete certainty that it was up to date with coding due to capacity issues and additional complications that had arisen since the introduction of its ePR system. She advised that a significant amount of work had taken place to address this and that this expected to come to fruition over the coming weeks.

Mr McDonald agreed on the importance of the Trust becoming more data driven and noted that there was currently a degree of variation in maturity across various data sets, particularly in community areas. He indicated that this was being addressed as part of the five national priorities outlined by Mr Hodgson earlier in the meeting.

Mr Hodgson noted that the points raised around staffing levels were another example of the balance that the Board was having to strike, as it had previously been criticised by the CQC for not having enough nurses in place. He added that the analysis work being done by Mrs Atkinson with PA Consulting around the growth in headcount would be crucial in order to address the challenge that the Trust was likely to receive around this.

Mrs Gilligan indicated that staffing levels would also be picked up as part of the wider service reviews that had been recommended by Mr Worthington in his report to the Trust. She confirmed that she had asked colleagues in the Medicine and Emergency Care (MEC) division to carry out a line-by-line review of ED staffing as part of this.

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

c) Caring

Mrs Pemberton reported that there were still a number of challenges around FFT scores in ED areas and confirmed that work was ongoing to address this. She added that the number of complaints was being kept as low as possible and that additional engagement work was taking place with families where necessary.

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

d) Effective

Mr Husain informed directors that the issues with the quality of data raised in previous meetings were still ongoing and that it was still not possible to provide assurance on the Trust's Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) performance as a result. He reiterated that the quality of this data was expected to improve from December 2024 onwards and that the first round of validated data would be available in April 2025. Mr Husain confirmed that immortality would continue to be closely monitored in the interim and highlighted that the Trust's crude mortality remained below the North West average of 2.5%

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

e) Responsive

Mrs Gilligan reported that the Trust continued to perform well against its key cancer targets and had exceeded its trajectory targets for the 62 day, 31-day, and faster diagnosis standard over recent months. She confirmed that UEC areas continued to be extremely busy, with 71 more patients per day on average coming through the Trust's services than the previous year and reported performance against the four-hour A&E standard at 76.7% in October and 77.46% in November to date. Directors noted that there was currently an average of over 3,0000 ambulance attends per month and that this was leading to additional challenges in ensuring low handover times. Mrs Gilligan highlighted that handover times had improved significantly in October and November following a notable rise in September.

Mrs Gilligan went on to reiterate that the Trust had achieved the national 65-week target by the September deadline and continued to work to keep this figure as low as possible. She explained that there was expected to be a total of eight patients outstanding by the end of December 2024 due to unavoidable delays with corneal graft procedures and confirmed that NHSE had been made aware of this.

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

f) Well-led

Mrs Quinn informed director that a substantial amount of work had taken place around sickness and absence but acknowledged that this was still a significant area of challenge for the Trust. She explained that a wellbeing review was currently being undertaken to determine the impact on staff from the current working environment and what additional support could be put in place. Mrs Quinn also advised that work was being done with PA Consulting to create a dashboard that would facilitate the easier setting of sickness reduction targets at a divisional level. She added that there was an ongoing focus on ensuring that management colleagues understood the Trust's absence management policy and the associated triggers.

In response to a request for clarification from Mr Sarwar as to whether the Trust's reduction in agency spend had led to a subsequent increase in bank spend, Mrs Quinn explained that this was potentially the case but advised that there were other factors at play, including the ongoing pressures in UEC areas referred to earlier in the meeting leading to rises in bank usage by the MEC division. She added that international and student nursing colleagues recruited over recent months would also be incorporated into the Trust's substantive staffing numbers later in the month and that there was expected to be a significant reduction in bank spend as a result.

Mr Sarwar noted the Trust was likely to receive significant challenge around its bank spend and emphasised the need to make reductions in this area as a priority.

Mrs Quinn went on to report that core skills training compliance was still below required levels in a number of areas. She explained that a national review on core skills training was currently taking place and whether all staff would be required to complete certain modules. Mrs Quinn also reiterated that core skills training had been relinked to staff pay progression and that manager sign off would be required going forward to ensure that colleagues were compliant.

In response to query from Mr Sarwar regarding high number of job plans still requiring sign off, Mr Husain explained that job plans were approved through a three-tier process and that the scrutiny panel stage of this could occasionally lead to additional delays. He added that there were additional challenges and complexities associated with specific specialities that could also lead to delays.

Mr Rehman pointed out that job planning had been a consistent area of challenge on the Audit Committee for a number of years. He suggested that more data was required around bank investment and requirements in order to provide a clearer picture around any areas that may have productivity related challenges.

Mr Hodgson agreed and confirmed that this would form a large part of the work currently being undertaken by PA Consulting.

Mrs Gilligan pointed out that there were occasions were bank spend was the most cost-effective way for work to be carried out and that it should not be condemned on face value. She agreed however that there was a need to drill down further into this area.

Mrs Simpson reported that compliance with the information governance toolkit was still under required levels and stressed that this would need to be raised as a priority through the Trust's communications avenues. She acknowledged that there was not a huge amount of finance information included in the report and indicated that she would review this for future iterations. Mrs Simpson went on to refer to the financial information provided for month six and emphasised the need to ensure that the level of detail around the Trust's waste reduction programme was sufficient to enable clear messaging around it for colleagues.

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/2024/157 **EAST LANCASHIRE HOSPITALS NHS TRUST SELF-ASSESSMENT REPORT 2023-24 FOR DEPARTMENT OF EDUCATION, RESEARCH AND INNOVATION**

At Mr Sarwar's request, directors confirmed that they were content to approve the Trust's self-assessment for the Department of Education, research and Innovation (DERI) for 2023-24 to be submitted to NHSE as outlined in the report.

Mr Rehman observed that a number of challenges around wellbeing were identified in the report and suggested that these were discussed further at the People and Culture Committee. Mr Sarwar agreed and requested that this was added to the agenda for a future meeting of the Committee.

Mrs Quinn highlighted that a number of other challenges were outlined in the report around placement capacity, training spaces and facilities and the team's base of operations at Park View offices deteriorating on a rapid basis.

Responding to a query from Mrs Sedgley regarding the potential for opportunities to support placement capacity through GP practices or other primary care venues, Mrs Quinn confirmed that this was being actively looked into. She stated that she would discuss this with DERI colleagues further with a view to a full report being provided to a future meeting of the People and Culture Committee.

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

An update on the challenges relating to staff health and wellbeing will be provided at a future meeting of the People and Culture Committee.

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.

TB/2024/158 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL STATEMENT

Mr McDonald referred directors to the previously circulated report and clarified that it was being presented to 'close the loop' on the Trust's EPRR Annual Statement compliance. He confirmed that the Trust had participated in the annual statement process as normal and had demonstrated compliance against 51 of the 62 EPRR standards. Mr McDonald clarified that there had been no core standards against which the Trust was non-compliant and that it had been labelled as partially compliant overall.

Directors confirmed that they were content to receive the action plan contained within the report and to receive the report as assurance that the Trust had robust, evidence based and tested EPRR practices in place and that it had fulfilled its related statutory and non-statutory duties and obligations.

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

TB/2024/159 RATIFICATION OF BOARD SUB-COMMITTEE TERMS OF REFERENCE

Mr Sarwar requested that the terms of reference presented for approval were deferred to a future meeting following the conclusion of the ongoing Trust wide governance review.

RESOLVED: The revised terms of reference for the Finance and Performance and Trust Charitable Funds Committees will be presented at a future meeting following conclusion of the Trust wide governance review.

TB/2024/160 TRIPLE A REPORT FROM PEOPLE AND CULTURE COMMITTEE

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its content.

TB/2024/161 TRIPLE A REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its content.

TB/2024/162 TRIPLE A REPORT FROM QUALITY COMMITTEE

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2024/163 TRIPLE A REPORT FROM AUDIT COMMITTEE

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2024/164 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2024/165 TRUST BOARD (CLOSED SESSION) INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2024/166 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2024/167 OPEN FORUM

Miss Ingham informed directors that a question had been received from a member of the public prior to the meeting:

"*I note the highest level of risk within ELHT is failure to meet internal and external financial targets for 2024-25. I also note the financial risk is made up of insufficient funds to provide the services to the population of East Lancashire.*
The adverse variance of £12.5m looks in most to be the gap in meeting financial waste reduction programme of £59.7m of which £6.3m has been delivered FYTD.

My question simply is this a realistic target to achieve?

It would be interesting to see published improvement actions bridging this gap just to conclude if this is indeed a SMART objective.

The NHS is a service provider and by nature capacity impacted by seasonality and unpredictable micro-economical events outside of its control. The reason I state this is that I assume looking at the target of waste reduction in most needs to be delivered through headcount savings which is in conflict to 'insufficient funds to provide services' and the environment in which the NHS operates."

Mr Hodgson confirmed that the Trust had signed up to a financial plan for the year, initially with an agreed deficit position. He added that additional funding had since been received and that the Trust had now agreed to a breakeven position.

Mrs Simpson explained that the variance between the Trust's current financial position and its targets for each month was related to a range of factors. She confirmed that the financial impact of operational pressures continued to be reviewed to inform a view on the forecast outturn.

Mr Hodgson confirmed that the Trust had a range of plans in place that, if delivered, would help it to hits its financial targets, both from a waste reduction programme point of view and from a general reduction in day-to-day spending. He added that both elements were being heavily supported by the Trust's tried and tested improvement methodology and included detailed reviews of services across all settings to determine if there were any areas where care could be provided at an equal or better level for less money to create better value for local communities.

Mr Sarwar requested that the Trust also formally responded in writing to the individual who had submitted the question.

TB/2024/168 BOARD PERFORMANCE AND REFLECTION

Mr Sarwar sought feedback from Directors as to whether they felt the Board had appropriately addressed and fulfilled its objectives in relation to its communities, staff, and stakeholders. He stated that he felt this had been achieved through the discussion around the patient story, maternity and clear recognition of the tension between staff activity and wellbeing. Mr Sarwar added that the presence of Mr Razaq was clear recognition from the Board of how public health could help the Trust in several areas.

RESOLVED: Directors noted the feedback provided.

TB/2024/169 DATE AND TIME OF NEXT MEETING

Mr Sarwar informed Directors that the next Trust Board meeting would be taking place on Wednesday, 25 January 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** **6**

15 January 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.

(6) 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: March 2025
TB/2024/154: Patient Safety Incident Response Assurance Report	Board compliance for the level 1b Patient Safety Training module to reach 95% compliance.	Executive Director of People and Culture	January 2025	An update will be provided at the next meeting of the Trust Board.
TB/2024/155: Maternity and Neonatal Services Update	The findings from the 'deep dive' exercise into neonatal deaths will be presented as part of the maternity update provided to the Board in January 2025.	Head of Midwifery	January 2025	Agenda Item: January 2025

Item Number	Action	Assigned To	Deadline	Status
	Future iterations of the maternity and neonatal services update will be amended to remove any patient names.	Head of Midwifery	January 2025	Agenda Item: January 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. 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 / Associate Director Staff Wellbeing & Engagement Executive Director of People and Culture	February 2025 February 2025	Agenda Item: People and Culture Committee Agenda Item: People and Culture Committee
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	January 2025	Agenda Item: January 2025

Lancashire and South Cumbria Provider Collaborative

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **8**

15 January 2025 **Purpose** Information

Title	Chief Executive's Report
Report Author	Sam Thomas, Head of Communications
Executive sponsor	Mr M Hodgson, Chief Executive
Date Paper Approved by Executive Sponsor	15 January 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

Winter pressure builds

Flu cases in hospital have already surpassed last year's peak, figures published by NHS England show. One in 20 hospital beds were being taken up or closed by a festive bug in mid-December, with 2,504 general and acute beds alone being taken up by flu patients – an increase of almost 40% from the beginning of the month.

The data showed cases of norovirus and RSV also remained high with 711 beds taken up by norovirus patients, almost a quarter more than last year, and 127 children in hospital with RSV each day – a quarter more children when compared to the same period last year (94 w/e 17 December 2023).

NHS colleagues continue their efforts to protect those most at risk of becoming seriously ill from flu, COVID-19 and RSV this winter and a total of 28.5 million vaccines have been delivered since the start of September.

Publication of Plan for Change

The Government and NHS England (NHSE) have published a joint plan to reform elective care and introduce a new target to see 65 per cent of patients within 18 weeks.

The announcement made by the Secretary of State and Chief Executive of NHSE on January 6 included an acknowledgement that the NHS was delivering more elective care than ever before and had made good progress on reducing waiting times, despite 1.3m more patients joining the waiting list since February 2022.

Plan for Change sets out steps to improve both the timeliness and experience of care for patients – making full use of the capacity, technology and good practice available to offer greater choice and convenience.

The plan includes a commitment to agreeing revenue and capital allocations for April 2026 to March 2029 as well as an approach to the remainder of this financial year and as part of the plan the Government and NHSE have asked all ICBs and acute trusts to take the following steps:

- Name an existing director who will be responsible for improving the experience of care and the experience of waiting for care
- Review and improve operational processes that affect how patients and their carers receive correspondence and access information on wait times
- Make customer care training available to non-clinical staff with patient-facing roles, and ensure take up of training already available on the e-Referral Service to support effective referral, booking and waiting list management processes

- Work across the system on capacity for community diagnostic centres and surgical hubs – to ensure maximum possible benefit

To support delivery of Plan for Change, NHS England have committed to:

- Support the optimisation of Advice and Guidance, to encourage GP practices to manage patients in the community
- Continue to roll out patient initiated follow-up (PIFU) and remote monitoring as appropriate to avoid unnecessary attendances
- Maximise the benefits from waiting list validation, scheduling and theatre optimisation
- Support more consistent use of the independent sector to increase capacity and choice for patients
- Continue working towards greater connectivity between the e-Referral System, patient engagement portals and the NHS App, so patients have more control over appointments and improve the productivity of clinic booking
- Continue to support the delivery of new community diagnostic centres and surgical hubs, including working with you to optimise their productivity

At the same time, NHS England will continue to support productivity and operational improvement by:

- Updating the finance and payment scheme to reflect elective priorities
- Running a capital incentive scheme for providers who improve the most in meeting

Plan to Change will also focus on improvements to the Referral To Treatment (RTT) standards by further developing the NHS IMPACT Clinical and Operational Excellence Programme to provide training for at least 8,000 clinical and operational leaders, and to spread proven improvement approaches for elective reform.

Reforms to GP and NHS services announced

Hundreds of thousands of patients will be able to get directly referred and booked in for tests, checks and scans as by their GP for a range of conditions as part of a radical new plan. People with conditions such as breathlessness, asthma in children and young people, and post-menopausal bleeding will benefit from a faster service, with patients no longer needing to see a consultant first.

As part of the Elective Reform Plan, they will receive quicker diagnosis and treatment to deliver routine care to nine in 10 patients within 18 weeks. The ambitious new blueprint will see more patients receiving a same day service – with a follow up consultation on the same day as their diagnostic test or scan. Acceleration of diagnosis times for patients will also come alongside a major expansion of ring-fenced elective capacity in both hospitals and the community – allowing routine care to be protected from winter pressures and future pandemics

Secretary of State set out plans to contain NHS agency spend

At the NHS Providers conference in November, plans to reduce the NHS's reliance on agency staff were revealed. The cost to the health service of hiring temporary workers is £3billion a year.

Under joint plans to be put forward for consultation, NHS trusts could be banned from using agencies to hire temporary entry level workers in band 2 and 3, such as healthcare assistants and domestic support workers.

The consultation will also include a proposal to stop NHS staff resigning and then immediately offering their services back to the health service through a recruitment agency.

National league tables to highlight performance

NHS league tables will be introduced as part of a package of reforms announced by the Health and Social Care Secretary Wes Streeting.

NHS England will carry out a review of NHS performance across the entire country, with providers to be placed into a league table. This will be made public and regularly updated to ensure leaders, policy makers and patients know which improvements need to be prioritised.

Persistently failing managers will be replaced and turnaround teams of expert leaders will be deployed to help providers which are running big deficits or poor services for patients, offering them urgent, effective support so they can improve their service. High-performing providers will be given greater freedom over funding and flexibility.

Review of physician and anaesthesia associates launched

The Government has launched an independent review of physician and anaesthesia associate professions. It will consider how these roles are deployed across the health system, in order to ensure that patients get the highest standards of care.

The review will look into how they support wider health teams, and their place in providing patients with good quality and efficient care. It will also look at how effectively these roles are deployed in the NHS, while offering recommendations on how new roles should work in the future. The review and next steps will be published in the spring.

North West has its say on the future of the NHS

A series of events took place across the country as part of a national public consultation to inform a new 10-year health plan. More than 100 people from the North West attended an event in Preston to share their views on the NHS in the region.

NHS England's Chief Nursing Officer, Duncan Burton, spoke directly to them about their opinions on how best to reform the NHS and how the government's 10 Year Health Plan could help tackle disparities in the wider region.

Colleagues across the NHS were also given the opportunity to have their say at a series of online events. A website set up to support the consultation has been visited over 1.2 million times and more than 9,000 ideas have been submitted.

The government's 10 Year Health Plan, which will be published in spring 2025 and will be underlined by 3 big shifts in healthcare, moving from:

- Hospital to community
- Analogue to digital
- Sickness to prevention

Revised workforce plan to be unveiled in summer

The government and NHS England will unveil a refreshed workforce plan in the summer with a focus on shifting care from hospitals and into the community.

Through a refreshed workforce plan, alongside reform and investment, the government is taking decisive action to ensure it has the right workforce in the right place at the right time to deliver its 10 Year Health Plan.

The 10 Year Health Plan is due out next spring. Following that, the workforce plan, which is due to be revised every two years, will be refreshed next summer.

Public-private health research boost

NHS England has announced 20 new clinical research hubs will be set up across UK to accelerate research into the next generation of treatments.

Commercial research delivery centres (CRDCs) will act as regional hubs for pioneering clinical trials, creating opportunities to test innovative new treatments with the latest equipment and technology. Legislation has also been laid that will transform clinical trials in the UK by speeding up trial approvals while protecting patient safety.

It is the biggest overhaul of regulations in 20 years and will remove administrative red tape and streamline processes to get clinical trials up and running as quickly as possible. The changes are being introduced by the Medicines and Healthcare products Regulatory Agency (MHRA) and Health Research Authority (HRA).

Martha's Rule 'already saving lives' in NHS hospitals

The roll-out of Martha's Rule in NHS hospitals in England has already begun triggering "potentially life-saving changes in care" for patients.

The major patient safety initiative aims to provide a way for patients and families to seek an urgent review if their or their loved one's condition deteriorates and they are concerned this is not being responded to. ELHT received funding as one of a number of pilot schemes and is known as Call4Concern, allowing patients to escalate concerns easily and with routes well publicised around the Trust.

Early data from participating hospital sites across England shows that there were at least 573 calls made to escalate concerns about a patient's condition deteriorating in September and October, including from patients, their family, carers and NHS staff. Around half of these calls required a clinical review for acute deterioration, with around one in five of the reviews leading to a change in the patient's care – such as receiving potentially life-saving antibiotics, oxygen or other treatment – while remaining on their current wards.

Artificial intelligence giving patients better care and support

The NHS is using AI to predict patients who are at risk of becoming frequent users of emergency services so staff can get them more appropriate care at an earlier stage.

The intervention will ensure that thousands of people get the support they need earlier, while also reducing demand on pressured A&Es.

Over 360,000 patients attend A&E more than five times every year, but now, using data-powered initiatives to identify them, NHS teams are proactively reaching out with support before they walk through the front door of an emergency room.

High Intensity Use (HIU) services use the latest data to find the most regular attendees in their area to identify and resolve the reasons patients are coming forward for care so regularly – often associated with poverty and social isolation.

The NHS has rolled out HIU services to support more than 125 emergency departments across England so far, providing patients with one-to-one coaching support in their own homes to tackle the root cause of why they are visiting A&E.

Anonymous reporting for NHS staff to report sexual misconduct at work

NHS staff will be able to anonymously report incidents of sexual misconduct, as part of major plans to improve safety for staff across the health service.

A new framework issued to local hospitals outlines how those working in the health service should recognise, report and act on sexual misconduct in the workplace.

As part of the support package, there will now be an additional route for staff to report sexual abuse via an anonymous form if they do not feel comfortable disclosing their name and personal details but want the incident to be properly investigated.

It includes brand new guidance for those conducting investigations following a disclosure from a colleague, including forming a specialist review group with access to subject matter experts and independent investigators, and a detailed set of steps to ensure the right support has been offered.

3. Regional Updates

Lancashire and South Cumbria ICB board meeting

Members of the Lancashire and South Cumbria Integrated Care Board (ICB) met on 13 November, 2024. More information and a recording of the meeting is available to watch online here.

Clinical blueprint

Work developed in collaboration with the four acute provider Trusts, LSCFT and colleagues from external consultancy Strasys has resulted in a first draft of a clinical blueprint for acute services and a delivery roadmap to support the suggested transformation.

This joined-up approach across the health and care system has also been discussed through a series of workshops with Trust Board colleagues, other senior leaders and clinical and care professional colleagues across the area.

The proposal has been developed based on how acute services could be configured to best serve the population in Lancashire and South Cumbria, taking a community and population health perspective, informed by data and intelligence.

Further work is now taking place with the expectation that an update will be presented to the Board for sign off in early 2025.

Financial turnaround plan

NHS England has placed a number of local health care systems into formal turnaround, including Lancashire and South Cumbria ICS, to underpin the delivery of a sustainable financial position for the future.

Additional support has been provided to help Trusts including ELHT to reduce costs with immediate effect and get financial budgets back on track.

A lot of work has taken place already to manage deficit positions. In ELHT, an incident management approach has been set up to manage this and enable quick decisions to be made.

Measures taken include a hold all on vacancies, the launch of a Mutually Agreed Resignation Scheme (MARS), a stop on all non-essential spending for every team without exception and reducing temporary staffing costs such as agency spend.

One LSC goes live

Over 3,500 colleagues from across Trusts in Lancashire and South Cumbria have transferred into One LSC.

Bringing teams together in this way will put Provider Collaborative corporate functions in a strong position in the future.

The go-live on 1 November was a significant milestone, following a lot of hard work and planning. One LSC's leadership team have continued to meet with colleagues and prioritise engagement activity, travelling around the different sites to meet people, provide reassurance and answer any questions.

A series of daily touchpoint calls were also organised to deal swiftly with any issues and around 1,500 colleagues joined them.

Proposed sites confirmed for two new hospitals in Lancashire

The New Hospitals Programme in Lancashire and South Cumbria has shared the proposed locations of two new potential sites for brand new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary. They are:

- Land between Stanifield Lane and Wigan Road, south of Stoney Lane in Farington, near to the end of the M65 West
- Bailrigg East, situated north of and in close proximity to Lancaster University

The two new hospitals are part of a wider programme of work that is considering how clinical services are configured across all acute hospital sites in Lancashire and South Cumbria to meet the needs of the population in the future.

Listening and involving local people

The ICB has hosted a series of public engagement activities, such as events, workshops and outreach activities, to hear from local people as part of their ongoing 'Your health. Your future. Your say' programme.

More than 200 people have attended public events which have included 10 conversations about the ICB's vision and priorities and listening to the challenges faced by local people. Their insights will help shape work regarding transformation across the system, with consistent themes emerging around improving access, joining-up better as services and improving the way technology supports our population.

NHS and Healthwatch partnership agreement

Lancashire and South Cumbria Integrated Care Board and Healthwatch Together have developed a partnership agreement which sets out how they will work together to ensure local people have a voice in NHS decision-making.

The formal agreement sets out the commitment to work together to ensure the views and needs of local people and communities will help shape local NHS services and the important role Healthwatch has in championing local voices. The partnership aims to ultimately improve the health and wellbeing of the people of Lancashire and South Cumbria.

Football club community organisations unite for cancer 'prehab'

Football club community organisations (CCOs) across Lancashire and South Cumbria are coming together to help people with cancer to prepare for treatment. From January, the CCOs of the region's eight English Football League sides will all be offering free 'prehab' training sessions to adult cancer patients with the goal of improving their health and fitness ahead of oncological care or surgery.

The one-year pilot programme, launched in collaboration with the Lancashire and South Cumbria Integrated Care Board (ICB) Cancer Alliance, will see the community organisations, including Accrington Stanley, Barrow AFC, Blackburn Rovers and Burnley FC hosting two-hour sessions aimed at encouraging patients to be more active as well as offering a chance for social and mental wellbeing support.

4. Local and Trust specific updates

SPEC success for Trust colleagues

A number of teams have been celebrating after achieving gold or silver Safe, Personal and Effective Care (SPEC) Award - an accolade that recognises departments and wards that have received high ratings in three unannounced nursing inspections:

- First gold award for Marsden Ward
- First silver award for Hyndburn Rural Community Nurses
- Gold award for Ribblesdale Ward

The 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.

Updates relating to the Trust Board

The Trust has welcomed a new Non-Executive Director (NED) to the Board. Sallie Bridgen, who has held similar roles in other NHS organisations including Tameside and Glossop Integrated Care NHS Foundation Trust, joined in December. A management consultant, Sallie has a number of existing links with the East Lancashire region and describes her interests as creating social justice through housing, healthcare and equality.

Dr Fazal Dad, who was a Non-Executive Director on the Board until July 2023, has been awarded a CBE (Commander of the Order of the British Empire) in the New Year's Honours.

Dr Dad is Principal and Chief Executive at Blackburn College and received the honour for his services to further education. He joined the college in 2019 but has over 30 years experience in education. He became a NED at ELHT in July 2022.

Relocating services from Accrington Victoria Hospital

Services have been relocated from Accrington Victoria Community Hospital, with minimal disruption to patients or services.

The latest and last part of the plan was to relocate the Minor Injuries Unit (MIU) and X-Ray departments to Acorn Health Centre in Blackburn Road, Accrington.

The Trust committed to keeping key services in Accrington and this has been made possible thanks to the hard work of colleagues and partners.

Signage is in place to redirect patients and memorabilia, including historical artefacts, plaques and pictures have been moved to a safe place.

Accrington Victoria is now effectively closed and will be secured and protected by the Trust whilst conversations about its future are finalised.

Site pressures

The Trust's urgent and emergency care pathways continue to experience huge pressures including in A&E where, at one point over Christmas, more than 150 patients were in the department at Royal Blackburn Teaching Hospital.

Whilst challenging, pressures are largely indicative of those being experienced at similar Trusts across England, which have been collectively exacerbated by an increase in seasonal illness, with flu in particular rising significantly. Face masks have been reintroduced in areas where vulnerable patients are present.

These challenges have resulted in media coverage of the pressure being experienced by the NHS as a whole, colleagues working in A&E in particular and patient experiences relating to waits to be seen and being cared for in escalation areas including the corridor.

Teams continue to work hard to improve the position, focusing on flow and discharge. This included:

- Opening a new 27 bed unit in December, in an area previously used as offices and staffed by existing colleagues
- In reach therapy teams actively identifying patients on wards who could be supported by out of hospital services
- Encouraging colleagues to prepare take home medication as early as possible to avoid delays in discharge
- Improvement to the discharge dashboard to ensure a continued focus on discharge planning for every patient

Maternity services rated amongst best in England

Maternity care at ELHT categorised among the best in England after being rated 'better than expected' in a 2024 Care Quality Commission (CQC) survey.

The national questionnaire gathered responses from mothers across the country who gave birth in the delivery suite at Lancashire Women's and Newborn centre or midwifery-led units at Rossendale, Blackburn and Burnley in February 2024.

It examined all aspects of maternity services, including antenatal care, care during labour and birth and post-natal care and from almost 19,000 responses nationally, ELHT was highlighted as one of just eight Trusts in England and one of only two in the North West whose results were 'better than expected' overall.

Patients praised the Trust for the ability of partners to stay with them as much as they wanted, taking their concerns seriously, and being able to get help from staff when needed.

Trust has record breaking month looking after patients in their own homes

More patients than ever are being cared for in their own homes by colleagues at the Trust. In October, Hospital at Home treated 1,568 people in the comfort of their own home rather than being admitted into hospital.

Through a virtual ward approach, patients are treated, given the necessary equipment and monitored and supported at home, helping to reduce the pressure on the Trust's inpatient wards and services and freeing up space for others to receive care quicker.

The Trust's community support teams across a range of professional groups and services are developing the Hospital at Home approach all the time, with results going from strength to strength. These include:

More requests for support from the Trust's community teams being made by care homes, reducing the number of people who may have been taken to hospital by ambulance

Assessing more than 1,000 patients in their homes within two hours of a request for help being made in October – the highest number responded to in a single month so far

Theatres lead the way for utilisation

Data released in December revealed that the Trust is top of the country for theatre utilisation. Getting it right first time (GIRFT), a national NHS England programme designed to improve the treatment and care of patients, set a target to achieve 85% theatre utilisation by 2024/25.

This includes measures to capture the time spent giving clinical care, such as administering anaesthetic and undertaking surgical procedures.

Data from the improvement tool Model Hospital, which benchmarks quality and productivity, showed ELHT has a score of 90.4%, which is testimony to the hard-working theatre teams.

More than 3,000 colleagues receive vaccinations

This year's vaccination campaign has come to an end, with over 3,000 ELHT colleagues vaccinated.

Vaccinators and the Occupational Health team have embarked on a range of activity to reach as many teams and colleagues as possible.

They have completed:

- 53 pop-up sessions where colleagues could attend without an appointment
- 80 vaxathons, where they attended workplaces at a set time and day to vaccinate an entire team
- An additional 16 pre-planned department visits
- Three full-day Well events at Burnley, Pendle and Blackburn hospitals

These activities have led to more than 3,000 colleagues receiving their vaccinations.

Anti-racism commitment results in award

A commitment to pro-actively tackling racism and encouraging colleagues and patients to speak up against it has resulted in a prestigious award for the Trust.

The Trust was presented with a certificate for reaching the bronze standard of the anti-racism framework operated by the North West Black, Asian and Minority Ethnic (BAME) Assembly.

The framework encourages organisations to progress from a passive stance of being against racism to one where they actively campaign and call out discrimination, encouraging people to be more assertively anti-racist, with a zero tolerance approach to poor language and behaviours as part of creating an inclusive culture as a whole.

Chairman of the Trust Shazad Sarwar received the honour during the Trust's first anti racist summit, which was the culmination of a two-week programme of events and the launch of a new anti-racism campaign

The summit heard from leaders on what work is taking place to address health inequalities within local communities, as well as more about the Trust's plan to become a truly inclusive, anti-racist organisation, including work to develop improved reporting mechanisms and support for colleagues.

New medicine recycling scheme

Medicine recycling units have been installed across wards and departments at all sites and colleagues are assessing whether medication can be re-used rather than thrown away. Anything that can be reused will be safely returned to stock or sent to another area that has higher usage of an item. The initiative will not only save a significant amount on drugs but will also support the Trust's on-going commitment to sustainability.

E-rostering project underway for medic colleagues

A project is underway to roll out a rostering platform to medical colleagues.

Electronic rostering is already in use in other parts of the Trust, ensuring there is a standardised approach across departments however it is not used by the majority of medical colleagues, where there are a variety of processes in place to manage rostering, sickness and leave.

Expanding the use of the rostering platform to medics will not only support them to manage this in a consistent way but also optimise when people are working to meet service demand which will help the Trust provide a more efficient service to patients.

Service launched to help people living with frailty stay safe and well at home

The Trust has been working with primary care, community services and Age UK to help people living with frailty to stay safe and well at home – and out of hospital.

East Lancashire has more than 100,000 residents aged 65 and over who are potentially at risk of developing frailty or already living with it.

The Trust has been working with Blackburn with Darwen primary care and East Lancashire primary care teams to develop pathways offering support and help staff to feel more confident to identify, assess and signpost people who live with frailty to the correct services.

A series of workshops have been carried out to develop teams who would have contact with people with frailty, including pharmacists, GPs, district nurses, physiotherapists and reception staff to spot early identification of frailty in a patient and refer them to the right service to prevent deterioration so they can be supported to stay safe and well at home. Posters have also been created for patients which detail the levels of frailty to help them manage their health better.

Hospital team supporting hundreds of domestic and sexual abuse survivors every year

Hundreds of domestic and sexual abuse victims who walk through the doors of East Lancashire hospitals every year are being supported by a trio of Independent Domestic Violence Advisors.

Their work was highlighted as part of the White Ribbon Campaign – an annual event taking place from 25 November to 10 December that aims to combat violence against women and girls.

As part of the campaign, the team raised awareness of the support available for patients and staff experiencing abuse and who find themselves in hospital.

From developing a safety plan to putting people in touch with the right community support, the team provides a range of help and guidance.

New neurodiversity colleague network

A newly-established neurodiversity network has met for the first time.

The group is dedicated to supporting colleagues who identify as neurodiverse or are pending diagnosis, providing a safe space for support and championing a work environment that celebrates these unique strengths.

Colleagues can join the network either as a member or an ally.

War veteran reunited with medals thanks to Veterans team

Thanks to the work of Armed Forces Team Manager, Shafiq Sadiq (Sid), a D-Day war veteran whose medals were stolen has been presented with replacements at his care home in Accrington.

Sadly, 101-year-old Jim Laughlin’s medal were stolen and a member of the Safeguarding Team approached Sid earlier this year to see if it was possible to replace them.

Sid was able to get in contact with the Ministry of Defence medal office and get five of his medals remade.

National award success for Toni

Preoperative Assessment Team Manager, Toni Bell, has won a Nursing Times award for work being done nationally.

Toni is part of the national non-medical preoperative assessment network, which won in the Theatre and Surgical Nursing category at this year's awards.

The Nursing Times Awards celebrate nursing and midwifery, showcasing the innovation, energy and dedication of nurses and midwives across the UK.

New vending machines at Burnley Hospital

As part of ongoing work to improve patient, colleague and visitor experience, vending machines have been installed at Burnley Hospital.

They offer a range of fresh food and hot drinks.

As there are limited shopping facilities at Burnley, alongside a range of hot food, travel overnight wash bags are also available.

The bags will be reviewed after the new pharmacy opens.

Blackburn pupils take part in innovative diabetes screening research

A Blackburn school is the first in the East Lancashire area to be involved in an innovative research study to identify children at risk of developing type 1 diabetes.

Pupils at Lammack Primary School had a simple finger stick blood test to show if they have any of four antibodies, which are markers found in the blood, for type 1 diabetes.

Identifying children at risk of developing the condition before they become unwell is important because it means treatment can be started sooner. It also means children can have more frequent check-ups and they may be able to access promising new treatments.

The ELSA study is open to families across the UK for children aged three to 13. It is being supported by the National Institute for Health and Care Research and in East Lancashire, it is being conducted by the research and development team from ELHT.

ENDS

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **10**

15 January 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	

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

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

Report linkages

Related Trust Goal	Deliver safe, high quality care Secure COVID recovery and resilience Compassionate and inclusive culture Improve health and tackle inequalities in our community Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities. 2 The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 3 A risk to our ability to deliver the National access standards as set out in the 2024-25 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence. 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.

	5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring. 6 (As Host of One LSC): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services. (As Partner of One LSC): One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.
Related to key risks identified on the Corporate Risk Register	Risk ID: Risk Descriptor As described
Related to recommendations from audit reports	Mersey Internal Audit Agency (MIAA) Risk Management Audit Report
Related to Key Delivery Programmes	Care Closer to Home Placed Based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement People Plan Priorities Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare Tackle inequalities in outcomes, experience and access Enhance productivity and value for money Help the NHS support broader social and economic development

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed?

Executive Summary

1. A summary of key points to note since the last meeting.
   a) The corporate risk register has twenty two risks, an increase of two from the last report. One risk has a reduced risk score of 12 awaiting approval for its removal. 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 two risks, an increase of two from the last report. One risk has a reduced risk score of 12 awaiting approval for its removal. 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 eleven (50%) are clinical management risks, four (18%) are data and digital risks, three are health and safety risks (13%), two are financial risks (9%) and one (5%) is a medical devices risk and one (5%) is a patient safety risk.

   d) A breakdown of risks by division shows ten (45%) are Trust wide, five (23%) are corporate services, two (9%) are diagnostic and clinical services, two (9%) family care services, two (9%) are surgical and anaesthetic services and one (5%) is within medicines and emergency care services.

   e) A summary and detail of risks held on the CRR is included within the appendices.

Risk Management Performance Activity

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

   a) Numbers of open risks held on the risk register are down from 682 risks in Q4 2034-24 to 639 in Q3 2024-25, a decrease of 6%.

   b) Risks identified as being significant or moderate have increased, from 215 risks in Q4 2023-24 to 247 in Q3 2024-25, an increase of 15%.

   c) Risks remaining open over 3 years old are down from 400 risks in Q4 2023-24 to 333 in Q3 2024-25, a decrease of 17%.

   d) Overdue risks have increased from 107 in Q4 2023-24 to 207 in Q3 2024-25, an increase of 94%.

   e) 12% of tolerated risks have currently surpassed their review date.

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

   g) A breakdown of clinical management risks shows the highest risk sub types are concerning capacity and demand (22%) followed by standards of care (9%), assessment / diagnosis (8%) and treatment or procedure (8%).

h) A breakdown of health and safety risks shows the highest risk sub types relate to buildings and infrastructure (29%) followed by security management (15%) and equipment management (non-clinical) (10%).

i) Highest numbers of risks are held within the diagnostic and clinical service division (27%) followed by surgical and anaesthetic services (21%).

j) Highest numbers of directorate risks are held within radiology (11%) followed by Trust wide (10%), pathology (9%) and estates and facilities (8%).

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 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
27th December 2024

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	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
4	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
5	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
6	9777	Corporate	2	Corporate	Loss of education, research and innovation accommodation and facilities	4	4	16	T McDonald	Limited	↑	New Risk
7	9746	Financial	5	Corporate	Inadequate funding model for research, development and innovation	4	4	16	K Quinn	Limited	⟷	People & Culture Committee / Finance & Performance Committee
8	9545	Clinical	2	SAS	Potential interruption to surgical procedures due to equipment failure	4	4	16	S Simpson	Limited	⟷	Medical Devices Steering Group
9	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
10	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
11	7165	H&S	2	Corporate	Failure to comply with RIDDOR	4	4	16	T McDonald	Limited	⟷	Health & Safety Committee
12	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
13	10065	Clinical	2	DCS	Pharmacy Technical Service refurbishment programme	3	5	15	J Husain	Inadequate	⟷	TWQG B / Quality Committee
14	10062	Clinical	2	Trust wide	Risk of harm and poor experience for patients with mental health concerns	3	5	15	P Murphy	Inadequate	⟷	TWQG A / Quality Committee
15	9900	NICE	2	Trust wide	Poor identification, management and prevention of delirium	5	3	15	J Husain	Limited	⟷	TWQG B / Quality Committee
16	9895	Clinical	3	SAS	Patients not receiving timely emergency procedures in theatres	5	3	15	J Husain	Limited	⟷	SAS DQSB
17	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
18	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
19	9301	H&S	2	Trust wide	Risk of avoidable patient falls with harm	3	5	15	P Murphy	Limited	⟷	Falls Strategy Group / TWQG A
20	8808	H&S	2	Corporate	Breaches to fire stopping and compartmentalisation at BGH	3	5	15	T McDonald	Adequate	⟷	Fire Safety Committee / TWQG B
21	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
22	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 16/12/2024** **Risk reviewed. No change in risk score** The Trust has reported a deficit of £32.2m, £24.5m behind the year to date plan and movement of £6.3m from previous month. Due to the phasing of the Deficit Support Funding the position is understated by £7.3m and a deficit of £39.5m. The 2024-25 capital programme has reduced by £1.2m to £33.6m with year-to-date capital spend at £7.5m, £0.7m behind plan. Cash balance was £8.2m, a reduction of £6.7m compared to the previous month which continues to be supported by £18.2m of Provider Revenue Support Public Dividend Capital (PDC). Better Payment Practice Code (BPPC) performance remains well below target. Year to date spend on agency staff represented 1.9% of total pay (was 2.0% last month) against the ceiling set by NHS England (NHSE) for 2024-25 of 2.9%. The Cost Improvement Programme (CIP) for the 2024-25 financial year is £59.7m, £17.3m has been achieved against a plan of £23.7m. Currently there is £23.8m unidentified. **Next Review Date 17/01/2025**	**Date last reviewed**	**16/12/2024**	
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				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.

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

Controls and Assurances in place

Controls

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

Assurances

1. Imaging incidents closely reviewed and monitored and linked to the management of risk.
2. Cerner e-PR has an imaging module, cloud storage and PAS patient list connection that capture, store, access and share imaging data and multimedia across the system providing a holistic patient view.
3. Current capacity levels regularly being monitored. Capacity within Childrens Observation and Admissions Unit is 117.2 GB (99.8% full) with 247.9 MB remaining. Capacity within COPD is approx. 250 GB and NICU is approx.. 800 GB with further capacity checks required.
4. The Technical Diagnostics Team within the Integrated Care Board (ICB) is exploring costs and solutions, with Bridgehead identified as a solution, along with cardio imagery. Planning parameters and vendor response in place for viability.
5. Work is underway with software providers for a temporary solution for the storage of images that does not add to current storage capacity. An approach has been considered for Siemens to partition VNA and assist with the holding of data and or for Sectra to provide a fully functional solution until a more permanent solution is found.
6. Regular meetings held between the Executive Medical Director, Chief Nurse, Director of Finance and Director of Operations for the Family Care Division to understand the risk and mitigations required.
7. Divisional Quality and Safety Meetings in place to review and support the management of this risk.
8. Medical Devices Management Group meetings in place to provide assurances of compliance regarding the lifecycle management of medical devices.

Gaps and potential actions to further mitigate risk

Gaps / weaknesses in controls

1. Additional cost implications for contract extension and a software storage solution.
2. Current ultrasound images stored on scanning machines have limited memory capacity.
3. Images transfers to desktop, through PACS and MS teams is ineffective. Attempted input of images onto PACS slows the entire system down, is too big to be sent via image exchange portal and has limited storage availability. Use of MS teams heavily reliant on availability of consultants to attend MS team meetings.
4. Patient transfers to other Hospitals may be unnecessary, unsafe and reliant on bed availability.
5. Limited assurance Royal College of Radiologists standards are being used to benchmark or measure performance or compliance.
6. Additional staff training in system use is required.
7. Development of a virtual private network (VPN) tunnel is under trial and not embedded as clinical management process.
8. Cranial ultrasound scans and echocardiogram images cannot be separated and stored with further exploration of how scans are stored required.
9. A planned strategy and system solution being brought in by the ICB to increase storage capacity is awaiting implementation.
10. Limited assurance policy and procedural controls regarding the lifecycle management of medical devices is robust, is being followed or suitably performance managed.

Gaps / weaknesses in assurances

1. Common incident themes relate to equipment malfunction, delays in diagnosis, clinical symptoms warranting emergency transfer of patient to another Hospital and difficulties transferring images.
2. Cerner e-PR imaging module and set up requires further exploration to determine effectiveness.
3. Limited evidence of assurance current capacity levels are regularly checked and monitored.
4. Bridgehead solution remains fully dependent on the release of funding and approval by the ICB.
5. Solution offered by Siemens does not help image sharing with other Hospitals and effectiveness of direct image transfers still requires exploration.
6. Effectiveness of the Medical Devices Management Group to support management of this risk.

Update since the last report

Update 10/12/2024
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 10/01/2025

Date last reviewed	**10/12/2024**			
Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
	20	20	20	
8-week score projection	12			
Current issues	System wide external influences			

No	ID	Title				
3	9336	**Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care**				
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. Staffing requirements are not calculated as standard to be able to care for increased patient numbers and complexity, with inadequate capacity within specialist areas such as cardiology, stroke etc. to ensure adequate clinical flow and optimum care.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls and assurances** 1. Ambulance handover and triage escalation processes only effective if patients are transferred elsewhere and interventions are carried out. 2. OPEL triggers consistently remain at Level 4 with no escalation strategy should triggers be continuously met. 3. Clinical pathways are not being effectively utilised. 4. Patients not always keen to follow 111 / GP direct booking pathways to UCC. 5. Daily staff assessments are completed but there is still not enough staff to send support. 6. Limitations of 'pull through' and what can be achieved are due to challenges regarding patient discharge. 7. Extreme escalation highly dependent on flow. It does not always decrease pressures due to same sex / side room requirements. 8. Zoning of departments is only effective where severe overcrowding does not take place. 9. The corridor care standard operating procedure, hourly rounding by nursing staff and processes across acute and emergency medicine cannot be safely followed at times of severe overcrowding. 10. Workforce redesign undertaken twice yearly and despite a clear recruitment strategy and positive campaign, gaps in vacancies continue to remain high locally and nationally. 11. Safe Care Tool is completed twice yearly and has highlighted gaps between need and decision making. 12. Departmental board and walk rounds can take several hours due to severe overcrowding. 13. Reduced thresholds for support result in pushback from clinical areas vs a pull model. 14. Delays in the HR onboarding process is resulting in slow recruitment of volunteers and not enough to support demand. 15. Bed meeting actions can be person dependent e.g. consultants to discharge patients etc. 16. Further in reach to department support does not always occur due to staffing levels and space constraints, creating further delays. 17. Staff are not always available to redeploy to support at times of increased pressure. 18. Compliance with UK guidance for isolation of infectious patients creates further risks e.g. availability of side rooms etc. 19. Not all patients or staff follow infection prevention control policy requirements. 20. Not enough side rooms to support clinical requirements, in particular, patients identified as being not for corridor when severely overcrowded. 21. Reports not always accessed and meetings can be stood down due to operational pressures meaning data is not always enacted upon. 22. Added demand s coming from other NHS organisations due to better management of risk by ELHT. 23. No additional plan to support patients who require higher levels of care once high observation beds within AMUB are occupied. 24. A patient experience strategy is in place to support patients within ED but is heavily reliant on demand vs capacity so complaints continue to increase yearly despite interventions being put in place. 25. Friends and family results highlighting increasing concerns of waiting times. 26. System partners ability to flex and meet demands of local health population compounded with offer of mutual aid, with support with hospital diverts increasing risk
Controls and Assurances in place	**Controls** 1. Ambulance handover and triage escalation processes to reduce delays 2. Operational Pressure Escalation Level triggers and actions completed for ED and Acute Medical Units. 3. Established 111 / GP direct bookings to Urgent Care Centre. 4. 111 pathways from GP / North West Ambulance Service (NWAS) directly to Ambulatory Emergency Care Unit. 5. Pathways in place from NWAS to Surgical Ambulatory Emergency Care Unit (SAECU), Children's Observation and Assessment Unit (COAU), Mental Health, Gynaecology and Obstetrics and the Community. 6. ED streamer tool in place to redirect patients to an appointment or alternative service where required. 7. Daily staff capacity assessments completed and staff flexed as required. 8. Divisional Flow Facilitators established across all divisions to assist with clear escalation and 'pull through'. 9. Escalation pathway and use of trolleys in place for extreme pressures. 10. Zoning of departments to enable better and clearer oversight, staffing and ownership and isolation of infected patients, in particular, those with influenza and risks of cross contamination. 11. Corridor care standard operating procedure embedded. 12. Workforce redesign aligned to demands in ED. 13. Safe Care Tool designed for ED. 14. Full recruitment of established consultants. 15. Matrons undergone coaching and development on board rounds. 16. Reduced thresholds within critical care to support patient admissions. 17. Patient champions in post to support patients on corridors and volunteers utilised to support with non-clinical tasks. **Assurances** 1. Support provided by IHSS Ltd. in regularly reviewing admission avoidance. 2. Gold command in place to provide support. 3. Bed meetings held x4 daily with Divisional Flow Facilitators. 4. Hourly rounding by nursing staff embedded in ED. 5. Daily consultant ward rounds done at cubicles so review of care plans are undertaken. 6. Daily 'every day matters' meetings held with Head of Clinical Flow and Patient Flow Facilitators. 7. Daily visit by Infection Control Nurse to ED with patients identified as being not for corridor. 8. Increased bed capacity within cardiology. 9. High observation beds in place on AMU to support patients who require high levels of care. 10. Further in reach to departments in place to help decrease admissions. 11. Discussions ongoing with commissioners in providing health economy solutions via A&E delivery board. 12. Continuous review of processes across Acute and Emergency medicine in line with incidents and coronial process.		

<table>
<tr><td rowspan="5">Update since the last report</td><td rowspan="5">Update 08/12/2024.
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 08/01/2025</td><td>Date last reviewed</td><td colspan="4">08/12/2024</td></tr>
<tr><td rowspan="2">Risk by quarter 2024-25</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>20</td><td>20</td><td>20</td><td></td></tr>
<tr><td>8 week score projection</td><td colspan="4">20</td></tr>
<tr><td>Current Issues</td><td colspan="4">Recovery and restoration pressures, recruitment and retention</td></tr>
</table>

No	ID	Title				
4	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 13/11/2024** **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 that will support mitigation of this risk and a reduced risk score. **Next Review Date 13/12/2024** **Reminder issued to risk handler to review risk**	**Date last reviewed**			**13/11/2024**
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				16	**20**	**20**	
			8 week score projection	**12**			
			Current issues	System pressures			

No	ID	Title
5	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

	Emergency preparedness, response and resilience - policy and procedural controls in place relating to emergency preparedness, response and resilience, major incident and business continuity planning - paper based contingencies remain in place to allow and record data capture Governance - e-Lancs managed from one command centre Digital - national data and digital strategy in place to help drive successful implementation of e-PR system - stability of existing systems i.e. clinical and patient flow system (including capture of nursing documentation), digital dictation and scanning - improved digital infrastructure, network upgrades and digital solutions including storage to maintain and manage existing systems in place to help best utilise data sets and information from e-PR system - extended contracts on existing digital systems that provide current cover - register of non-core systems capturing patient information (feral systems) - decommissioning programme of digital systems underway - IT helpdesk and self-service portal in place to help resolve technical and general issues Patient and staff safety - staff access to a wide ranging staff health and wellbeing support mechanisms e.g. occupational health and wellbeing teams, employee assistance programmes, external organisations, staff side, freedom to speak up guardians etc. Task based - improved digital infrastructure and investment in new technology and equipment e.g. connectivity, large screen monitors for status and track boards, bed planning and control centres, use of barcode scanners for medication, patient wristband supply and scanning, workstations on wheels, laptop trolleys and bedside usage, medicine trolleys specifically built for ward medication dispensing, anaesthetic machines within theatres, badge readers for logging within inpatient and theatre areas, use of 24/7 device computers with access viewer software installed in clinical areas etc. - use of personalisation lab to allow customisation of system to suit individual needs e.g. doctor, allied health professional, nurse etc. **Assurances** General - digital solution meets regulatory and data set compliance requirements - system designed around national clinical requirements - back office and application support teams triage, troubleshoot and resolve issues - support with staff familiarisation and confidence on clinical management systems readily available from Cerner e-PR and e-Lancs expertise - business as usual support roles from executive team, directors, on call senior managers, matrons, enhanced service desk and self-service portal - early go live period identified has identified a number of issues relating to the technical design and adoption by staff which is expected due to the size and scale of implementation Clinical management - a stop, start and continue project, led by a clinical lead in improvement practice involving cross divisional engagement, has reviewed working practices across all clinical, operational, administration, human resources and governance processes - key control issues identified are being closely monitored with executive leads and through working groups - clinical document library outlining electronic and paper based systems covering policy and procedures, clinical risk assessments, bundles, care plans etc. - patient and statutory data sets captured in Bedrock Data Warehouse with reports in place - patient flow monitored through Alcidion MiyaFlow - patient care is visible and monitored through e-PR - patient activity is captured leading to accurate income reports - digital medical record capability shared within treatment and support teams Communication - regular webinars and team brief sessions held Education, training and competency - use of access fairs to ensure smooth staff logins - additional 940 hours available to support adoption and optimisation of system provided by Cerner for individual and team coaching Emergency preparedness, response and resilience - the EPRR committee benchmarks performance against national standards and provides assurances of organisational compliance Governance - weekly e-PR Programme Board meetings chaired by Medical Director - weekly incident management meetings chaired by Chief Operating Officer and Director of Service Improvement - weekly e-Lancs Improvement and Optimisation Group - use of specific working task groups as required - e-PR programme included as standing agenda item at Executive and Senior Leadership Group meetings		appropriate method of control, are being followed by staff or are being monitored and reviewed Communication - human factors and behaviours may be as a result of information fatigue and or culture/change acceptance Education, training and competency - accessing e-Coach may not be clearly understood or being utilised effectively by staff Emergency preparedness, response and resilience - limited assurance major incident and business continuity plans covering digital and clinical management systems may not be reviewed, tested, updated or followed to reflect e-PR implementation Governance - work underway to review longer term governance structure and arrangements to support the digital transformation journey - limited assurance monitoring and review of data within e-PR is being assessed to determine how well it is being used and of driving improvements - impact on mandatory national and local audit activity i.e. coding timelines, delays and observed changes in coded diagnosis reducing numbers of expected cases for submission - data behind GIRFT metrics and model hospital data is not being updated in a timely manner Staff safety - limited assurance HR/occupational health systems are being monitored against implementation to determine whether major system change is having a negative impact on staff health and wellbeing

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

Update since the last report	**Update 07/11/2024** **Risk reviewed. No change in risk score** A full review of the risk controls and assurances is being undertaken by the data and digital senate group, with a view to a new risk being raised which will focus on system based issues, clinical management issues, governance issues, education and training issues, competency and behavioural issues that will support mitigation of this risk and a reduced risk score. **Next Review Date 06/12/2024** **Reminder issued to risk handler to review risk**	**Date last reviewed**	**07/11/2024**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			20	**20**	**20**	
		8-week score projection	**15**			
		Current issues	System wide external influences			

No	ID	Title
6	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** **Next Review Date** 06/01/2025	**Date last reviewed**	**06/12/2024**

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

No	ID	Title
7	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 04/12/2024** **No change in risk score.** Income recovery work progressing at pace with a dedicated team set up and seconded to the role of recovering historical income, cross referencing study activity and invoices as well as setting up new processes on EDGE for new studies opening. Agreement reached for this work to continue to Mar-25 that will support mitigation of this risk and a reduced risk score. **Next Review Date 05/01/2025**	**Date last reviewed**	**04/12/2024**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			16	**16**	**16**	
		8-week score projection	**12**			
		Current issues	System wide external influences			

No	ID	Title				
8	9545	**Potential interruption to surgical procedures due to equipment failure**				
Lead		Risk Lead: J Preston Exec Lead: S Simpson	**Current score**	**20**	**Score Movement**	⇔
Description		Theatre items that are out of service or obsolete pose a significant risk of complete failure which will impact on service delivery and patient safety. These items include theatre stack systems and Integrated theatre solutions which are now out of service contract. Additional critical medical devices and items are also due to be without support in the short and medium term		**Gaps and potential actions to further mitigate risk**		**Gaps / weaknesses in controls** 1 No spare parts availability internally or with supplier 2 Supplier has confirmed items now obsolete and replacement parts are no longer available 3 Possibility for loan kit to be unavailable 4 Potential for equipment to break and be no longer available 5 Field Safety Notices are not applicable as failure is due to age of equipment 6 Planned preventative maintenance of equipment for obsolete items is not included as part of contractual arrangements 7 A review of the responsibilities and arrangements within the medical devices policy is required **Gaps / weaknesses in assurances** 1 Increasing numbers of incidents identified 2 Meetings of the Medical Devices Management Group have not consistently taken place to allow monitoring and overview of equipment service contracts 3 Potential failure to report incidents of equipment issues or breakages 4 Delays in progress of the task and finish group may be experienced due to financial pressures
Controls and Assurances in place		**Controls** 1 Loan kit ordered when equipment broken if available (parts and items dependent) 2 Theatre staff fully trained and competent to work the equipment 3 Specialty scheduling and theatre oversight in place 4 Service contracts in place jointly managed between EBME and Theatres 5 Policy in place for the lifecycle management of medical devices monitored by the Medical Devices Management Group **Assurances** 1 Capital bids process in place 2 Business case to propose moving to a managed service and potential solution to the risk accepted by Board 3 Good relationship with and support from EBME, supplier and company representative 4 Breakages of choledoscopes fully investigated with theatres, EBME and supplier with the outcome of investigations finding no particular trend, with some breakages due to fragility of equipment and increased complexity of cases 5 Task and Finish Group established to progress replacement of equipment and managed service option 6 Monitoring at theatre and divisional meetings 7 Monitoring of incidents linked to risk and likelihood scoring criteria				
Update since the last report		**Update 04/11/2024** **Change of risk lead. No change in risk score** Further issues with failure of equipment experienced which have been mitigated on these occasions to avoid service impact. Secured loan equipment from supplier. Managed service contract in place from Sep-24. Equipment to be replaced in the next three months and upgrade of integrated equipment within gynae theatres expected to be completed before Feb-25 which will help support movement towards a reduced risk score. **Next Review Date 04/12/2024** **Reminder issued to risk handler to review risk.**		**Date last reviewed**		**04/11/2024**
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
					20	**20**	**20**	
				8-week score projection	**12**			
				Current issues	Management of Medical Devices			

No	ID	Title				
9	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**			
Controls and Assurances in place		**Controls** 1 Red, Amber, Green (RAG) ratings included on all outcome sheets in outpatient clinic. 2 Restoration plan in place to restore activity to pre-covid levels. 3 RAG status for each patient to be added to the comments field on the patient record in Outpatient Welcome Liaison Service (OWLS) to capture current RAG status. This will allow future automated reports to be produced. 4 All patients where harm is indicated or flagged as a red rating to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers. 5 A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at the time of putting them on the holding list. 6 Process has been rolled out and is monitored daily. 7 Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reducing the reliance on holding lists in the future. 8 Administrator appointed to review all unknown and uncoded patients requesting clinical input and micromanagement of red patients in chronological order to find available slots. **Assurances** 1 Updates provided at weekly Patient Transfer List (PTL) meetings. 2 Daily holding list report circulated to all Divisions to show the current and future size of the holding list. 3 Meetings held between Divisional and Ophthalmology Triads to discuss current risk and agree next steps. 4 Requests made to all Directorates that all patients on holding list are initially assessed for potential harm due to delays being seen, with suitable RAG ratings applied to these patients. 5 Specialties continue to review patients waiting over 6 months and those rated as red to ensure they are prioritised. 6 Audit outcomes highlighted no patient harm due to delays. 7 Meetings held with Directorate Managers from all Divisions to understand position of all holding lists. 8 Individual specialities undertaking own review of the holding list to identify if patients can be managed in alternative ways. 9 Updates provided weekly to Executive Team.		**Gaps / weaknesses in controls** 1 Holding list remains high due to backlog from COVID-19. 2 General lack of capacity across specialties impacting on reducing holding list numbers. 3 Not all staff are following standard operating procedures for RAG rating of patients, leaving some patients without a rating. **Gaps / weaknesses in assurances** 1 Automated reporting system in development that will ensure oversight of risk stratified lists by specialty. 2 Current level of patients without a RAG rating classed as uncoded and unknown. 3 Patient appointments not RAG rated will drop onto the holding list if appointments are cancelled. 4 Patients added onto the holding list from other sources such as theatres, wards etc will not have a RAG identified.	
Update since the last report		**Update 02/12/2024** **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. **Next Review Date 02/01/2025**	**Date last reviewed**	**02/12/2024**		
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				16	**16**	**16**	
			8 week score projection	**16**			
			Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
10	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 06/11/2024** **Risk Reviewed. No change in risk score.** MUST compliance remain static at 51% completion within 23hrs, 27% after 24hrs and 21% of patients with no MUST. Data triangulated from retrospective report generated by Power BI/EPR and NAPF data. Multifactorial issues associated with patients not being weighed and challenges of completing MUST tool with correct data. A recent review has found MUST eLearning to be out of date. MUST remain part of the NAPF auditing process. The impact of poor MUST compliance has been highlighted at the Clinical Effectiveness Group along with similar compliance to care planning, fluid balance chart and food record completion which also continues to be audited via NAPF. Nutrition questions in NAPF have been revisited and are more visible as NAPF adopts an MDT approach. Policy and procedural arrangements regarding nutrition and hydration provision are being reviewed. **Next Review Date 06/12/2024** **Reminder issued to risk handler to review risk**		**Date last reviewed**		**06/11/2024**
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
					16	**16**	**16**	
				8 week score projection	**16**			
				Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
11	7165	**Failure to comply with RIDDOR**				
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. RIDDOR reporting requirements contained within scope of incident management policy and procedure. 2. Responsibilities of staff to report any health concerns embedded within organisational health and safety at work policy. 3. Improved data capture and utilisation of Datix incident management module. 4. Centralised process firmly established for the health and safety team to review and submit RIDDOR reportable incidents externally to the HSE. 5. Days lost off work as a result of a workplace accident or injury captured as part of the 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 developed by health and safety team and rolled out to targeted staff groups i.e. members of the health and safety committee, lead specialisms and or subject matter experts, occupational health services, divisional quality and safety leads and teams and patient safety investigation leads. Further ad hoc training across divisional groups available, where necessary. 8. Increased senior management awareness of RIDDOR to help drive and reinforce the importance of ensuring legislative compliance. 9. New Occupational Health Management System OPAS-G2 now being used to capture and inform of the types of medically diagnosed occupational related disease, infections and ill health identified as being RIDDOR reportable. **Assurances** 1. Full review of legislative requirements completed and reviewed. 2. Specialist advice, support and guidance on RIDDOR reporting requirements readily available from the health, safety and risk team. 3. Continuous monitoring and review of all accidents and incidents to staff, patients, contractors and members of public reported in DATIX undertaken by the health, safety and risk team. 4. Thematic review of RIDDOR performance against legislative requirements included as an agenda item of the Health and Safety Committee, with escalation and or exception reporting to the 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 help identify and determine potential RIDDOR reportable incidents to patients. 8. RIDDOR performance included as part of Quality and Safety KPI performance metrics for senior management oversight and review. 9. Increase in RIDDOR compliance has increased from 56% in 2023/24 to 71% at present	**Gaps and Potential actions to further mitigate risk**		**Gaps / weaknesses in controls** 1. Delays experienced determining RIDDOR status due to increasing volume and complexity of accidents and incidents requiring review and investigation. 2. Limited assurance policy or procedural controls regarding the timely reporting of accidents or incidents are being followed, 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 numbers of days lost off work as a result of workplace accident or injury leading to its 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 impact on external regulatory reporting requirements. 5. Improvements in compliance heavily reliant on major changes to the incident management and triage processes and limited capacity and resource within the health and safety team. 6. Lead specialisms and or subject matter experts are not being utilised effectively with regards the review and investigation of incidents within their own areas of responsibility and control and of determining external reporting requirements of RIDDOR when undertaking investigations. 7. Investigations to determine RIDDOR reportable incidents highlighting gaps in quality safety management systems or processes and of policy/procedural controls and risk assessment processes not being followed. **Gaps / weaknesses in assurance** 1. RIDDOR performance increasingly attracting the interest of the HSE and CQC. 2. No evidence of assurance lead specialisms or subject matter experts in safety critical roles are benchmarking or using RIDDOR performance as an important driver in reducing mitigating risks or improving safety management systems, processes or behaviours. 3. Numbers of accidents and incidents being reviewed or investigated by the health, safety and risk team to determine RIDDOR status account for 25-30% of all accidents and incidents reported in DATIX. This continues to significantly impact on the work and resources of the team e.g. 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 3,539 (Oct-24) 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 28 RIDDOR reportable incidents have occurred this FYTD, 8 of which have been reported outside of timescales.		
Update since the last report		**Update 06/12/2024** **Risk Reviewed. No change in risk score.** A new RIDDOR process went live on 1 Oct-24 to help support a reduced risk score. All stakeholders consulted on changes in process. Notifications to the HSE remain centrally coordinated by the health, safety and risk team. RIDDOR awareness training including the new process has been rolled out to support divisional services. 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 06/01/2025**	**Date last reviewed**		06/12/2024		
			Risk by quarter 2024-25	Q1	Q2	Q3	Q4
				16	16	16	
			8 week score projection	12			
			Current issues	Systems, capacity and workforce pressures			

No	ID	Title				
12	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** 11/01/2025		**Date last reviewed**	**10/12/2024**	
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
							15	
				8 week score projection	**15**			
				Current issues				

No	ID	Title				
13	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.	**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
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.		
Update since the last report	**Update 16/12/2024** **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 15/01/2025**	**Date last reviewed**	**16/12/2024**
		Risk by quarter 2024/25	**Q1**: 15 · **Q2**: 15 · **Q3**: 15 · **Q4**:
		8-week score projection	**15**
		Current issues	Systems, capacity and workforce pressures

No	ID	Title
14	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.	**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
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.		

Update since the last report	**Update 04/12/2024** **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. 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 06/01/2025**	**Date last reviewed**	**04/12/2024**		
		Risk by quarter 2024/25	**Q1**	**Q2**	**Q3**	**Q4**
			15	15	15	
		8-week score projection	12			
		Current issues	System wide influences			

No	ID	Title				
15	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				
Controls and Assurances in place		**Controls** 1. A paper based delirium bundle and assessment in place for clinical teams investigating and managing delirium. 2. A delirium awareness training module is available to staff with rapid tranquilisation training in support. 3. Available guidance on agitated delirium in elderly persons. 4. Patients with suspected delirium can be referred to relevant specialist nursing teams for support and review where required. **Assurances** 1. Delirium reports and updates produced and shared at dementia strategy meetings and the patient experience group. 2. Diagnostic data has identified a downward trend in delirium diagnosis since the introduction of the electronic patient record system. 3. A dementia champion documentation audit is being piloted monthly that includes seeking assurances of the effectiveness of delirium assessments. 4. A share point site has been created for signposting and resource identification. 5. A change request for the identification, management and prevention of delirium workflow has been approved with work underway to produce a single assessment question to identify delirium (SQID). 6. A training programme is in place to deliver delirium awareness key points training with training delivered to c.`40 staff members between Jan-24 to May-24. 7. A nationally accredited delirium awareness e-learning module has been added to the learning hub.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Existing digital clinical assessment does not fully identify delirium or populate a problem list. 2. Existing paper based delirium bundle does not utilise the 4AT delirium assessment and is not being routinely used in practice. 3. Compliance with dementia audits and outcomes requires stronger divisional support. 4. The training module for delirium is not a mandatory training requirement and does not fully mitigate the risks associated with delirium. 5. Published guidance and recommendations (agitated delirium in elderly) are not always followed. **Gaps / weaknesses in assurances** 1. Poor compliance with pilot assurance measures. 2. No reported compliance of delirium assessments for clinical areas captured. 3. No digital pathway for delirium management available. 4. A revised care plan for the prevention and management delirium is to be integrated into Cerner e-PR. 5. Work to create an investigation prompt for clinicians as part of the delirium diagnostic work flow and to assist clinical judgement underway.
Update since the last report		**Update 07/11/2024** **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 06/12/2024** **Reminder issued to risk handler to review risk**		**Date last reviewed**	**07/11/2024**	
				Risk by quarter 2024/25	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**15**	
				8-week score projection	**15**			
				Current issues	System wide influences			

No	ID	Title				
16	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. **Gaps / weaknesses in assurances** 1. Potential for inappropriate categorisation when booking emergency patients. 2. Failure to discuss patient safety and risk at theatre triad and at divisional and directorate meetings. 3. Incident reports not always completed or capture severity of harm as unknown if there is a delay to surgery or disease progression. 4. Issues not highlighted if coordinator is not on duty. 5. Actions from meetings may not be enacted upon 6. Failure to manage capacity list due to lack of resource.
Controls and Assurances in place	**Controls** 1. All patients listed in accordance with NCEPOD guidance and time to theatre. 2. Patients reviewed by medical team to ensure they remain appropriately categorised and have not deteriorated. 3. Standing down of elective theatre based on clinical urgency and prioritisation. 4. Escalation standard operating procedure in place for patient flow. 5. Scheduling to ensure elective theatres are run in accordance with session time. 6. Senior theatre coordination and duty anaesthetist ensure efficient running of all operating theatres to prevent overrun. 7. Policy arrangements in place for ensuring elective procedures are booked in a timely manner to facilitate correct staffing for the elective capacity. 8. Additional second theatre at weekends to cover capacity. **Assurances** 1. Daily review of acuity of emergency list and capacity to assess availability of opening a second emergency theatre where required. 2. Theatre triad, directorate meetings held to discuss patient safety and risk at divisional and theatre directorate level. 3. Monitoring and review of incidents. 4. Emergency coordinator highlights capacity issues to duty anaesthetist and theatre operational manager. 5. Scheduling and oversight meetings in place for elective lists 6. Business case being made for additional theatre sessions.		
Update since the last report	**Update 06/12/2024** **No change in risk score** A number of NCEPOD category targets have been achieved but the risk score remains the same due to 62 category breaches. A second emergency list currently runs on Sundays on a capacity basis to help alleviate breach issues. Awaiting official data from theatres **Next review date 07/01/2025**	**Date last reviewed**	**06/12/2024**
		Risk by quarter 2023-24	**Q1**: 15 · **Q2**: 15 · **Q3**: 15 · **Q4**:
		8 week score projection	**15**
		Current issues	Recovery and restoration pressures, recruitment and retention

No	ID	Title				
17	9851	**Lack of standardisation of clinical documentation process and recording in Cerner**				
Lead		Risk Lead: C Owen Exec Lead: P Murphy	**Current score**	**16**	**Score Movement**	⟺

Description	The introduction of Cerner e-PR system has created changes in documentation processes. There are numerous ways to navigate the system and document information in Cerner. As a result there is a lack of standardisation in documentation. This requires a coordinated way of standardisation and of providing policy and procedural guidance, education and support and effective ways to audit compliance of new systems and processes. A lack of standardisation when documenting in Cerner could result in the omission of documentation, evidence of care, duplication or contradictory information relating to the provision of care and potential that processes no longer align to clinical management policies, standard operating procedures and national guidance, with elements of documentation captured in existing audits no longer available to view.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Staff unaware of variation of processes in Cerner at go live so all processes need review and agreement to standardise. 2. Compliance audit reporting for some elements may not be possible or align to Cerner. 3. Unable to set up compliance reports until agreement of standardised process. 4. No electronic document management system or guidance on scanning in place. **Gaps / weakness in assurance** 1. Due to the volume of change requests and system analyst capacity, the alignment of system builds, audit and policy review is taking time to work through and prioritise. 2. Availability of lead experts to review system and advise and update policies is a timely process. 3. Limited assurance of monitoring scanning activity. 4. Limited capacity of reporting team to work on clinical reporting due to pressure for business as usual reports and resolving data quality issues for operational reporting.
Controls and Assurances in place	**Controls** 1. Appointment of a Chief Nursing Information Officer (CNIO) now in post. 2. New Integration Architect has been recruited to assist and upskill system analysts to execute change requests. 3. Head of Nursing leading review of the effectiveness of clinical management policy and procedural controls, risk assessment processes and care plans. 4. Library of quick reference guides on step by step instructions on common processes available via e-coach. 5. Training videos available on OLI, YouTube and the Learning Hub. 6. Review of clinical documentation included as part of Nursing Assessment and Performance Framework (NAPF). 7. Standardisation of clinical information and records management now obtained and can be audited. 8. Ward manager training delivered by CNIO to all ward managers to standardise nursing documentation. **Assurance** 1. Key processes lacking in standardisation are being identified. 2. Assurances provided by policy authors of the effectiveness of policy, procedural and risk assessment controls being aligned to Cerner. 3. Escalation process for Cerner related issues in place. 4. Engagement groups with staff and subject leads in progress to understand the issues. 5. A clinical records management group has been established to monitor and receive assurance of compliance. 6. Nursing risk assessments now available via systems reporting portal with other reports awaiting development. 7. Mini NAPF and audits of clinical areas undertaken by matrons with outcomes shared and enacted upon. 8. 93% of staff have received training on Cerner e-PR before 'go-live' date and all new staff complete training on commencement of employment. 9. Ongoing updates, including changes or handy tips, issued via trust wide approved communication systems. 10. Creation of One LSC model allows for pooling of resources across the region that will help address capacity.		
Update since the last report	**Update 06/12/2024** **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 03/01/2025**	**Date last reviewed**	**06/12/2024**

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

No	ID	Title				
18	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	Extra bed capacity is achieved by use of escalation beds in areas that have been risk assessed. Since January 2024 a standard operating procedure has been developed that introduced an extra trolley on each ward where there is inability to offload ambulances and patients are nursed on hospital corridors. There is an increased risk extreme escalation to increase capacity within hospital environments will result in patient and staff physical and or mental harm as well as increasing privacy and dignity issues, hospital acquired infection, complaints, poor patient experience and reputational damage.	**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.
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. Signature sheets kept with assessment and compliance of its use audited as required. 2. 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. 3. 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. 4. Use of extreme escalation trolleys is monitored, incidents are reviewed, linked to the risk and investigated as appropriate, with lessons learned shared with staff. 5. The Electronic Patient Tracking System is updated to ensure the correct ward area is used at all times of extreme escalation. 6. Quarterly review of risk assessments undertaken by the health and safety team via use of audits and incident review. 7. Monthly meetings set up to review any incident reports received to identify any ongoing themes or increased risk. 8. Beds utilised in surge spaces as necessary to maximise area usage and increased capacity on wards across MEC and SAS		
Update since the last report	**Update 16/12/2024** **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 16/01/2025**	**Date last reviewed**	**16/12/2024**
		Risk by quarter 2024-25	**Q1**: **15** · **Q2**: **15** · **Q3**: **15** · **Q4**:
		8 week score projection	**15**
		Current Issues	System wide influences

No	ID	Title
19	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	**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
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		
Update since the last report	**Update 11/12/2024** **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 10/01/2025**	**Date last reviewed**	11/12/2024

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

8 week score projection	12
Current issues	System wide influences

No	ID	Title				
20	8808	**Breaches to fire stopping and compartmentalisation at BGH**				
Lead		Risk Lead: J Houlihan Exec Lead: T McDonald	**Current score**	**15**	**Score Movement**	⟺
Description		Phase 5 breaches to fire stopping compartmentalisation in fire walls and fire door frame surrounds due to poor workmanship or incorrect product usage may result in faster spread of smoke or fire between compartments within a timescale <1 hr or 30 mins that compartments and doors are designed to provide.		**Gaps and Potential actions to further mitigate risk**		
Controls and Assurances in place		**Controls** 1. Contractual arrangements in place between the Trust and its PFI partners in establishing duty holder responsibilities of building controls, testing and servicing of alarm systems and planned preventative maintenance programme. 2. Upgrade of suitable building fire detection systems in place to provide early warning of fire. 3. Fire risers and fire-fighting equipment in place, tested and maintained. 4. Fire safety management policy and procedural controls in place. 5. Fire safety risk assessments in place for occupied (Trust) and non-occupied (Consort) areas. 6. Fire safety awareness training forms part of core and statutory training requirements for all staff. 7. All relevant staff trained in awareness of alarm and evacuation methods. 8. Emergency evacuation procedures and business continuity plans in place across services. 9. Fire protection remedial works and find and fix process in place and project managed. 10. Random sampling and audit of project works being undertaken. **Assurances** 1. A fire safety committee has been established, chaired by an exec lead, to seek assurance and monitor progress and compliance. 2. Collaborative working arrangements in place between the Trust, its partners and third parties to identify and prioritise higher risk areas, address remedial works and defect corrections to fire doors and frame sealings 3. All before and after photographic evidence of remedial works recorded and appropriately shared 4. Fire wardens in place with additional fire wardens provided by partner organisations to maintain extra vigilance, patrol common areas across hospital sites and undertake fire safety checks 5. Provision of on-site fire safety team response in place. 6. External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place. 7. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England. 8. Independent consultant employed to review and oversee project.			**Gaps / weaknesses in controls** 1. Delays in implementing works 2. Lack of confirmation of integrity of fire door architrave surrounds and general gaps around and under fire doors. 3. The adequacy of fire stopping compartmentalisation between phase 5 and adjacent building (Wilson Hey) via survey remains outstanding, with no decision made on work to progress. 4. Not all locations within occupied areas have an updated fire safety risk assessment. 5. The review of the effectiveness of collaborative working arrangements regarding the completion, review and sharing of fire safety risk assessments for both occupied and non-occupied areas is required. **Gaps / weaknesses in assurances** 1. Lack of cooperation from partner organisations with information relating to construction drawings, test evidence and material in situ which is slowing down survey and project remedial / management works 2. Limited assurance of the robustness of fire safety management policy and or procedural controls regarding the risk assessment process and effectiveness of on-site fire wardens.
Update since the last report		**Update 06/12/2024** **Risk reviewed. No change to risk score.** A formal review of the risk is being undertaken by key stakeholders and reported at the next Fire Safety Committee meeting scheduled to take place in Dec-24 for approval that will support a reduced risk score **Next Review Date 06/01/2025**		**Date last reviewed**	**06/12/2024**	
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**15**	
				8 week score projection	**12**			
				Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
21	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**			
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.		**Gaps / weaknesses in controls** 1. 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. 2. 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** 1. No gaps or weaknesses identified that remain the responsibility of the Trust. 2. Little evidence of assurance received from the supervisory body of it meeting its obligations for the assessment of patients	
Update since the last report		**Update 11/11/2024** **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 11/12/2024** **Reminder issued to risk handler to review risk score**	**Date last reviewed**	**11/11/2024**		
			Risk by quarter 2024/25	**Q1**	**Q2**	**Q3**	**Q4**
				15	**15**	**15**	
			8-week score projection	**12**			
			Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

No	ID	Title				
22	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	**Controls** 1. Action plan and ongoing service improvements identified to reduce demand. 2. Expanded non-medical roles e.g. orthoptists, optometrists, specialised nurses etc. 3. Use of clinical virtual pathways where appropriate 4. Additional capacity sessions offered to clinicians when opportunity arises 5. Operational management team in place including administrative support for waiting list validation 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. **Assurances** 1. Weekly divisional and performance meetings held to discuss current position 2. Weekly operational meetings held with Chief Operating Officer to challenge outpatient activity and recovery. 3. Bi weekly 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 05/12/2024** **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 10/01/2025**	**Date last reviewed**	05/12/2024		
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			16	16	16	
		8 week score projection	12			
		Current Issues	Recovery and restoration pressures, recruitment and retention			

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

15 January 2025

Item **11**

Purpose **Approval**

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

Summary: The Executive Directors and their deputies have reviewed and revised the BAF during the course of December 2024. Due to the timing of the Committees in December it was not possible to share the BAF at all of the Committee meetings, therefore members of the Finance and Performance Committee and Quality Committee have received the risks relevant to each Committee outside of the formal meeting cycle to allow them to provide feedback or ask questions about the document in advance of its presentation to the board in January 2025. The members of the People and Culture Committee received the report at their meeting on 13 January 2025. The members of the Committees have agreed to recommend the BAF risks within their remit to the Board for ratification.

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

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

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

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Deputy Directors and Executive Directors, December/January 2025

(11) Board Assurance Framework

Finance and Performance Committee, week commencing 6 January 2025

Quality Committee, week commencing 6 January 2025

People and Culture Committee, 13 January 2025

Introduction

1. The Executive Directors and their deputies with BAF risks assigned to them have reviewed and revised the individual risks.
2. This document sets out an overview of the changes that have been made to the BAF since the Board meeting that took place in November 2024, including any updates to the actions, assurances and controls.
3. The full BAF is presented to the Finance and Performance Committee, Quality Committee and People and Culture Committee. However, the Committees are only asked to discuss the risk scores, mitigations and actions for the risks that are within their remits as follows:
   a) **Finance & Performance Committee:** BAF 1, BAF 3, BAF 5 and BAF 6.
   b) **Quality Committee**: BAF 2 and BAF 6.
   c) **People and Culture Committee**: BAF 4 and BAF 6.
4. Due to the timings of the Committee meetings in December 2024 and early January 2025 being revised to accommodate the festive period, it was not possible to present the BAF to the committees. Instead the BAF has been provided to members of the aforementioned committees outside of the meeting schedule to allow feedback, comments and questions to be raised and responded to in advance of the BAF being presented to the Board on 15 January 2025.
5. For ease of reference, we have produced the following heat map of the BAF risks for 2024-25 below.

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

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

6. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
7. There have been no updates to the controls or assurances section of the risk.
8. With regard to the actions section of this risk, there have been a number of updates, including changes to the BRAG (blue, red, amber, green) ratings from green to amber for actions 2, 4, 6 and 7.
9. The rationale for the change of BRAG rating for actions 2 and 4 is as a result of the work being undertaken to identify key priorities to support improvement of year end position, particularly in respect of improvement work to support urgent and emergency care pressures to support a reduction in run rate.
10. The rationale for the BRAG rating change for action 6 relates to the delay to the publication of the planning guidance for 2025-26. In addition the rationale for the

change of BRAG rating for action 7 is noted to be as a result of ongoing development of the improvement hub team priorities to further support identification of cost improvement schemes to improve the year end financial run rate.

11. There have also been updates to other actions, the details of which can be found in the detailed BAF sheet.

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

12. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
13. There has been a number of small updates/revisions to the controls section which are highlighted in green in the detailed BAF sheet.
14. The assurances section of the BAF risk has had a number of updates, including confirmation that Patient Safety Partners are involved in a number of quality governance meetings and the embedding of internal audit recommendations relating to the Trust's complaints management process.
15. With regard to the actions section of the risk, there have been updates provided to the progress section for actions 3 and 5 and further information added to the action required section of action 1.

Risk 3: (Risk Score 20 (C4 x L5) - A risk to our ability to deliver the National access standards as set out in the 2024-25 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.

16. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
17. There have been no further updates to the controls section of the risk and one update to the assurance section, which is highlighted in green in the details BAF sheet.
18. There have been updates to all bar one of the actions, the details of which are clearly marked in green in the detailed BAF sheet.

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

19. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
20. There have been two additions to the controls section and one new addition to the assurances section of the risk, these are highlighted in green in the detailed BAF sheet.
21. There have been updates to all of the actions, with actions 2 and 5 having revised RAG ratings from green to amber. A number of the actions have revised deadlines (1, 2, 3 and 4), updates will be provided on each of these at the board meeting on 15 January 2025.

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

22. The risk descriptor has been slightly revised as follows: **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 *and the Trust does not deliver Value for money.***
23. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
24. There have been a number of minor updates to the controls section of this BAF risk, all are highlighted in green on the detailed BAF sheet. A further 4 controls have been included in the controls section to reflect recent improvements to internal processes.
25. There have been 2 additions to the assurances section of the risk, they relate to the financial governance review that is taking place and the wider Lancashire and South Cumbria system-wide financial review that has been instigated by the regulator. Details of these additions can be found highlighted in green in the detailed BAF risk.
26. There have been updates to all actions, with action 4 being re-RAG rated as amber. The remaining action points have had revised timelines for completion, the rationale for these changes will be provided at the Board meeting on 15 January 2025.

27. In addition to the updates provided, 2 additional gaps in control have been identified as have resultant actions. They have been set out in full in the detailed BAF sheet but relate to the work being carried out to correct the in-year financial misstatement, strengthen financial governance and participate meaningfully in the LSC regulatory intervention.

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

28. The current risk scores remain unchanged for this risk, as do the tolerated and target risk ratings.
29. There have been minor updates to the controls section of the BAF risk, including the confirmation of the Trust's Chief Executive taking on the role of chair of the Central Services Executive Sub-Committee.
30. There had been one new source of assurance added, which is highlighted in green on the detailed BAF sheet.
31. A number of the original actions have been completed and either removed or revised.
32. Four new actions have been included, two of which relate to the development of One LSC and the associated maturing of professional working groups to develop governance and monitor performance. Other new actions relate to the development of plans for the transformation of services and realisation of anticipated benefits.
33. As reported in the last BAF paper, work continues to review and update this BAF risk to acknowledge the early stages of implementation. The majority of the updates to the risk in this iteration relate to governance/oversight, transformation, and staff engagement.

Recommendation

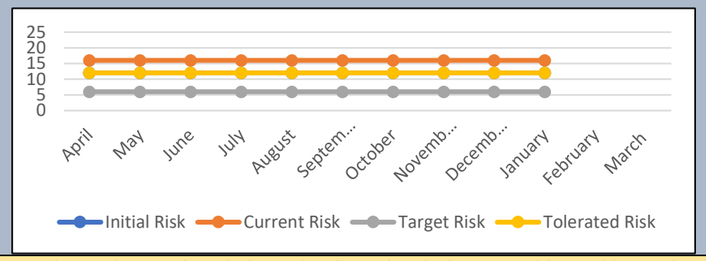
34. The Board is asked to review, discuss, and approve the revised BAF.

BAF Risk 1 – Integrated Care / Partnerships / System Working

Risk Description: The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in unimproved health and wellbeing for our communities.		**Executive Director Lead:** Chief Executive / Executive Director of Service Development and Improvement	
Strategy: ELHT Strategic framework (Partnership Working)	**Links to Key Delivery Programmes:** Care Closer to Home/Place-based Partnerships, Provider Collaborative	**Date of last review:** Executive Director: December 2024	**Lead Committee:** Finance and Performance Committee
Links to Corporate Risk Register (CRR): Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 1.			

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

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



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

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

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

Provider Collaborative Board (PCB):

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

Place-Based Partnership (PBP):

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

ELHT:

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

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

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

- ICS/PCB/PBP Updates are a standing agenda item at Executive meeting and Senior Leadership Group.
- PCB Programme Update reports to the PCB Joint Committee.
- Weekly monitoring of Key Delivery and Improvement Programmes via Executive Improvement Wall
- Trust Improvement Register monitored at Divisional Transformation Boards and Clinical Effectiveness Committees.
- Organisational plans for operational planning established and agreed via Trust and System planning processes.
- Accountability Framework implemented from January 2023 including weekly Improvement Wall updates as part of the weekly Executive Team meetings, Senior Leadership Group and quarterly Divisional Performance meetings.
- Community Services have successfully transferred from LSCFT to the Trust in July 2024.

Specialist support, policy and procedure setting, oversight responsibility:

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

Independent challenge on levels of assurance, risk and control:

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

BAF Risk 1 – Integrated Care / Partnerships / System Working

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	System strategies will continue to be developed and aligned as they are agreed.	Work with system partners to finalise system strategies and ensure full alignment with commissioning intentions and delivery plans.	Director of Service Development and Improvement with SRO leads	April 2025	With the exception of clinical strategy development work all actions complete and focus is now on delivery of benefits for 202425 and 20265/26 (refer to actions 3, 4 and BAF risk 6 on One LSC). Work ongoing on development of system clinical strategy and roadmap.	G
2.	System (LSC, PCB, Place) delivery structures are still maturing to support effective implementation and realisation of benefits	Work with system partners to optimise delivery structures	Executive leads	April 2025	Initial development of plans and alignment across the system complete. Clear programmes in place which now need to focus on delivery of benefits for 2024/25 and 20205/26 (refer to actions 3, 4 and BAF risk 6 on One LSC). Work underway to identify key priorities to support improvement of year end position, particularly in respect of improvement work to support urgent and emergency care pressures to support a reduction in run rate.	A
3.	Clear Clinical Transformation Programme development and delivery plans	Agreement of clear timescales for delivery of key priority programmes and benefits	Chief Executive and lead SROs	April 2025	Clinical strategy work to inform a roadmap to delivery of priority programmes over next 5 years and long-term plan linked to New Hospital Programme Work progressing on fragile service specialty priorities with clear programmes established. System stroke event held in September 2025. Work underway to accelerate programmes of work on fragile services and focus on delivery of benefits for 2024/25 and 2025/26.	A
4.	Benefits for community services/out of hospital priorities not yet fully realised.	Work with Place + partners to further develop community services in line with the Community Transformation Programme to maximise benefits to support patients to receive care in their own home where possible.	Executive Director of Integrated Care, Partnerships and Resilience	April 2025	Co-production and co-delivery with place partners of service development and transformation including enablement hub, UEC pathways, End of Life, Care Home improvements, Integrated Neighbourhood Tean development and Acute Respiratory Infection (ARI) hub mobilisation. Special cause improvement observed in Frailty programmes for numbers of over 65s attending ED. Work underway to identify key priorities to support improvement of year end position, particularly in respect of improvement work to support urgent and emergency care pressures to support a reduction in run rate.	A
5	Lack of clarity and understanding of decision-making mechanisms between Place and Trust footprint resulting in disconnect and/or micro-management by Place(s)	Lead Trust Executive for Place Partnerships, Robust Divisional Leadership Structure via Community and Intermediate Care Division (CIC) and engagement in Place based structures.	Executive Director of Integrated Care, Partnerships and Resilience	April 2025	Lead Trust Executive is Executive Director of Integrated Care, Partnerships and Resilience with regular meetings wit Place Leads. CIC Divisional Leadership mirrors Clinical Divisional triumvirate structure. Representation on Place Partnership structures with delivery on Place Plus basis where appropriate (e.g. UECDB). Monitoring of strategies and impact of Place strategies to ensure appropriate linkages to Trust Strategic Framework and footprint.	A
6.	Trust planning process will continue to mature to support floor to board connections of goals and priorities alongside wider system alignment	Ongoing review and improvement of planning processes at organisational and system level	Director of Service Development and Improvement	April 2025	All Trust strategy plans 2024/25 signed off via sub-committees with reporting mechanisms throughout 2024/25 agreed. Ongoing alignment of place with place and system partners. Ongoing work with Divisions to support connection of Trust goals to teams and individual objectives. Work underway to launch planning processes for 2025/26 which will be reviewed/improved to support financial recovery National planning guidance not yet published.	A
7.	Ongoing development of SPE+ improvement Practice to support delivery of key improvement priorities and to build improvement capability across the organisation/system	Ongoing review and development of SPE+ Improvement Practice at organisational and system level to build capability and support delivery and refresh of SPE+ Practice Plan/Strategy in line with NHS Impact	Director of Service Development and Improvement	April 2025	'Year of Improvement' launched to develop SPE+ training offer to reach 3000 staff in 2024/25 – teams delivering bitesize training to staff across the organisation over Winter to support generation of improvement ideas. Improvement hub team capacity identified to support key improvement priorities for 2024/25, increased monitoring in place to support realisation of benefits for 2024/25. Ongoing review of Improvement Hub team priorities to support key improvement actions to support reduction in run rate and delivery of cost improvement plans.	A

BAF Risk 1 – Integrated Care / Partnerships / System Working

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Scoping of work to refresh Trust SPE+ Practice Plan/Strategy commenced to align to the new NHS Impact framework and ongoing engagement with NHS Impact. Continue to review the offer from NHS Impact to align organisational and national improvement priorities. Executive improvement wall refreshed to support focus on key improvement priorities in Quarter 4.	
8.	Trust Accountability Framework can mature further to support and assure delivery of Trust priorities and realisation of benefits.	Review effectiveness of Trust Accountability Framework and further improve to support delivery	Director of Service Development and Improvement	April 2025	Review commenced of Accountability Framework including effectiveness of Divisional Quarterly Performance meetings, measurement and reporting framework Review of Integrated Performance Report (IPR) underway and to be published in September. Work underway to review and update the Accountability Framework during Q4, Board Development Workshop on revised IPR completed and new IPR agreed to run in shadow form, review of quarterly performance meetings complete.	A

BAF Risk 2 – Quality and Safety

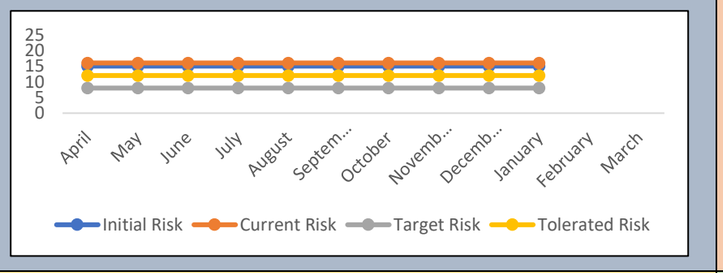
Risk Description: The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.		**Executive Director Lead:** Executive Medical Director and Chief Nurse	
Strategy: Quality Strategy	**Links to Key Delivery Programmes:** Quality and Safety Improvement Priorities	**Date of last review:** Deputy Chief Nurses, December 2024 Medical Director, December 2024	**Lead Committee:** Quality Committee

Links to Corporate Risk Register:

Risk ID	Risk Descriptor	Risk Rating
10086	Lack of adequate online storage for images may result in missed or delayed diagnosis	**20**
9336	Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care	**20**
8126	Poor records management due to sub optimal implementation of new e-PR system	**20**
8941	Increased reporting times in histology due to increased activity outstripping resource	**20**
9545	Potential interruption to surgical procedures due to equipment failure	**16**
9777	Loss of education, research and innovation accommodation and facilities	**16**
8061	Patients experiencing delays past their intended clinical review date may experience deterioration	**16**
8033	Increased requirement for nutrition and hydration intervention in patients resulting in delays	**16**
7165	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	**16**
9851	Lack of standardisation of clinical documentation processes and recording in Cerner	**15**
8808	Breaches to fire stopping and compartmentalisation in walls and fire door surrounds – Burnley General Teaching Hospital.	**15**
4932	Patients who lack capacity to consent to hospital placements may be unlawfully detained	**15**
10065	Pharmacy Technical Service refurbishment programme	**15**
10062	Risk of harm and poor experience for patients with mental health concerns	**15**
9900	Poor identification, management and prevention of delirium	**15**
9653	Increased demand with a lack of capacity within ELHT can lead to extreme pressures and delays to patient care	**15**
4932	Patients who lack capacity to consent to hospital placements may be being unlawfully detained	**15**
9301	Patients who lack capacity to consent to hospital placements may be being unlawfully detained	**15**

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

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



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Minimal

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

Strategy and Planning:

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

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

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

- Monitoring against Model Hospital, Getting it Right First Time (GIRFT), National Institute for Health and Care Excellence (NICE) guidelines, Internal and Clinical Audits (local and national), specialist commissioning, CQC insight data (monthly)
- Quality Walkrounds including Executive and Non-Executives Establishment of 3s visits to all areas of the Trust, to listen to both staff and patients/carers, receive feedback and take action.
- Nursing Assessment Performance Framework (NAPF) Process ongoing and reports to Quality Committee. Document currently been reviewed to reflect Trust policy's and CQC quality standards.
- Safe, Personal, Effective Care (SPEC) process and the ratings of green/silver/gold wards/areas (mapped to the CQC Key Lines of En quiry).
- Co-ordination of GIRFT through Audit and Effectiveness Team to identify Trust wide efficiency and effectiveness gains and reported to the Quality Committee regularly.
- Direct patient referrals into Same Day Emergency Care (SDEC) pathways to help bypass urgent care and ED.
- Admission avoidance through the use of Intensive Home Support Service (IHSS) in ED.

BAF Risk 2 – Quality and Safety

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

- The Trust has an established quality assurance process supported through a formal Committee Structure. This provides the golden thread enabling reporting and escalation between the Divisions and the Board.
- The Trust Board, Quality Committee, Finance and Performance Committee, People and Culture Committee and Audit Committee all receive reports on risk/quality as part of their annual workplan, or as escalation where indicated.
- Escalation required outside of standard Committee processes is enabled through a weekly Senior Leadership Group, chaired by the Chief Executive or other Executive member to enable timely decision making and trust wide focus where required.
- All Divisions (including Estates and Facilities) have Quality and Safety meetings which coordinate Directorate assurance reports and escalation. Divisional reports are escalated to the Quality Committee via the Trust Wide Quality Governance Group.
- Statutory requirements are monitored specifically through Trust Wide assurance meetings including, but not limited to Mortality Steering Group, Patient Safety Group, Patient Experience Group, Clinical Effectiveness Committee, Infection Prevention and Control Steering Group, Safeguarding Board, Medicines Safety and Optimisation, Hospital Transfusion Committee, Organ Donation Committee, Health and Safety Committee, all of which report directly or indirectly to the Trust's Quality Committee, which is a sub-committee of the Board.
- The Professional Standards Group and Employee Relations Case Review Group monitor professional/staff behaviours and all referrals to professional bodies.
- The Risk Assurance Meeting coordinates and monitors all risks reported as potentially scoring 15 or above and escalates to the Executive Risk Assurance Group (ERAG) before inclusion onto the Corporate Risk Register.
- The Patient Safety Incident Response Plan, Patient Experience Framework, Risk Management Framework and Clinical Effectiveness Framework co-ordinate the operational implementation of the priorities which are reported and monitored through respective assurance groups, and exceptions reported to Quality Committee.
- Implementation of the Extreme Escalation Policy which replaces beds with trolleys in clinical spaces to assist the transfer of patients from ED into AMU/more appropriate environment. This in turn assists the capacity within the ED to see and treat other patients. Every morning at 8am, there is exec lead clinical safety meeting with A&E, divisions and flow team to manage and monitor patient admissions and flow.
- The Trust continues to manage current pressures through an IMT approach.
- A&E Delivery Board lead by an Executive Director ensures processes are in place to help co-ordinate the care of patients between community, primary care, NWAS and ELHT.
- A&E improvement board, developed with weekly executive review
- Quarterly Divisional performance meetings where all elements of quality and performance are discussed.
- Data and Digital Senate and Data and Digital Board are the forums for implementing and monitoring data and digital strategy.
- The current local priorities of the Patient Safety Incident Response Framework are due for review/update in March 2025. However, due to the high number of National Priorities, cases for Coroners Court and operational pressures within the Trust, it has been agreed that the current PSIRF would be extended to September 2025. This will allow adequate time for the local priorities to be completed and to hold workshops to review, discuss and agree new local priorities for commencement in October 2025.

- Acute Care Team supporting resus in ED.
- Acute medical physician in-reach into A&E from 8.30am to 8.30pm
- Patient champions in A&E
- Use of 24/7 ambulatory care on an intermittent basis to assist acute care (staffing dependent).
- Work is being undertaken with colleagues in primary care regarding patient pathways.
- Medical Examiners review the care provided to patients who have died in the Trust and can make recommendations or seek further action dependent upon their findings.
- Complex Case meeting weekly to monitor and allocate for investigation any patient/staff safety incidents identified.
- Monthly complaints and inquest drop-in sessions with each Division to monitor performance and highlight risk
- Mobilisation of 24/7 IHSS service complementing the 24/7 Intermediate Care Allocation Team (ICAT) service Monday to Friday between 8am – 4pm for the ED front door team.
- New PSIRP priorities have now been identified and included in the update Patient Safety Incident Response Plan approved at Quality Committee on 1st November.
- New model for patient safety culture reflecting the Insight/Involve/Improve model – integrating patient and staff safety data (in line with the National Patient Safety Strategy) has been agreed in principle with the Quality and Safety team.
- Patient safety specialists are working with Deputy Director of HR to integrate staff safety metrics alongside patient safety.
- New Clinical Lead for Retention, Resilience and Experience commenced in post on 1 August 2023 with a focus on nursing and AHP workforce.
- Work is being undertaken with ward managers and team leaders to review and learn from observations of patient care to improve patient care, outcomes and experience.
- Quality Wall walkrounds have commenced (reviews of the quality KPI's in ED)
- Triple S visits which are informal and report to People and Culture committee quarterly
- An ED Improvement Wall has commenced with weekly attendance from front line clinical leaders, divisional leaders and Trust Executives.
- A new Patient Experience Strategy has been approved by the Board of Directors and launched in September 2024.
- Back to the floor session by execs attending different clinical and non clinical areas

Specialist support, policy and procedure setting, oversight responsibility:

- Integrated Care Board (ICB) have confirmed their contract requirements in relation to Quality reporting. Internal systems have been updated to ensure timely data and exception submission. First submission completed at the end of Q2. The Trust has continued to strengthen reporting against the updated Quality contract requirements and is proposing updates to the Quality metrics contained within the IPR to further strengthen internal assurance and visibility of these metrics
- ICB Improvement and Assurance meetings (IAG), monthly executive to executive assurance meetings
- ICB has split the assurance and safety functions with new leadership and focus.
- Monthly Quality Review Meetings with ICB Quality Team continue.
- Maternity and Newborn Safety Investigations (MNSI) (formerly Health Safety Incident Board) reports – review deaths and Health and Safety incidents.
- Engagement meetings with Care Quality Commission (CQC) in place monitoring performance against the CQC standards. The Trust is preparing for its next Well-Led review,
- Patient Safety Incident Response Framework (PSIRF) supported through regular contact with NHS England Implementation Team. The Trust is supporting the adoption of PSIRF across the system as an active member of the implementation group.
- Early adoption of Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards supported through regular contact with PHSO Local Safeguarding Children's Board (LSCB)/Safeguarding Adults Board (SAB) reporting on Care Act and Children Act Standards.
- Arctic Willow winter specific EPRR exercise undertaken to ensure the NHS is adequately prepared for the winter period. Next ICB wide EPRR exercise planned for January 2025
- Regular Updates on ICB EPRR.
- Regular meeting with Specialist Commissioner for tertiary services (Vascular, HPB, Neonates)

Independent challenge on levels of assurance, risk and control:

- Annual organisational appraisal report.
- CQC inspections and preparation/evidence gathering ongoing. Internal assurance processes evidencing performance against CQC Quality Standards have been aligned to the updated regulatory framework.
- The Internal Audit Plan for 2024-25 has being developed by the Mersey Internal Audit Agency (MIAA) in conjunction with Trust colleagues and improvement actions plan reporting to Audit Committee.
- Regular Engagement meetings with General Medical Council (GMC). Coroner reviews of care provided through Inquest Processes.
- Public Participation Panel (PPP) involvement in improvement activities and walk rounds.
- Patient Safety Partners now participating in a quality governance meetings such as Venous Thromboembolism (VTE) Committee and Accessible Information Standards Task & Finish group.

BAF Risk 2 – Quality and Safety

	• Customer Relations Team undertaking recommendations from the Mersey Internal Audit Agency (MIAA) report into complaints management at ELHT. • PHSO complaints monitoring and external reports. Elective Care Recovery Board which includes regional and ICS level representation and scrutiny. • Quarterly Guardian of Safe Working report (GOSW) for junior doctors provided to the People and Culture Committee • JAG accreditation in Endoscopy • Regular GIRFT assessment and bench marking • Participating in GIRFT Further Faster 20 project. • Annual organ transplant report to NHSE • Patient Safety Walkrounds • Board sign-off for SPEC recommendations • Review of MHUAC with Stakeholders • ICB Quality reviews of services

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Fragility and availability of the medical workforce Health and Wellbeing of the Workforce	As part of Waste Reduction Programme (WRP) work has commenced to identify opportunities to reduce agency spend on medics. Focus on completed job plans. Service line reviews underway to identify gaps in demand and capacity To strengthen the Patient Safety Culture in line with the Workforce Plan and a Just Culture Approach.	Executive Medical Director/ /Executive Director of People and Culture	Quarterly reviews with projected completion in Q4.	Long term This has been partially achieved and the Governance Assurance structure review completed. Job Planning Scrutiny Committee now embedded and focusing on productivity and VFM, recognising the need to increase effectiveness of Medical workforce in support of individual medics achieving their job plans. PCB and ICB are working closely in addressing the fragile services identified across LSC. Compassionate Conversations approach introduced as part of leadership training module to support psychological safety whilst learning from mistakes has been embedded as part of leadership training. Nursing professional judgment review process completed was presented to the Quality Committee in February and to the Trust Board in July 2024. This is now complete reported to Board and approved in July 2024. Medics have now started the introduction of the process of professional judgement. Strengthening of job planning scrutiny panel with support provided to CDs by medical staffing team in job planning. Nurse vacancies have now significantly reduced with an anticipation of zero vacancies in Q3. Trust's Q&S Team are providing support to the Staff Safety Group in relation to violence against staff. This review had identified that the risk will continue into the 2025-26 year as it is an ongoing pressure as evidenced I the recent Lord Darzi report. The proposed NHS 10-year plan will help to provide a blueprint in addressing workforce gaps.	A
2.	Provision of pathology services, with specific issues with histopathology within the Trust (medical and healthcare scientists)	Work is taking place across providers via mutual aid, facilitated via the ICB and external outsourcing and open recruitment. Improvement work within Cell Pathology has initiated to identify internal efficiency opportunities.	Executive Medical Director	Review Q3	The Trust's cell pathology lab in May 2024 confirmed with NHSE that NRLS will be deactivated nationally significant backlog of samples at various stages of the process from 30 June 2024 and the reception to report. This has been escalated to the Executive Team and there is a risk on the risk register. From April 24 consultant vacancies in Histopathology have now all been filled. There are BMS and MLA vacancies which have impacted on the lab's productivity and throughput.	R

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
		Continued effort to appoint into Biomedical Scientist (BMS) and Medical Laboratory Assistant (MLA) vacancies in the department.			From April 24 the improvement team are supporting within the lab to identify opportunities for efficiency. New job plans and ways of working for histopathologists are being implemented in December 2024.	
	Functionality of ePR causing issues with data quality, performance and affecting users capability to maximise the potential of the electronic system.	There is a need for relevant clinical document formats to be standardised and uploaded to Cerner eLancs team best use of resource needed to manage data cleansing and accuracy issues to enable timely reporting and performance monitoring and acting on change and service requests from staff/departments. Within current contract The upgrade of the Cerner system has been put back to April 2025 due to financial constraints. This will impact the functionality of the EPR system.	Executive Medical Director	Delay in implementation due to lack of resource 2025	Issues with ePR and Data Quality continue to be escalated and are being managed through the Data and Digital Senate/Board.	A
3.	Management of Deprivation of Liberty Safeguards processes.	Continuous programme of audit Trust wide and implementation of action plan including: • Strengthened MCA/DoLS training offer • Development of 'heat map' to identify areas in need of greatest support • Development of 7 minute briefings • Development of a 'myth-busting' animation which will be mandatory for all level 3 staff • Strengthened documentation on Cerner • Working with the NAPF team to ensure a consistent approach	Executive Director of Nursing/ Executive Medical Director/ Executive Director of Integrated Care, Partnerships and Resilience	This date has been removed and there is no further date for implementation confirmed.	On trajectory for improved referrals. The number of DoLS applications was 255 in October and 217 in November. The number of DoLS are still slightly below the expected number given the size of the organisation however, the Trust is now on an upward trajectory. . This needs monitoring to ensure the number are sustained. A new matron for mental health started in October 24 who will continue to monitor the going forward An announcement was made on 05.04.2023 that the implementation of LPS would be delayed 'beyond the life of this Parliament'. As a result, all internal and external local and national working groups have been stood down for the immediate future. The Trust will await any update from the new Labour government in relation to if and how this will progress. Lancashire and South Cumbria NHS Foundation Trust (LSCFT) have agreed in principle to formalise support of Mental Health (MH) registration through the management of psychiatric medication, oversight of MH care plans, management of MH Act paperwork for any Section 5(2)s applied within ELHT and to provide training to staff on MH and Restraint. LSCFT have proposed a formal Service Level Agreement (SLA) at cost. SLA is in the process of being signed. Individual patient MH risk assessment and MH strategy shared by LTHT, currently being adapted for adoption at ELHT.	G
4.	Financial Constraints	Constraints in finances will result in lack of investment into workforce, development of service, capital investment and revenue. This has the potential to negatively impact on quality and safety.	Executive Director of Finance / all Executive Directors	March 2025	Organisational focus on improvement methodology to improve productivity and efficiencies. Waste reduction programme with Execs leading as SRO for various workstream – chaired by the CEO. Consolidation of previously approved schemes and QIA for ongoing projects and the ones which have been deferred for a later date. Ongoing work through PCB on clinical strategy and services. Recruitment and retention campaign being undertaken as well as work to improve recruitment from overseas. This has now been reviewed and stopped as registered nurse vacancies recruited to with a trajectory that assures sufficient registered nurse supply New arrangements: better care, better value meetings now in place, with SLG members meeting twice per week (chaired by Clinical Executive	R

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Director) and once per week with Executive Team members (chaired by CEO). Agreed a standardised QuIRA process.	
5	Lack of capacity to manage increased activity across the Trust	Bed remodelling for managing increased activity Work with Place based partners in improving patient pathways Implement GIRFT and Model Hospital best practice approaches to care Data submission to national teams on activity, mortality, coding, audit to ensure that accurate and validated assumptions on income, HSMR/SHMI and activity. Quality of information added to the system remains an issue. Training is taking place with clinical/admin colleagues Coding and quality and affect mortality indicators too.	Executive Director of Finance / Executive Medical Director / Executive Chief Nurse / Chief Operating Officer	Quarterly review undertaken in November 2024 – on track An update will be provided to the board in January 2025	Established relationships through interface meetings with Place based leadership. Clinical Lead with responsibility for GIRFT and Model Hospital working with Q and S team. Ongoing work with our East Lancs team, coders and the Mortality Steering Group (with deep dives into outliers). Working with divisions on ensuring that that we capture activity levels. Working with national teams. Bed remodelling exercise about to complete. Service line reviews taking place to determine demand & capacity, non commissioned services and productivity Improvement Case being developed to open permanent clinical accommodation to reduce corridor care. Further capital work planned to increase ED footprint Improvement case being developed to increase senior medical presence in UEC. In July 2024 the Trust opened a further 24 medical beds on ward C2 and intend to open a further 28 beds on the newly created B3. This was agreed at the Board meeting held on 10 September 2024.	G

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

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

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

Strategy: Clinical Strategy & Operational Strategy

Links to Key Delivery Programmes: Elective and Emergency Pathway Improvement

Date of last review: Deputy Director Review: December 2024
Executive Director Review: December 2024

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register

Risk ID	Risk Descriptor	Risk Rating
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**20**
8126	Poor records management due to sub optimal implementation of new e-PR system	**20**
8941	Increased reporting times in histology due to increased activity outstripping resource	**20**
8061	Patients experiencing delays past their intended clinical review date may experience deterioration	**16**
9895	Patients not receiving timely emergency procedures in theatre	**15**
9851	Lack of standardisation of clinical documentation processes and recording in Cerner	**15**
9653	Increased demand with a lack of capacity within ELHT can lead to extreme pressures and delays to patient care	**15**
10095	PAC issues impacting on efficiency and ability to meet targets and obstructive workflow	**15**

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

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

Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Moderate

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

Overall planning and delivery processes:

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

Operational Management processes:

- Active implementation and monitoring of elective improvement plans for 2024/25, diagnostic clearance plans and OP booking to ensure effective support for delivering the overall plan.
- Monthly Emergency Care Improvement Programme (ECIP) meetings have been refreshed and is now called the Emergency Care Improvement Group (ECIG) with a revised membership are being refocused to support UEC improvements.
- Robust flow management system and processes in place with flow team and bed meetings for ongoing Situation Reports (SitRep) reporting and agreement of actions over 24/7 period and ongoing plans to strengthen discharge matron and patient flow facilitator role for supporting timely 7-day discharges

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

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

- The Trust achieved agreed trajectories against all performance standards.
- A trajectory is in place to eliminate 65 weeks waits by September 2024 in line with planning guidance.
- Clear trajectories for other key targets for Referral to treatment times, 4-hour UEC target, Cancer, Diagnostics and activity levels in place and monitored via reporting to weekly operational team meeting, executive team meeting, senior leadership group.
- Site meetings 7 days a week ensuring timely escalation of delays (potential and actual) with corrective actions.
- Mobilisation of 24/7 IHSS service complementing the 24/7 ICAT service and Monday to Friday between 8am – 4pm for the ED front door team.
- Established a Trust Health and Equalities Committee chaired by the Chief Nurse feeding to the Quality Committee and People and Culture Committee
- Outpatient transformation review has been carried out. The review had led to an improved booking processes as part of the Trust QI process ensuring standardisation across all outpatient areas.
- The Trust had implemented the Elective Improvement Productivity Group (EPIG).The Trust has embedded the discharge bundle across all wards with clinical champions who promote best practice. In addition, there had been a release of discharge matron colleagues from community bed management functions to enable a dedicated focus on pathway, discharges and ward support for preparing pathways 1, 2 and 3 patients for the community teams to case manage
- As a first step towards ensuring viable data after the implementation of the Cerner system all operational reports have been rebuilt to the previous standard.
- Capped theatre utilisation has been sustained at a minimum of 85% since September 2024, week of 17th November 2024 Capped utilisation was 90.4% - highest in the country

Specialist support, policy and procedure setting, oversight responsibility:

- Executives meet all with all divisions every morning (Monday – Friday) at 8.00am to support delivery manage risks and address any issues for UEC and operational flow.
- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital.

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

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

Oversight arrangements:

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

- Cancer Alliance support on focussed areas requiring improvement.
- Lancashire and South Cumbria oversight and co-ordination via Elective Activity Co-ordination Team, Elective Care Recovery Group, Lancashire and South Cumbria Chief Operating Officers meetings.
- System level plan monitoring at Pennine Lancashire via UECDB and Integrated Care Board (ICB) level via relevant system forums
- Enhanced escalation policy which is activated when patients have been in the emergency department for an excessive amount of time (12 hours from arrival) in place 24/7supported by surge escalation capacity on the inpatient wards during times of pressure.

Independent challenge on levels of assurance, risk and control:

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

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Activity 109% of 2019-20 levels not achieved consistently.	The controls and weekly monitoring taking place to work towards the achievement of the 107% of 2019/20 activity.	Chief Operating Officer	March 2025	Plans are in place to achieve in 2024/25. Year To Date @ November 2024/25 Performance RESTORATION ELHT V's PLAN New Outpatient 108.40% EL/DC 87.6% Outpatients & EL/DC: 108.4% against plan Delivery is monitored through regular performance meetings	A
2	Diagnostic clearance to 95% of patients receiving a diagnostic test within 6 weeks of referral by March 2025.	Implementation of Modality level delivery plans.	Chief Operating Officer	March 2025	ICS wide modelling completed, and discussion are ongoing around mutual aid to across the Lancashire and South Cumbria area ensuring patients have equity of access. The Trust continues to performance better than the national average and a trajectory is in place to meet the 95% standard by March 2025 in the in-line with the planning guidance. Endoscopy remains the biggest pressure area, but recovery plans are in place and monitored by the Chief Operating Officer.	A

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

<table>
<tr><th>No.</th><th>Gap in controls and/or assurance</th><th>Action Required</th><th>Exec Lead</th><th>Due Date</th><th>Progress Update</th><th>BRAG</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Echocardiogram, performance had deteriorated due to staffing levels due to sickness & vacancies – Endoscopy have a recovery plan in place DM01 performance November performance was 84.68%.</td><td></td></tr>
<tr><td>3</td><td>Meeting Cancer Standards
National Ambition for the standards
62 day – 70% by March 2025
31 day – 96%
28 day – 75% (77% by March 2025</td><td>Joint work with the Cancer Alliance on improvement
Continued Tumour site level detail to prevent backlog
Continued transparency of backlog delays at tumour site level for targeted preventative interventions
Refresh of the cancer action plan to focus on delivery of faster diagnostic standard, 31 and 62-day standards.
Weekly patient tracking with divisions for all tumour sites</td><td>Chief Operating Officer</td><td>March 2025</td><td>Achieving the national ambition for faster diagnosis standard, and trajectory for 31-day standard and working to get back on trajectory for 62-day standard – October position was impacted on due to the complexity of treatments, and pressures on pathology and Endoscopy – both have plans in place to improve performance
Cancer action plan refreshed and updated and monitored through the Cancer Steering Board Current Performance against the National Ambition
<table>
<tr><th>October Performance (Trust)</th><th>National Ambition by March 2025</th></tr>
<tr><td>62-day standard 65.9%</td><td>70%</td></tr>
<tr><td>31-day standard 96%</td><td>96%</td></tr>
<tr><td>FDS standard 77.4%</td><td>77%</td></tr>
</table></td><td>A</td></tr>
<tr><td>4</td><td>Continued risk of >78 week RTT breaches and risk of not delivering < 65 week maximum wait by March 2024.</td><td>Demand and capacity at specialty review completed with improvement actions
With daily micromanagement.
Target for Trusts is Zero 65 weeks breaches by December 2024 (Change in Due Date)</td><td>Chief Operating Officer</td><td>December 2024</td><td>There are daily meetings with divisional reps on managing all patients at risk of breaching 78 and 65 weeks.
Planning guidance altered the target for managing 65-week maximum wait from March 2024 to September 2024
The Trust achieved the target by September, November & December with the exception for patients waiting for Corneal grafts (due to tissue availability)
In October there were 2 breaches in addition to the grafts as result of unexpected sickness
Daily monitoring continues to maintain this position for 65 weeks performance</td><td>G</td></tr>
<tr><td>5</td><td>Bed model for medicine suggests a gap of around 100 beds (including the 53 de-escalated beds). This is further exacerbated with the immediate need to create decant wards at BGTH and RBTH sites resulting in a 53-bed reduction from 17th April 23.</td><td>Monitor impact of 53 bed reduction.
Increased efforts around pathway 0 discharges with the discharge matron team.
Continued admission avoidance via ED and SDEC pathways as well as IHSS team.
Home including rehab as a default for pathways 2. Increased use of pathway 1.
Use of escalation beds and trolleys when required in extreme pressures</td><td>Executive Director of Integrated Care Partnerships and Resilience/ Chief Operating Officer</td><td>December 2024</td><td>December 2024 – There has been an increase of 11 Acute beds, due to ward moves following the availability ofB3, but we decided not to open the additional ward due to financial constraints
There has been full organisational focus on improving discharge led by Divisional Director of Operations for Community Integrated Care and Divisional Director of Nursing for MEC – creation of a discharge dashboard to support is now operational and rolled out across the organisation</td><td>G</td></tr>
<tr><td>6</td><td>Ambulance handover times</td><td>As part of an LSC collaboration the Trust is working with NWAS colleagues to improve ambulance handover times, admission avoidance and direct streaming to alternative pathways and service</td><td>Chief Operating Officer</td><td>End of March 2025</td><td>As part of the 2024-25 planning, the Trust is committed to improving ambulance handovers within 30 minutes.
Working collaboratively with NWAS colleagues on handover times. There are dedicated meetings with NWAS & ELHT staff on a collaborative approach to improvement.
December has been particularly challenging, due to high numbers of ambulance arrivals, acuity of patients.</td><td>A</td></tr>
</table>

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Despite these challenges the trust took ambulance handovers quicker than the NWAS average in October and November and was only 11 seconds slower in average in December. Continue to progress the improvement project of NWAS deflection of ambulatory activity into 2-hr UCR and streaming to alternative pathways. December 2024 saw the highest number of care home referrals to IHSS exceeding the care home attends in ED. This is a reversal of previous patterns of care home attendance	
7	Temporary lack of data, including theatre utilisation data as a result of the implementation of Cerner (this was an expected outcome of the implementation of the system).	As a first step there is a need to rebuild all operational reports to the previous standard, with the second stage of the work to improve upon the quality of reports.	Chief Operating Officer/Chief Nurse	End of January 2025	The BI team continue to work internally and with Cerner on on-going data quality issues and monitoring through data quality reports. Issues are managed as identified. There is considerable work ongoing and mitigation in place around the UEC pathways, particularly regarding redefining datasets. An Executive Director led assurance meeting has been established and is chaired by the Chief Nurse to consider improvements within ED. In January a triple A system is being established which will also consider datasets and will be led by the Chief Nurse, Executive Medical Director and Chief Operating Officer. The Trust BI team are now able to replicate the worklists within Cerner, October development and teams are now reviewing methods to cleanse data. December 2024 – BI lead with Cerner Support are working through an electronic solution for data cleansing	A

BAF Risk 4 – Culture Workforce Planning & Redesign

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

Executive Director Lead: Executive Director of People and Culture

Strategy: People Plan

Links to Key Delivery Programmes: People Plan Priorities

Date of last review: Director of People and Culture: December 2024

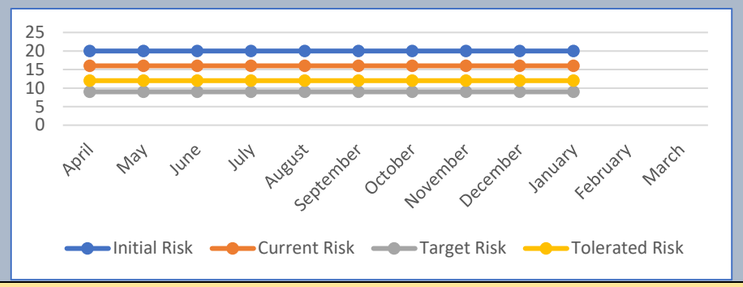
Lead Committee: People and Culture Committee

Links to Corporate Risk Register:

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

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

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



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

- Freedom to Speak Up (FTSU) Guardian and Ambassadors – in line with the national FTSU agenda. They report to the Staff Safety Group, People & Culture Committee and Trust Board.
- ICB People Board has re-established and will be developing a revised workforce strategy. PCG has established a number of Professional Working Groups (PWG) that will report through PCB Exec Co. Operational issues from these forums are picked up through the Executive team and reporting on progress is provided through the quarterly workforce report to the People and Culture Committee.
- The Trust People plan is operationally delivered through the Senior Leadership Group (SLG) and Divisional Management Boards (DMBs) and delivery is accountable through People and Culture Committee (PCC) as part of the Trust workforce report. This also forms part of the workforce section of the Integrated Performance Report (IPR).
- There is an agreed ICB Workforce Strategy that will be managed and delivered through the ICB People Board.
- Health and Wellbeing – a comprehensive health and wellbeing strategy and offering in place and leading the ICS Enhanced Health and Wellbeing and occupational health workstream. This is monitored through the One LSC governance structures. Regular updates are provided to the Board on wellbeing and a NED wellbeing guardian is in post.
- Department of Education, Research, and Innovation (DERI) Strategy clearly articulates the ambition of the Trust to support workforce, research and innovation to make the Trust a more attractive place to work. DERI reporting to the PCC.
- Recruitment – multi-disciplinary recruitment steering group in place, meeting monthly, to review vacancies and recruitment activity. . Close work between Divisions, HR and DERI around education opportunities (nursing associates, apprenticeships), as well as centralised, value-based recruitment and development of new Healthcare Assistants. Medical recruitment group also in place and opportunities around medical apprenticeships ongoing – likely to commence September 2025.
- Anti-racism - Project team (Aarushi) established as part of the CQA with support from the improvement team taking forward four themes. BAME network engagement underway on antiracist statement, framework and draft strategy led by Aarushi leads, Campaign support being provided by communications team. Health equity training piloted with ops teams to be rolled out by HE Lead and Inclusion Team with support/ eLearning to be developed by Marmot foundation. Developing an EDI dashboard which will support Trust and Divisional EDI goals. Regular updates to be provided in the overall EDI update paper that will come to the PCC and to Board. Establishment of work programmes is underway including inclusive recruitment, talent management, anti-racism campaign.

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

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

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

BAF Risk 4 – Culture Workforce Planning & Redesign

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

BAF Risk 4 – Culture Workforce Planning & Redesign

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

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Reducing the Trust vacancy gap	To achieve zero registered nurse vacancies and improve turnover through recruitment and workforce transformation activity.	Executive Director of People and Culture	January 2025 A detailed update will be provided to the Board in January 2025	A recruitment and retention group continues to work towards a trajectory to deliver zero vacancies by September 2024. This group is also developing initiatives to assist in retention of staff through greater flexible careers, flexible working, benefits etc. The Trust is working with colleagues across the ICS to deliver a workforce capacity programme aimed at reducing vacancies and securing future workforce pipelines. Specific work is underway to address shortages in specific roles, leading to fragile services such as diagnostics. International recruitment has been a success, delivering on plans and a decision has been taken to cease, so as not to impact on opportunities for newly qualified nurses, where we have a very strong pipeline. Some additional vacancies, due to creating new clinical space – start dates now planned for newly qualified nurses, who will all be in post by November 2024, which has resulted in minimal vacancies. Vacancy controls in place to address unsustainable workforce growth to look at controlled workforce reduction in line with financial plans. Workforce reviews being planned to ensure that we get back into financial balance. Targeting corporate in January and then prioritising clinical services. This will include possible service and workforce redesign and inform workforce plans.	G
2	Improve Trust retention levels / Develop Retention Strategy	Implementation of targeted plan to deliver the national People Promise of Flexible Working and development of a Trust Retention Strategy.	Executive Director of People and Culture	January 2025 A detailed update will be provided to the Board in January 2025	Work on developing the Trust's strategic approach to is ongoing through participation with the People Promise Exemplar programme. Regular updates are taken to the Executive Team, Staff Sponsor Group and were presented to People and Culture Committee in September 2024. Following the submission of the PID, the People Promise Manager (PPM) reports through to the national and regional teams and was identified as being an exemplar who has gone further faster than	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					other Trusts, leading to an invitation to present to the national and regional teams. The PPM has developed a suite of 'you said we listened' posters to share back with teams. This includes highlighting improvements to appraisal, new line manager induction and share point site, handbook for line managers and greater support for clinical teams with team based rostering and opportunities for flexible working. The PPM is making good progress and held a visit with the national, regional and local team to share our progress in key aspects of the people promise plan and next steps. Some priorities have had to be phased due to capacity. Starting to submit data to national team. Received positive feedback from the national team so far. Refocus of PPM around sickness absence linked to the financial recovery work. Managing sickness absence bite-sized learning, reasonable adjustments training, line manager induction all in place. Risks around sustainability and capacity as year 2 funding is not secured.	
3	Risk of staff leaving the NHS due to burnout.	On-going delivery of the ELHT People strategy underpinned by a compassionate and inclusive culture	Executive Director of People and Culture	A milestone report will be provided to the People and Culture Committee in January 2025	The People & Culture Directorate continue to explore how staff can be further supported during this ongoing period of unprecedented demand. Given the on-going need identified regarding supporting staff with their mental health an external review has been commissioned to review the existing staff mental health pathways and interventions. This work has completed and we are now considering how we meet these needs. Project M – a peer support group for line manager wellbeing was launched in January 2024 by the CEO and now well embedded. The LSC occupational health and wellbeing collaborative programme has been identified as one of the functions to move across to OneLSC. PCB OH and Wellbeing services are currently scoping a future service specification and common IT platform in readiness for the future model. People Promise Exemplar programme – project initiation includes a pilot project linked to burnout, full project plans have been copmpleted. Areas currently being highlighted, and budget being allocated subject to approvals in light of financial challenges. This project has funds allocated but has not yet commenced. PPM and Associate Director of OD to confirm a pilot site and appropriate model for delivery. Line manager development in place with people promise induction for new managers Feedback has been very positive, plans to extend to full day to enable greater use of case studies and hot topics to be explored. Wellbeing for leaders programme is now available in the Trust (NHS England) and will be revised for cohort 2 from 2 day to 1 day programme. Financial recovery as key priority for our Trust. We must release time for activity and clinical staff and as such training has paused or become bite-sized to release time. PPM work to be incorporated into the workforce reviews and improvement projects to help sustain progress.	A
4	Risk of loss of service due to national industrial action.	Ongoing management of action through Industrial Action Cell.	Executive Director of Integrated Care,	Ongoing with next update to the Board in January 2025.	There are currently no live mandates. The 2024/25 was actioned in October 2024, with backpay to April 2024. RCN formally rejected the pay offer for 2024/25, although no industrial action followed.	G

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
			Partnerships and Resilience		The recommendation for the 2025/26 pay offer has recently been announced at 2.8%. This has not been well received by trade unions and we will continue to speak with our local representatives around any likely action, re-establishing our industrial action cell if required.	
5	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients due to the specific impact of racism.	Trust becoming anti-racist. Progress being made through using improvement science, adoption of NW BAME Assembly framework. Programme of transformational culture change to be developed through allyship as a journey of development.	Executive Director of People and Culture	End of March 2025	**Anti-Racism** CQA comnpleted but project group remain in place and meeting fortnightly to maintain focus on the four themes. Trust developed divisional EDI dashboards which will support EDI goals. Divisions nominated EDI lead. Gap Analysis tool to be tested in DCS to supplement the data> Still being developed Regular updates to be provided in the overall EDI update paper that will come to the PCC (July) and to Board. Achievement of Bronze Award. Silver action plan developed. Anti-Racism Summit took place to share and spread. Anti-racism pledge cascade from Board through to senior leaders to their teams. Training is paused due to the financial challenge to release time and capacity. Planning to take place for April onwards. Allyship framework developed. Engagement - Aarushi Project team presenting at different forums within the Trust to raise awareness OneDMB presentation still to be arranged. Meeting with UCLAN has now taken place to develop joint statement and share approaches and resources. Some challenges now for campaign focus and resources due to refocusing resource around financial recovery	A
6.	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients due to protected characteristics.	Development of a culture of inclusion and belonging. Ensuring that inclusion is embedded as everyone's business. Person-centred approaches to people practices, through informed and engaged line managers. Processes for reasonable adjustments are improved and embedded. Vibrant staff networks.	Executive Director of People and Culture	End of March 2025	**General** Inclusion Group has been reset. All divisions to confirm their EDI lead, and to present to the next meeting. Template for networks to assist with planning shared with Chairs. Gap analysis tool being developed to aid awareness of actions and supporting offers. EDI audit carried out. Management response in progress. **Inclusive recruitment** - A working group has been formed, to review attraction, recruitment, selection and progression, through an inclusion lens. The outcome will be a manager toolkit and updated manager training, focussing on quality and inclusion, with changes made to policy based on improvement work. Initial pilot of toolkit to take place from July 2024, finalised toolkit and training by end of November 2024. Training is fully booked. Train the trainer carried out and training plan being developed. Training paused due the refocus on financial recovery until new financial year. **DAWN** Following valuable feedback through the People & Culture Committee staff story and a recent presentation to Executives, a working group has been formed to improve how we support colleagues with a disability, including making reasonable adjustments in a timely manner. An initial meeting was held on 25 June 2024to commence a QI.A business case has been developed to support a centralised process, enhance staff experience, support for managers and navigation and recharge from Access to Work. Business case getting approval so that we can put resources in place. Training has been developed. Metrics to support divisions to manage this locally being developed so hot spots can be identified.	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Mental Health Review into the provision of MH support for colleagues is underway following the MH staff survey carried out by the network. **Neurodiversity** TAFG in place for 12 months and has recently become a network. Aim is for group to lead the development of a positive culture regarding neurodiversity including a toolkit, training, and support. A hidden disabilities project has launched with greater awareness in key teams like people and culture, awareness for line managers. **LGBTQ+** The Network is aware of the impact of national messages related to gender identity having a negative impact on wellbeing of the community. It will join with system partners to advance LGBTQ+ inclusion and help to develop the allyship framework for the Trust whilst the future of the Rainbow Badge accreditation becomes clearer. **Women's Network** Is supporting the advancement of the Sexual Safety charter in the Trust which is being led by the Head of Safeguarding with support from HR and other teams. Project restart meeting took place but resources are redirected to financial recovery so need to look at what the art of the possible is.	

BAF Risk 5 – Financial Sustainability

Risk Descriptor: 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 and the Trust does not deliver Value for money.

Executive Director Lead: Executive Director of Finance

Strategy: Finance Strategy

Links to Key Delivery Programmes: Waste Reduction Programme

Date of last review:

Deputy Director of Finance, December 2024

Executive Director of Finance, January 2025

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR):

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

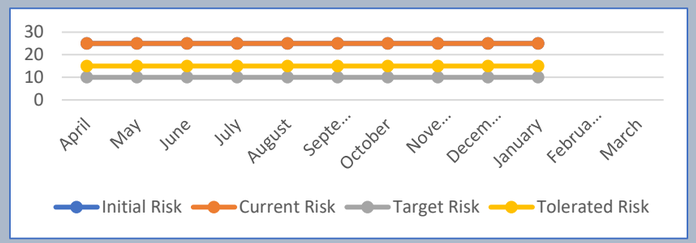
Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: C5 x L5 = 25

Initial Risk Rating: C5 x L4 = 20

Tolerated Risk Rating: C5 x L3 = 15

Target Risk Rating: C5 x L2 = 10



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/Moderate

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

Organisation

- A full review of the financial accountability meeting structure has taken place to make the best of use of time
- A Clinically led Better Care Better Value IMT cell is in place– senior leaders twice a week and executive team once a week per week with targeted finance actions, using improvement methods
- A weekly Vacancy Control Panel is in place at divisional and Trust level with Chief Executive sign off for all posts.
- A weekly Non-Pay Control Group is in place reviewing all discretionary spend
- A weekly Pay Control Group is in place that reviews the oversight and process behind all payments to staff and contractors. The 2024 Medium-term financial strategy has been shared with the Executive team and has been presented to Finance and Performance Committee in August 2024 and has been shared with the Trust Board in September 2024.
- The Financial plan for 2024-25 has been developed via the annual planning process, and the updated breakeven plan for 2024-25 was signed off at the Trust Board in September 2024.
- An early forecast outturn for 2024-25 submitted to ICB and national team (2nd August 2024)
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations. The last review was completed in July 2024.
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Cost Improvement Programme (CIP) are reported and scrutinised through the monthly Finance Assurance Board with Executive and cross-Divisional team representation, Capital Planning Board chaired by the Director of Finance, and Finance and Performance Committee.
- A new Cost Improvement Programme governance structure is in place that is now integrated across the Trust. Supported by dedicated resource by way of the Benefits Realisation Team and the Improvement Team in addition to divisional transformation leads. Additional reports have been generated and are available following a mid-year review
- Service Reviews are taking place, initially across 10 key specialties but with the longer term aim to roll out across the Trust

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

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

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

Specialist support, policy and procedure setting, oversight responsibility:

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

BAF Risk 5 – Financial Sustainability

- A Financial Recovery taskforce has been pulled together to help deliver some of the key workstreams required to support the Trust's financial recovery.
- The Trust extended the PA Consulting resource for a further 12-week period to support the Trust with a review of the financial and workforce controls, analytical support and service reviews of the loss-making services.
- Additional team brief sessions have taken place to reach out to the wider Trust focussed on the financial challenge.

System

- System finances monitored through System Finance Group (includes representation of all providers and Integrated Care Board (ICB)) to facilitate understanding and actions associated with the overall system financial position.
- One LSC Central services collaborative programme underway with ELHT confirmed as the host, all affected staff transferred to ELHT as the host of One LSC on 1st November 2024.
- System financial controls implemented from August 2023 and remain in place

- The Trust and L&SC system has a NHSE nominated lead who is working with the LSC System up to summer 2025.
- PWC are working with the Trust and LSC System as the system enters formal regulatory intervention.
- A financial governance review is taking place in January 2025.

Independent challenge on levels of assurance, risk and control:

- Internal and external audit – agreed internal audit plan for 2024-25, clean Head of Internal audit opinion received, clean external audit of annual accounts for 2023-24. Counter fraud workplan for 2024-25 agreed.
- One NHS Finance Towards Excellence Accreditation shows that the finance team's processes and procedures are working. It proves that we have developed a culture where staff feel appreciated, and successes are celebrated. ELHT Finance Team are accredited at the highest level (Level 3). High level of qualified staff in department (53%) with a further 35% in training. The 3-year reaccreditation was awarded in October 2024

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Lack of full knowledge of system financial flows recognised in the NHSE review	Work with system CFOs to determine full flows and impact on ELHT	Executive Director of Finance	Q4 2024-25 An update will be provided in January 2025 Monthly updates to be provided	Ongoing – A Block contract review underway, part of financial strategy and recovery. Work has progressed; no agreement has yet been made. This will form part of the planning and contract negotiations for 2025-26 Work to continue through Provider Finance Groups. Work is ongoing to achieve full transparency A full contract review will take place as part of the 2024-25 review process. With the appointment of a PCB Managing Director in July 2024, we should see an improvement in the governance and oversight LSC have a further 6-month support from the NHSE who have appointed a nominated lead to work with the system	A
2	ICB/PCB workplan identification and capacity	Work with system to ensure plan developed and capacity gaps rectified and mitigated	Executive Director of Finance	An update will be provided in January 2025 Monthly updates to be provided	2 system meetings to identify specifics. Joint meeting CFOs/Operational colleagues to take place. Work on the system roadmap to be continued with new PCB finance lead. System transformation programme in place. Benefits realisation currently being defined. Limited delivery is expected in 2024-25. One LSC is now in place, but there will be no financial savings in 2024-25 as the transformation will start on 2025-26+ System Investigation and Intervention process in place. First draft reports out, which identify areas of support required across providers and ICB.	R

BAF Risk 5 – Financial Sustainability

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
3	No agreed System Financial plan for 2024-25 – it is still a draft plan awaiting NHSE confirmation that the £175m deficit financial plan has been accepted	Continue to develop plans for system, region and national sign off, and documenting all risks of reducing expenditure in line with expectations.	Executive Director of Finance	An update will be provided in January 2025 Monthly updates to be provided	The System plan has been agreed across the LSC System but not formally accepted by NHSE. The financial plan was signed off by the Trust Board in June 2024 with full documentation on the risks attached to the delivery of such a high-risk plan. The plan has been accepted but the significant risk is that it will not be delivered.	A
4	No signed Contract for 2024-25	To work with the ICB to agree the contract disputes	Executive Director of Finance	End March 2025	The Trust has signed and returned the contract to the ICB with a detailed side letter of contract disputes that need resolving in the coming months. There are still gaps in assurance as the contract issues in the side letter have still not been resolved and it is almost the end of the financial year - and will not be resolved before the planning for 25/26.	A
5	The financial plan that was agreed which is now a breakeven plan following the receipt of the non-recurrent Service Development Funding (SDF), will not be met in 2024-25	To work collectively across with the Trust and with external support to help to turnaround the financial position and financial recovery.	Executive Director of Finance	February 2025 Regular reports are provided to the Board, with the next report being provided in January 2025.	Additional measures are in place with additional control groups in place, weekly IMT sessions External support in form of PA Consulting has been sought NHSE have carried out an independent review and report to support the Trust PWC will be part of the system from January 2025+ for a minimum of 6 months to help turnaround the financial deficit A Turnaround Director will be appointed in early 2025	A
6	The misreporting in year of the financial position externally resulted in a lack of understanding of the in-year financial position	To report the correct in-year financial position as soon as highlighted and address the financial governance arrangements that allowed this to happen. To introduce revised reporting and governance arrangements.	Executive Director of Finance	End March 2025 Regular reports are provided to the Board, with the next report being provided in January 2025.	Revised reporting commenced from month 7 and the revised governance is underway Any actions identified following this review will be assessed and implementation timescales agreed.	A

One LSC BAF Risk- ELHT as Host

Risk Descriptor

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

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

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

Strategy: Indirectly links to all and overall Trust strategy.

Links to Key Delivery Programmes: Provider Collaborative

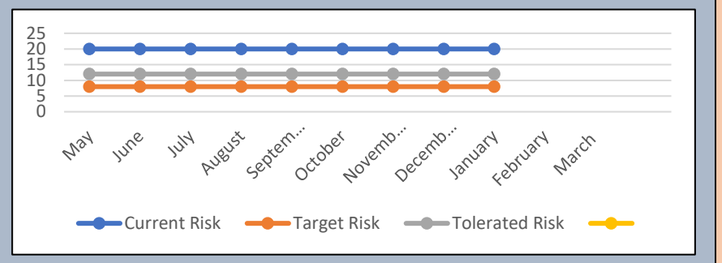
Date of last review:
Director of Service Development and Improvement, January 2025

Lead Committee:
Finance and Performance Committee
People and Culture Committee

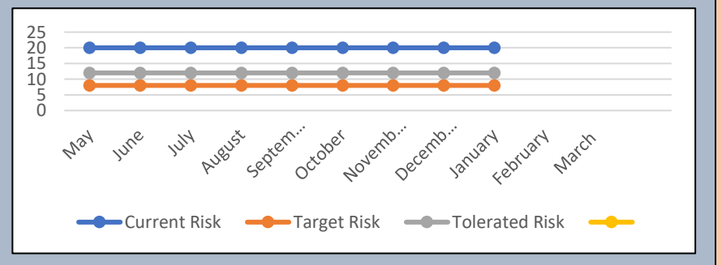
Links to Corporate Risk Register (CRR):

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

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



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



Effectiveness of controls and assurances:

As Host

	Effective
x	Partially Effective
	Insufficient

As Partner

	Effective
x	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

- The LSC Provider partners and ICB have been working together to identify ways of collaborating (refer to BAF risk 1 for details of collaborative working) on the delivery of central services across the area. This had resulted in delegated powers bestowed by the individual Trust Boards to the PCBJC to deliver on the agreed objectives.
- The process included identifying a host Trust (ELHT) with a comprehensive programme for the planned transfer in November2024. Services successfully transferred on 1 November 2024.
- One LSC Managing Director and senior leadership team in place.

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

- Provider Collaborative Board Joint Committee (PCBJC) meeting monthly and regular reporting on progress and decisions sought on delegated items as required.
- Central Services Executive Sub-Committee (CSESC) as a sub-committee of the PCBJC with a remit for the delivery of the collaborative element for central services under the delegated authority for operational matters. Membership made up of 5 provider CEOs or their deputies who are voting Executive Board members of the provider Trusts. CSEC chaired by ELHT Chief Executive as Host from January 2025.
- Strategic Collaborative Agreement sets out the high level legal, commercial and governance principles of collaboration amongst the partners. Trust Boards signed off the Business Transfer Agreements and Supply Agreements prior to transfer on 1st November 2024. The Supply Agreement set out the services to be provided as transferred during the baselining period.

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

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

- ELHT Hosted Services Board will add an additional layer of governance to ensure seamless service delivery and management and mitigation of risks at host and partnership level
- ELHT Hosted Services Committee is in place and held its first meeting on 8 October 2024
- Formal governance structures are now in place for One LSC workstreams and the overall One LSC programme. In addition, the performance framework is in place which will seamlessly dovetail into the governance processes of the partners organisations
- Assurance around the people element of One LSC will be provided through ELHT People and Culture Committee

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

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

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

- MIAA as internal auditors will audit the governance and management processes of One LSC

One LSC BAF Risk- ELHT as Host

• Professional Working Groups in place and continue to develop to oversee performance and planning of all portfolios of One LSC. ELHT • ELHT (as partner and host) has put in place and continues to develop the governance infrastructure to ensure that it delivers on its partner and host obligations. The monitoring of the One LSC and other services hosted by ELHT will be through the hosted services Board, which will report to Finance and Performance Committee. Regular monitoring of host and partnership activities and assurance about governance and risk management will occur through the ELHT Board and sub-committee structure and operational groups, such as the Executive Team, ERAG and One LSC Planning Group. 1. Trust Board 2. Audit Committee 3. Finance and Performance Committee 4. People and Culture Committee 5. Quality Committee 6. Executive Team 7. Executive Risk Assurance Group 8. Finance Assurance Board 9. ELHT Hosted Services Committee • The SCA sets out key hosting obligations and risk share through the partnership arrangements. The due diligence process associated with the completion of key schedules of the SCA (e.g. Business Transfer Agreement) ensured that the Trust as host can fully risk assess its ability to meet Host obligations and standards and work with partners to mitigate these risks accordingly.	• ICB as the regulatory body will also provide a scrutiny of the collaborative arrangements for central services. • Legal Due Diligence completed as part of the transfer process, risks identified, and mitigation plans agreed. • NHSE fully signed off the creation of One LSC in advance of the transfer date and will monitor progress.
Gaps in controls and assurance: Any issues implementing controls or activities which enforce a control that do not go ahead are known as Gap's in Controls. Gaps in assurances show us what we need to improve on to ensure we can deliver assurances that the risk is progressing. **Mitigating actions:** actions, which when taken, will either reduce or eliminate the likelihood of the risk occurring or reduce the organisations exposure to that risk. **Progress update/Impact:** Update by exception and effectiveness of impact on address gap in control/assurance	

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	CSEC and Professional Working Groups continue to mature and develop in order to ensure effective oversight and monitoring of performance and development of One LSC.	Ongoing development of oversight and governance arrangements.	Managing Director One LSC CSEC Executive Leads	March 2025	ELHT Chief Executive has taken over chair of One LSC as Host Chief Executive CSEC transitioning from early go-live stabilisation focus to future working arrangements.	A
2.	Host governance and oversight arrangements in place but will continue to mature.	Ongoing development of oversight and governance arrangements as host.	Director of Finance Director of People and Culture Director of Service Development and Improvement	March 2025	Hosted Service Board in place. Quality governance arrangements agreed with ELHT and partners and undergoing monthly review.	A
3.	ELHT Corporate capacity to support One LSC is still in development and being monitored to determine capacity requirements	Close liaison with Managing Director for One LSC and Directors for confirmation of requirements and agreement with partners for appropriate transfer of resources in line with SCA.	Executive Directors of all corporate functions	March 2025	Initial agreements sought on resource requirements and provision of support through transfer from partners or mutual aid. Ongoing monitoring now underway in order to determine resource requirements for discussion and agreement via CSEC.	A
4.	The benefits of One LSC will be through the transformation of services and these work programmes are in the early stages of development.	Agreement of transformation programmes across all service areas.	Managing Director One LSC Professional Working Groups	March 2025	Ongoing work to determine baseline f services and identify variation in services across One LSC. Work commenced via CSEC and Professional Working Groups to agree priorities and approaches to transformation of services. Opportunities through planning processes to agree immediate priorities and assessment of benefits.	A
5.	Ongoing engagement of staff side and partnership working continues to mature.	Further development of staff side relationships to support transformation of services. Continued development of communications plans	Managing Director One LSC Professional Working Groups	March 2025	The One LSC Engagement and Communications Partnership Group commenced its bi-monthly meeting schedule on 25 November 2024. This group is a partnership with Staff Side colleagues from across the system. It has been established to ensure Staff Side colleagues are engaged with and included in the development of One LSC. Implementation of One LSC communications plan.	A

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

15 January 2024

Item	**12**
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

Patient Safety Incident Response Framework Report

Reporting Period:		October - November 2024
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group. The last meeting held was 26th November 2024 with 19 members in attendance and the meeting was quorate.
1a.	**Alert**	The Trust has reported its second Never Event within the reporting period of April 2024 to March 2025. The Never Event was reported under the criteria of retained foreign object which occurred on 5th December (outside of the reporting period of this report but required alerting to Trust Board). A retained vaginal pack which was left in situ after a lady was returned to theatre after giving birth and a bakri balloon and a vaginal pack were inserted to be removed 24 hours later. Bakri Balloon was removed but not the pack. Pack was identified 24hrs later when lady was having a catheter fitted due to an ileus. Both mother and baby are doing well and have been discharged home. The Division completed a round table investigation where it was agreed that the incident met the Nation Priority of a Never Event. The round table identified immediate safety learning and actions regarding the purple wrist band guidance which had been updated in 2023 within theatres but not shared with maternity and obstetric teams. Immediate learning has been shared whilst a full PSII in currently taking place.
1b.	**Advise**	There has been a significant increase in the number of Oral Nutrition and Hydration incidents resulting in low physical harm reported in November 2024. This has been discussed with the Consultant Allied Health Professional for Nutrition and Hydration, and the incidents are related to the SLT reporting an incident when they have not been able to attend to an urgent referral within 24 hours. However, on review these do not appear to be incidents by definition, as no patients could or have come to harm as a result. The SLT team will be reminded of what should be reported as an incident and it will be reiterated that this should be managed via the existing risk. There has been a significant increase in the number of Infection Control incidents resulting in low physical harm reported in November 2024. Assurance has been sought from the Head of Infection Prevention, and it has been confirmed this is due to delayed reporting due to the team being in Business Continuity and back reporting incidents.
1c.	**Assure**	At the end of November 2024 253 incidents were awaiting final approval. This has now remained within target for 2 consecutive months. The team will continue to ensure that this performance continues and work to progress the 141 that cannot be finally approved. 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. The average since July 2024 is 56.4 per month, with 59 reported in November 2024. We will continue to monitor.

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.

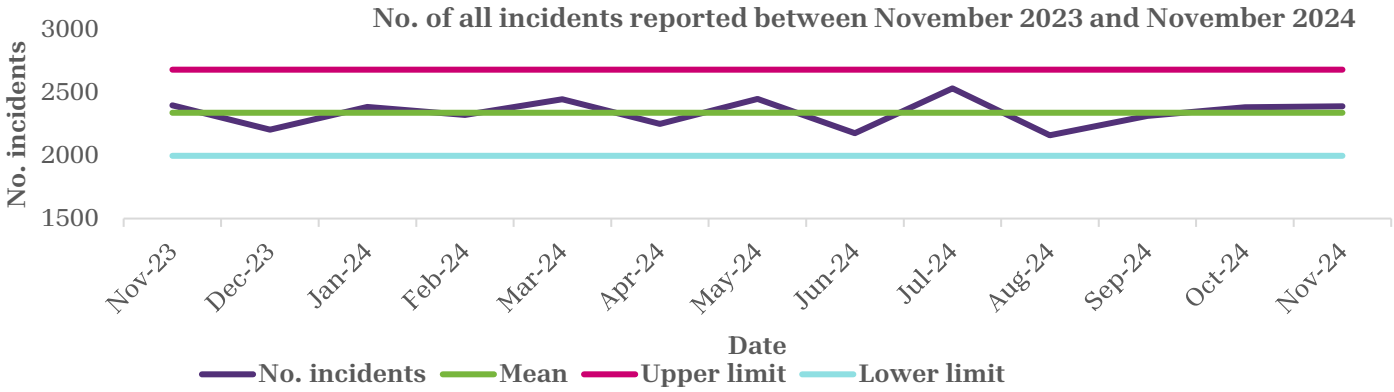


Figure 1: Incidents reported over last 12 months.

1.2 **2390** reported incidents were triaged within 2 working days of being reported in **November 2024**, which equates to **99.87%** of all incidents reported in **November 2024.**

1.3 At the end of **November 2024** there were **253** incidents awaiting final approval. Of these **141** 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.

1.4 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. The average since July 2024 being 56.4 per month.

1.5 After an increase in September and October 2024, the number of severe harm incidents reported has reduced in November 2024.

1.6 The four fatal incidents reported in November 2024:

1.6.1 One is being investigated as a PSII and is related to a potential missed opportunity for diagnosis and treatment.

1.6.2 Two have been graded as Fatal however it is not clear that an incident has preceded the outcome, and the harm will be reviewed accordingly.

1.6.3 One is under review for potential PSII

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 a small overall decrease in **October 2024** in IR2 completion, however most Divisions are achieving over 80% compliance consistently. One Division has reduced their open IR2s to within range.

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 decrease 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 **October 2024** and **November 2024**, the Complex Case meeting reviewed **5** new incidents of which all **5** met the PSIRF Priorities for reporting and require a PSII, these have been allocated to lead investigators within the Patient Safety Team. All PSII reports and safety improvement plans are presented at the Patient Safety Incidents Requiring Investigation (PSIRI) Panel for Trust approval and signoff.

5.2 A KPI dashboard of PSIIs is provided is appendix D. At the end of **November 2024**, the Trust had **23** open PSII incidents of which **10** were being investigated by MNSI.

5.3 At the end of **November 2024** there were **6** PSIIs which had been open longer than 6 months and **4** MNSI reports.

5.3.1 The **4** MNSI reports that are overdue are outside of the control of trust.

5.3.2 3 of the 6 overdue PSII reports were completed in time and presented at PSIRI were not approved, 2 are awaiting amendments to improvement plans by divisions and 1 requiring amendment by the PSII Lead with. All 3 reports are due back in December 2024.

- 1 PSII has been delayed due to missing clinical records in Cerner (now found by IT and the investigation ongoing).
- 1 PSII has been delayed due to late allocation of a FLO and subsequent delayed FLO contact with the family. The investigator has also required time of work for a bereavement and then to attend Jury service.
- 1 1 draft report was completed in time, however, was delayed due to the family requesting longer to review the draft report (requested a month) family informed coroner they wanted longer.

5.4 In **October 2024** and **November 2024**, **4** PSII reports have been approved by PSIRI with learning and closed.

6 Never Events

7 PSIRI Panel Approval and Learning from Reports

7.2 During **October** and **November 2024, 18** reports were reviewed, of these there were **13** new PSII reports. See appendix E for the detail of these reports and the review outcome.

7 Mandatory National Patient Safety Syllabus Training Modules

8.1 At the end of **November 2024**, the Trust has achieved **94.80%** Level 1a, **85.60%** Level 1b and **92.00%** Level 2 for National Patient Safety Training since making it mandatory for all staff to complete within the Trust.

8.2 There has been a slight drop in figures due to One LSC staff being moved on to separate tracking. Level 1a and 2 are both over 90% and nearly at target.

Table 1: Patient Safety Syllabus Training (as of end of **November 2024**)

Patient Safety Training Modules	KPI Target	% of staff completed training
Patient Safety Level 1a – all staff	95%	94.80%
Patient Safety Level 1b – Boards and senior leadership	95%	85.60%
Patient Safety Level 2 – Essential to role	95%	92.00%

9 Trust Wide Policies and SOPs

9.1 At the end of **November** 2024, there were **0** Trust wide SOPs out of **144** overdue their review date, and only **11** out of **294** policies are currently overdue their review date.

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

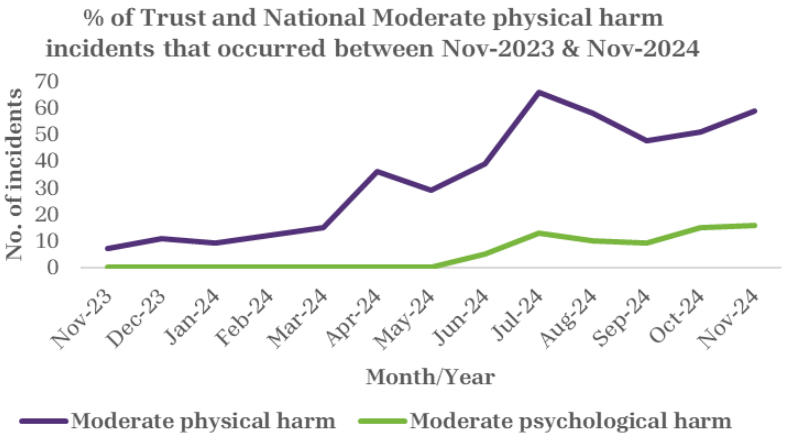
Policies / SOPs	Target	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Trend
Trust wide Policies	90%	89.55%	90.53%	90.88%	88.15%	86.11%	84.83%	83.10%	88.97%	88.70%	93.20%	94.56%	95.56%	↑
Trust wide SOPs		90.51%	92.14%	90.78%	93.06%	93.75%	95.86%	93.75%	88.37%	86.90%	100%	98.63%	100%	↑

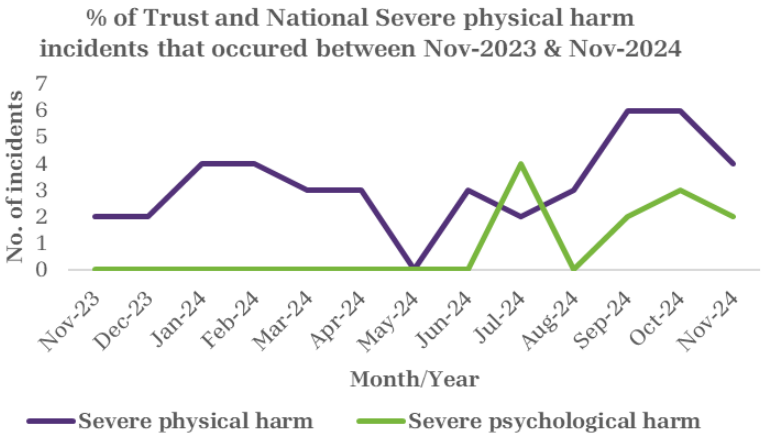
10 Maternity specific serious incident reporting in line with Ockenden recommendations

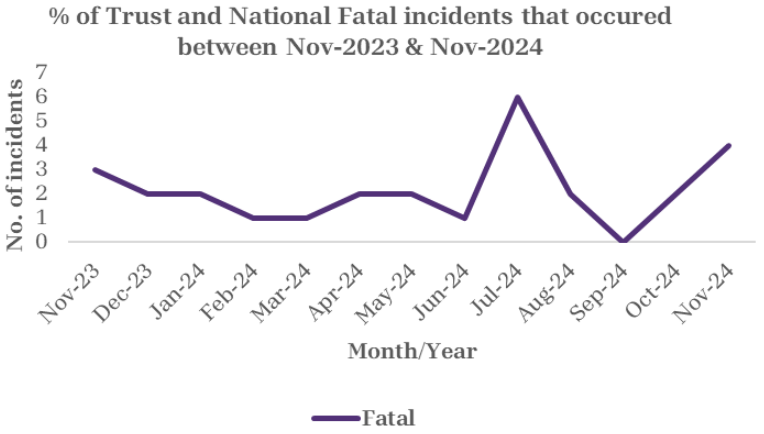
10.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 **73** maternity related incidents have been reported on StEIS of which:

- **45** have been approved and closed
- **15** have been agreed for de-escalation from StEIS
- **3** have had closure on StEIS requested
- **9** 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%	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Trend
CIC	Total IR2 reported	362	314	410	378	341	315	360	344	471	375	398	444	
	(total number investigated) % complete within 30 calendar days	(313) 86.46%	(247) 78.66%	(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%	
DCS	Total IR2 reported	143	148	138	129	110	112	136	103	149	125	116	164	
	(total number investigated) % complete within 30 calendar days	(90) 62.94%	(104) 70.27%	(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%	
FC	Total IR2 reported	307	245	237	221	284	283	314	239	272	232	259	235	
	(total number investigated) % complete within 30 calendar days	(173) 56.35%	(193) 78.78%	(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%	
MEC	Total IR2 reported	880	947	947	915	992	903	899	873	936	849	945	936	
	(total number investigated) % complete within 30 calendar days	(772) 87.73%	(793) 83.74%	(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%	
SAS	Total IR2 reported	425	346	415	397	434	344	426	371	393	346	347	341	
	(total number investigated) % complete within 30 calendar days	(332) 78.12%	(270) 78.03%	(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%	
Corp	Total IR2 reported	78	69	82	89	83	87	97	85	82	52	67	74	
	(total number investigated) % complete within 30 calendar days	(39) 50.00%	(14) 20.29%	(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%	
Trust Total	Total IR2 reported	2195	2069	2229	2129	2244	2044	2232	2015	2303	1979	2132	2194	
	(total number investigated) % complete within 30 calendar days	(1719) 78.3%	(1621) 78.3%	(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%	

Total number of IR2s open on DATIX over 30 calendar days old						
Division	CIC	DCS	FC	MEC	SAS	Corp
No. open	50	98	21	242	83	300

Appendix C: KPI Dashboards for PSRs

Division	Number of PSRs open	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Trend >90
CIC	No. open	73	47	29	39	55	40	44	61	56	51	52	72	
	No. open more than 90 calendar days	2	7	5	7	5	5	9	8	2	1	3	5	
DCS	No. open	19	19	21	7	9	8	9	22	14	24	12	13	
	No. open more than 90 calendar days	2	3	5	2	1	0	1	2	1	2	0	0	
FC	No. open	43	40	47	40	53	54	51	55	54	37	39	39	
	No. open more than 90 calendar days	12	12	16	9	11	17	14	11	14	7	6	4	
MEC	No. open	105	107	125	94	124	115	88	102	96	93	60	61	
	No. open more than 90 calendar days	12	19	15	16	18	24	25	28	27	32	13	7	
SAS	No. open	71	76	60	56	51	50	31	47	34	37	35	41	
	No. open more than 90 calendar days	21	19	15	16	13	17	17	16	12	10	5	6	
Trust	No. open					292	277	223	287	254	242	198	226	
	No. open more than 90 calendar days					48	66	66	65	56	52	27	22	

Appendix D: KPI Dashboards for PSIIs

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

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

During October 2024 five new PSII reports were presented at the Trusts PSIRI panel.

- Incident resulting in death (eIR1278952) – The report was approved with some minor amendments required to the improvement plan. The areas identified for improvement identified were:
    - Consideration to be given to the installation of a public address system within the Urgent Intervention and Treatment area of the Emergency Department.
    - Review of EDSOP08: Standard Operating Procedure for the Coordination of the Emergency Department Resuscitation Area at Royal Blackburn Teaching Hospital to mitigate for cover during the co-ordinators breaks and the documentation of this.
    - Incident resulting in death (eIR1285024) – The report was approved with some minor amendments required to the improvement plan. The areas identified for improvements were:
    - Use of the investigation's findings withing teaching sessions for all grades of medical and nursing staff to highlight the importance of open communication to ensure a wholistic and joined up approach to care and treatment particularly for complex and urgent patients.
- Never Event (eIR1282530) – The report was approved however the improvement plan required strengthening. The areas identified for improvement were:
    - Review and update of the protocol for counting swabs, needles and instruments in ELHT maternity services, ensuring it is fit for purpose, easy to follow and includes clear guidance on the use of LocSSIPs and whiteboards for counts.
    - New and returning staff to after a period of rotation need to complete an induction to the unit which must include local guidance for birth suturing and the use of LocSSIPs and whiteboards for counts.

- Ensure all safety actions already put in place have been completed and that it includes checks of paper LocSSIPs available in all birth rooms each day.
- Implement the use of the 'perfect whiteboard'.
- Ensure that if there are any concerns regarding retained swabs during or after a procedure that the patient is x-rayed.
- Share the report with midwives for information regarding when patients may report with pain and a foul smell the need to explore this further with the patient if necessary.

- Incident resulting in death (eIR1287940) – The report was approved, how no improvement plan was submitted and will require submission at a later date. The areas identified for improvements were:
  - Explore ways of ensuring that there is a safe process when triaging patients to ensure that all relevant paramedic information is available to Emergency Department staff.
  - Consideration of the auto creation of a Primary Survey for relevant patients, which can be assigned to that patient record as a reminder to complete the task.
  - Review document templates and explore the creation of a proforma for clinical assessments in Cerner.

Three reports that were previously reviewed by the panel were returned for approval of the improvement plan; all reports were approved; however, one required some minor information adding to improvement plan and did not require resubmission, and one required submission of a completed improvement plan.

During November 2024 eight new PSII reports were presented at the Trusts PSIRI panel.

- Incident resulting in death (eIR1288433) – The report was approved. The investigation did not identify any safety recommendations.
  - Incident resulting in death (eIR1272339) – The report was approved with some minor amendments required to the report. The areas identified for improvements were:

- Speech and Language Therapy Team to consider further training particular in reference to SLT staff recording on the patient record whether there is a yellow sign in place when undertaking a tolerance check.
- The Trust via Nursing and Midwifery Forum to consider including call buzzer checks in bedside handover safety checks.
- Neonatal death (eIR1271530) – This investigation was completed by MNSI, the report was approved with some correction to typographical errors in the improvement plan. The report identified some safety recommendations for the Trust however the Division do not agree with the findings in the report and it is in contradiction to the PMRT findings.

- Incident resulting in death (eIR1282904) – The report was approved, with some minor rewording to one of the actions identified in the improvement plan. The areas identified for improvements were:
  - Division to provide clarity on the process for follow up of x-rays and investigations in the Emergency Department for patients whose care has been handed over to another area/clinician.
  - Division to consider increasing initial monitoring frequency of compliance within the Emergency Department handover protocol and associated documentation to enable areas for improvement to be identified and addressed.
  - Emergency Department to review the secondary assessment process to include obtaining a basic past medical history from a patient to assist in the diagnosis and treatment of patients requiring care in the Emergency Department.
  - Incident resulting in death (eIR1281230) – The report was not approved and required some additional information and the safety recommendations to be reworded.
- Incident resulting in death (eIR1279596) – The report was approved. The areas identified for improvements were:
  - Division to ensure staff working on AMU caring for patients who may require transfer between AMU A & B to do so in line with the appropriate guidance.
  - Division to ensure all staff consider moving any equipment not required for patient's safe transfer as part of the risk assessment.

- Intrapartum Stillbirth (eIR1285609) – This investigation was undertaken as a Perinatal Mortality Review. The report was not approved and required some additions to the improvement plan. The areas identified for improvements were:
    - Reason for appointments to documented at the time of booking
    - Risk assessment to completed for EPR system not showing what appointments are for
    - Training to be delivered for breaking bad news to parents to improve communication
    - Hypoxic ischaemic encephalopathy (eIR1283691) – This investigation was undertaken by MNSI, the report was approved. The report did not identify any safety recommendations

Two reports that were previously reviewed by the panel were returned for approval of the improvement plan; one required some rewriting of the improvement plan and the other was approved.

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT | **Item** | **13**

15 January 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 regarding ELHT maternity and neonatology services in response to the NHS England/Improvement (NHS E/I) – Full Ockenden review, Three Year Delivery Plan and neonatal critical care review are submitted to sub-group Quality Committee to inform Trust Board.

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

2. CNST - MATERNITY INCENTIVE SCHEME

2.1 Summary overview

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 risk** – 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 88.57%. Overall Target for the reporting period is 95%. Steps taken to mitigate this risk are detailed in the report below. ● The quarter 3 PMRT report covering October-December cases will be submitted to March 2025 Trust Board.
2. Maternity Services Data Set (MSDS)		● The July 2024 scorecard shows all metrics as **'Pass**'. July is the month reviewed for compliance of this safety action. The action is therefore complete and has been signed off by the Local Maternity and Neonatal System (LMNS). See most recent dashboard showing September data below.
3. Transitional Care (TC)		● The most recent Transitional Care (TC) audit covering October-November is attached for submission **(Appendix 2**) ● A temperature management quality improvement (QI) has been registered with the central improvement team and an update on this was provided at Floor to Board in November 2024.
4. Clinical Workforce		● The Neonatal Nursing Workforce Action Plan was submitted to September 2024 Trust Board for review, as the neonatal unit does not currently meet the British Association of Perinatal Medicine (BAPM) neonatal nursing standards. Neonatal nursing workforce calculator (2020) annual review completed to inform the action plan/ supporting review paper to demonstrate findings. ● A report detailing the compliance position of neonatal medical workforce against BAPM standards was also submitted to September Trust Boards, highlighting that the unit meets the requirements for Tiers 1 and 2, and is expected to become compliant with Tier 3 in January. ● The quarter 3 July-Sep consultant attendance audit covering October-December will be submitted to March 2025 Trust Board.
5. Midwifery Workforce		● Midwifery Safe staffing July 2024 -December 2024 report is included as an appendix to this report (**appendix 4**). ● **Identified risk** - Current funded midwifery establishment does not reflect Birthrate + findings and recommendations. Both phased and step wise approach taken by ELHT trust board to mitigate this risk are detailed in the report below.

6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 92% overall implementation following the LMNS assurance visit on 6th of November 2024. ● Further progress and sustainability of current implementation plan with associated actions continues with close oversight from Obstetrics Clinical Director/Perinatal Quadrumvirate.
7.User Feedback		●Following a demand and capacity review of the Maternity and Neonatal Voices Partnership (MNVP) Lead role in partnership with Healthwatch, an Engagement Lead has been appointed to support the MNVP tasks within Safety Action 7. ● The Maternity Transformation Team are working with the Engagement Lead and MNVP Lead to plan the schedule of works to meet and deliver the asks of Safety Action 7.
8. Training		● All required thresholds for training have been met by the end of the reporting period (30th November 2024). This Safety Action is therefore complete.
9. Board Assurance		● This safety action has been signed off as complete at the LMNS assurance visit on the 6th of November 2024. ● Floor to Board bi-monthly meetings with Board-level, maternity, and neonatal safety champions in place. The minutes of the November meeting are included as an appendix (**Appendix 3**). ● Perinatal Quality & Surveillance Model (PQSM) October 2024 data set submitted. ● A further meeting for the ongoing work for triangulation of claims, incidents and complaints is scheduled with Board and Maternity Safety Champions on 25th February 2025.
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Assurance from governance leads that all requirements for Maternity and Newborn Safety Investigation (MNSI) reporting are met. The quarter 3 report will be submitted to March 2025 Trust Board.

2.2 Key updates and exceptions per Safety Action

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

Table 1 Perinatal Mortality Review Tool – Dashboard of PMRT Cases

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

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

CNST - PMRT

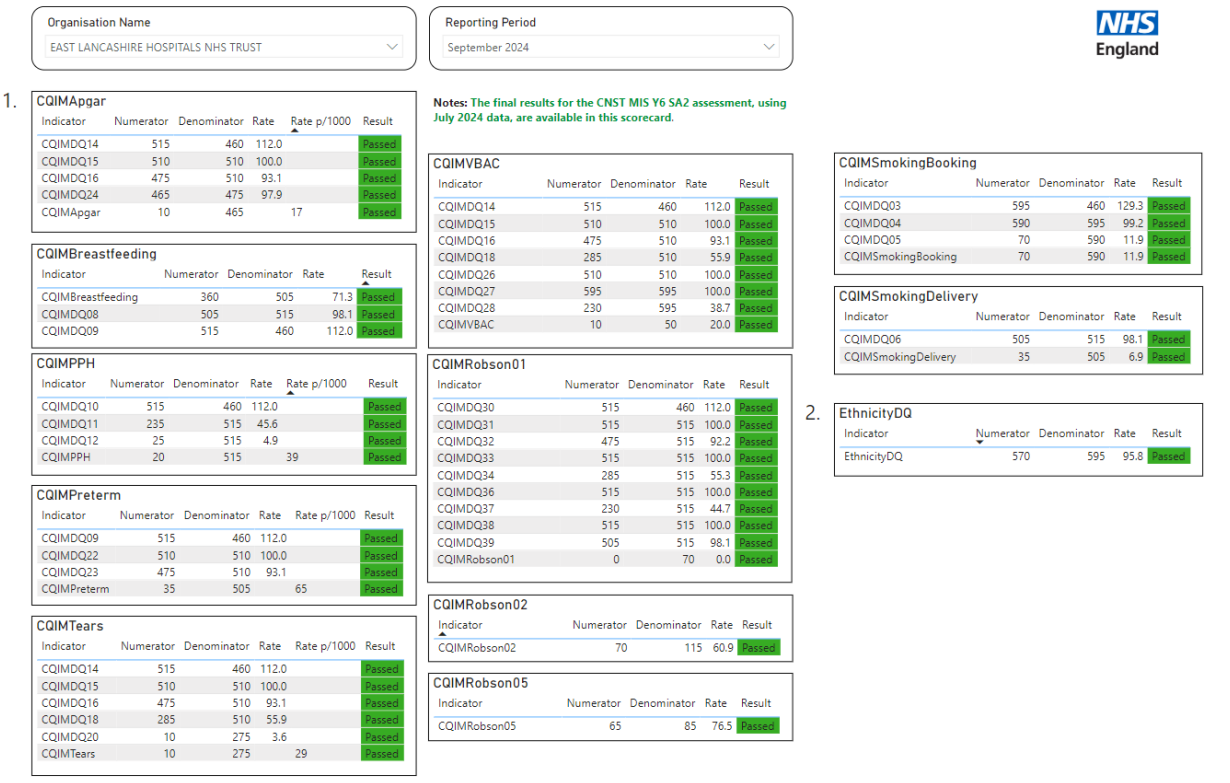
	Reporting Measure	Threshold	###[--	###[--	Jan-[--	###[--	Mar-[--	Apr-[--	###[--	Jun-[--	Jul-[--	###[--	###[--	Oct-[--	Monthly Tren
	Total Number of Stillbirths (= 24 weeks)		2	1	1	1	1	2	3	0	1	1	2	3	
	Number of Neonatal Deaths		3	1	0	1	1	3	3	3	3	0	0	0	
	Number of late fetal loss between 22+0 and 23+6 weeks		0	0	0	1	0	0	0	0	1	0	0	0	
SAFETY ACTION 1	Total Eligible Cases		5	2	1	3	2	5	6	3	5	1	2	3	
	a) i Number of cases reported to MBRRACE within 7 days		5	2	1	3	2	5	6	3	5	1	2	3	
		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%	
	c) i Number PMRT tool started 2 months		5	2	1	3	2	5	5	2	5	1	2	0	
		95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	66.7%	100.0%	100.0%	100.0%	-	
	c) ii Number PMRT published reports by 6 months		4	2	1	2	2	3	6	2	0	0	0	0	
		60%	80.0%	100.0%	100.0%	66.7%	100.0%	60.0%	100.0%	66.7%	-	-	-	-	
	Number PMRT published reports not due		0	0	0	0	0	0	0	1	5	1	2	3	

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 timeframe (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%.

A deep dive into these cases was completed by the PMRT lead consultant, however there is no audit trail to review which FQs were not answered. As such, guidance from MIS was sought. ELHT have been advised by MIS to submit a mitigation request to MBRRACE-UK as the external validator for this Safety Action. This request was submitted in December, and the meeting with MBRRACE-UK is scheduled on the 6th of January 2025 with the maternity safety champions.

As an immediate response to this, the maternity safety champions have reviewed failsafe processes, to ensure that all criteria are met for PMRT reviews. A weekly report is submitted to the Maternity Safety Champions and the Maternity Transformation Team for assurance with all aspects of governance aligned with CNST requirements. A weekly meeting is also in place every Thursday for any discussions with summaries to support. The shortfall regarding the failsafe process has been further reviewed and extended to a wider team.

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: September 2024

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	515	460	112.0		Passed
CQIMDQ15	510	510	100.0		Passed
CQIMDQ16	475	510	93.1		Passed
CQIMDQ24	465	475	97.9		Passed
CQIMApgar	10	465		17	Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	360	505	71.3	Passed
CQIMDQ08	505	515	98.1	Passed
CQIMDQ09	515	460	112.0	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	515	460	112.0		Passed
CQIMDQ11	235	515	45.6		Passed
CQIMDQ12	25	515	4.9		Passed
CQIMPPH	20	515		39	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	515	460	112.0		Passed
CQIMDQ22	510	510	100.0		Passed
CQIMDQ23	475	510	93.1		Passed
CQIMPreterm	35	505		65	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	515	460	112.0		Passed
CQIMDQ15	510	510	100.0		Passed
CQIMDQ16	475	510	93.1		Passed
CQIMDQ18	285	510	55.9		Passed
CQIMDQ20	10	275	3.6		Passed
CQIMTears	10	275		29	Passed

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

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	515	460	112.0	Passed
CQIMDQ15	510	510	100.0	Passed
CQIMDQ16	475	510	93.1	Passed
CQIMDQ18	285	510	55.9	Passed
CQIMDQ26	510	510	100.0	Passed
CQIMDQ27	595	595	100.0	Passed
CQIMDQ28	230	595	38.7	Passed
CQIMVBAC	10	50	20.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	515	460	112.0	Passed
CQIMDQ31	515	515	100.0	Passed
CQIMDQ32	475	515	92.2	Passed
CQIMDQ33	515	515	100.0	Passed
CQIMDQ34	285	515	55.3	Passed
CQIMDQ36	515	515	100.0	Passed
CQIMDQ37	230	515	44.7	Passed
CQIMDQ38	515	515	100.0	Passed
CQIMDQ39	505	515	98.1	Passed
CQIMRobson01	0	70	0.0	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	70	115	60.9	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	65	85	76.5	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	595	460	129.3	Passed
CQIMDQ04	590	595	99.2	Passed
CQIMDQ05	70	590	11.9	Passed
CQIMSmokingBooking	70	590	11.9	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	505	515	98.1	Passed
CQIMSmokingDelivery	35	505	6.9	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	570	595	95.8	Passed

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

July 2024 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 September 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 is attached for submission to Trust Board **(Appendix 2**). The audit found no evidence that babies were admitted to Special Care Baby Unit (SCBU) with the mother an inpatient on postnatal ward where they could have been managed in TC, however again highlighted the ongoing staffing review to explore whether full Nasogastric Tube (NGT) feeding support could be offered in TC. This would allow earlier transfers to Postnatal Ward reflected in a small number of cases. Following the neonatal Jaundice pathway pilot, launched in September 2024 the training and opportunity for NGT tube feeding will be considered as an option to model in the Transistional care pathways.

Following discussions at the November LMNS CNST and Saving Babies' Lives assurance visit and the LMNS Quality Assurance Panel, a decision has been made to change TC audits to be completed annually, meaning that following the March submission the next audit will be completed at the end of CNST Year 7.

As per the CNST requirement, a temperature management quality improvement (QI) has been registered centrally. 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?

Obstetric medical workforce

The quarter 2 July to September consultant attendance audit was submitted to November Trust Board and was presented at Perinatal Governance Board in November 2024. The quarter 3 October to December audit will be submitted to March Trust Board. Following recommendations by the audit lead, the Trust Datix manager is exploring options for adding a consultant attendance box to Datix, to allow real-time reporting so that incidents can be dealt with in a timely manner.

Neonatal nursing workforce

A review of compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020) has been completed in the year 6 period with a supporting document to evidence calculations and shortfalls in baseline establishments.

Although a board paper was not requested within the year 6 reporting period, it was deemed good practice to review all requirements of MIS year 5 to inform the findings, recommendations and annual succession plan for qualified in speciality (QIS) nurse staffing. For units that do not meet the standard, Trust Board should agree the action plan and evidence progress with MIS year 5 action plan previously developed and presented to address deficiencies.

As the ELHT neonatal unit does not meet British Association of Perinatal Medicine (BAPM) standards for nursing staffing, the neonatal nursing workforce action plan submitted for MIS year 5 evidence has been updated with a full review of progress to complete the MIS year 6 reporting period. This action plan was agreed and submitted on the 11th of September Trust Board report to evidence progress against actions and was presented to the LMNS Quality Assurance Panel on the 17th of September 2024.

Neonatal medical workforce

A report evidencing neonatal medical workforce compliance with the BAPM standards for Tier 1 and 2 was also submitted to September Trust Board. This report also detailed actions being taken to reach compliance with BAPM standards for Tier 3, with which the service is expected to achieve compliance in January. The Trust Board are asked to formally record this assurance within the meeting minutes.

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

The bi-annual midwifery staffing report for the period 1st July to 31st December 2024 is included as an appendix for submission as per the CNST requirement (**Appendix 4**).

The current risk (9259- risk score 8) identified remains present as the funded midwifery staffing budget. Currently midwifery establishment does not reflect funded birth rate plus requirements. The risk addresses the controls and gaps in place with the appropriate risk, evaluation, and monitoring. A business case for the deficit in funding has been completed and presented through the relevant ELHT business case process. ELHT maternity services have led a three-year phased approach with the delivery of funding received into baseline establishments to fulfil birth rate plus requirements. Given the financial pressures the final phase of funding to be received is currently under review although remains in the action plan for the end of the three-year phased approach being September 2025.

A round table midwifery staffing exercise has been completed in October 2024 with LMNS/Integrated Care Board (ICS) colleagues to review the Birthrate+ recommendations together with the application of professional judgment and the deliverables set out in the national report recommendations to fulfil. The findings from the additional and helpful round table exercise with LMNS colleagues will be presented to the Trust Board aligned with the risks and benefits.

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

The Birthrate+ Acuity App continues to be used to monitor supernumerary status and provision of one-to-one care in active labour on Central Birth Suite (CBS) as per the CNST requirement. Close surveillance of Midwifery red flags is standard practice triangulated with the birth rate plus acuity app. An escalation plan has been reviewed further with the central birth suite team, although in place prior to the year 6 reporting period, where the process for providing a substitute coordinator with the correct skill set and shadow mentoring approach is in place in the unexpected event of sickness or absence. A substitute coordinator rota will be submitted into CNST evidence to reflect this plan.

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 6th of November 2024. Compliance has increased to 63/70 interventions implemented overall, which equates to 92%. This is an increase from 84% at the previous LMNS assurance visit in September. A breakdown of elements is provided below.

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	7/10 interventions implemented and evidenced **(70%)**
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 Y6 reporting period as below, this provides the forum to meet the ask '*continued quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle.'* Two of these meetings have now taken place, with the final assurance meeting to take place in January.

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

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

Following a demand and capacity review of the Maternity and Neonatal Voices Partnership (MNVP) Lead role in partnership with Healthwatch, an Engagement Lead was appointed to support the MNVP tasks within Safety Action 7. An induction meeting took place in November 2024 between the new Engagement Lead and ELHT colleagues, including the Divisional Director of Midwifery & Nursing, the Consultant Midwife, the Transformation Team, and the Trust Inclusions Officer.

The Maternity and Neonatal Transformation Team are meeting regularly with the new Engagement Lead to support with the coproduction work schedule and to target feedback around those service users at risk of experiencing the worst outcomes, as per the CNST guidelines and the LMNS Equity and Equality Plan (**appendix 5**).

The MNVP Lead is involved in the translation services working group, a QI within Maternity and Neonatal that is working to improve our use of the Trust's translation services. Colleagues from Home Start are working alongside the MNVP lead to support with the collation of patient feedback, to inform the ongoing work for this QI. This work undoubtedly targets the aforementioned most at-risk groups as aligned with the national MBRRACE-UK report findings

MNVP colleagues are working with the Transformation Team to set up service user focus groups targeted around the communications strategy and a website review for Maternity and Neonatal services. This is ongoing work, with a focus group due to take place in February 2025.

Reports have now been submitted to the Transformation Team on the findings from the MNVP 15 Steps exercises that took place on the Neonatal Intensive Care Unit (NICU), Antenatal Ward, Postnatal Ward and TC in October 2024. These reports have been taken to the Maternity and Neonatal Patient Experience Group to share improvement suggestions with Matrons and Ward Managers. These suggestions have been taken onboard and will be used to inform a standardisation of visiting restrictions working group, and to make environmental improvements in areas such as Postnatal Ward.

Work continues on the co-produced CQC action plan based on the results of the 2023 CQC Maternity Survey, as submitted to November 2024 Trust Board. Additional actions will be added when the full breakdown of the 2024 results is provided to the Trust. The initial overview of the 2024 results shows improvements on the previous year and places ELHT Maternity Services in the top 8 Trusts within the country. We are extremely proud of the ongoing demonstrable continuous improvements regarding rich patient feedback and acknowledge this journey requires a direct focus aligned with ELHT patient experience strategy launched in 2024.

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

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

- ***Fetal monitoring and surveillance (in the antenatal and intrapartum period) training*** – 90% attendance for midwives, obstetric consultants and all other obstetric doctors who contribute to the obstetric rota. The threshold has been met for all relevant staff groups by the end of the reporting period.
- ***Maternity emergencies and multi-professional training (PROMPT)*** - 90% attendance for obstetric consultants and doctors, midwives, maternity support workers, and anaesthetic consultants. The threshold has been met for all relevant staff groups by the end of the reporting period.
- ***Neonatal basic life support*** –
  90% attendance for neonatal consultants, junior doctors (who attends any births unsupervised), neonatal nursers (who attend any births unsupervised), advanced neonatal nurse practitioners, and midwives. Midwives and Maternity Support Workers complete this module within the PROMPT training day.
  The threshold has been met for all relevant staff groups by the end of the reporting period.

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?

At the LMNS assurance review on the 6th of November 2024, Safety Action 9 was signed off as complete for the MIS Year 6 period.

Safety Champions are continuing to meet with the perinatal leadership team at a minimum of bi-monthly as evidenced by the Floor to Board Minutes of the last meeting on the 27th of November 2024 (**Appendix 3**). The next meeting is scheduled for the 6th of February 2025.

Perinatal Quality Surveillance Model (PQSM) Minimum Data Set September and October 2024 data:

Perinatal Quality Surveillance Dataset

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

	Metric	Standard	July 24	August 24	Sept 24	Oct 24
Perinatal Data	1:1 care in labour	100%	100%	100%	100%	100%
	Stillbirth rate	<4.4/1000	0	3.68	6.02	7.83
	Term admissions to NICU	<7%	4.46%	3.96%	6.73%	7.77%
	Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	5.55%	4.47%	4.44%	4.16%
	3rd/4th degree perineal tear	<5%	2.96%	3.74%	3.27%	2.80%

	Metric	Standard	July 24	August 24	Sept 24	Oct 24
Staffing/Training	Maternity NICE red flags		0	0	0	0
	Dedicated obstetric consultant presence on labour ward	90hrs/week	90	90	90	90
	Midwife to birth ratio (establishment)	<1.28	<1.28	<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%

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

Stillbirth rate:
There have been3 stillbirths in September – 1 of these was a MTOP. There have been 4 stillbirths in October; 3 of these were intrapartum stillbirths and have been reported to MNSI. 1 was an antepartum stillbirth.

Term admission to NICU:
The Term admission rate has increased in September and October – 3 in September and 4 in October were planned admissions. 1 of these admissions has bene referred to MNSI for investigation – this is in progress. 3 others are having further review to establish if they were avoidable admissions. The remaining 65 admissions in this period were unavoidable admissions. 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%.

Training Compliance:
The average for training compliance across all staff groups remains >90% attendance, there has been a decrease in the medical and anaesthetic staff compliance this month but this is due to the rotation of junior doctors. MIS CNST standards for year 6 suggest that all anaesthetists who may occasionally work in the birth suite must attend PROMPT. This may be difficult to achieve.

	Metric	Standard	July 24	August 24	Sept 24	Oct 24
Feedback	Service user feedback (MNVP)		0 sessions attended	0 sessions attended	1 sessions attended	0 sessions attended
	FFT satisfaction rated as good	>90%	90%	87.8%	88.13%	84.03%
	Number of level 4 complaints	-	1	0	2	2
	Executive safety walkaround	Bi-Monthly	0	1	1	1
	Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	2	0		

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

	Metric	July 24	August 24	Sept 24	Oct 24
CNST	Progress with CNST 10 safety action compliance				

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

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MNVP Service User Feedback:
15 Step walk rounds have been performed in Antenatal ward, postnatal ward and NICU. Feedback from these will be reported at next Patient Experience meeting.
An Engagement Officer has been appointed in the MNVP team and a schedule of events is being planned for early 2025.

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

Level 4 Complaints
There has been 2 level 4 complaints in both September and October.

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

Moderate or above incidents:
There have been 5 reported incidents in September and October – a 3rd degree tear, 2 babies born onto the floor, a missed cleft palate and cooled baby that declined MNSI. These are stillunder review.

Coroner referral:
1 case has been referred to the Coroner in September, this was a neonatal death. 0 case have been referred in October.

MNSI referral:
There has been 1 cases referred to MNSI in September – this was a cooled baby and 3 cases referred in October – these were Intrapartum stillbirths.

CNST:
The quarter 2 visit took place on the 6th November 2024 and assurance we are working towards all ten safety actions. Risks around SA1 were highlighted to the LMNS.

'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 25th of February 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.

'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, 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 26th of February 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 now completed this training from the NHS England Perinatal Culture and Leadership Team and will begin to hold sessions starting on the 4th of February 2025.

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 will be submitted to March 2025 Trust Board.

3. CONCLUSION

On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board will continue to inform progress of the ten CNST maternity safety actions throughout the year 6 reporting period. Final LMNS quality assurance meeting is the 8th of January 2025, trust board report for year 15th January 2025.

Board declaration to be completed with Trust CEO and AO of clinical commissioning group/integrated care systems sign off. This is due to be submitted by the 17th of February 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

January 2025

Appendix 1 – CNST-MIS Y6 Guidance

MIS-Year-6-guidance .pdf

Appendix 2 – TC Audit

TC audit Oct-Nov2024.pptx

Appendix 3 – Floor to Board Minutes 27.11.24

[5] 27.11.2024 - Floor to Board.docx

Appendix 4 – Midwifery Staffing Paper

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

Appendix 5 – LMNS Equality and Equity Plan

2021 - Equality and Equity .pdf

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

15 January 2025 **Purpose** Information

Title	**Financial Performance Report Month 8 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	7 January 2025

Summary:

At M8, period ending 30th November 2024, the Trust is reporting a year-to-date deficit of £32.2m, £24.5m behind the year-to-date plan and a movement of £6.3m from the previous month.

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

Executive Summary

1. At M8, period ending 30th November 2024, the Trust reported a year-to-date deficit of £32.2m, £24.5m behind the year-to-date plan and a movement of £6.3m from the previous month. Due to the phasing of the Deficit Support Funding (DSF), the position is understated by £7.3m so would be a deficit of £39.5m

2. The Trust had an agreed deficit financial plan of £21.9m, and a result of the allocation of the DSF, all of which was received and recognised at month 6, the Trust's revised annual financial plan is to deliver a breakeven plan. The DSF is a non-recurrent benefit in year.

3. The breakeven plan is inclusive of a £59.7m cost improvement programme (CIP), also referred to as the waste reduction programme (WRP).

4. The table below reflects the reported position against plan.

	Annual Budget	In month			Cumulative		
		Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000
Operating Income							
Operating Income from Patient Care Activities	722,770	62,205	60,777	(1,428)	491,076	497,603	6,527
Other Operating Income	42,216	3,601	3,860	259	29,026	30,485	1,459
Employee expenses	(553,544)	(46,320)	(48,098)	(1,778)	(370,500)	(382,400)	(11,900)
Operating expenses excluding employee expenses	(188,961)	(18,496)	(21,226)	(2,730)	(142,345)	(163,755)	(21,410)
Operating (Deficit)	**22,481**	**990**	**(4,687)**	**(5,677)**	**7,257**	**(18,067)**	**(25,324)**
Net Finance Costs	(34,556)	(521)	(235)	286	(32,468)	(31,556)	912
Gains/(Losses) on disposal of assets	0	0	0	0	0	63	63
(Deficit) for the period/year	**(12,075)**	**469**	**(4,922)**	**(5,391)**	**(25,211)**	**(49,560)**	**(24,349)**
Remove impairments	0	0	0	0	0	0	0
Remove impact of PFI liability remeasurement	12,102	(1,350)	(1,380)	(30)	17,499	17,265	(234)
Remove capital donations/grants I&E impact	(27)	(12)	36	48	6	57	51
Breakeven duty financial performance (deficit)	**0**	**(893)**	**(6,266)**	**(5,373)**	**(7,706)**	**(32,238)**	**(24,532)**

5. At the end of Month 8, the Trust continues to incur additional cost pressures in year. The increased pressures are particularly around the additional ward areas being used - B6, B18 and CCU; the increased staffing in the Emergency Department, including to provide care for patients requiring care in additional capacity; the cost of increased sickness absence and the increased cost to deliver additional activity in the surgical and family care divisions. These are impacting both the direct service and the support services.

6. The Cost Improvement Programme for the 2024/25 financial year is £59.7m. As at month 8, £17.3m has been achieved to date, an improvement from the previous month (£14.6m) by £2.7m. The CIP delivery has been reassessed at month 8 and the updated reporting shows the year-to-date performance and the delivery status. There is a significant proportion, £38.8m of the total £59.7m in the plans in progress, opportunity and unidentified. This is a key focus of the recovery work underway in the Trust.

7. The capital programme has reduced by £1.2m to £33.6m with forecast expenditure now £0.6m above plan, which the Trust expects to be able to manage. At £7.5m, the year-to-date position is £0.7m behind plan.

8. The cash balance on 30th November was £8.2m, a reduction of £6.7m compared to the previous month. This position continues to be supported by £18.2m of Provider Revenue Support Public Dividend Capital (PDC).

9. Largely because of the continued need for the Trust to manage its cash position whilst delivery of the financial plan is off track, the Better Payment Practice Code (BPPC) performance remained below target in November. The Trust continues to meet the target to pay 95% of invoices on time for the financial year to date by value for NHS invoices; performance for the value of non-NHS invoices paid on time is not far below target at 91.8%.

10. Year to date spend on agency staff represented 1.9% of total pay against the ceiling set by NHS England (NHSE) for 2024/25 of 2.9%.

11. The risk of delivering the financial plan remains significant. The key risks relate to the operational pressures that the Trust is seeing and the lack of delivery of CIP. This is why the Trust has stepped up the financial controls and is reviewing the effectiveness of these controls. The risks are the subject of discussions with the LSC Integrated Care Board (ICB), NHSE and the LSC System Turnaround Director now that the Trust is subject to the formal LSC system intervention.

Recommendation

12. The Trust Board is asked to:

    - Note the contents of this report.
    - Discuss the financial performance for 2024/25.

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TRUST BOARD REPORT **Item** 15

15 January 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 November 2024

Recommendation: Members are requested to note the attached report for assurance

Report linkages

Related Trust Goal

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

Related to key risks identified on Board Assurance Framework

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

2 The Trust 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	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement People Plan Priorities Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare Tackle inequalities in outcomes, experience and access Enhance productivity and value for money Help the NHS support broader social and economic development

Impact

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

Previously considered by:

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

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- Average fill rates for registered nurses/midwives and care staff remain above threshold.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) was above the 77% target in November at 77.70%.
- No patients waited over 78 weeks and the number of RTT pathways over 65 weeks in November is 4 against the trajectory of 0. 4 breaches due to national graft tissue availability.
- In November, the Referral to Treatment (RTT) number of total ongoing pathways has reduced on last month to 65,265.
- The Cancer 28 day faster diagnosis standard was above target in October at 77.4%.
- Performance against the cancer 31 day standard met the internal trajectory of 92% in October at 94.9%
- Friends & family scores remain above threshold for inpatients, outpatients, and community in November.
- The overall Trust performance from the range of patient experience surveys was above the threshold of 90% for 4 of the 4 competencies.
- There were no maternal deaths in November.
- The Trust turnover rate continues to show usual variation compared to pre-covid levels at 7.46% and remains below threshold.

Areas of Challenge

- Performance against the ELHT four hour standard of 77% was not met at 76.84% in November.
- There were 4 Steis reportable incidents in November. There were no never events.
- There was 1 P.aeruginosa bacteraemia identified in November.
- There were 10 healthcare associated clostridium difficile infections identified in November.
- There were 12 post 2 day E.coli bacteraemia identified in November.
- There were 6 Klebsiellas detected in November.
- There are some issues impacting the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). This includes: coding backlog, removal of SDEC data and data quality in the submission. As a result, neither metric is currently considered a robust measure of mortality.
- There was 1 stillbirth in November.

- There were 1164 breaches of the 12 hour trolley wait standard (49 mental health and 1115 physical health).
- There were a total of 3151 ambulance attends with 880 ambulance handovers > 30 minutes and 288 > 60 minutes. This is still a reduction on September & October
- Friends & family scores in A&E and maternity are below threshold.
- Performance against the cancer 62 day standard was below the 70% threshold (by March 25) in October at 65.9%.
- In November, there were 2,738 breaches of the RTT >52 weeks standard, which is above the trajectory of 2,601.
- The 6wk diagnostic target of 5% by March 25 was not met at 15.32% in November.
- The Trust vacancy rate is above threshold at 6.4%.
- Sickness rates are above threshold at 6.40%
- Compliance against the Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 10%.
- The Trust is reporting a £32.2m deficit for the 2024-25 financial year to date, £24.5m behind plan.

No Change

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

Data Completeness

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

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

Metric	Data Source	Lead	Nov-24	Date available
C diff, e coli, p.aeruginosa, klebsiella		Infection Control - Laura Moores		
Mixed sex breaches		Corporate information		
Average fill rates		Corporate information		
Staffing narrative		Heather Coleman		
Nurse Staffing - Fill rate table		Heather Coleman		
Steis		Incidents team		
VTE		Corporate information		
Pressure ulcers		Jane Pemberton		
Friends & Family		Corporate information		
Number of complaints	Datix	Corporate information		
Complaints per 1000 contacts		Corporate information		
Patient experience		Quality - Sarah Ridehalgh/ Melissa Almond		
SHMI trend	National published SHMI	Performance team		Awaiting update following resubmission
HSMR	Dr Foster	Performance team		Awaiting update following resubmission
LeDeR		Julie Clift/ Alison Brown		No update provided
Structured judgement reviews (SJR)	Datix	Performance team		
Stillbirths	Maternity dashboard	Kathryn Sansby/ Carol Bell		
Maternal deaths	Maternity dashboard	Kathryn Sansby/ Carol Bell		
CQUIN	CQUIN Update	Andrew Costello		CQUINs paused nationally 2024/25
A&E ELHT performance	Submitted performance	Corporate information		
A&E national performance	NHS Statistics	Performance team		
12 hr trolley waits		Performance team		
Ambulance handovers	NWAS	Performance team		
Ambulance handovers ELHT breaches	NWAS	A&E - Adele Dibden/ Claire Ashcroft		
RTT ongoing, over 40, over 52 wks	Submitted performance	Corporate information		
RTT ongoing graphs	Submitted performance	Corporate information		
RTT admitted/non-admitted	Submitted performance	Corporate information		
RTT average wait and ongoing %	Submitted performance	Corporate information		
RTT national	NHS Statistics	Performance team		
ELHT cancer - ELHT	Submitted performance	Cancer services - Victoria Cole		
ELHT cancer - national position	NHS Statistics	Cancer services - Victoria Cole		
Delayed Discharges Chart		Andrea Isherwood/ Kathryn Heyworth		
Emergency readmissions		Corporate information		Metric in development
Diagnostics % waiting over 6 weeks		Corporate information		
Diagnostic national performance	NHS Statistics	Performance team		
Average lengths of stay		Corporate information		
Operations cancelled on the day		Corporate information		
Sickness, vacancy, turnover		HR - Mudassir Gire		
Overtime & Temporary costs		Finance - Ammaarah Yakub		
Appraisals		Learning hub team		
Appraisals AFC		Learning hub team		
Job plans		Salauddin Shikora		
Information governance		Learning hub team		
Core skills training		Learning hub team		
Finance/use of resource		Finance - Allen Graves		

Safe

	Indicator	Target	Actual	Variation	Assurance
M65	MRSA	0	0		
M64	Clostriduim difficile (C.diff) - 'Hospital onset healthcare associated (HOHA)'	n/a	10		
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	0		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	n/a	81		
M124	E-Coli (HOHA)	n/a	9		
M124.ii	E-Coli (COHA)	n/a	3		
M124.iv	E-Coli cumulative from April (HOHA & COHA)	n/a	101		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	0		
M155.ii	P. aeruginosa bacteraemia (COHA)	n/a	1		
M155.3	P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)	n/a	8		
M157	Klebsiella species bacteraemia (HOHA)	n/a	3		
M157.ii	Klebsiella species bacteraemia (COHA)	n/a	3		
M157.3	Klebsiella species bacteraemia cumulative from April (HOHA& COHA)	n/a	35		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	30.9		
M69	Serious Incidents (Steis)	No Threshold Set	4		
M70	Central Alerting System (CAS) Alerts - non compliance	0	1		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	87%		

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	96%		
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	35%		
C40	Maternity Friends and Family - % who would recommend	90%	90%		
C42	A&E Friends and Family - % who would recommend	90%	69%		
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	12%		
C44	Community Friends and Family - % who would recommend	90%	96%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	94%		
C15	Complaints – rate per 1000 contacts	0.40	0.14		
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	N/A	N/A		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at May-23)	N/A	N/A		
M74	Hospital Standardised Mortality Ratio - Weekday (as at May-23)	N/A	N/A		
M75	Hospital Standardised Mortality Ratio - Weekend (as at May-23)	N/A	N/A		
M159	Stillbirths	<5	1		
M160	Stillbirths - Improvements in care that impacted on the outcome	No Threshold Set	n/a		
M89	CQUIN schemes at risk	CQUIN schemes have been reintroduced for 2022/23			

Responsive

	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	77.0%	76.8%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	77.0%	77.7%		
M62	12 hour trolley waits in A&E	0	1164		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	880		
M84	Handovers > 60 mins (Arrival to handover)	0	288		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	42.1%		
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set	58.3%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	75,608	65265		
C37.4	Referral to Treatment (RTT) 65 Weeks (Ongoing)	0	4		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	2601	2738		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	5.0%	15.3%		
C50.1	62d General Standard	70.0%	65.9%		
C50.2	31d General treatment standard	96.0%	94.9%		
C50.3	28d General FDS	75.0%	77.4%		
M9	Urgent operations cancelled for 2nd time	0	0		
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	9		
M138	No.Cancelled operations on day	No Threshold Set	86		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re-admissions within 30 days				
M91.1	Emergency average length of stay (excluding 0 and 1 days)	No Threshold Set	11.4		
M91.2	Emergency average length of stay (including 0 and 1 days)	No Threshold Set	8.5		

Well Led

	Indicator	Target	Actual	Variation	Assurance
M77	Trust turnover rate	12.0%	7.5%		P
M78	Trust level total sickness rate	4.5%	6.4%		?
M79	Total Trust vacancy rate	5.0%	6.4%		F
M80.3	Appraisal (Agenda for Change Staff)	90.0%	82.0%		F
M80.35	Appraisal (Consultant)	90.0%	99.0%		?
M80.4	Appraisal (Other Medical)	90.0%	96.0%		?
M80.2	Safeguarding Children	90.0%	95.0%		P
M80.21	Information Governance Toolkit Compliance	95.0%	94.0%		?
F8	Temporary costs as % of total paybill	4%	10.0%		F
F9	Overtime as % of total paybill	0%	0%		
F1	Cumulative variance to planned financial performance (deficit) (£m)	£0.0	-£24.5		
F2.1	WRP achieved YTD - variance to plan (£m)	£0.0	-£6.4		
F3	Liquidity days	-21.1	-20.8		
F4	Capital spend v plan	85.0%	91.1%		
F18a	Capital service capacity	0.3	0.0		
F19a	Income & Expenditure margin	-4.4%	-6.1%		
F21d	Agency spend as a proportion of total pay bill (£m)	3.2%	1.9%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	75.0%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	91.8%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	83.0%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	95.3%		

NB: Finance Metrics are reported year to date.

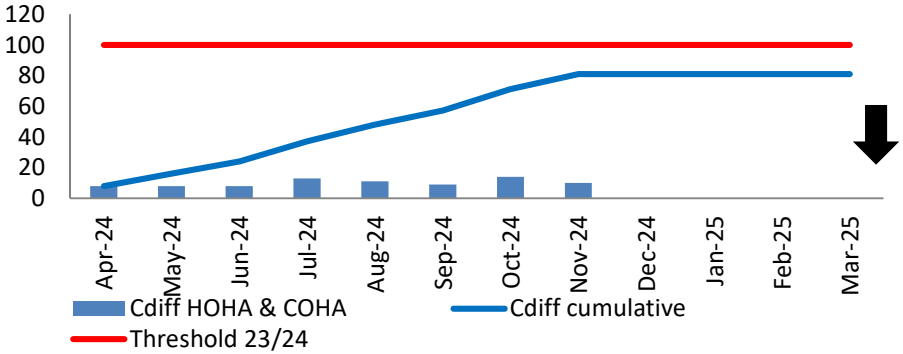
KEY

SPC Control Limits

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

SAFE

C Difficile (HOHA &



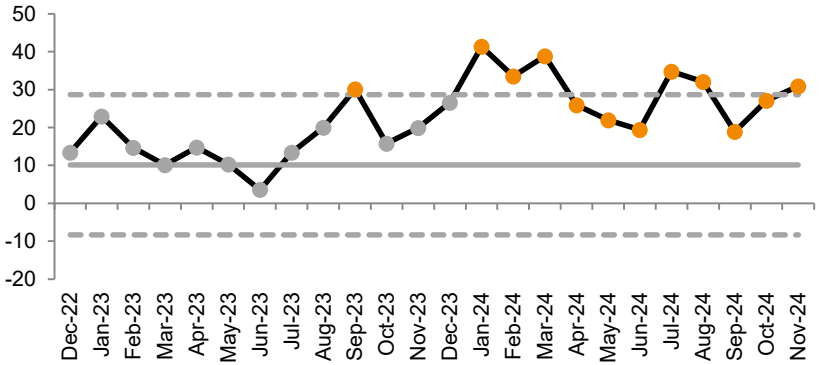
From April 2024 there will be a change in reporting of hospital acquired HCAI data as per updated guidance from UKHSA (UK Health Security Agency). Where a patient has been admitted directly after attendance to A&E it is requested the decision to admit date is entered as the A&E decision to admit date rather than the inpatient admission date.

There were 0 post 2 day MRSA infections reported in November. So far this year there have been 2 cases attributed to the Trust. The objective for 24/25 is to have 0 MRSA cases.

The Clostridium difficile toxin objective for 24/25 is to have no more than 100 cases 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)'. The year to date cumulative figure is 81. There were 10 Clostridium difficile toxin positive isolates identified in the laboratory in November; all were HOHA.

The detailed infection control report will be reviewed through the Quality Committee.

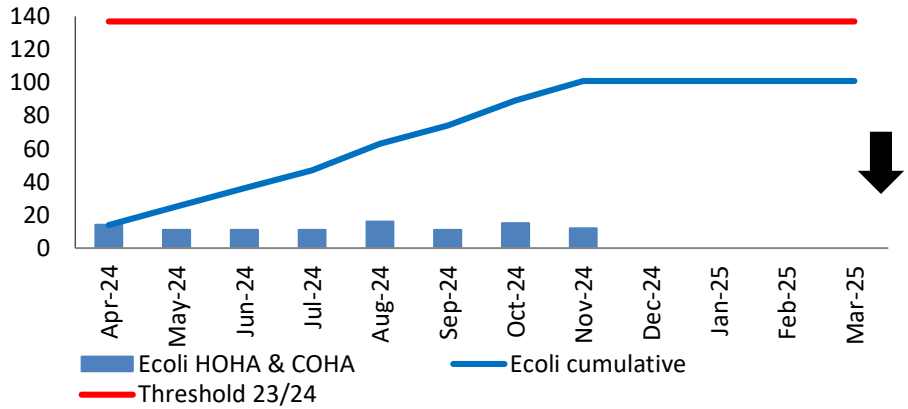
C Diff per 100,000 Occupied Bed Days (HOHA)



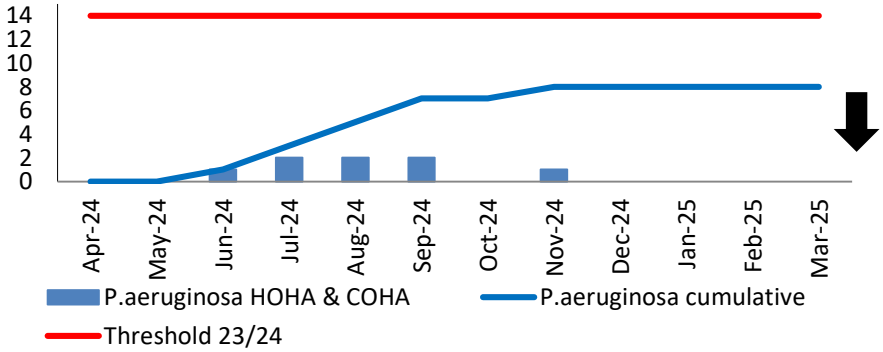
The rate of HOHA infection per 100,000 bed days is significantly higher than normal variation in November.

SAFE

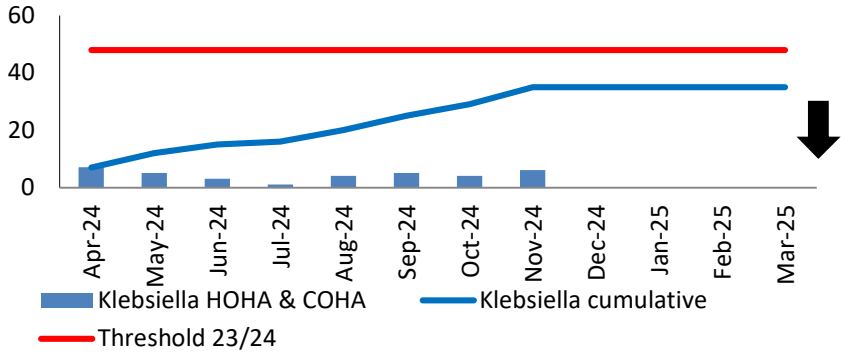
E. Coli (HOHA & COHA)



P.aeruginosa



Klebsiella



The UK Government has developed a new AMR 5 year national action plan, 'Confronting antimicrobial resistance 2024 to 2029', which builds on the achievements and lessons from the first national action plan. Its overall aims are to:

* optimise the use of antimicrobials.
* reduce the need for, and unintentional exposure to, antibiotics.
* support the development of new antimicrobials.

The National action plan contains a number of ambitions, including:

* By 2029, we aim to prevent any increase in a specified set of drug resistant infections in humans from the 2019 to 2020 financial year baseline.
* By 2029, we aim to prevent any increase in gram-negative bloodstream infections (which are described as difficult to treat infections) in humans from the FY 2019 to 2020 baseline.
* By 2029, we aim to increase UK public and healthcare professionals' knowledge on AMR by 10%, using 2018 and 2019 baselines, respectively.
* By 2029, we aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline.
* By 2029, we aim to achieve 70% of total use of antibiotics from the access category (new UK category) across the human healthcare system.

The 24-25 trajectory for reduction of E.coli is 137 HOHA & COHA. The year to date cumulative figure is 101. There were 12 reportable cases of E.coli bacteraemia identified in November; 9 HOHA and 3 COHA.

The 24-25 trajectory for reduction of Pseudomonas is 14 HOHA & COHA. The year to date cumulative figure is 8. There was 1 reportable case of COHA Pseudomonas identified in November.

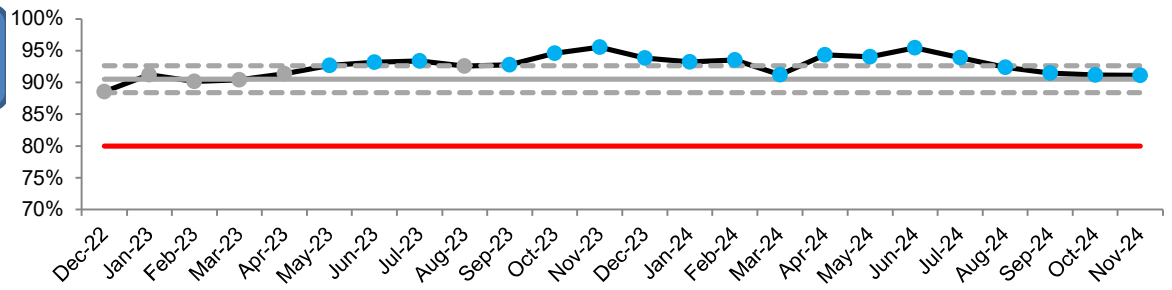
The 24-25 trajectory for reduction of Klebsiellas is 48 HOHA & COHA. The year to date cumulative figure is 35. There were 6 reportable cases of Klebsiella identified in November, 3 HOHA and 3 COHA.

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

SAFE

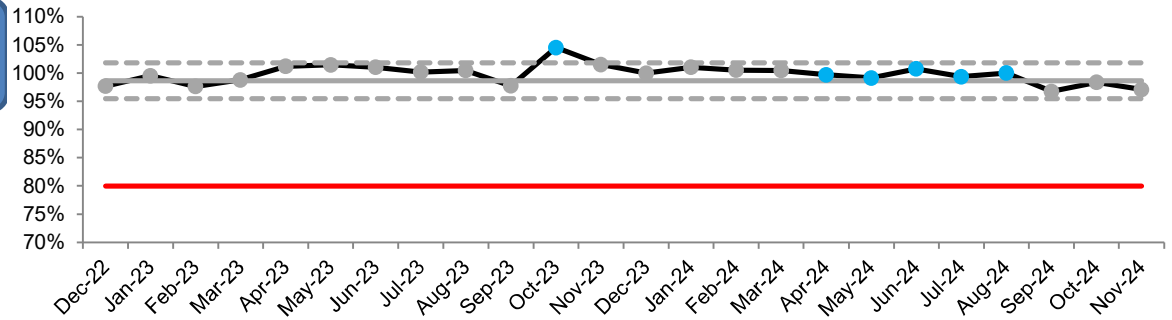
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



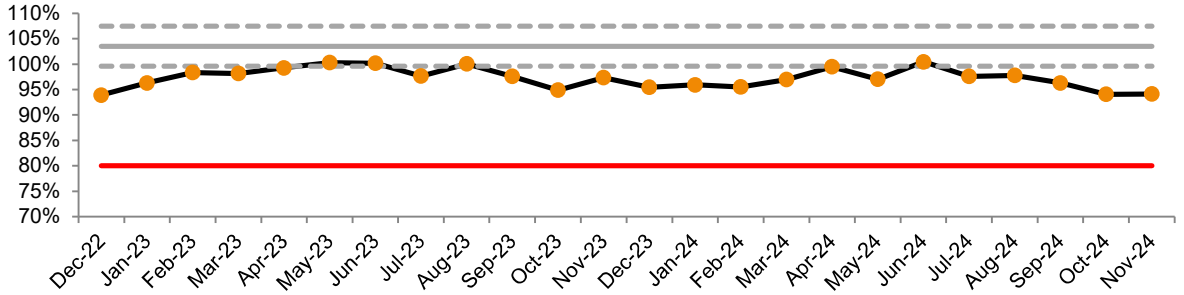
The average fill rate for registered nurses/ midwives during the day is showing improving variation when compared to the pre covid levels. Based on current variation it will consistently be above threshold.

Registered Nurses/ Midwives - Night



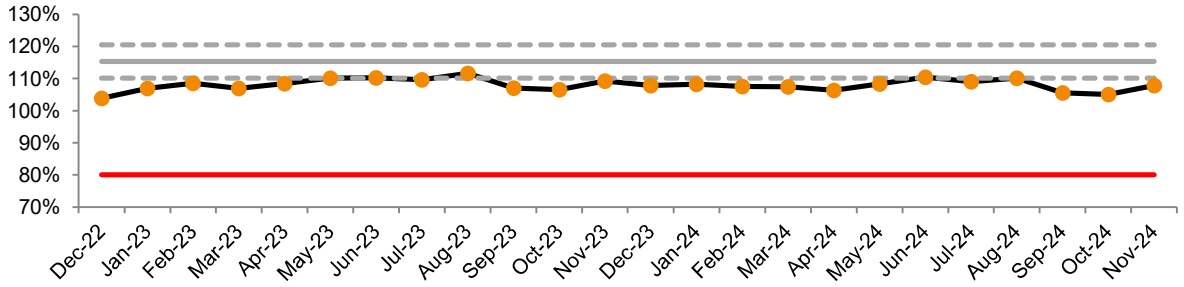
The average fill rate for registered nurses/ midwives at night is showing usual variation when compared to pre-covid levels. Based on current variation it will consistently be above threshold.

Care Staff - Day



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

Care Staff - Night



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

SAFE

Throughout the month, the planned nursing and midwifery staffing levels for the 46 inpatient wards at East Lancashire Teaching Hospitals were compared with the actual staffing levels daily. This allows the calculation of a percentage fill rate for each ward, day, and night,
The table below demonstrates the overall fill rates and the average fill rates per hospital site at ELHT in November.

	Day Average Fill Rate %		Night Average Fill Rate %	
Hospital site	**Registered nurses / midwives (%)**	**Care staff (%)**	**Registered nurses / midwives (%)**	**Care staff (%)**
Royal Blackburn	90.2	93.9	96.8	110.0
Burnley General	94.6	98.2	97.0	107.3
Clitheroe Community	86.3	110.0	103.3	97.5
Pendle Community	95.2	106.2	100.0	97.1
Total	**91.1**	**96.1**	**97.1**	**107.9**

*Clitheroe Community (Ribblesdale Ward) has a shortfall in RN establishment and due to the remote location, the permanent allocation of international nurses is not an option however a process is now in place to rotate staff to Ribblesdale Ward.

Latest Month - Average Fill Rate

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Nov-24	91.1%	96.1%	97.1%	107.9%	32370	7.98	0	2	0	0

SAFE

Monthly Trend

The table below demonstrates the month-on-month overall average fill rate, CHPPD and wards < 80%.

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)
Oct-23	94.6%	94.9%	104.5%	106.6%	31,679	8.09	0	2	0	1
Nov-23	95.5%	97.4%	101.5%	109.3%	30,083	8.35	0	3	0	0
Dec-23	93.4%	95.4%	100.0%	108.0%	30,111	8.52	1	2	0	1
Jan-24	93.2%	95.9%	101.0%	108.3%	31,392	8.19	0	4	0	1
Feb-24	93.5%	95.5%	100.5%	107.6%	29,830	8.04	1	2	1	1
Mar-24	91.2%	97.0%	100.5%	107.5%	30,877	8.23	0	2	0	1
Apr-24	94.3%	99.5%	99.7%	106.4%	30,852	8.05	0	1	1	1
May-24	94.1%	97.1%	99.2%	108.3%	31,886	8.02	0	1	0	0
Jun-24	95.5%	100.5%	100.7%	110.4%	30,887	8.34	0	1	0	0
Jul-24	93.9%	97.6%	99.4%	109.1%	31,622	8.24	2	1	0	0
Aug-24	92.4%	97.8%	100.0%	110.2%	31,181	8.3	4	0	0	0
Sep-24	91.5%	96.3%	96.7%	105.6%	31713	7.92	1	2	1	1
Oct-24	91.1%	94.1%	98.3%	105.1%	33266	7.71	1	3	0	0
Nov-24	91.1%	96.1%	97.1%	107.9%	32370	7.98	0	2	0	0

During November <80% fill rate:

< 80% Care staff		
Day	Children's Unit	65.00
	NICU	76.70

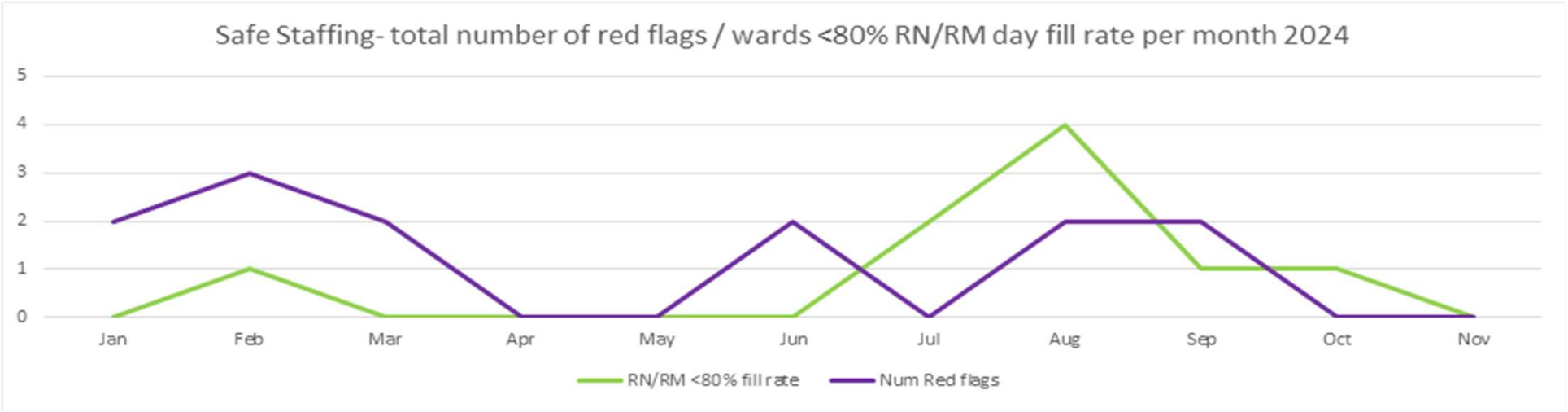
Children Unit – shortfall due to vacancies, sickness, and re-deployment across the rest of the Trust. A pragmatic approach is taken as to whether to backfill daily based on ward activity/acuity.

NICU – there was a short period of significantly reduced activity, and the team did not need to cover any of the staffing gaps due to short/long term sickness or maternity leave. They were able to ensure the unit was safely covered with the staff available.

National Red Flags

0 national nursing red flags reported in November.
0 maternity red flags reported in November.

The graph below demonstrates the number red flags and wards < 80% RN day fill rate per month trend.



SAFE

Family Care

Month	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Staffed to full Establishment	01:27	01:26	01:26	01:26	01:25	01:26	01:26	01:26	01:26	01:26
Excluding mat leave	01:26	01:27	01:27	01:27	01:26	01:28	01:28	01:28	01:28	01:28
Maternity leave	6.40	6.40	9.60	9.60	15.76	17.12	17.12	18.32	19.77	18.44
With gaps filled through ELHT Midwife staff bank	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage
Per week	24.19	23.16	28.47	20.65	9.20	19.92	21.85	16.22	17.35	17.82
Midwifery vacancies (Maternity VRS) -11wte	10 wte backfill for Maternity leave incl	12 wte backfill for Maternity leave incl	15 wte Backfill 11 for Maternity leave incl	15 wte Backfill 11 for Maternity leave incl	12 wte Backfill 6 for Maternity leave incl	6 wte Backfill 11 wte for maternity leave	5 wte Mat leave included start dates pending	10 wte Mat leave included	0 wte 11 wte backfill for mat leave	3.7 WTE pending start dates, 18.44 WTE mat leave

Maternity - Safe midwifery staffing levels also continue to be reviewed with the appropriate risk assessments 4 times a day at each safety huddles. Additional staffing/ leadership huddles will take place in periods of extreme staffing pressures to mitigate throughout maternity services; midwives are redeployed to other areas to support acuity and activity as and when required. There has been a slight increase in bank filled duties.. Maternity leave is reported as 18.44 WTE with further maternity leave pending.

Escalation and discussion with the Chief Nurse/ Executive Maternity Safety Champion when risk to post-natal flow/ patient care in the absence of a 7-day coordinator/ 7 days a week. Local midwifery red flags noted at each handover and reviewed by the local governance team on a weekly basis. All new midwifery recruits commenced in post mid-October, induction weeks have been completed and all midwives are now working clinically across all areas of maternity. 3.70 WTE appointed to vacancies and are currently awaiting recruitment checks prior to commencing in post, early in the new year.

Neonatology – Staffing levels meet the requirements for the acuity/ activity aligned with the NW connect safe staffing tool. The planned versus actuals meet the safe staffing requirements for the days in month of November 2024, this is equal to the number of infants required intensive, special, and high dependency care. Daily maternity/ Neonatology safety huddles inclusive of safe staffing tool completed twice daily, more frequently if required. Risk assessments prior to agency nurse cover requests are discussed with the Deputy Chief Nurse and Chief Nurse. No agency cover used in November. Enhanced pay for Bank has now discontinued, and Bank usage throughout November has been significantly reduced. There have been no closures of the Unit throughout November and activity, and acuity is currently within very manageable parameters.

Gynaecology – Safe Care reflected some exceptions in November. This will continue to reflect inaccuracies until the e-roster template is amended for the ward as one of the RN's are allocated to work in the SDEC/EPAU pathway on the twilight shift. A request has been submitted to the e-rostering team, by the matron, to rectify the roster template as soon as possible.

Paediatrics -. Staffing continues to be risk assessed with matrons, ADN and DDN oversight. RN sickness has reduced throughout November and newly qualified RN's have come into post working through supernumerary shifts. Availability of HCA's to enhance RN numbers has been reduced due to vacancy from leavers. Supernumerary band 7 ward manager and practice education team have supported where required. Upskill in training to fulfil some requirements for HDU nurse team cover with risk added to risk register specific to CPAP competent RN's/ Acuity/dependency and activity starting to reflect typical seasonal pressures with an increase in children requiring respiratory support. Pressures across the system have meant that patients typically transferred for onward tertiary care for level 3 critical care are being cared for longer at ELHT which is an added pressure as these patients are 1:1's. Training is being stood down on a week-by-week basis to cover gaps that arise due to sickness. Twice weekly forward plan meetings to review staffing. Daily staffing huddle used to move paediatric staff across teams to cover where demand is high.

Nurse and Midwifery Staffing Data - November

Current vacancies

Vacancies	Establishment	SIP	Vacant	Vacant %
Midwife	300	294	6	1.96%
Nurse	2894	2736	157	5.43%
HCA	1339	1174	157	5.43%
Grand Total	**4532**	**4204**	**328**	**7.25%**

Ethnicity

Ethnicity	HCA	Midwife	Nursing	Grand Total
BME	295	45	878	1218
Not Stated	10		15	25
White	1058	316	2145	3519
Grand Total	**1363**	**361**	**3038**	**4762**

Gender

Gender	HCA	Midwife	Nursing	Grand Total
Female	1181	361	2845	4387
Male	182		193	375
Grand Total	**1363**	**361**	**3038**	**4762**

Age Band	HCA	Midwife	Nursing	Grand Total
<=20 Years	27			27
21-25	90	25	186	301
26-30	118	52	418	588
31-35	187	61	520	768
36-40	161	61	483	705
41-45	138	57	350	545
46-50	158	37	319	514
51-55	185	27	349	561
56-60	185	26	240	451
61-65	101	14	152	267
66-70	9	1	15	25
>=71 Years	4		6	10
Grand Total	**1363**	**361**	**3038**	**4762**

HCA Vacancies Band 2&3

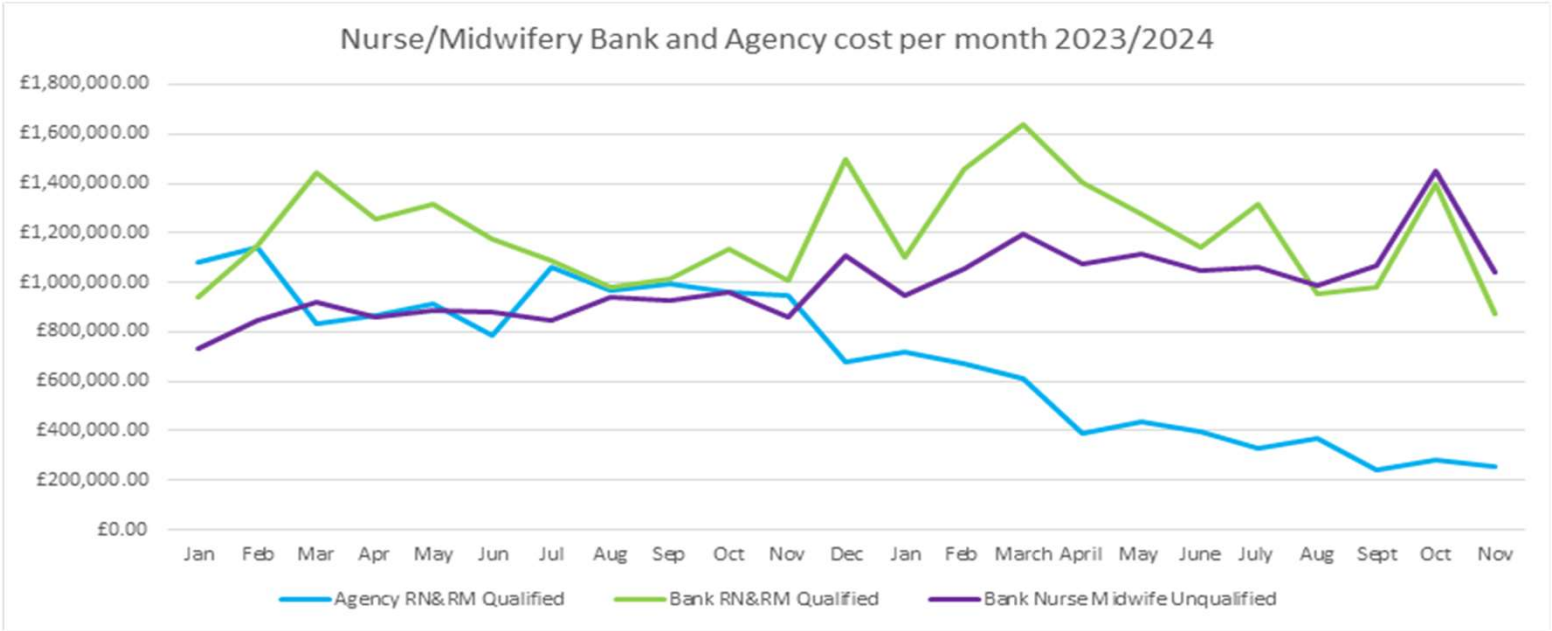
Vacancies	Est	SIP	Vacant	Vacant %
Band 2	852	730	121	14.27%
Band 3	446	396	50	11.24%
Grand Total	**1298**	**1126**	**172**	**13.22%**

SAFE

Safe staffing processes / interventions to mitigate risk
Twice daily staffing calls
The Trust has a twice daily (Monday to Friday) and daily (weekends) Trust wide safer staffing review which utilises the safe care software (Safer Nursing Care Tool) to assess staffing levels with current acuity and dependency. This is routinely chaired by a Divisional Director or Heads of Nursing. The meeting is outcome focused and manages the risk across the Trust.

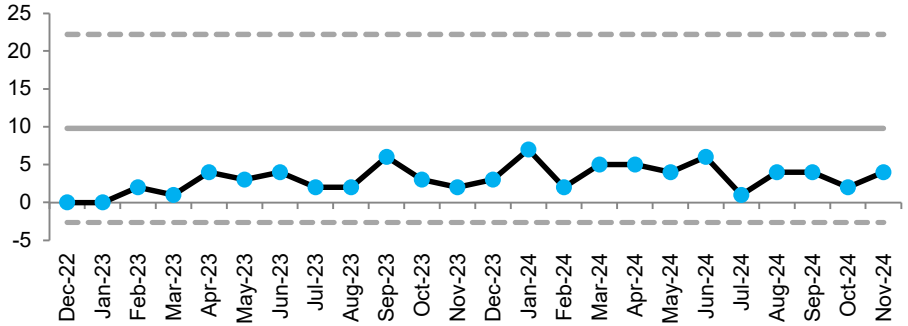
Recruitment / Retention Nursing and Midwifery Trust Activity overview
HCA Recruitment – Event on 10th December, headed by Andrew Wells.
International Nursing Recruitment – no recruitment at the moment.
RN Recruitment – No update available at present.

Nursing and Bank and Agency Spend



SAFE

Serious Incidents



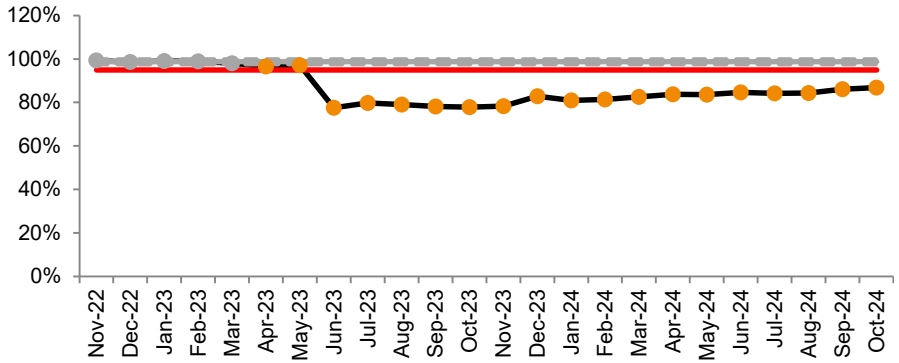
PSIRF Category	No. Incidents
National priority - every baby counts	3
National priority - incident resulting in death	1

There were no never events reported in November.

Four incidents meeting a national or local priority and whereby a patient safety incident investigation (PSII) are underway, have been reported onto STEIS in November. The Trust started reporting under these priorities on 1st December 2021.

A detailed report providing assurance on the management of each of the STEIS reported incidents is submitted monthly to the Trust Board and Quality Committee.

VTE assessment



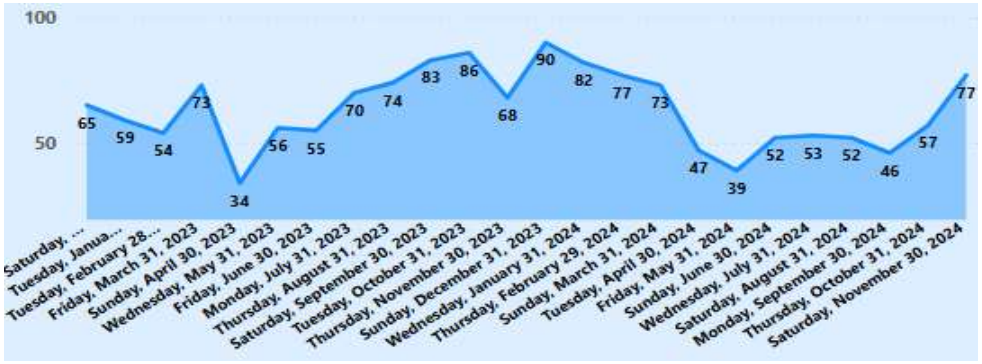
Venous Thromboembolism (VTE) data between June 23 and March 24 was not submitted nationally, figures are calculated retrospecively.

SAFE

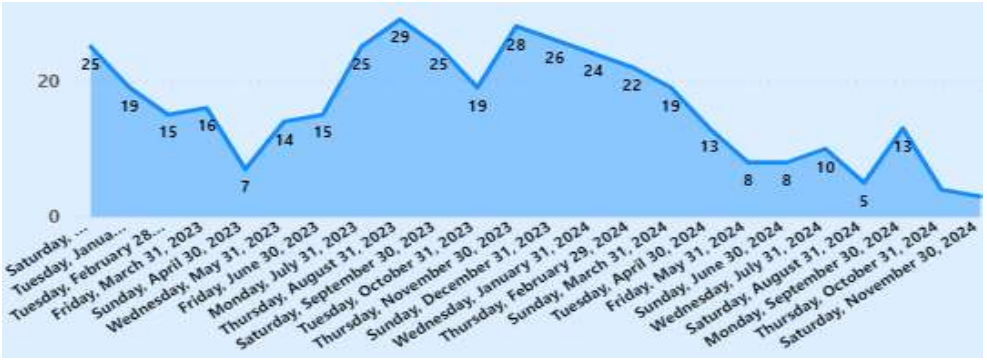
Pressure Ulcers

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

Total pressure ulcers - developed in ELHT



Total pressure ulcers - developed in ELHT - lapses in care



November continued to see an increase in the number of incidents being reported to 71 from 58 in October 2024.

The ED department continued to experience high attendances of complex and high acuity patients resulting in long waits within the ED department in some cases, following a decision to admit, despite increasing the bed base across the inpatient sites.

The District Nursing service continues to average between 1300 - 1400 daily visits with a caseload of approx. 4,200 patients. Since the 1 April 2024, 415 pressure ulcer incidents in total have been reported on patients under the care of the ELHT with 61 confirmed lapses in care (15%).

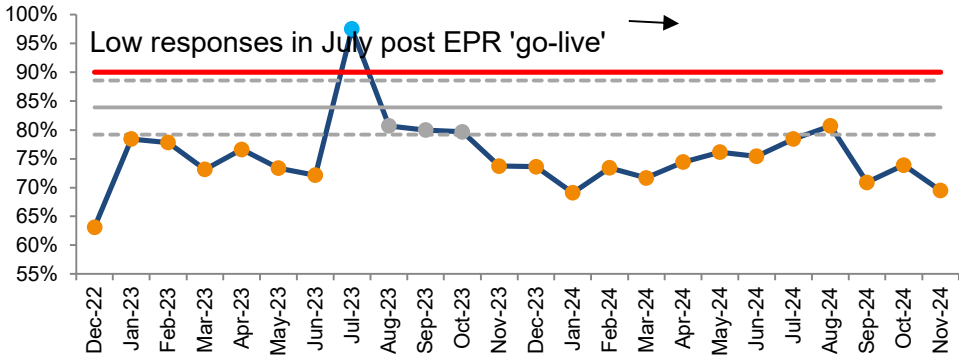
	Total Number of Incidents developed under ELHT Care	
	2023 - 2024	1.4.2024 – 30.11.2024
	847	415
Category of Pressure Ulcer	Total Number of Incidents developed under ELHT Care	Total Number of Lapses in Care
2	78	23
3	17	36
4	10	2

CARING

The Friends & Family Test (FFT) question – “Overall how was your experience of our service” is being used to collect feedback via SMS texting and online via links on the Trust’s website.

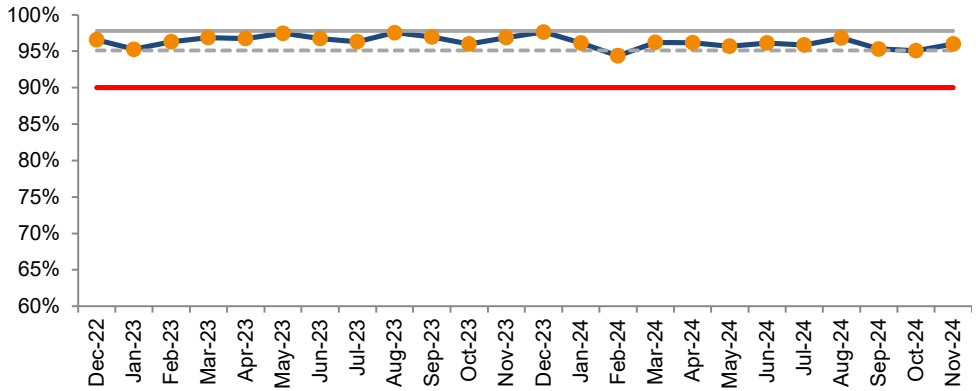
Baseline period for SPC comparison is Apr 18 - Mar 20

Friends & Family A&E



A&E scores are below threshold in November. The trend is showing significant deterioration when compared to the baseline (Apr 18 - Mar 20). Based on current variation this indicator is not capable of hitting the target routinely.

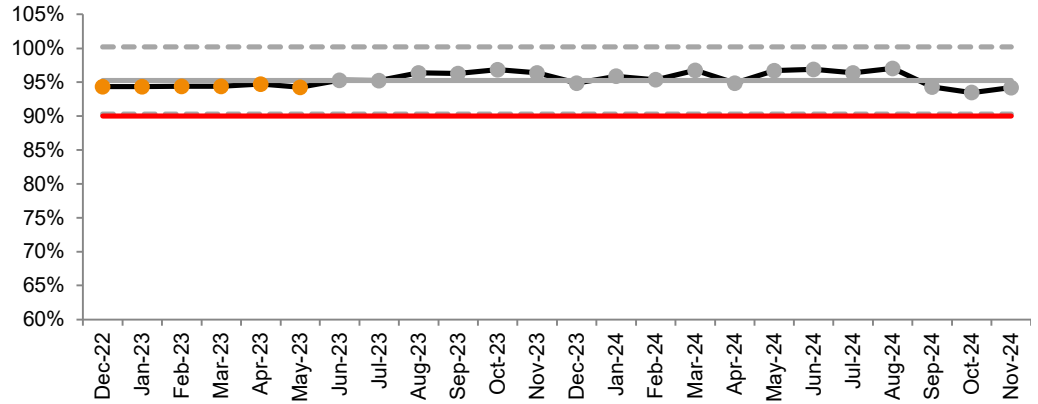
Friends & Family Inpatient



Current performance is above target but is showing significant deterioration from the pre-covid baseline, however based on recent performance will consistently be above threshold.

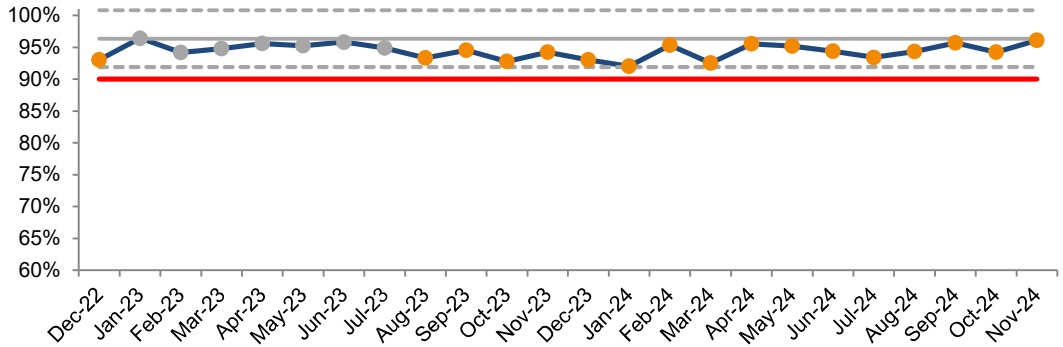
CARING

Friends & Family Outpatients



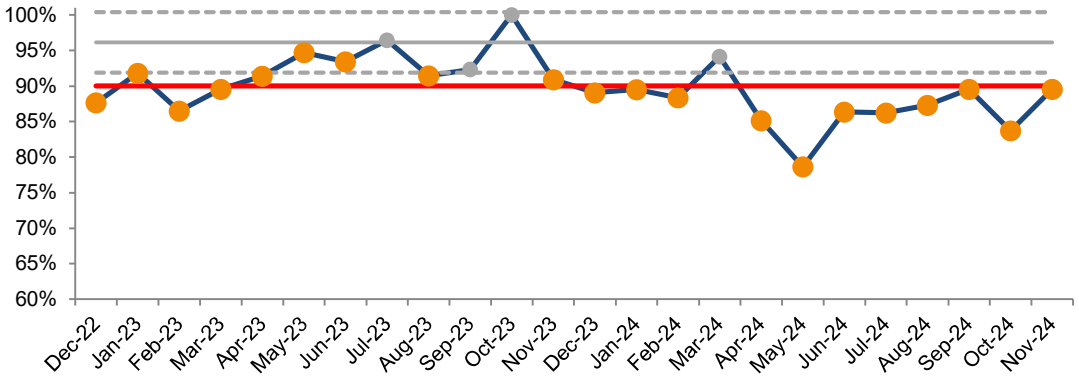
Outpatient scores continue to be above target and are within the normal range when compared to the pre-covid baseline. Based on current variation this indicator should consistently hit the target.

Friends & Family Community



Community scores are above target but showing deterioration when compared with pre-covid levels. Based on normal variation this indicator should consistently hit the target.

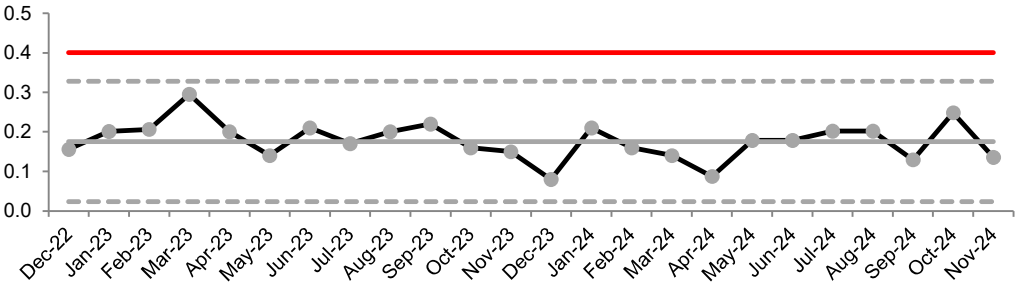
Friends & Family Maternity



Maternity scores are below target this month and show deterioration when compared to the pre-covid levels. Based on normal variation this indicator would consistently hit the target.

CARING

Complaints per 1000 contacts



The Trust opened 19 new formal complaints in November.

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

For November the number of complaints received was 0.14 Per 1,000 patient contacts.

The trend is showing usual variation and based on variation will consistently acheive the target.

Patient Experience

		Dignity	Information	Involvement	Quality	Overall
Type	**Division**	Average Score	Average Score	Average Score	Average Score	Average Score
Community	Community and Intermediate Care Services	94.58	91.79	91.09	95.36	92.99
Community	Diagnostic and Clinical Support	100.00	99.49	100.00	100.00	99.78
Community	Family Care	100.00	-	-	100.00	100.00
Community	Surgery	100.00	97.75	-	-	98.38
Delivery	Family Care	100.00	100.00	100.00	96.88	98.11
ED_UC	Diagnostic and Clinical Support	-	-	-	100.00	100.00
Inpatients	Community and Intermediate Care Services	85.64	82.13	84.40	85.55	84.34
Inpatients	Diagnostic and Clinical Support	100.00	92.70	94.44	98.46	96.38
Inpatients	Family Care	98.10	95.83	96.50	97.10	96.87
Inpatients	Medicine and Emergency Care	91.28	82.11	89.71	89.62	88.32
Inpatients	Surgery	94.91	88.02	92.54	93.32	92.22
OPD	Diagnostic and Clinical Support	99.34	99.59	97.92	93.42	98.84
OPD	Family Care	98.81	96.15	100	91.67	96.59
OPD	Medicine and Emergency Care	98.24	94.79	98.78	97.01	96.92
Postnatal	Family Care	100.00	92.86	85.71	90.48	91.84
SDCU	Family Care	97.22	96.88	95.83	97.06	96.63
	Total	**95.42**	**93.29**	**92.17**	**94.72**	**93.75**

The table demonstrates divisional performance from the range of patient experience surveys in November 2024.

The threshold is a positive score of 90% or above for each of the 4 competencies.

The overall Trust performance from the range of patient experience surveys was above the threshold of 90% for all 4 of the competencies.

Divisions are encouraged to review survey feedback to identify areas for improvement.

EFFECTIVE

SHMI Published Trend

There are some issues impacting the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR), including:
- Backlog in coding
- Removal of Same day emergency care (SDEC) from Admitted Patient Care (APC) dataset
- Data quality issues with SUS submission impacting spell counts

The Trust has an established mortality steering group which meets monthly to review performance and develop specific action plans for any alerting mortality groups identified.

HSMR

EFFECTIVE

Structured Judgement Review Summary

Stage 1	Month of Death																					
	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar	Apr 20 - Mar 21	Apr 21 - Mar	Apr 22- Mar 23	Apr 23 - Mar 24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	TOTAL
Deaths requiring SJR (Stage 1)	47	212	250	262	214	163	231	167	14	12											26
Allocated for review	46	212	250	262	214	163	231	132	2	2											4
SJR Complete	46	212	250	262	214	162	230	94	0	0											0
1 - Very Poor Care	1	1	0	0	1	1	1	1	0	0											0
2 - Poor Care	8	19	22	34	35	22	41	17	0	0											0
3 - Adequate Care	14	68	70	70	65	49	75	23	0	0											0
4 - Good Care	20	106	133	129	103	78	106	49	0	0											0
5 - Excellent Care	3	18	25	29	10	12	7	4	0	0											0
Stage 2																					
Deaths requiring SJR (Stage 2)	9	20	22	34	36	23	42	22	1	0											1
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	0	0	1	0											1
Allocated for review	6	18	21	30	35	22	42	22	0	0											0
SJR-2 Complete	6	18	21	30	35	22	42	20	0	0											0
1 - Very Poor Care	1	1	1	2	0	1	1	0	0	0											0
2 - Poor Care	3	6	7	13	13	10	21	8	0	0											0
3 - Adequate Care	2	10	13	13	21	10	16	8	0	0											0
4 - Good Care	0	1	0	2	1	1	4	4	0	0											0
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0											0

	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar	Apr 20 - Mar 21	Apr 21 - Mar	Apr 22- Mar 23	Apr 23 - Mar 24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
stage 1 requiring allocation	1	0	0	0	0	0	0	35	12	10											22
stage 1 requiring completion	0	0	0	0	0	1	1	38	2	2											4
Stage 1 Backlog	1	0	0	0	0	1	1	73	14	12											26
stage 2 requiring allocation	0	0	0	0	0	0	0	0	0	0											0
stage 2 requiring completion	0	0	0	0	0	0	10	2	0	0											0
Stage 2 Backlog	0	0	0	0	0	0	10	2	0	0											0

The new structured judgement review process was launched at the beginning of December 2017 for deaths meeting specified criteria. A team of reviewers have been trained on how to complete SJR's and are now undertaking the monthly reviews.

The table shows a breakdown of SJR's completed and the scores allocated. Any death allocated a SJR score of 1 or 2 will have a stage 2 SJR completed.

The stage 2 SJR reviewer will determine whether or not any lapses in care may have contributed to the death and if so a SIRI and RCA will be triggered.

The Revalidation & Mortality Officer post has been approved/advertised and interviews will take place w/c 16/12. Once in post the focus will be on training and starting to bring both backlogs down.

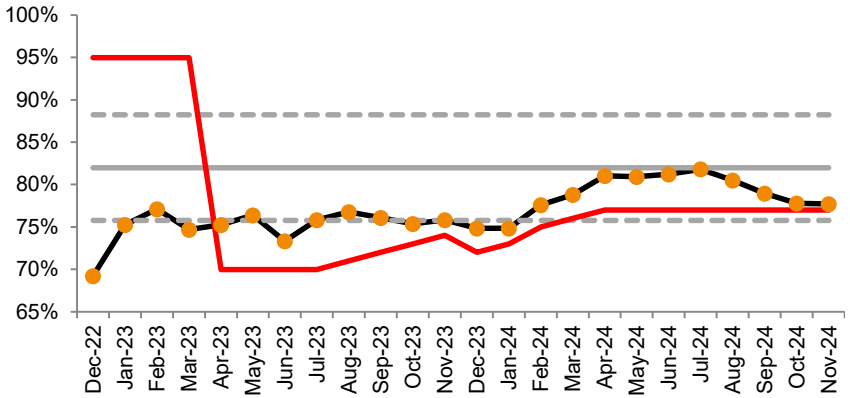
This gap is impacting both processes which are essentially paused and Doctors revalidations are having to go ahead without the required information and the SJR backlog is increasing significantly.

Learning Disability Mortality Reviews

No update provided

RESPONSIVE

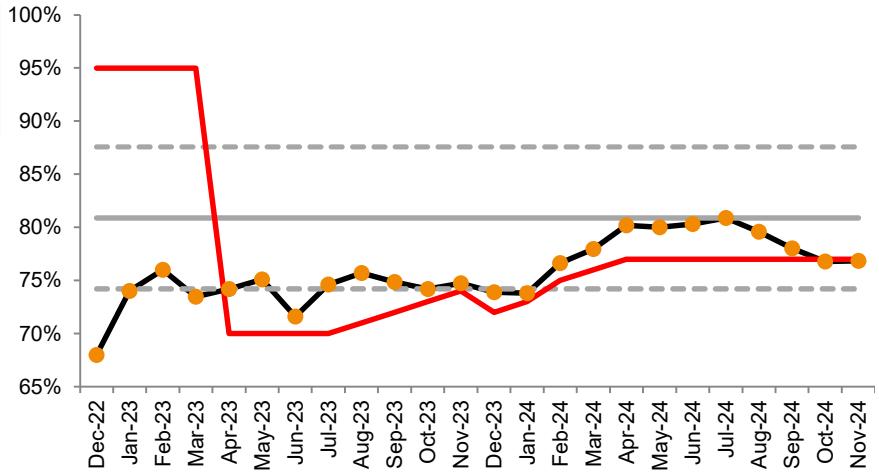
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 77.70% in November, which is above the 77% target.

The trend continues to show a deterioration on previous performance but may deliver the 77% target.

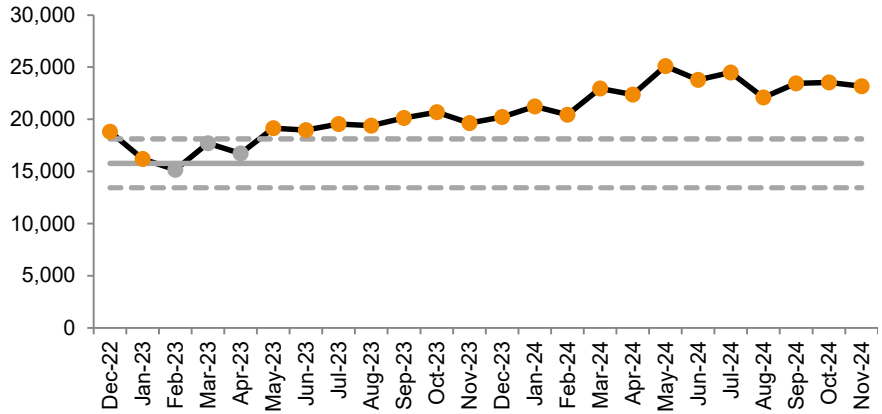
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 76.84% in November, below the 77% trajectory.

The national performance was 72.1% in November (All types).

A&E Attendances - Trust

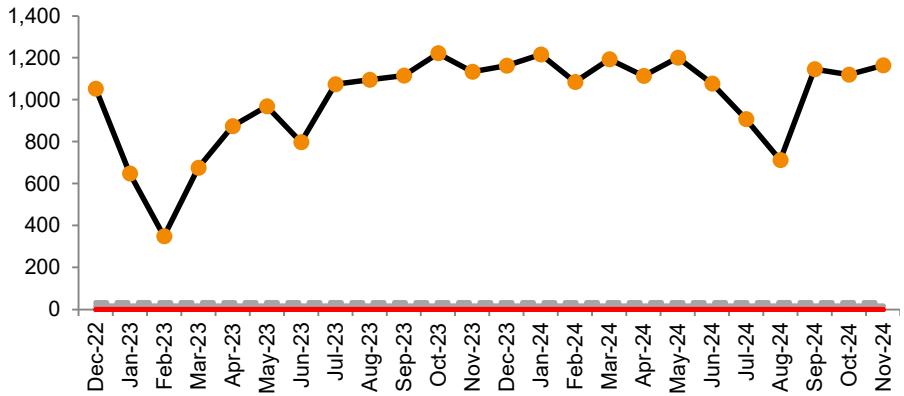


The number of attendances during November was 23,178, which is above the nornal range when compared to the pre-covid baseline.

Following NHSE guidance, the attendance count has been amended in June 23, to include patients who are appointed following inital assessment, which was previously excluded from the count.

RESPONSIVE

12 Hr Trolley Waits

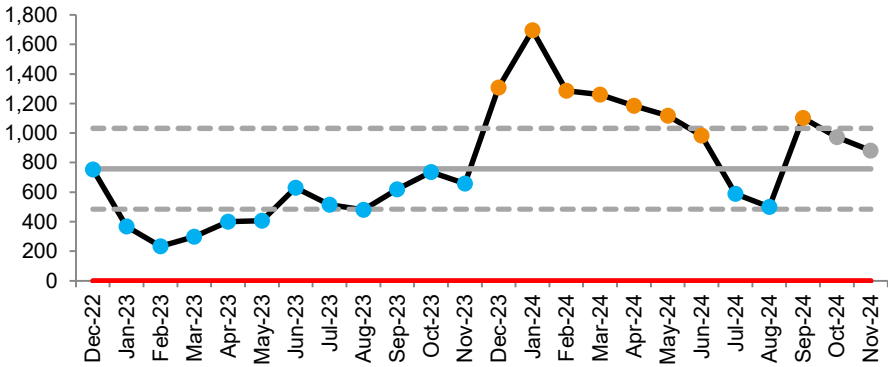


There were 1164 reported breaches of the 12 hour trolley wait standard from decision to admit during November, which is higher than the normal range. 49 were mental health and 1115 were physical health.

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

	Mental Health	Physical Health
No. 12 Hr Trolley Waits	49	1115
Average Wait from Decision to Admit	51hr 25min	24hr 10min
Longest Wait from Decision to Admit	131hr 42min	55hr 38min

Ambulance Handovers - >30Minutes

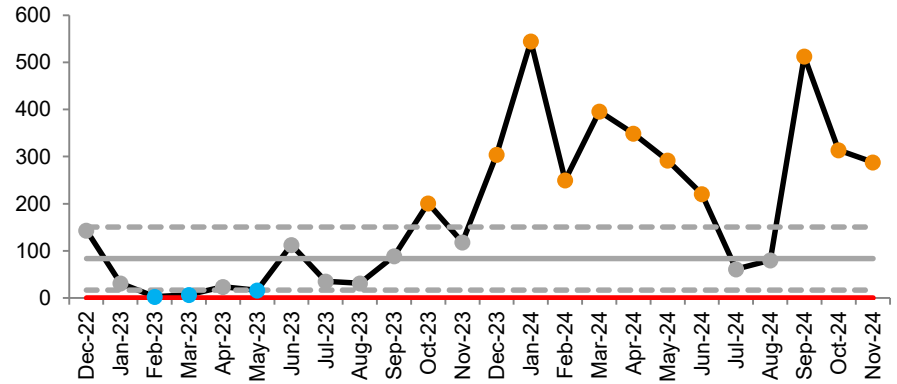


There were 880 ambulance handovers > 30 minutes in November. The trend is showing usual variation, and based on current variation is not capable of hitting the target routinely.

There were a total of 3151 ambulance attends with 880 ambulance handovers > 30 minutes and 288 > 60 minutes.

It is no longer possible to split between ED delays and HAS compliance due to the HALO system. Work is ongoing with NWAS to identify a method for reporting this.

Ambulance Handovers - >60 Minutes



The average handover time was 35 minutes in November, which is an improvement on September & October.

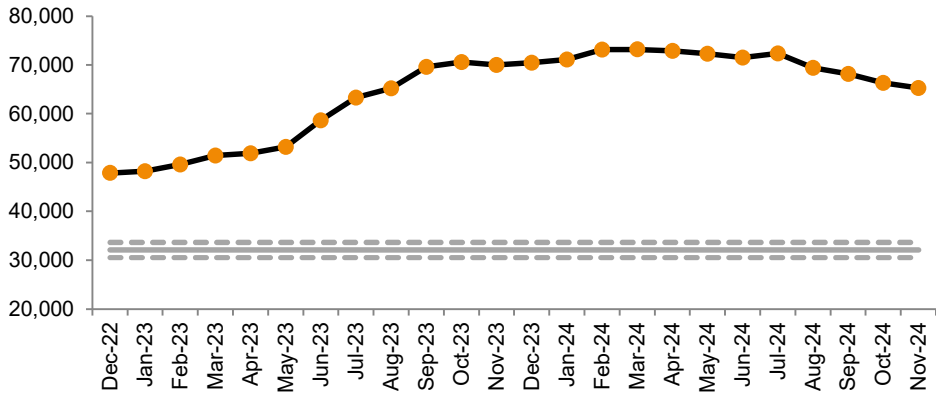
The longest handover in November was reported as 6hr 8 minutes. We are working with NWAS to reduce longer waits due to cohorting since the introduction of the HALO system.

RESPONSIVE

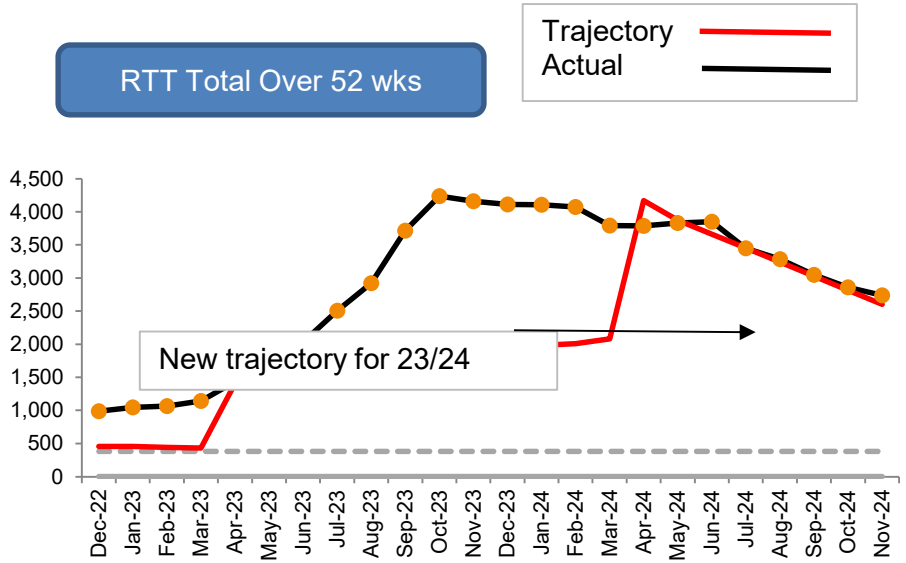
At the end of November, there were 65,265 ongoing pathways, which has reduced on last month but is above pre-COVID levels.

There were 2738 patients waiting over 52 weeks at the end of November which has reduced on last month and is above trajectory.
There were 4 patients waiting over 65 weeks at the end of November which has reduced on last month and is above trajectory. the 4 were due to national graft tissue availability.
We are aware of a number of data quality issues impacting on performance post EPR go live, which the Trust is working on to resolve.

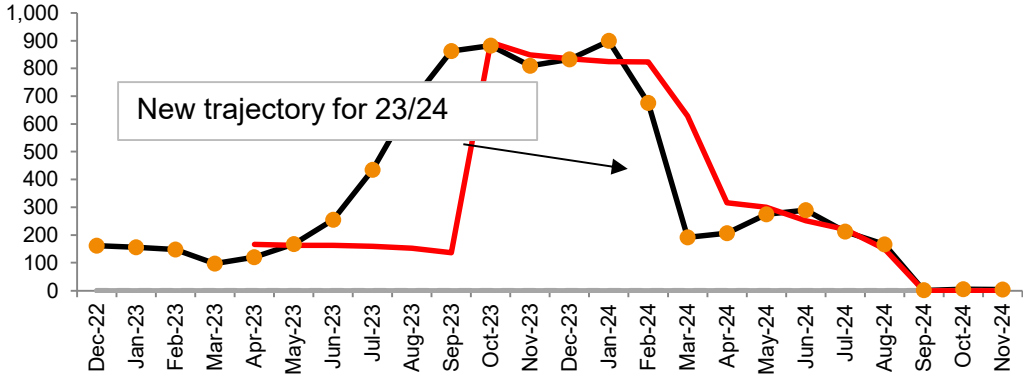
Referral to Treatment (RTT) Total Ongoing



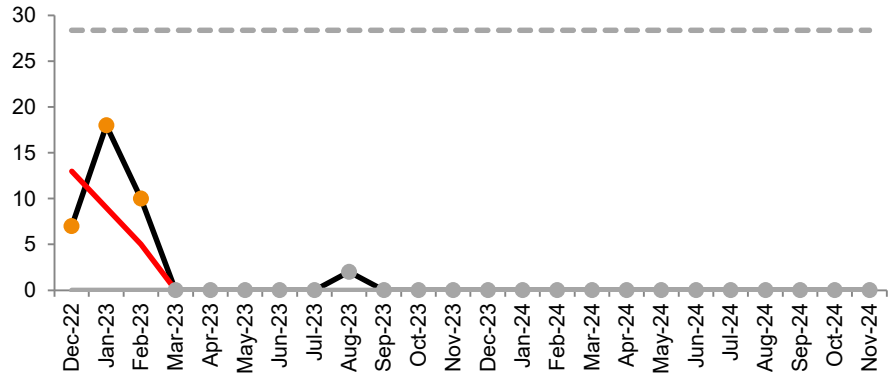
RTT Total Over 52 wks



RTT Total Over 65 wks



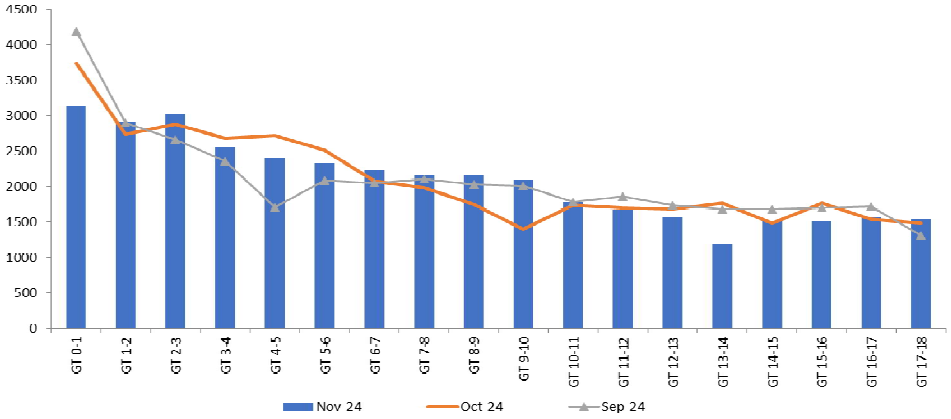
RTT Total Over 78 wks



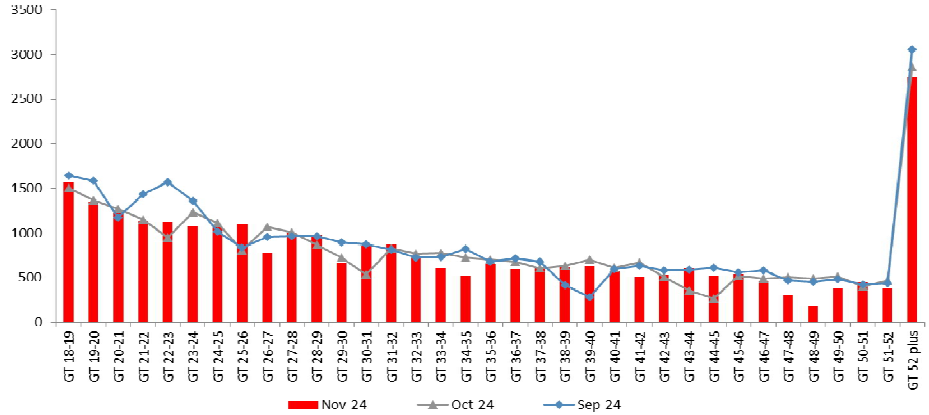
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

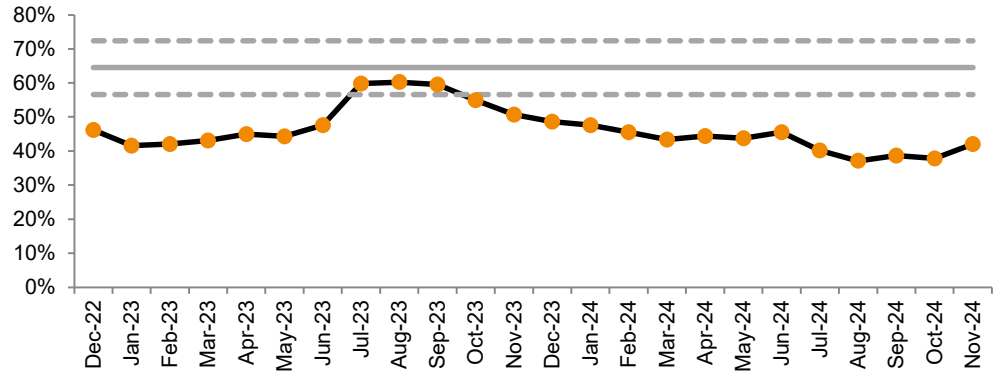


RTT Over 18 weeks

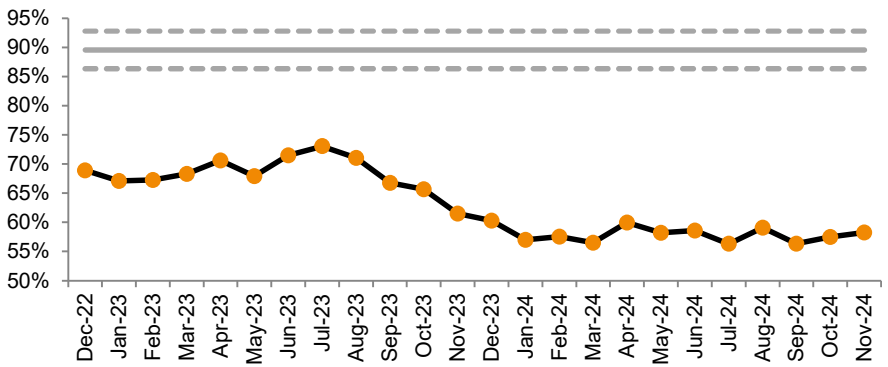


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted



RTT Non-Admitted

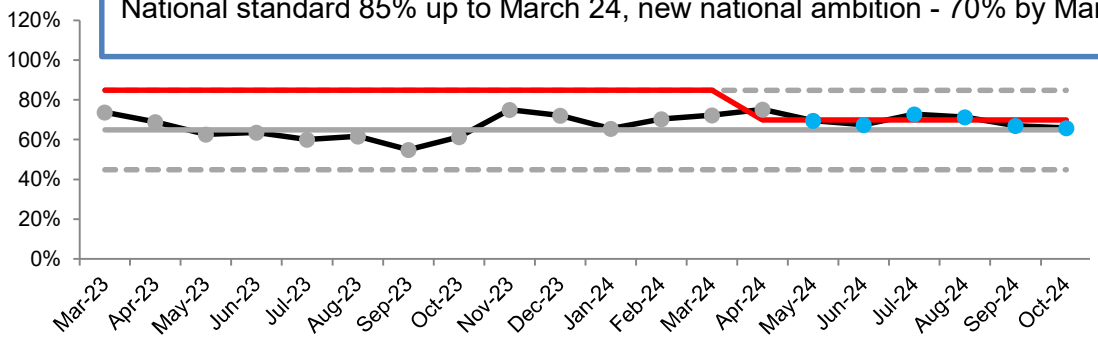


RESPONSIVE

Three new national cancer standards were introduced from 1st October 23. Previously there were 10 standards, which were simplified down to 3. Although graphs show what performance would have been against the new standards, trusts were not being monitored against them prior to October

Cancer 62 day general

National standard 85% up to March 24, new national ambition - 70% by March 25

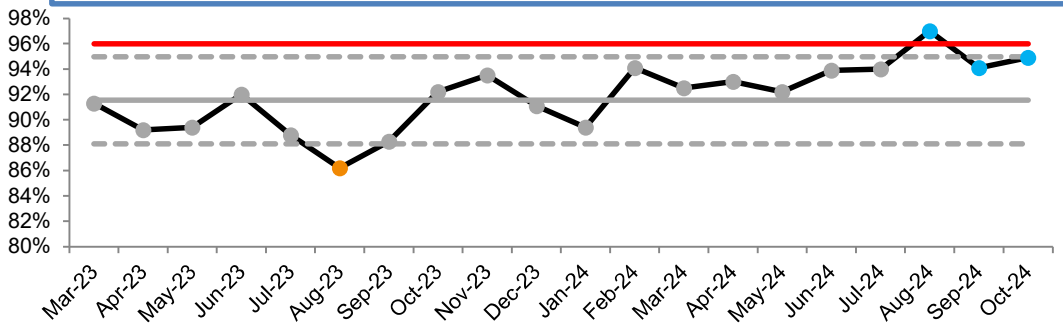


The 62 day standard was not acheived in October at 65.9%. This is also below the 80% internal trajectory. The trend is showing improving variation and may deliver the target.

National performance October - 68.2%

Cancer 31 day general treatment

National standard 96% up to March 24, continues as national ambition for 2024/25

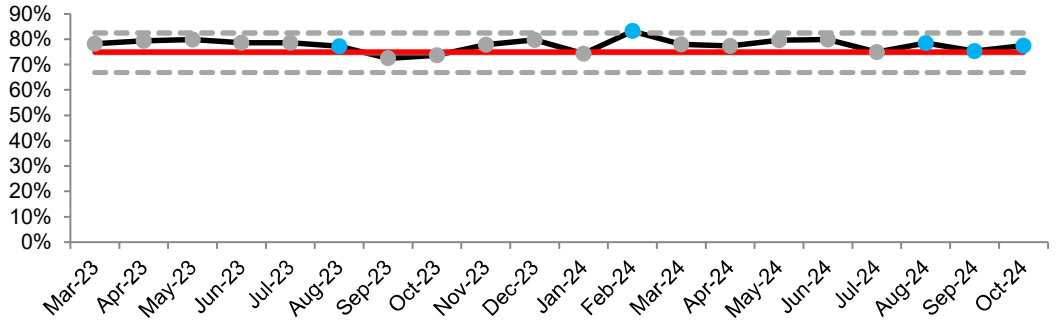


The 31 day standard was not achieved in October at 94.9%, below the 96% standard. This is above the internal trajectory of 92%. The trend is showing improving variation but is not capable of hitting the target routinely.

National performance October - 91.5%

28 day general FDS

National standard 75% up to March 24, new national ambition - 75% (77% by March 25)

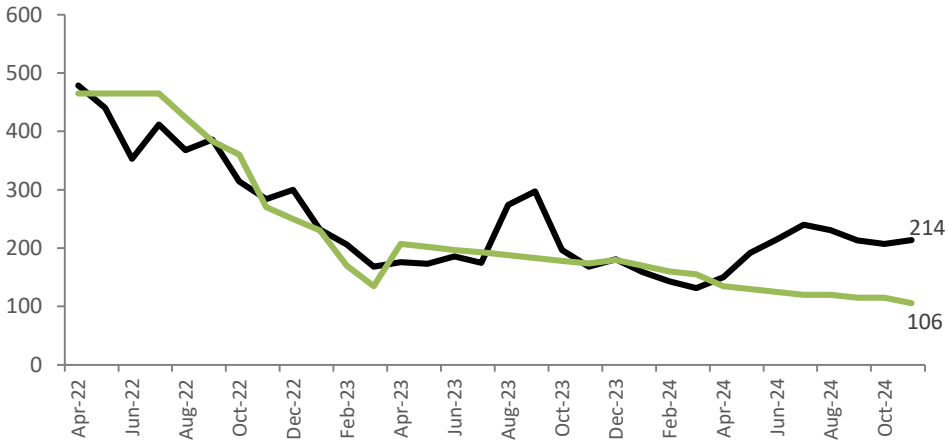


The 28 day FDS standard was achieved in October at 77.4%, above the 75% standard. The trend is showing improving variation and based on current variation will consistently hit the target.

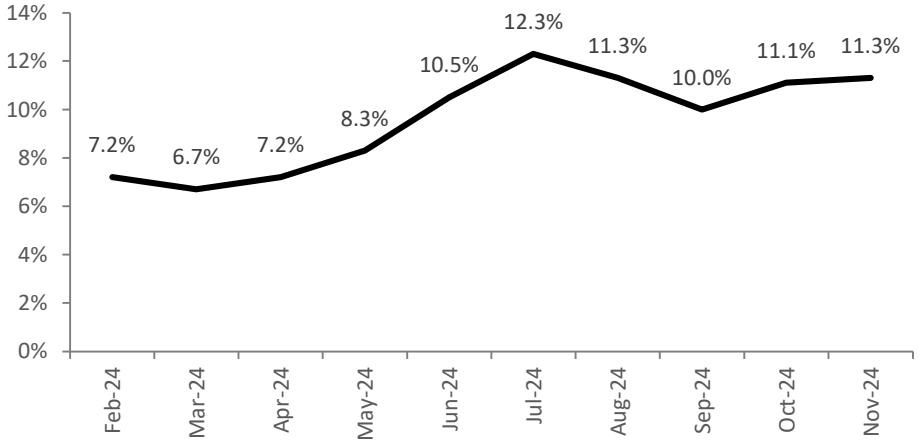
National performance October - 77.1%

RESPONSIVE

Cancer >62 day vs trajectory



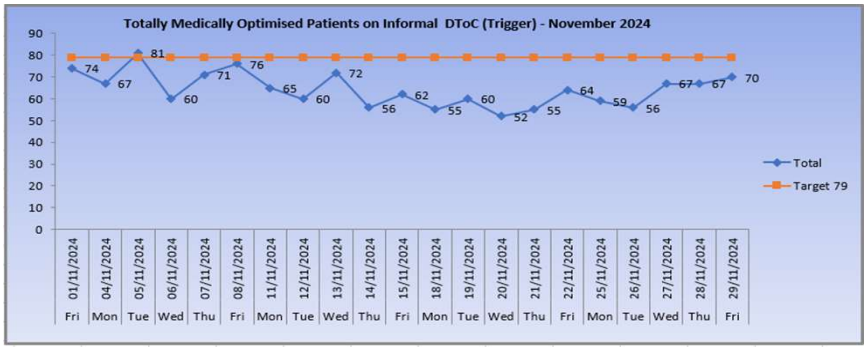
Cancer % Waiting >62days (Urgent GP Referral)



At the end of November the number of patients >62 days was 214 vs 106 trajectory. This was 11.3% of the total wait list.

RESPONSIVE

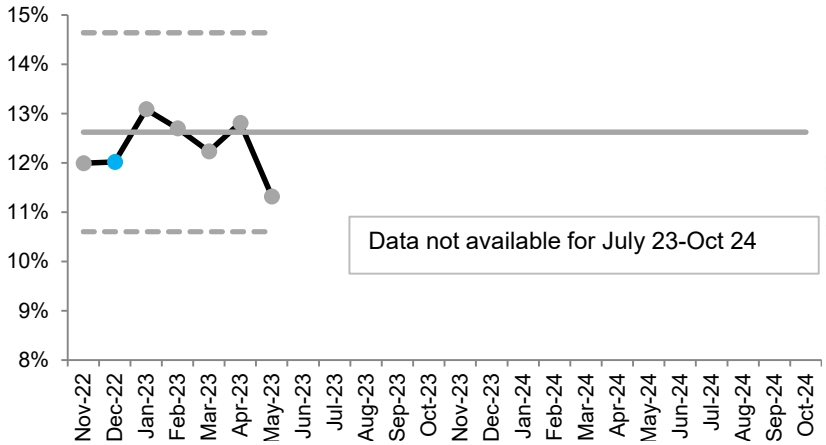
Delayed Discharges



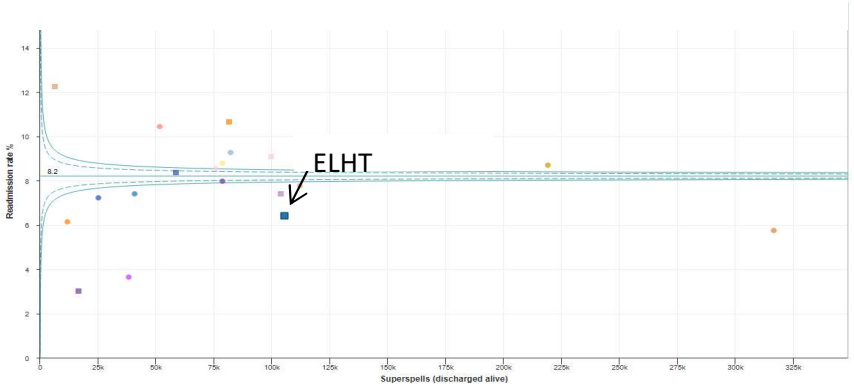
We continue to discharge patients using the rapid discharge principles set out in the Hospital discharge and community support: policy and operating model government guidance, utilising pathways 0-3. Pathways are being used to ensure patients have a discharge plan identified from admission, with pathway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

Dr Foster benchmarking (June 23 - May 24) shows the ELHT readmission rate is lower than the North West average.

Emergency Readmissions

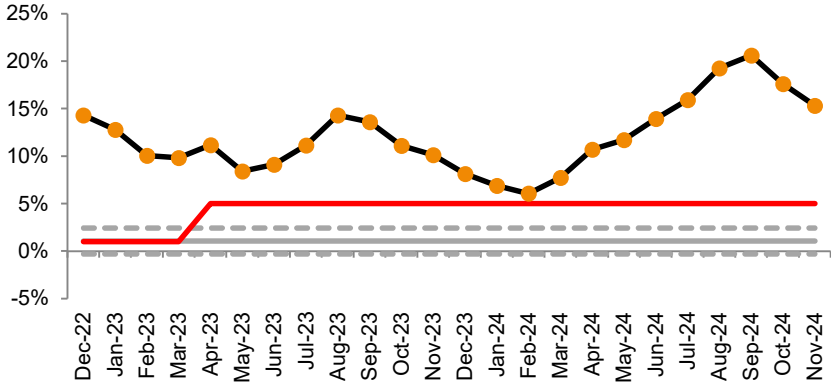


Readmissions within 30 days vs North West - Dr Foster



Data not available for emergency readmissions.

Diagnostic Waits



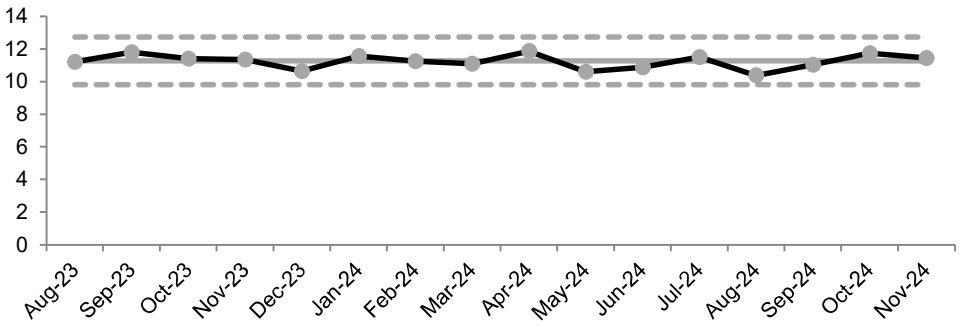
In November, 15.32% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is above the 5% threshold. (95% of patients to receive a diagnostic test within 6 weeks by March 2025).

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

Nationally, the performance is failing the 5% target at 20.7%

RESPONSIVE

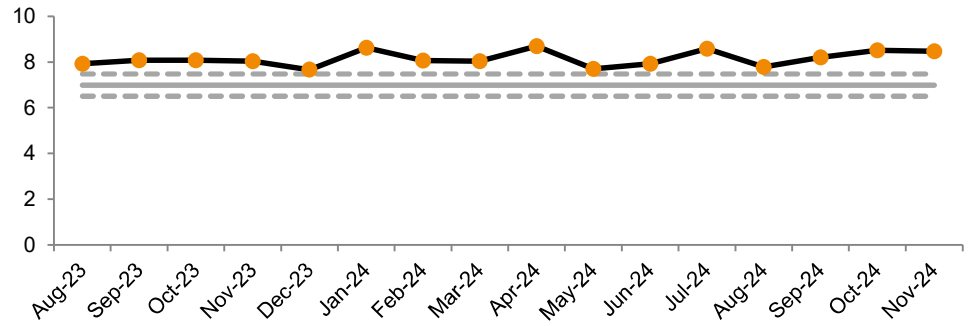
Emergency average length of stay - excluding 0 and 1



Emergency average length of stay methodology in model health excludes 0 and 1 days. Using this methodology, November 24 is within normal variation for this time period.

Please note, there are known data quality issues with recorded discharge date after true discharge discharges.

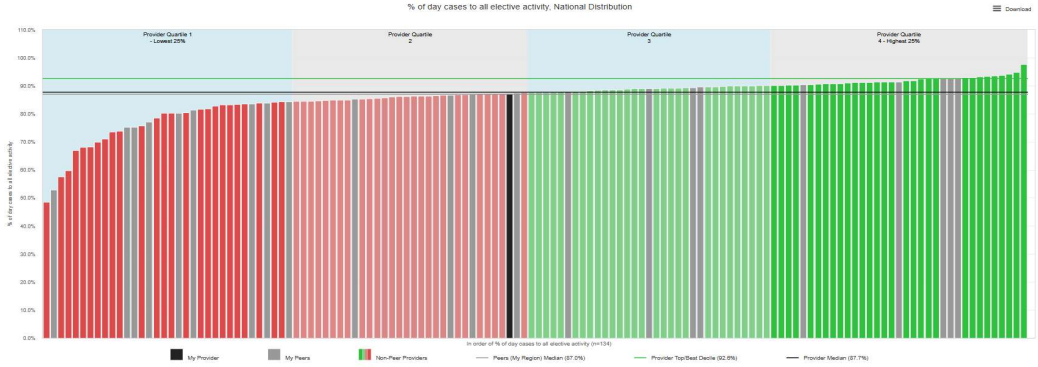
Emergency average length of stay - including 0 and 1



Step change from June 23 is due to the removal of Same Day Emergency Care (SDEC) activity which was previously recorded as a non-elective admission and is now recorded as a type 5 A&E attendance.

Daycase Rate

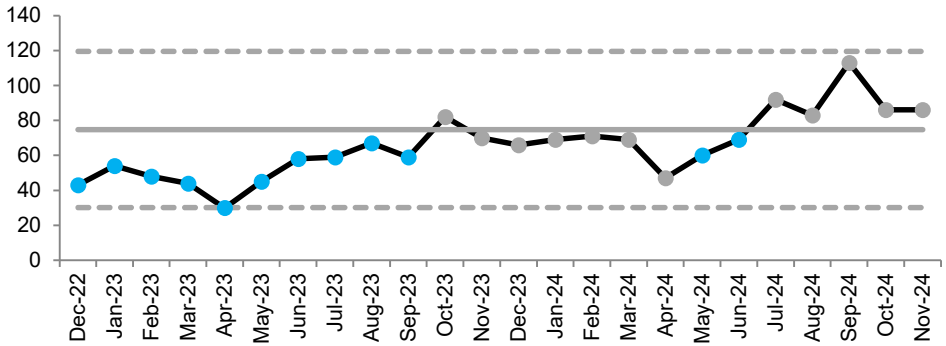
ELHT (87.3%, LTH 75.2%, BTH 90.4%, UHMB 92.7%)



Model health data shows ELHT in the second quartile for daycase rates at 87.3% (August 24).
Due to a change in model health reporting, this graph includes all elective activity whereas the previous graphs included only BADS procedures.

RESPONSIVE

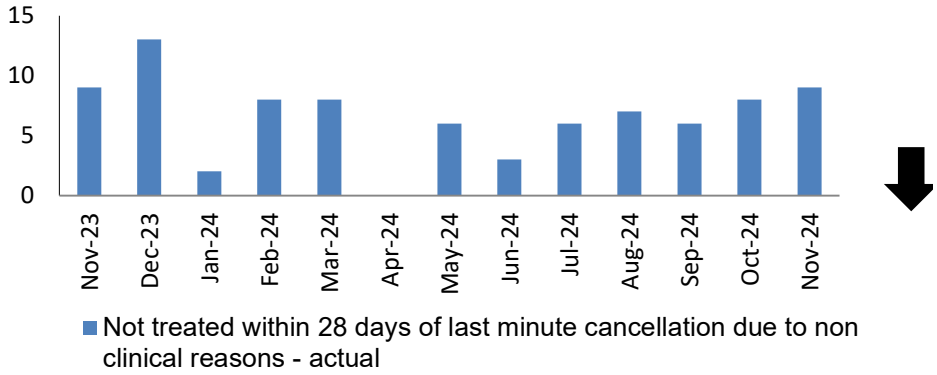
Operations cancelled on day



There were 86 operations cancelled on the day of operation - non clinical reasons, in November. Work is ongoing to better understand the reason for these cancellations with a view to reducing them.

The trend is similar to pre-covid levels.

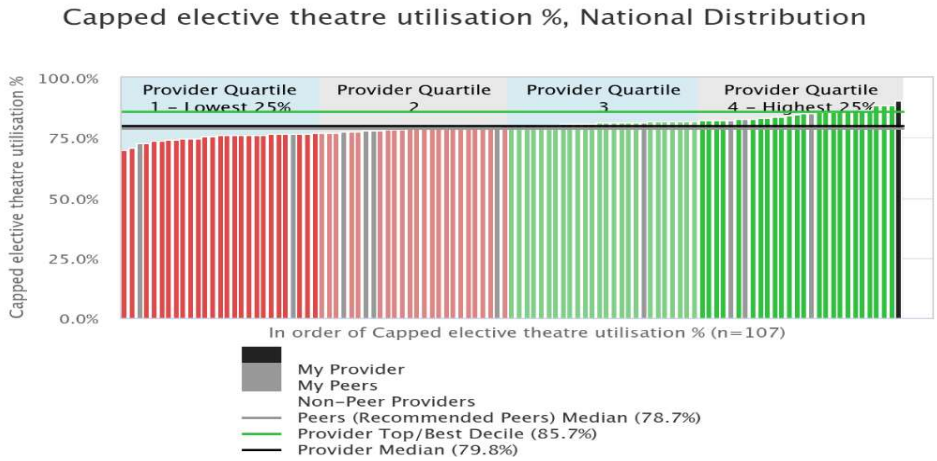
Operations cancelled on day - breaches of 28 day



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

Patients that had procedures cancelled on the day are monitored regularly to ensure dates are offered within the 28 days. Risks are escalated to senior managers and escalated at the weekly operations meeting.

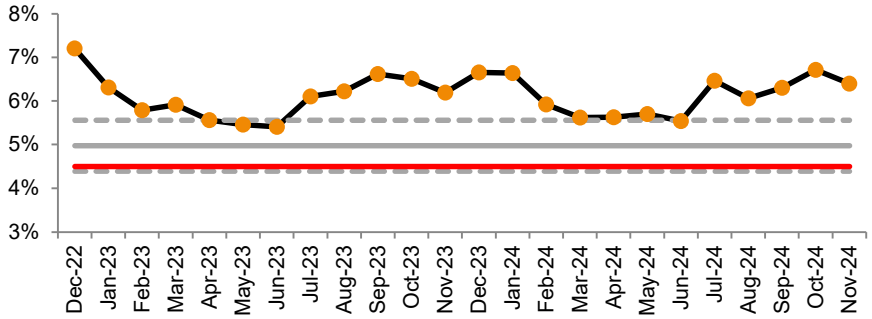
Theatre Utilisation



Data taken from 'The model hospital' shows capped theatre utilisation at 90.4% for the latest period. ELHT are 1st nationally

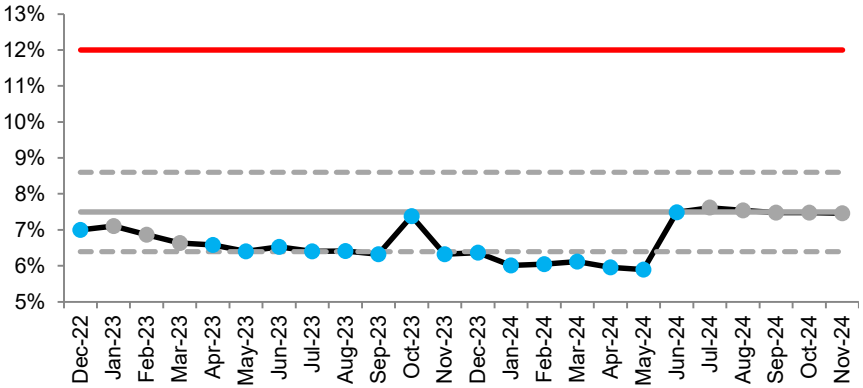
WELL LED

Sickness



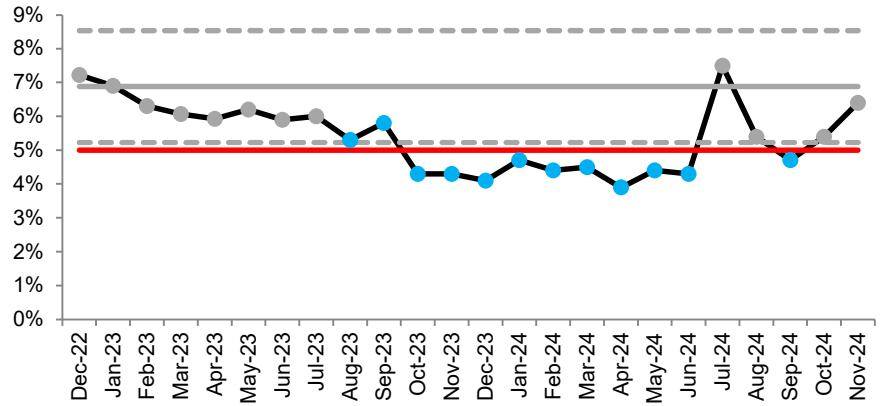
The sickness absence rate was 6.40% for November which is above the threshold of 4.5%. The trend is significantly higher than the pre covid baseline and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 7.46% in November and remains below threshold. This is showing usual variation this month when compared with baseline. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate

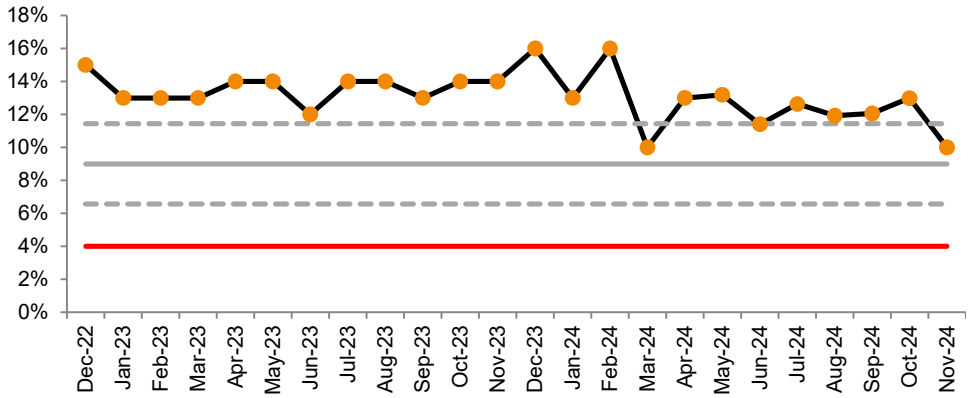


The vacancy rate is 6.4% for November which is above the 5% threshold. The trend is below usual variation and this indicator is not capable of hitting the target routinely.

A detailed action plan has been developed and a quarterly progress update will be provided to the Trust Board.

WELL LED

Temporary costs and overtime as % total pay bill



In November 2024, £4.8m was spent on temporary staff, consisting of £0.7m on agency staff and £4.1m on bank staff.

WTE staff worked (10,168 WTE) was 200 WTE less than is funded substantively (10,368 WTE).

Pay costs are £1.8m more than budgeted establishment in November 2024.

At the end of November 24 there were 651 vacancies.

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

Job Plans

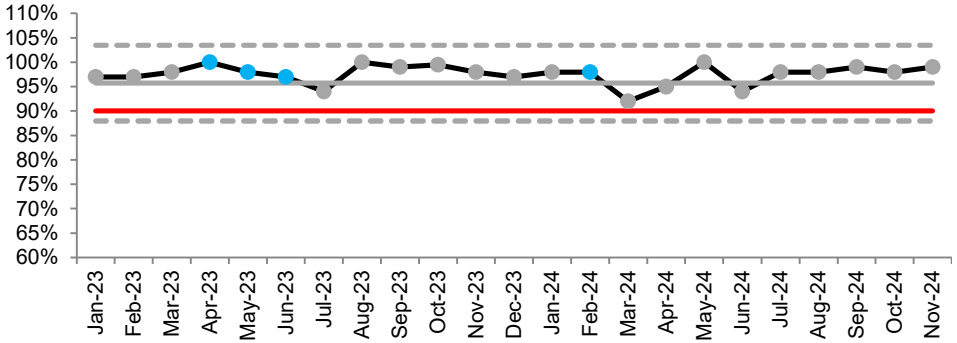
Stage	Consultants	Non consultant grades
Awaiting Signatures	168	44
Complete	62	28
Due Soon	4	0
In Progress	96	15
No Current Job Plan	21	7
Not Started	25	15
Referred Back	7	1
Uploaded	2	0
Total	385	110

As at November 2024, the table shows the numbers in each stage of the job planning process.

Job Planning Consistency panels are scheduled with directorates over August, September and October 24. The purpose of the panel is to provide additional scrutiny and to ensure fairness and equity Trust wide. The panels will form part of the final sign off process.

WELL LED

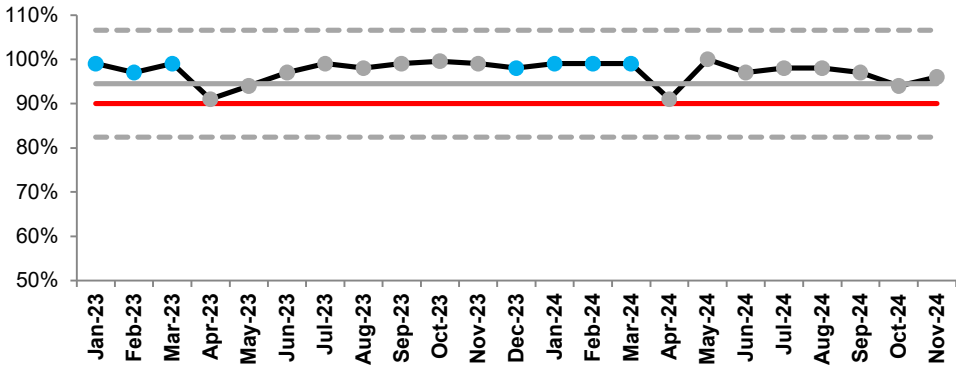
Appraisals, Consultant



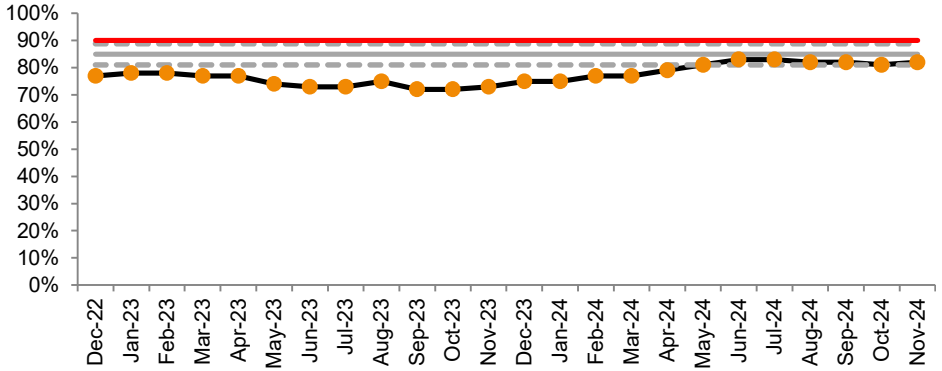
The appraisal rates for consultants and career grade doctors are reported for November 24 and reflect the number of reviews completed that were due in this period.

They both continue to be above target with 99% (consultants) and 96% (other medical) completed that were due in the period.

Appraisals, Other Medical



Appraisals Agenda for Change (AFC) Staff



The AFC appraisal rate continues to be reported as a rolling 12 month figure and remains below threshold. Appraisals were suspended until March 21, due to COVID pressures.

The trend is significantly lower than previous levels and based on current variation the indicator is not capable of achieving the target

There has been a range of Trust wide actions to support compliance which are on-going. These actions are monitored through the Finance & Performance Committee.

WELL LED

Core Skills Training % Compliance

	Frequency	Target	Compliance at end November
Basic Life Support		90%	89
Conflict Resolution Training L1	3 years	90%	96
Equality, Diversity and Human Rights	3 years	90%	96
Fire Safety L1	2 years	95%	95
Health, Safety and Welfare L1	3 years	90%	97
Infection Prevention L1	3 years	90%	98
Infection Prevention L2	1 year	90%	92
Information Governance	1 year	95%	94
Preventing Radicalisation Level 1	3 years	90%	96
Preventing Radicalisation Level 3 †	3 years	90%	95
Safeguarding Adults L1	3 years	90%	96
Safeguarding Adults L2	3 years	90%	96
Safeguarding Adults L3*	3 years	90%	83
Safeguarding Children L1	3 years	90%	95
Safeguarding Children L2	3 years	90%	96
Safeguarding Children L3	3 years	90%	89
Safeguarding Children L4	3 years	90%	100
Safer Handling Level 1	3 years	95%	95
Safer Handling Level 2 (Patient Handling)	3 years	95%	89

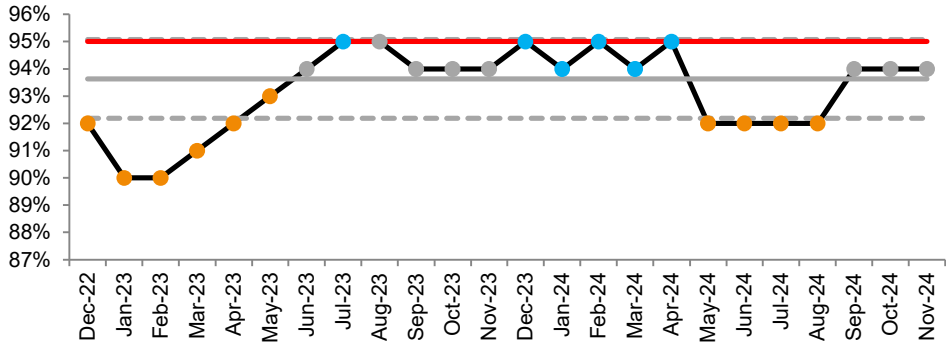
The core skills framework consists of eleven mandatory training subjects, with 19 modules in total. Training is via a suite of e-learning modules and knowledge assessments on the learning hub.

The threshold has been set at 90% for all areas except Information Governance, Fire Safety and Safer Handling which have thresholds of 95%

5 of the 19 modules are below threshold in November. Preventing Radicalisation Level 3 and Safeguarding Adults Level 3 are new mandatory requirements for some staff from April 23.

New starters are now being requested to complete as much of their Core Skills e-Learning requirements as possible prior to attending the Trust Induction training programme via the e-Learning for Healthcare platform. Additionally, there will be a limited amount of time for new starters to undertake any incomplete Core Skills e-Learning/training during the one-day Trust Induction training programme.

Information Governance Toolkit Compliance

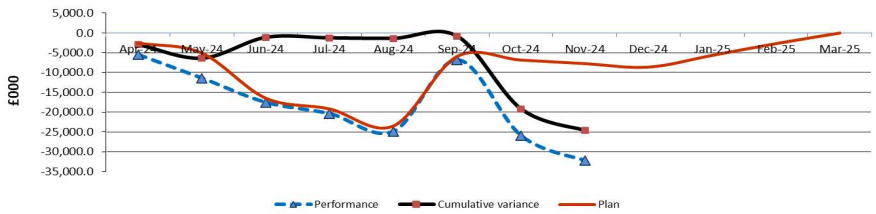


Information governance toolkit compliance is 94% in November which is below the 95% threshold. The trend is at risk of not meeting the target.

WELL LED

Adjusted financial perfomance

Adjusted financial performance surplus (deficit)

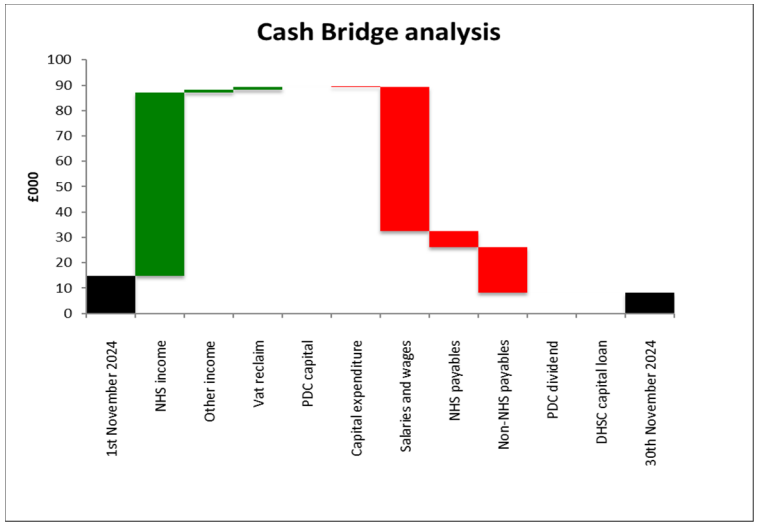


The Trust is reporting a £32.2m deficit for the 2024-25 financial year to date, £24.5m behind plan.

The Trust is reporting a deficit of £32.2m, against a planned deficit of £7.7m for the 2024-25 financial year to date; £24.5m behind the revised breakeven plan.

The 2024-25 capital programme has reduced by £1.2m to £33.6m with year-to-date capital spend at £7.5m, £0.7m behind plan. This carry's a risk to the 2025-26 plan as the Emergency Village works have been deferred while the department is seeing high number of patients, and the theatre electrical upgrade has been deferred due to the activity going through theatres. Both schemes will be reviewed ahead of the 2025-26 capital plan being agreed as the capital programme would be over-committed in 2025-26.

Cash



The Trust's cash balance is £8.2m as at 30th November 2024.

The cash balance on 30th November was £8.2m, a reduction of £6.7m compared to the previous month. This position continues to be supported by £18.2m of Provider Revenue Support Public Dividend Capital (PDC).

Largely 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 November. 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 for the value of non-NHS invoices paid on time is not far below target at 91.8%.

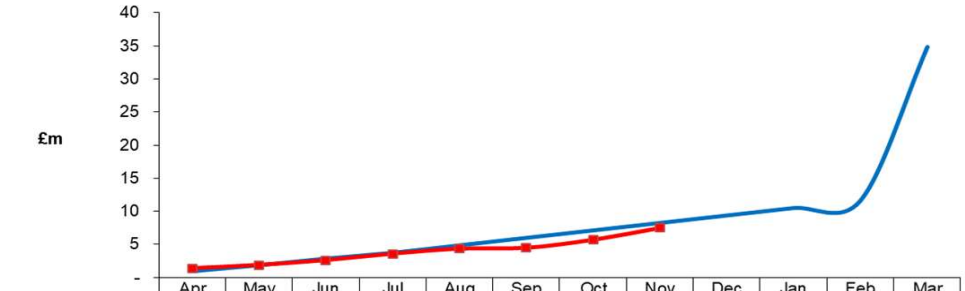
Year to date spend on agency staff represented 1.9% of total pay against the ceiling set by NHS England (NHSE) for 2024-25 of 2.9%.

The Waste Reduction Programme for the 2024-25 financial year is £59.7m. As at month 8, £17.3m has been achieved against a plan of £23.7m, representing a £6.4m underperformance to plan.

WELL LED

Capital expenditure

Capital expenditure profile



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	0.92	1.84	2.84	3.73	4.85	5.98	7.11	8.23	9.36	10.49	11.61	34.82
Actual	1.37	1.87	2.61	3.59	4.36	4.48	5.72	7.51				

The Trust is £0.7m behind planned capital spend as at 30th November 2024.

Waste reduction programme

WRP schemes analysis

ELHT CIP Performance (£000')

Division	CIP Annual Target 2024/25	YTD Performance					Recurrent Actuals		Delivery Status					
		2425 Annual Delivered	YTD Delivered	YTD Target Plan	Variance	% Varr.	Recurrent 2425 Act.	Recurrent YTD Act.	Delivered YTD	Fully developed / in delivery	Plans in Progress	Opportunity	Unidentified	TOTAL
MEC	11,620	£6,353	£5,711	£4,623	£1,087	24%	£5,537	£4,936	£5,711	£1,054	£1,579	£355	£2,922	£11,620
SAS	11,649	£3,563	£2,483	£4,635	-£2,152	-46%	£1,323	£1,122	£2,483	£977	£1,698	£1,820	£4,672	£11,649
FC	6,686	£1,534	£1,062	£2,660	-£1,598	-60%	£1,534	£1,062	£1,062	£252	£111	£2	£5,258	£6,686
DCS	8,485	£2,116	£1,553	£3,376	-£1,823	-54%	£1,365	£1,142	£1,553	£941	£367	£171	£5,452	£8,485
CIC	3,619	£982	£982	£1,440	-£458	-32%	£177	£167	£982	-£187	£903	£265	£1,656	£3,619
Corp.	2,956	£1,505	£1,177	£1,176	£0	0%	£928	£600	£1,177	£343	£110	£75	£593	£2,298
Est.	4,498	£998	£969	£1,790	-£820	-46%	£514	£503	£969	-£198	£426	£6	£3,295	£4,498
DERI	1,175	£1,175	£897	£468	£429	92%	£1,175	£897	£897	£281	£0	£0	£0	£1,177
Central	8,991	£2,513	£2,483	£3,577	-£1,094	-31%	£2,513	£2,483	£2,483	£30	£7,134	£0	£0	£9,647
ELHT Total	59,679	£20,748	£17,316	£23,745	-£6,429	-27%	£15,065	£12,913	£17,316	£3,492	£12,328	£2,695	£23,848	£59,679

Schemes to the value of £17.3m have been transacted in the year to date.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**16**
15 January 2025		**Purpose**	Assurance Information

Title	Care Quality Commission Urgent and Emergency Care Survey Results 2024
Report Author	Mr B Williams, Assistant Director of Patient Experience
Executive sponsor	Mr J Walton-Pollard, Deputy Chief Nurse
Date Paper Approved by Executive Sponsor	

Summary: The report outlines ELHT 2024 Urgent and Emergency Care Survey results.

Recommendation: Board members are requested to consider the survey results.

Report linkages

Related Trust Goal	Deliver safe, high-quality care	
Related to key risks identified on Board Assurance Framework	2	The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
	3	A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
Related to key risks identified on Corporate Risk Register	-	
Related to recommendations from audit reports	-	
Related to Key Delivery Programmes	Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement	
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access.	

Impact

Legal	Yes	Financial	No
Equality	Yes	Confidentiality	Yes

Previously considered by: Patient Experience Group, Quality Committee.

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

ELHT 2024 Urgent and Emergency Care Survey results

1. This report presents the Trust's performance against key indicators from the 2024 Urgent and Emergency Care Survey, a mandated survey by the CQC to gather patient feedback and identify areas for improvement in healthcare services across England.

2. The survey was undertaken on behalf of East Lancashire Hospitals NHS Trust (Trust) by IQVIA (previously Quality Health), a CQC approved contractor. Comparisons are made exclusively with other NHS Trusts that also use IQVIA to conduct the survey. This means that the comparisons are not representative of all NHS trusts that participated.

3. The Trust has underperformed compared to other organisations using IQVIA. The Trust had not achieved any scores in the top-20% range of organisations surveyed by IQVIA. There were 4 scores that are in the intermediate-60% and 24 in the bottom-20%. Due to this year's questionnaire being re-developed, there are no year-on-year comparisons available.

4. The survey was offered to patients who had used Urgent and Emergency Care between April and July 2024. The survey is split between both type 1 (Accident & Emergency) - Royal Blackburn Hospital Emergency Department, and type 3 (Urgent Care) emergency services - Urgent Care Centre (RBH ED/CC, and type 3 Urgent Care Centre at Burnley General Hospital (BGTH) and the Minor Injuries Unit at Accrington Victoria Community Hospital (AVH). There are separate reports for each.

5. Trusts with only type 1 have a sample size of 1,250 and Trusts with both type 1 & 3 have a total sample size of 1,530 (950 for type 1 and 580 for type 3).

6. Summary of Accident and Emergency survey results

7. 209 completed questionnaires were returned from the sample of 950 from East Lancashire Hospitals NHS Trust. A group of 45 service users were excluded from the sample for the following reasons:

8. Moved / not known at this address 21
9. Deceased 24
10. Ineligible 0

11. The final response rate for East Lancashire Hospitals NHS Trust was 23%.

12. Top level results for Accident and Emergency

13. Overall patient satisfaction score for the Trust, based on Q43 "*Overall, how was your experience while you were in A&E?*" was 5.89. The low rating was predominantly from those surveyed over the age of 65 (55%). Highest scoring Trust was 8.38.

14. Overall, the following question performed well for all trusts (9.34) and should be considered an area of achievement. The Trust's score for this question is: 8.47 – "*patients said after assessment they were told what would happen next"*.

15. Overall, the following question performed poorly for all trusts (2.65) and should be considered an area for concern. The Trust's score for this question is: 1.89 – "*patients said they were informed of their wait time before examination / treatment".*

In general:

16. The Trust's results were much worse than most trusts for 5 questions.
17. The Trust's results were worse than most trusts for 13 questions.

18. The Trust's results were somewhat worse than most trusts for 3 questions.
19. The Trust's results were about the same as most trusts for 8 questions.
20. The Trust's results were somewhat better than most trusts for 0 questions.
21. The Trust's results were better than most trusts for 0 questions.
22. The Trust's results were much better than most trusts for 0 questions.

23. Table 1 compares the Trust's top 10 scores to those of the lowest and highest-scoring trusts. Notably, 7 of the Trust's top 10 scores fall within the lowest-scoring range.

Table 1. Top 10 scores

	Question number	Questions	ELHT Score	Lowest Scoring Trust	Highest Scoring Trust
1	37	To what extent did you understand the information you were given on how to care for your condition at home?	8.48	7.99	9.08
2	12	After your first assessment, did the nurse or doctor tell you what would happen next?	8.47	8.47	9.79
3	38	From the information you were given by hospital staff, did you feel able to care for your condition at home?	8.16	7.85	9.06
4	25	Were you given enough privacy when being examined or treated?	7.51	7.51	9.21
5	42	Overall, did you feel you were treated with respect and dignity while you were in A&E?	7.23	7.23	9.30

6	39	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E?	7.16	7.16	8.59
7	19	Did the doctors and nurses listen to what you had to say?	7.07	7.07	9.05
8	28	If you had any tests, did a member of staff explain why you needed them in a way you could understand?	6.93	6.93	8.80
9	21	Did you have confidence and trust in the doctors and nurses examining and treating you?	6.80	6.80	8.71
10	26	If you needed help to take medication for any pre-existing medical conditions, did staff help you?	6.69	6.21	8.55

24. Table 2 presents the 10 questions where the Trust's performance was the weakest. A concerning four of these questions were the lowest scoring across all the trusts surveyed.

Table 2. Bottom 10 scores

	Question number	Questions	EHLT score	Lowest Scoring Trust	Highest Scoring Trust
1	13	Were you informed how long you would have to wait to be examined or treated?	1.89	1.84	3.99
2	14	Were you kept updated on how long your wait would be?	2.77	2.29	5.58

3	35	Thinking about any new medication you were to take at home, were you given any of the following?	3.95	3.06	5.38
4	15	While you were waiting, were you able to get help with your condition or symptoms from a member of staff?	4.47	3.69	6.85
5	20	If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	4.65	4.65	7.40
6	30	Do you think the hospital staff helped you to control your pain?	4.80	4.80	7.05
7	41	If you contacted any health or social care services after leaving A&E, was the care and support available when you needed it?	5.46	4.64	7.05
8	36	Before you left A&E, did hospital staff give you information on how to care for your condition at home?	5.57	5.56	7.83
9	10	Were you given enough privacy when discussing your condition with the receptionist?	5.81	5.81	7.65
10	43	Overall, how was your experience while you were in A&E?	5.98	5.98	8.38

25. The survey participants provided feedback on their hospital experience reveals a varied mix of positive and negative experiences, with a significant emphasis on long waiting times, overcrowding, and a lack of communication.

26. Prominent themes:

27. Long Waiting Times:

    a. A recurring theme is the excessive time spent waiting to be seen and treated, both in A&E and on wards. This often leads to frustration and discomfort, particularly for patients in pain or distress.

28. Overcrowding:

    a. Many respondents mentioned feeling overwhelmed by the sheer number of patients, with corridors filled with beds and patients waiting for treatment. This can create a chaotic and stressful environment for both patients and staff.

29. Communication Issues:

    a. Patients often felt a lack of information regarding their treatment plans, progress, and expected wait times. With poor communication potentially leading to anxiety and uncertainty.

30. Staff Attitudes and Care:

    a. While many praised the kindness and professionalism of the staff, some reported negative experiences, including dismissive attitudes and a lack of empathy.

31. Physical Environment:

    a. Concerns were raised about the cleanliness and overall environment of the hospital, particularly in crowded areas.

32. Table 3 sets out IQVIA's recommendations from the Accident and Emergency survey findings.

Table 3.

Recommendations	
Doctors and Nurses	Further ensure staff take time to ask about and address any anxieties or fears patients have about their condition or treatment.
Doctors and Nurses	Make sure patients are spoken to in a way that they are able to understand, check with them that this is the case and encourage staff to adapt to the patients needs where necessary.
Pain	Look at why some patients felt that hospital staff did not help them to control their pain. Consider what action can be taken, given the lower score in this area.
Overall	Overall, patients felt they had a poor experience when visiting A&E. Look to prioritise two or three areas for action which will make the biggest difference to patient experience.
Your Care and Treatment	Healthcare professionals should use and adapt the person-centred approach to meet the needs of patients that often feel that they are not involved in decisions about their care and treatment as much as they want to be.

33. Summary of Urgent Treatment Centre survey results

34. 87 completed questionnaires were returned from the sample of 580 from East Lancashire Hospitals NHS Trust. A group of 9 service users were excluded from the sample for the following reasons:

35. Moved / not known at this address 6
36. Deceased 3
37. Ineligible 0

38. The final response rate for East Lancashire Hospitals NHS Trust was 15% (87 usable responses from a usable sample of 571).

39. The scores for the Trust are mostly in line with the sector scores. At the question level, 3 scores were among the top 20% of organizations surveyed by IQVIA. Fourteen scores were in the middle 60%, and 10 were in the bottom 20%. Due to this year's questionnaire being re-developed, there are no year-on-year comparisons available.

40. Top Level Results

41. The overall patient satisfaction score for the Trust, based on Q40 "Overall, how was your experience while you were in the Urgent Treatment Centre?" 8.31**.** The highest scoring trust was 9.23**.**

42. Overall, the following question performed well for all Trusts (9.38) and should be considered an area of achievement. The score for this question is: Patients felt they understood information given about care at home 9.80

43. Overall, the following question performed poorly for all trusts (4.13) and should be considered an area for concern. Your score for this question is: 3.40 - Patients said they were informed of their wait time before examination / treatment.

44. Table 4 sets out the top 10 scores for the Trust and compare them against the lowest and highest scores in the overall survey. The majority of the Trust's scores are in the intermediate range.

Table 4. Top 10 scores

	Question number	Questions	ELHT Score	Lowest Scoring Trust	Highest Scoring Trust
1	9	After your first assessment, did the health professional tell you what would happen next?	9.80	8.89	9.80
2	22	Were you given enough privacy when being examined or treated?	9.19	8.26	9.75
3	39	Overall, did you feel you were treated with respect and dignity while you were in the Urgent Treatment Centre?	9.11	8.40	9.64
4	16	Did the health professional listen to what you had to say?	8.93	8.24	9.35
5	14	Did you have enough time to discuss your condition and treatment with the health professional?	8.83	7.40	9.39
6	28	While you were in the Urgent Treatment Centre, did you feel safe around other patients or visitors?	8.55	8.17	9.79
7	34	To what extent did you understand the information you were given on how to care for your condition at home?	8.55	8.13	9.49

8	25	If you had any tests, did a member of staff explain why you needed them in a way you could understand?	8.46	6.56	9.35
9	18	Did you have confidence and trust in the health professional examining and treating you?	8.33	7.96	9.23
10	40	Overall, how was your experience while you were in the Urgent Treatment Centre?	8.31	7.18	9.23

45. Table 5 presents the Trust's 10 lowest-scoring questions. Once again, most of these scores fall within the intermediate range.

Table 5. Bottom 10 scores

	Question number	Questions	ELHT Score	Lowest Scoring Trust	Highest Scoring Trust
1	10	Were you informed how long you would have to wait to be examined or treated?	3.40	1.93	6.41
2	32	Thinking about any new medication you were to take at home, were you given any of the following?	3.71	3.52	5.90
3	12	While you were waiting, were you able to get help with your condition or symptoms from a member of staff?	4.82	2.88	7.03
4	11	Were you kept updated on how long your wait would be?	4.87	2.00	6.64

5	38	If you contacted any health or social care services after leaving the Urgent Treatment Centre, was the care and support available when you needed it?	5.21	4.81	8.10
6	37	Did a member of staff discuss with you whether you may need further health or social care services after leaving the Urgent Treatment Centre?	6.42	6.42	9.38
7	17	If you had any anxieties or fears about your condition or treatment, did a health professional discuss them with you?	6.51	6.49	7.84
8	27	Do you think the staff helped you to control your pain?	6.59	4.85	7.52
9	29	While you were at the Urgent Treatment Centre, were you able to get food or drinks?	6.75	3.87	7.96
10	7	Were you given enough privacy when discussing your condition with the receptionist?	7.11	6.12	8.12

46. A compilation of comments from multiple individuals provides insights into their experiences at the Urgent Treatment Centre.

47. Prominent points from survey participant comments include:

48. Positive feedback about staff being courteous, professional, and efficient.

49. Complaints about long waiting times, uncomfortable seating, and issues with the pharmacy.

50. Specific incidents such as delays in blood results, unhelpful receptionists, and being sent to different hospitals for treatment.

51. Some comments highlight the need for better communication and consistency in patient care.

52. A few comments mention specific medical conditions and treatments received.

53. Overall, the feedback is mixed, with both praise for the staff and criticism of the system's inefficiencies.

54. Table 6 provides IQVIA's recommendations from the Urgent Treatment Centre survey findings.

Table 6.

Recommendations	
Information	Ensure that staff discuss with patients whether they need support from health and social care services after leaving the Urgent Treatment Centre and the next steps to access these services.
Information	Evaluate why patients felt that when they contacted health or social care services after leaving the Urgent Treatment Centre, they could not access the care and support they required when they needed it.
Medications	When prescribing new medication for a patient to take home, ensure that they are provided with sufficient information, both written and verbal, including an explanation of its purpose, side effects, and how to take the medication.
Waiting	Ensure that patients are given a clear and realistic indication of how long they will have to wait to be examined by a health professional.
Health Professionals	Further ensure health professionals take time to ask about and address any anxieties or fears patients have about their condition or treatment.

55. The survey findings underscore the significant emotional and practical challenges faced by patients, carer, and relatives in accessing healthcare, especially during times of heightened stress and vulnerability. The findings also highlight the immense pressure on accident and emergency and urgent care services, which can have a direct impact on the quality of care provided to patients.

56. The Trust is aware of the themes from the survey through ongoing feedback from patients and their supporters via metrics such as complaints, Healthwatch Enter and View reports, Friends and Family the Trust (FFT). It is noteworthy to highlight that Accident and Emergency an average 75% positive FFT rating for this reporting period, the national average for A&E was 80%.

57. In response, several initiatives have commenced to strengthen aspects such as pain management, improve communication between staff and patients and their supporter, and develop the environment.

58. Recommendations

59. The Trust to continue to monitor the impact of ED quality improvements through PEG

Barry Williams
Assistant Director of Patient Experience
19 November 2024

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **17**

15 January 2025 **Purpose** Assurance

Information

Title	Freedom to Speak Up Report
Report Author	Mrs J Butcher, Freedom to Speak Up Guardian
Executive sponsor	Mrs K Quinn, Executive Director of People and Culture

Summary: This report has been prepared to advise the Committee of progress made since the last bi-annual report in May 2024. It includes number of staff who have raised concerns in 2023/24, emerging themes, actions taken, service updates and national updates. This report is also being shared with Trust Board in December 2024.

Recommendation: The Board is asked to note and approve the content of the report. Once approved the report will be made available to managers and staff.

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Healthy, diverse and highly motivated people
Related to key risks identified on Board Assurance Framework	1 The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter. 2 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Freedom to Speak Up Review Assignment Report 2022/23 Report Ref: 127ELHT_2223_013

Impact

Legal	No	Financial	No
Equality	Yes	Confidentiality	Yes

Background

1. The importance of listening to staff cannot be overemphasised. When staff raise concerns, they want to know that they are encouraged and supported to do so and can do it safely in a protected environment. Following on from the Sir Robert Francis Review, it is a requirement of the NHS Standard Contract that Trusts appoint a Freedom To Speak Up (FTSU) Guardian with the organisation who is "someone to whom staff can go to, who is recognised as independent and impartial, has authority to speak to anyone within or outside the Trust, is expert in all aspects of raising and handling concerns, has the tenacity to ensure safety issues are addressed and has dedicated time to perform this role".

Introduction

2. This report has been prepared to advise the Committee of progress made since the last bi-annual report in May 2024 and includes a bi-annual summary Quarter 1 and Quarter 2 (April to September 24). It includes number of staff who have raised concerns, emerging themes, actions taken, service updates and national updates. This report is also being shared with Trust Board in December 2024. This report also includes information regarding current number of unprecedent ongoing concerns within in Quarter 3.

Summary of Progress

3.

a) 101 concerns have been raised through the service in Quarter 1 and Quarter 2, Meaning over 1604 colleagues have spoken up since the role was introduced at the Trust in April 2016.
b) As mentioned in the last report, both Guardians have now received training in Anti-racism and Allyship.
c) FTSU training of all levels is now mandated for all staff.
d) 22 FTSU Ambassadors have been embedded throughout the Trust for almost 12 months.
e) Presentations and promotion of the services continues widely within the Trust and information is embedded within various different policies and processes.
f) FTSU information is being shared and highlighted through more agendas.

g) We have seen an unprecedented spike in concerns being raised during the current quarter (Quarter 3) which is leading to a potential waiting list for colleagues wishing to have an appointment with the Staff Guardians

h) There are currently 93 cases open, again this is unprecedented.

i) We are currently awaiting advice from the National Guardian office in relation to where the responsibility will be allocated for the additional 2,500 plus colleagues that have joined ELHT through 1LSC. Their advice is currently that all of these additional colleagues will sit within the current Staff Guardian service at ELHT. If this remains the advice, then there will need to be additional funding to bring in additional resources, as the service is already under extreme pressure heading towards a waiting list system and without this additional resource the capacity will not be there to maintain the current service that is offered and will not be able to offer such service to 1LSC.

Freedom to Speak Up – Number of cases, themes and actions taken

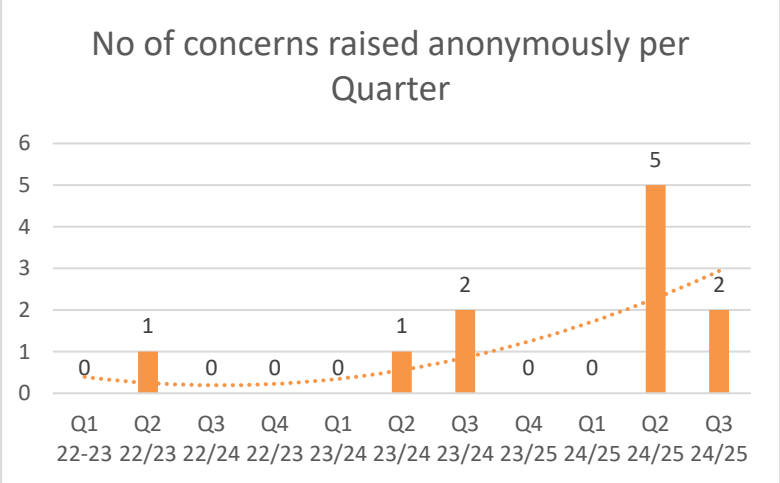
4. During Quarter 1 and Quarter 2, 101 concerns have been raised, which is on par with the average concerns raised which is 53 per quarter. The same period last year saw 117 concerns raised which is 58 per quarter.

During the first 6 weeks of Quarter 3, we have seen 83 concerns raised. This would see an average of 166 per quarter if this trend continued which is an increase of 183%. Although we normally see an increase of concerns in October due to the Freedom to Speak up Month promotions, this is the highest number of concerns raised ever seen during the first 6 weeks of Quarter 3.

	Q1	Q2	Q3 – to date (21/11/24)	Q4
Total no	**40**	**61**	**83**	**0**
Raised anonymously	0	5		
Element of patient safety	3	0		
Element of bullying and harassment	11	16		
Element of worker safety or well-being	18	34		
Element of inappropriate behaviours and attitudes	21	35		
Staff member suffered detriment as a result of raising a concern				

Concern raised by:	**AHP**	1	1		
	Medical and Dental	3	2		
	Ambulance	0	0		
	Nurses & Midwives	13	25		
	Administrative and Clerical	12	19		
	Additional Professional Scientific	1	0		
	Additional clinical services	3	4		
	Estates and Ancillary	7	4		
	Healthcare Scientists	0	0		
	Students	0	0		
	Not Known	0	5		
	Other	0	0		
No. of staff providing feedback about the service		3	6		
Given their experience would they speak up again?	**yes**	3	5		
	no	0	1		
	maybe	0	0		
	I don't know	0	0		

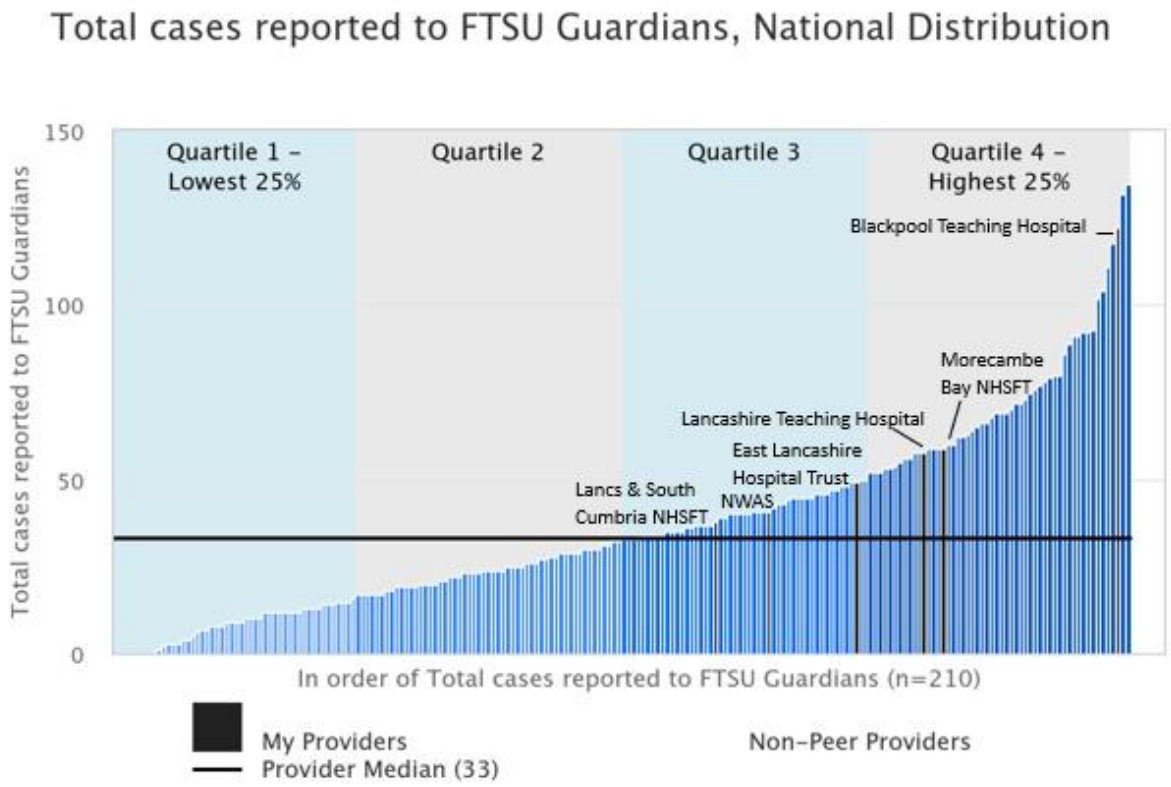
5. We have had 5 cases raised anonymously which shows the trust staff have in the service and that the promise of confidentiality is honoured.



6. Of those that responded to feedback about the service, we have had consistent positive feedback that they found the process helpful, the service approachable and appreciated in depth feedback being provided. One user said "*I have recently an extremely difficult time at work and was not able to find resolution or support from my*

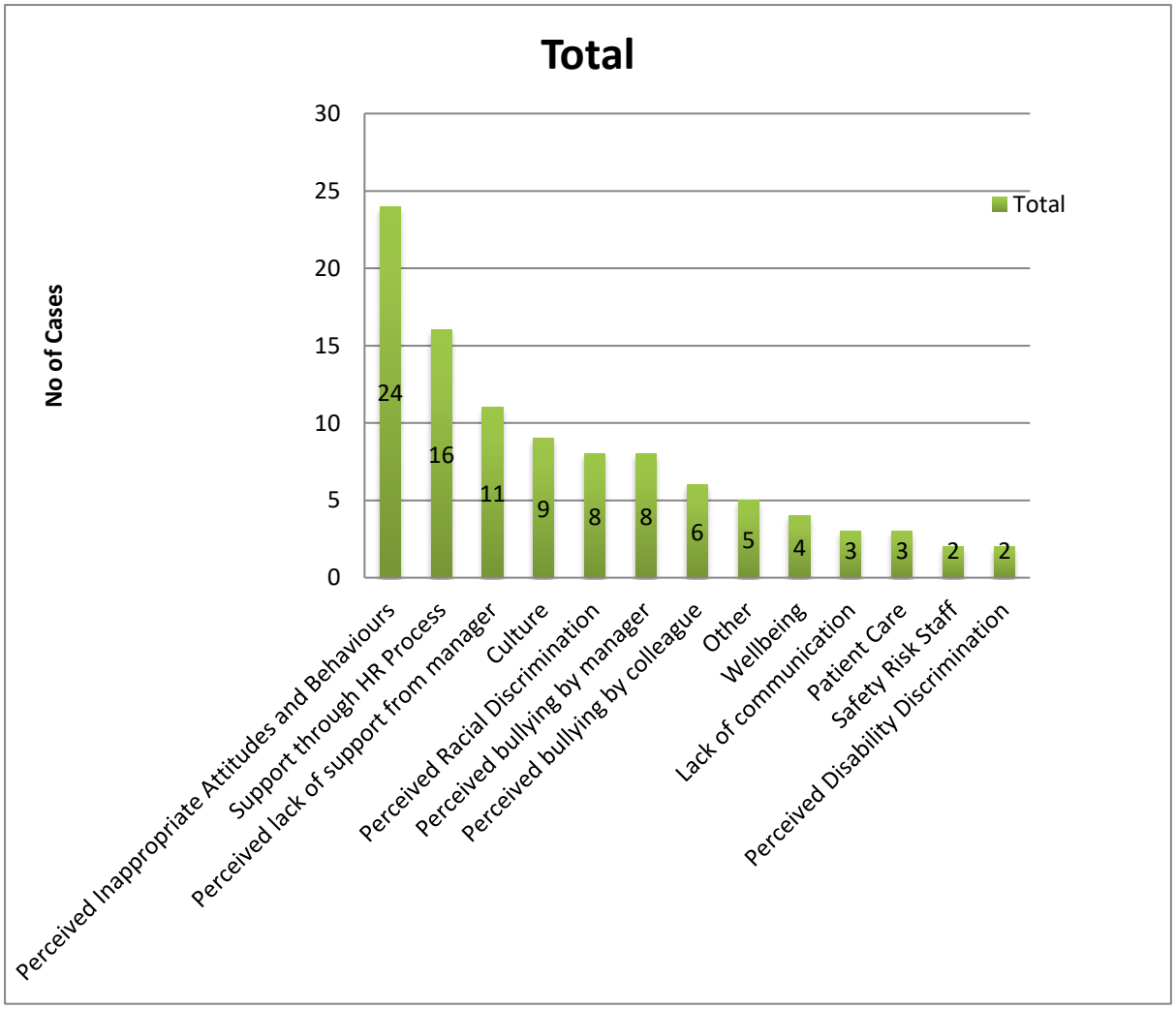
line management. Staff Guardian provided me with care, compassion and practical support at a time when I felt lost and vulnerable. One of the most important services I have ever accessed. They gave me practical options and always put my wellbeing and care at the centre of their support. A resolution was found which would have not been possible without their direct support. Without them my health would have deteriorated.

7. We are currently working with the ESR team to establish a way to connect our recording data to enable us to identify equality monitoring data for every case.



8. Data available on Model Hospital for Quarter 4 2023/24 shows where East Lancashire Hospital Trust sits alongside our peers for total cases reported through FTSU. We have moved from Quartile 4 to Quartile 3 for the highest 25% of reported cases. We are on par with our peers in the region.

Total number of concerns raised by theme Quarter 1 and Quarter 2



9. The highest number of concerns raised is perceived inappropriate attitudes and behaviours at 24 cases. Followed by 16 for support through HR process and then 11 concerns reporting a perceived lack of support from managers. The three concerns have remained the top three constant concerns within the last few years, however currently in quarter 3 we have experienced a shift towards Culture and Working Environment which will be reported on in more detail in the next report.

10. Staff seeking support through a HR process can range from a pay or pension query, support through the resolution process or queries about policies and procedure such

as flexible working. We work extremely closely with HR and Union colleagues to resolve these concerns for the individual. We can also be involved in policy updates to improve processes.

11. It is worth highlighting that we have seen 8 concerns with an element of potential racial discrimination theme come through our service during this reporting period. 2 of the cases has been brought to us and is being supported by our Ambassadors.
12. Often the individual seeks confidential support about a situation or incident which has occurred. At which point we can signpost to the appropriate service such as Occupational Health or mediation, escalate the matter on their behalf, or empower them to raise it themselves following an in-depth conversation.
13. It remains that through concerns raised, we are hearing that staff of all grades are feeling the recent system and financial pressures evident throughout the Trust. This is manifesting in staff feeling a lack of support, burnout, increased inappropriate behaviours and low morale. Managers are struggling to find the time to support staff as they usually would, meaning traditional routes of speaking up are becoming impaired or not addressed. Many staff comment they are currently part of the sickness absence process or are thinking about leaving due to current morale.
14. We have seen at least 4 colleagues who have raised concerns leave the Trust or their current post due to concerns not being addressed.
15. To demonstrate some of the actions that have taken place this year because of staff speaking up, we have summarised some anonymised cases below:
    a) Due to several concerns being raised within a department regarding culture, we are in the process of undertake a staff guardian review and will share the results of our finding in a report to the executive director sponsoring this review. This will result in an action plan being fed back to staff and working through together to resolve any issues identified.
    b) Staff at Burnley General raised concerns regarding the stress and anxiety caused by the lack of car parking availability. The Trust has now agreed to trail the opening of additional car parking.
    c) A colleague raised concerns in relation to the lack if support by their line manager in relation to reasonable adjustment. We have worked closely with the manager and Occupational Health and HR colleagues and an agreement has now been reached which will allow the colleague to undertake their role with this additional support.

Freedom to Speak Up Mandatory training

16. FTSU training Levels 1 and 2 became mandatory for all staff on 18 October 2023. FTSU training Level 3 became mandatory for Band 9 and above on 26 February 2024.

Level	Name	Audience	Compliance rate (as of 25/11/24)
Level 1	Speak Up	All staff	87.5%
Level 2	Listen Up	All staff	76.2%
Level 3	Follow Up	Band 9 and above	47.1%

17. Compliance has increased from 0.8% to 87.5% (Level 1) and 0.7% to 76.2% (Level 2). However this has fallen short of the 90% target. Mainly due to the fact that the number of staff who are eligible for the training has increased from 10506 to 15256.

18. Compliance for Level 3 has increased from 0% to 47.1%. The grace period for completing Level 3 ended in May 2024 and we ask that any staff Band 9 and above who have not yet completed this training to do so.

Freedom to Speak Up Ambassadors

19. During October 2023 we relaunched and recruited to the existing the FTSU Champions role and renamed them FTSU Ambassadors. We are pleased to announce we have now trained/retrained 22 Ambassadors who have been officially launched in January 2024 who have been selected from a variety of roles, departments and sites within the organisation.

20. A comprehensive campaign was launched to introduce the FTSU Ambassadors explaining their roles and how staff can engage with them. Clear governance, pathways and guidance has been established for FTSU Ambassadors to ensure confidentiality and protection for those who speak up. Quarterly meetings have been set up to provide support and guidance for the FTSU Ambassadors with the FTSU Guardians. Staff have already started using this route and we are pleased that staff now have an additional route for speaking up.

Big Conversations

21. During the recent civil unrest that we saw in summer of this year, we took part in a big conversation held by the executive directors of the trust to encourage colleagues from a BAME background to speak up especially if they felt a victim of racial discrimination As a result of this we saw 8 colleagues speak up and their concerns were in relation to potential racial discrimination. We also saw colleagues throughout the Trust speak up through other pathways raising the concerns about inappropriate post regarding the civil unrest on social media. The intention is to share the results of those that led to a formal investigation (protecting confidentiality) and demonstrate that the Trust will not tolerate any form of discrimination.

National Updates

22. The National Guardian has welcomed the review into the safety of the health and care landscape that the government have asked Dr Penny Dash to lead. This review will look at improving the safety and quality of care that patient receive. This is an important opportunity to exam the impact of the 6 patient safety organisations and how we work together.
23. They have responded to several of the reviews / reports recently undertaken and we are working closely with them to improve speaking up services and the importance of the service.

Next Steps

24. To obtain the advice from the National Guardian Office in relation to the responsibility for those colleagues joining to form 1LSC and work through a robust plan on how we can offer this service whether it be the responsibility of the ELHT Guardians or joint responsibility with the Guardian in the partnering Trust.
25. To work through the 93 cases that are currently open and address / identify any reason for delay in these cases.
26. Regardless of 1LSC above, due to the recent increase in activity we will need to introduce a waiting list for colleagues using the service.
27. To look at the possibility of FTSU Ambassadors attending the Anti-racism and Allyship training.
28. Continue to work closely with each division regarding specific areas of concern.

Recommendation

29. To approve to note and approve the content of the report. Once approved the report will be made available to managers and staff.

30. To commit to completion of the Level 3 FTSU Follow Up training for staff members Band 9 and above as there has been no increase since the last report.

Lancashire and South Cumbria Provider Collaborative

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TRUST BOARD REPORT **Item** **18**

15 January 2025 **Purpose** Approval

Title	ELHT&Me Annual Report and Accounts 2023-24
Report Author	Mrs K Lewis, Deputy Head of Financial Control
Executive sponsor	Mrs S Simpson, Executive Director of Finance

Summary: The 2023-24 Annual Report and Accounts for ELHT&Me are presented for review and approval by the Trust Board, as Corporate Trustee, prior to submission to the Charity Commission.

Recommendation: The Charitable Funds Committee recommends the Trust Board to approve the 2023-24 Annual Report and Accounts for ELHT&Me for submission to the Charity Commission

Report linkages

Related Trust Goal	Deliver safe, high quality care Compassionate and inclusive culture Improve health and tackle inequalities in our community. Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

(18) ELHT&Me Annual Report and Accounts 2022-23

ELHT&Me Annual Report

Annual Report 2023-24

Contents

Front cover photo = NHS 75 balloons

Chairman's Report

Welcome to ELHT&Me Annual Report for 2023-24.

It is my pleasure to present this Annual Report, highlighting how we are supporting our hospital Trust to provide the best possible care to our communities. Our commitment to delivering safe, personal, effective care remains at our core and we are making progress towards achieving the objectives outlined in our three-year strategy. We continue to focus on quality healthcare and continuous improvement, fulfilling our mission year after year.

Our support continues to make a big difference to our patients and the hard-working teams at the Trust and every bit of investment made brings a huge amount of pride, knowing it is the result of fundraising efforts and donations.

In the last year, we proudly celebrated the 75th anniversary of the NHS with a calendar of special events and activity, including Wear it Blue, Big NHS Tea and The Big NHS Tee-Off golf competition. This has enabled us to create new relationships and strengthened existing ones, bringing our community together as one big NHS hospital charity team working towards a single goal.

We have also grown our charity team, building capacity to support and engage volunteers and the local community and to raise awareness and income. We are now connected to more organisations that ever before, helping ELHT&Me be in the heart of our local communities.

I extend my thanks to our wonderful colleagues, volunteers and community members who support us in countless ways; with special mention of our dedicated trustees, whose skills and enthusiasm ensure that ELHT&Me continues to thrive. With renewed motivation, we aim to further enhance our services – offering a charitable embrace for the people of East Lancashire.

Insert photo of Shazad

Shazad Sarwar

Chair, East Lancashire Hospitals NHS Trust

Objectives and Activities

ELHT&Me is a registered charity (Registered number 1050478) in accordance with the Charities Act 2011.

ELHT&Me is the official charity for the five hospitals that make up East Lancashire Hospitals NHS Trust – Royal Blackburn and Burnley General Teaching Hospitals and community hospitals in Clitheroe, Pendle and Accrington Victoria.

Funds are used for any charitable purpose or purposes relating to the NHS or to general or specific purposes of East Lancashire Hospitals NHS Trust.

As a public benefit entity, the main charitable activities of the charity are to fund:

- Improvements to the services provided to patients, primarily through the purchase of equipment that would be outside the NHS funding, as well as improvements to the patient environment and experience.
- Training for Trust staff and to help to develop and improve staff amenities. The trustees have considered the Charity Commission's guidance on public benefit when reviewing the charity's aims and objectives and in planning future activities and setting the grant making policy for the year. To achieve our aims and objectives ELHT&Me will actively seek and apply for grants, become front facing through the charity hub creation at Royal Blackburn Teaching Hospital and increase corporate relations. The charity will also design and deliver large scale events whilst establishing legacies to generate income.

Our Purpose

In 2023-24, our main aim has been to provide funding for a range of initiatives that support the health of the Trust's community by continually enhancing the patient care and experience across the hospitals and beyond. This includes providing additional equipment; supporting staff and their development; funding new and innovative research projects and working in partnership with other organisations to support community health initiatives. To achieve this aim we continue to support:

- The purchase of specialist equipment and investment into new technology to empower our team to leverage the latest advancements in their area of care.
- Fostering the wellbeing of our teams by resourcing wellbeing projects and initiatives, enabling them to deliver the highest quality of care.
- Creating inviting spaces for staff, patients and visitors to enjoy together.
- Providing the extra touches that enhance comfort and make time in hospital more pleasant for everyone.

Achievements and Performance

ELHT&Me is honoured to have continued to support the NHS as well as the patients, staff and wider communities of East Lancashire Hospitals throughout 2023-24. This could not have been done without the brilliant support from all our donors, fundraisers, partners and supporters.

Patient and family support

Experiencing baby loss during early pregnancy is devastating but we are helping support patients through this difficult time with holistic care. This includes the thoughtful provision of Bear Hug Bags, that contain a teddy bear, a footprint bracelet, a feathered angel wing, a Reiki-blessed healing heart and a packet of forget-me-not seeds. These items are carefully selected to provide comfort and support, helping to honour the memory of the lost baby and aid in the emotional healing process for patients during their heartbreak.

Environment

The physiotherapy space at Pendle Community Hospital has been significantly brightened. Our latest project features a stunning, full-wall mural of Pendle Hill, the iconic landmark under whose shadow our hospital resides. This artwork is more than just a visual enhancement; it embodies our commitment to creating a therapeutic and uplifting environment for our patients.

Equipment

1. The Lancashire Diabetic Eye Screening Programme offers comprehensive diabetic eye screening services to over 79,000 patients annually across the Pennine Lancashire region. Our new community-based Optical Coherence Tomography (OCT) provision is minimising unnecessary referrals to hospital eye services. This innovation ensures that surveillance activities can take place within the community, with referrals to secondary care made only when treatment is necessary and most effective.

   This patient-centred approach, where lower-risk referrals are managed and imaged locally, is helping to keep patients out of the hospital environment by providing a high standard of community care. This in turn is significantly increasing the availability of appointments for patients with sight-threatening conditions, such as diabetic retinopathy, who require timely intervention.

2. Patients at Royal Blackburn Teaching Hospital now have access to state-of-the-art cancer diagnostics equipment the only one of its kind in the UK. The introduction of the Olympus Evis endoscopy ultrasound system has significantly enhanced the hospital's diagnostic capabilities within the endoscopy service, allowing for more precise and effective cancer detection and treatment planning. This advanced technology uses ultrasound waves and other cutting-edge methods to accurately identify, define, and stage cancers, particularly of the pancreas, bile duct, liver, oesophagus and stomach. It also facilitates the collection of tissue samples, supporting more accurate diagnoses and enabling tailored surgical and chemotherapeutic interventions.

Wellbeing

The children's wards at both Burnley and Blackburn hospitals have been enriched with the addition of gaming carts, providing young patients with engaging activities that support their overall wellbeing. These carts offer a variety of interactive and entertaining options, helping to distract children from the stress of being in hospital and promoting a positive environment.

Alfie, our therapy dog, visits patients, staff, and visitors across all hospital and community healthcare sites within East Lancashire Hospitals NHS Trust. Having graduated this year, he continues to provide incredible support and comfort to everyone he meets.

Plans for Future Periods

Looking forward, ELHT&Me will continue to work in partnership with East Lancashire Hospitals NHS Trust to complement their healthcare services. Building on what has already been achieved, the charity's ambition is to further strengthen its role and increase the impact it makes on improving the health of the region and beyond.

We are committed to enhancing our front-facing retail and visitor space. Our goal is to generate increased income while maintaining operational efficiency. We will make it easier for visitors to recognise and connect with our charity. To achieve this, we plan to incorporate materials and interactive elements that highlight our impact and inspire support.

Financial Review

Annual review of income and expenditure

The principal source of funding for the charity is income from donation and legacies, including grant funding, which are used to fund improvements to the services provided to patients, patient environment, and experience, as well as to fund training for Trust staff and to help to develop and improve staff amenities, in line with the Charity's purpose.

Total income for 2023-24 is £997,000 (2022-23, £839,000) which includes a donation of £250,000 from the Cancer Assessment Rapid Early Support (CARES) charity for the purchase of an endoscopy ultrasound system and a donation of £145,000 from Roche pharmaceuticals for the purchase of a retinal camera.

Trading income of £71,000 relates to the sales generated through the Charity Hub shop at Blackburn Hospital which was established as ELHT&Me Trading Limited. All Charity Hub activities were transferred to the LTD company from the 18 January 2024.

East Lancashire Hospitals NHS Trust holds 100% of the share capital in this company (Company Registration Number 15424896). From the year ending 2024-25 all net profits will be donated to the Charity under the Gift Aid scheme.

Analysis of income	2023-24 £'000	2022-23 £'000
Income from donation and legacies		
Donations	515	383
Legacies	-9	118
Grants	216	77
	722	578
Income from other trading activities		
Income from training activities	50	92
Income from trading	71	43
Other income	93	87
	214	222
Income from investments		
Investments listed on the London Stock Exchange	48	35
Interest on cash/bank	13	4
	61	39
Total	**997**	**839**

Total expenditure for 2023-24 of £968,000 (2022-23, £804,000). At £535,000 expenditure on medical equipment represents the largest use of charitable funds. This includes £199,000 for the endoscopy ultrasound system, £48,000 for the OCT imaging camera, £44,000 for a surgical saw and £34,000 for consoles for head and neck surgery procedures.

Analysis of expenditure	2023-24 £'000	2022-23 £'000
Expenditure on raising funds		
Investment management and admin fees	14	9
	14	9
Expenditure on charitable activities		
Fund raising expenses	13	18
Gifts in kind	42	127
Staff welfare / training / amenities	133	194
* Retirement gifts and long service awards	3	35
Trading expenses	50	33
Furniture and equipment	12	55
**Training	-	44
Medical and surgical equipment	535	117
Other expenditure	166	172
	954	795
Total	**968**	**804**

* The charity ceased funding retirement vouchers from August 2023.

** Training is included in staff welfare/training/amenities for the year 2023-24.

When net gains on investments of £88,000 are taken into account, fund balances have increased by £117,000.

The market value of the Charity's investment portfolio as at 31 March 2024 was £1,727,000 (31 March 2023: £1,652,000), £1,549,000 of which is managed by the Charity's investment managers. The total return, income generated plus capital appreciation, over the period was 8.4%. This is against the FTSE 100 and British Government Securities (BGS) benchmark of 4.2%. The £45,000 of income generated equates to an income yield of 2.7%.

The Charitable Funds Committee aims to turn over the majority of charitable funds, excluding specific long-term legacies, once every three years.

Investment Strategy and Policy

The aim of the investment strategy is to 'invest funds so as to provide as high a current income as possible, consistent with the objective of at least preserving the income generating value of capital over the long term'. The balance of investments after taking into account the reserved funds are managed in an investment portfolio designed to provide a return in the medium to longer term. The Charitable Funds Committee is assisted in this aspect by the professional advice of independent Investment Managers.

The Trustees believe that companies which act in a socially responsible way are more likely to flourish and to deliver the best long-term balance between risk and return. In developing the ethical investment principles, the Charitable Fund Committee has considered the aims and objectives of the charity, the NHS Constitution, the NHS' purposes and fundamental principles and the Trust's responsibilities as a good corporate citizen.

The Trustees believe that the following principles are consistent with these considerations and where exclusions are applied it is on the basis of inconsistency with one or more of the responsibilities or guidance outlined below:

Investment will not be permitted in companies or organisations manufacturing, promoting and/or distributing alcohol and tobacco products, arms and armaments.

Investment will also not be permitted in companies or organisations which may bring criticism to the Trust in its health promotion and educational roles or where Charitable Fund Committee members have reason to believe the human rights of those employed are not respected and upheld.

The Trust will seek to make socially responsible investments in companies or organisations having a regard to their environmental management, policies and reporting practices, as well as investments in locally based companies where they are considered to be an acceptable financial risk and fall within the overarching principles detailed above.

The Trust is an apolitical organisation and will seek to avoid investment in politically motivated organisations and companies.

Risk Management

Since the Charity's key systems are designed and implemented by East Lancashire Hospitals NHS Trust, the Charity therefore benefits from the Trust's robust internal control and risk management framework.

Where significant risks and uncertainties are identified for the Charity, they are considered at meetings of the Charitable Funds Committee, together with mitigating actions.

Income and expenditure is monitored by the Charitable Funds Committee as part of the risk management process to avoid unforeseen calls on reserves and to ensure that the Charity is well-positioned to meet its objectives throughout the year.

Reserves Policy

The Charity derives its income mainly from donations and legacies, the level of which cannot be accurately predicted year on year.

Since the charity aims to spend the income it receives for its charitable purpose, there are a number of reasons why it needs to retain a proportion of the income it receives as reserves, which include:

- ensuring income from donations and legacies are spent in line with the donors' wishes, particularly where restrictions have been placed on its use.
- ensuring sufficient funds are available to fund planned future projects.
- for gifts of endowment where the charity has no power to treat the monies as income to fund charity related expenditure; and
- meeting current or anticipated expenses such as management, administration and governance costs, including examination costs.

For these reasons, the Charity holds reserves at a minimum level of £500,000.

Structure, Governance and Management

The Charity which was formerly known as the East Lancashire Hospitals NHS Trust Charitable Fund and other related charities is now known as ELHT&Me.

The Charity was created under a Trust deed executed on 28 January 2004 and constituted with East Lancashire Hospitals NHS Trust as sole corporate trustee. This deed consolidated a number of charitable funds held by the former Burnley Healthcare and Blackburn, Hyndburn, and Ribble Valley Health Care NHS Trusts prior to their merger to form the East Lancashire Hospitals NHS Trust. A deed of the amendment was executed on 11 July 2018 to provide clarity as to the purposes for which the charitable funds are held and to simplify the administration of the Charity.

As ELHT&Me has a corporate trustee, in accounting terms, it is controlled by the Trust and is, therefore, its subsidiary. Financially, the Charity is not material to Trust, so it is not consolidated into its accounts.

The Trust is funded by the Charity to employ a Charity Manager and a Community Fundraising Officer to support ELHT&Me. These posts reflect the important role that fundraising has to play in the enhancement of the patient experience and patient and public engagement.

Charitable funds received by the charity are accepted, held, and administered as funds and property held on Trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990.

In practice, responsibility for the monitoring and approval of activities relating to charitable fundraising and the uses to which charitable funds are applied has been delegated by the Trust Board (Corporate Trustee) to the Trust's Charitable Funds Committee. The terms of reference for the Committee are reviewed annually by the Trust Board and compliance with these terms of reference is also assessed on an annual basis by the Committee and reported back to the Trust Board as part of the reporting from the Charitable Funds Committee.

Membership of the Charitable Funds Committee is drawn from the Trust Board and comprises a Non-Executive Director Chair of the Committee, one further Non-Executive Director/Associate Non-Executive Director member, the Executive Director of Finance (as lead director for the Committee), the Executive Director of Nursing and the Executive Director of Communications and Engagement. The Director of Corporate Governance/Company Secretary, together with the Deputy Director of Finance or Deputy Head of Financial Control and the Head of Charity attend meetings of the Committee to provide advice and assistance.

All Trust Board members are entitled to attend the meeting and have sight of the supporting documents. The Committee provides regular reports of its decisions to the formal Trust Board meetings.

There are a number of individual funds within the umbrella of the Charity, each of which has a designated funds manager with day-to-day responsibility for the administration of the fund, being involved in fundraising activities, and decisions on how donations should be expended within the financial framework of the charity.

The decision-making process is aligned to financial limits, as outlined in the scheme of delegation for the Charity.

Fund managers have delegated authority to incur expenditure below £3,000.

Expenditure above £10,000 requires the following signatories, Fundholder, Deputy/Executive Director of Finance, plus one of the following:

- The Charitable Fund Committee approval; or
- Three members of the Trust Board, of which one must be either the Charitable Trust Committee Chair or Executive Director of Finance.

In addition to fund manager approval, expenditure between £3,000 and £10,000 also requires approval from either the Deputy Director of Finance or Executive Director of Finance.

Director Recruitment, Appointment, Induction and Training

There are different recruitment and appointment processes for the Executive and Non-Executive members of the Trust Board.

From 1 April 2016, NHS England has had responsibility for the appointment of Non-Executive members to NHS Trust Boards on behalf of the Secretary of State for Health and Social Care. Executive members of the Board are subject to the recruitment and appointment processes of the Trust.

All Directors are subject to the induction and training processes of the Trust.

Committee Membership

- Stephen Barnes Chairman of the Committee (to 31 December 2023)
- Richard Smyth Chairman of the Committee (from 1 January 2024)
- Michelle Brown
- Pete Murphy
- Liz Sedgley (from 1 January 2024)
- Shelley Wright

The Members of the Corporate Trustee (Board) for 2023-24 were:

- Mr Shahzad Sarwar, Trust Chairman
- Mr Martin Hodgson, Chief Executive
- Mrs Trish Anderson, Non-Executive Director
- Mrs Kate Atkinson, Executive Director of Service Development and Improvement
- Professor Graham Baldwin, Non-Executive Director
- Mr Stephen Barnes, Non-Executive Director (to 31 December 2023)
- Mrs Michelle Brown, Executive Director of Finance
- Dr Fazal Dad, Associate Non-Executive Director (to 30 June 2023)
- Mrs Sharon Gilligan, Chief Operating Officer
- Mrs Melissa Hatch, Associate Non-Executive Director (from 1 December 2023)
- Mr Jawad Husain, Executive Medical Director
- Miss Naseem Malik, Non-Executive Director (to 31 August 2023)
- Mr Tony McDonald, Executive Director of Integrated Care, Partnerships and Resilience
- Mr Pete Murphy, Chief Nurse
- Mrs Feroza Patel, Associate Non-Executive Director (to 30 June 2023)
- Mrs Kate Quinn, Executive Director of People and Culture
- Mrs Catherine Randall, Non-Executive Director (from 1 September 2023)
- Mr Khalil Rehman, Non-Executive Director
- Ms Elizabeth Sedgley, Non-Executive Director (from 1 September 2023)
- Mr Richard Smyth, Non-Executive Director
- Ms Shelley Wright, Joint Executive Director of Communications and Engagement

Declaration

The Corporate Trustee declares that it has approved the Annual Report of ELHT&Me for 2023-24.

Signed …….

Richard Smyth
Non- Executive Director
Charitable Funds Committee Chair
East Lancashire Hospitals NHS Trust

Signed …….

Charlotte Henson
Executive Director of Finance
East Lancashire Hospitals NHS Trust

Reference and Administrative Details

Registered charity name: ELHT&Me

Charities Charity Registration Number: 1050478

Principal Office Address: East Lancashire Hospitals NHS Trust, Trust Headquarters, Royal Blackburn Teaching Hospital, Haslingden Road, BB2 3HH

Trustee: East Lancashire Hospitals NHS Trust

Key Management Personnel: Trust Charitable Funds Committee

The following key professional services are provided to the Charity by external organisations:

Charity bankers: Governing Banking Service c/o NatWest, Bolton Customer Service Centre, PO Box 2027 Parklands, De Havilland Way, Horwich, Bolton, BB6 4YU

Charity independent examiner: Nicola Wakefield, Forvis Mazars, One St Peter's Square, Manchester, M3 3EB

Charity investment managers: Brewin Dolphin, 1 The Avenue, Spinningfields Square, Manchester, M3 3AP

Charity solicitors: Hempsons, City Tower Piccadilly Plaza, Manchester, M1 4BT

Charity internal auditors: Mersey Internal Audit Agency (MIAA), Regatta Place, Brunswick Business Park, Summers Road, Liverpool, L3 4BL

Charity Insurance: PIB Insurance Brokers, Poppleton Grange, Poppleton, York , Yorkshire, YO26 6GZ.

Independent Examiner's Report to the Trustees of ELHT&Me

I report on the financial statements of ELHT&Me for the year ended 31 March 2024, which are set out on pages 1 to 10.

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the financial statements. The charity's trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the financial statements under section 145 of the 2011 Act;
- follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- state whether particular matters have come to my attention.

This report, including my statement, has been prepared for and only for the charity's trustees as a body. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body for my examination work, for this report, or for the statements I have made.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the financial statements presented with those records. It also includes consideration of any unusual items or disclosures in the financial statements, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the financial statements present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

Since the charity's gross income exceeded £250,000, your examiner must be a member of a body listed in section 145 of the 2011 Act. I confirm that I am qualified to undertake the examination by being a qualified member of the Institute of ICAEW which is one of the listed bodies.

In connection with my examination, which is complete, no matters have come to my attention which give me reasonable cause to believe that in any material respect:

- accounting records were not kept in respect of ELHT&Me in accordance with section 130 of the 2011 Act; or
- the financial statements do not accord with those records; or
- the financial statements do not comply with the applicable requirements concerning the form and content of financial statements set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the financial statements give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which, in my opinion, attention should be drawn in order to enable a proper understanding of the financial statements to be reached.

Nicola Wakefield
Forvis Mazars LLP
One St Peters Square
Manchester
M2 3DE

Date:

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Enquiries to Allen Graves
Email allen.graves@elht.nhs.uk

Royal BlackburnTeachingHospital
Haslingden Road
Blackburn
BB2 3HH

20 November 2024

Forvis Mazars LLP
One St Peter's Square
Manchester
M2 3DE

Dear Sir/Madam,

ELHT&Me – independent examination of the financial statements for the year ended 31st March 2024

This representation letter is provided in connection with your Independent Examination of the financial statements of the Fund for the year ended 31st March 2024.

We confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the following representations to you.

Our responsibility for the financial statements and accounting information

We believe that we have fulfilled our responsibilities for the true and fair presentation and preparation of the financial statements in accordance with applicable law and the applicable Financial Reporting Framework.

Our responsibility to provide and disclose relevant information

We have provided you with:

- access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other material;
- additional information that you have requested from us for the purpose of the Independent Examination; and
- unrestricted access to individuals within the charity you determined it was necessary to contact in order to obtain Independent Examination evidence.

We confirm as trustees that we have taken all the necessary steps to make us aware, as trustees, of any relevant Independent Examination information and to establish that you, as examiners, are aware of this information.

As far as we are aware there is no relevant information of which you, as examiners, are unaware.

Accounting records

We confirm that all transactions undertaken by the charity have been properly recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all management and trustee meetings, have been made available to you.

Accounting policies

We confirm that we have reviewed the accounting policies applied during the year in accordance with the requirements of applicable law and applicable Financial Report Framework and consider them appropriate for the year.

Accounting estimates, including those measured at fair value

We confirm that any significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

Contingencies

There are no material contingent losses including pending or potential litigation that should be accrued where:

- information presently available indicates that it is probable that an asset has been impaired, or a liability had been incurred at the balance sheet date; and
- the amount of the loss can be reasonably estimated.

There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the charity have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with applicable law and applicable Financial Reporting Framework.

Laws and regulations

We confirm that we have disclosed to you all those events of which we are aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

We have complied with all aspects of contractual agreements that would have a material effect on the financial statements in the event of non-compliance.

Fraud and error

We acknowledge our responsibility as trustees of the charity, for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

We have disclosed to you:

- all the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- all knowledge of fraud or suspected fraud affecting the charity involving:
- management and those charged with governance;
- employees who have significant roles in internal control; and
- others where fraud could have a material effect on the financial statements.

We have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the charity's financial statements communicated by employees, former employees, analysts, regulators or others.

Legacies and other income

We confirm that there have been no legacies or other income received after the year end that should be accrued for at the year end.

Related party transactions

We confirm that all related party relationships, transactions and balances, (including sales, purchases, loans, transfers, leasing arrangements and guarantees) have been appropriately accounted for and disclosed in accordance with the requirements of applicable law and the applicable Financial Reporting Framework.

We have disclosed to you the identity of the charity's related parties and all related party relationships and transactions of which we are aware.

Impairment review

To the best of our knowledge, there is nothing to indicate that there is a permanent reduction in the recoverable amount of the fixed assets below their carrying value at the balance sheet date. An impairment review is therefore not considered necessary.

Charges on assets

All the charity's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

We have no plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

Subsequent events

We confirm all events subsequent to the date of the financial statements and for which the applicable law and applicable Financial Reporting Framework require adjustment or disclosure have been adjusted or disclosed.

Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, we will advise you accordingly.

Audit requirement

We confirm that there are no specific requirements for an audit to be carried out in the governing document of the charity, in any special trusts associated with the charity or as a condition of any grants made to the charity.

Yours faithfully

Name Richard Smyth

Position Chair

Date

Signed on behalf of the Corporate Trustees for ELHT&Me

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **20a**

15 January 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 25 November 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

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

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

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

Committee Name:	Finance and Performance Committee
Date of Meeting:	25 November 2024
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting Finance, Performance and Workforce Divisional Meeting Summaries Improvement Update Project Blue One LSC Update Integrated Performance Report Tenders Update 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 was briefed upon the in-month mis statement of the financial position as at month 6 resulting in the revised deficit for the year to date at Month 7 of £26 million.
- The Committee were briefed by the Chief Executive on the disappointing results of the Care Quality Commission Urgent Care patient satisfaction survey. the Trust acknowledged that the patient experience for urgent care is not what the Trust aspires. Despite the huge amount of financial support given to the Emergency Department (ED) and Urgent and Emergency Care (UEC) departments and the success of a large number of projects with stakeholders to deflect patients away from ED into more appropriate care settings, the volume

of patients attending ED and UEC is still far higher than previous years and waiting times are still too high.

- The planning update for 2025/26 highlighted the continuing pressures on the Trust's finances as the net cost uplift factor is in effect negative 0.8%. This includes the impact of convergence and the repayment of deficit support.
- The Committee heard that work is ongoing to better understand the changes in commissioning intentions as the Integrated Care Board (ICB) updates the basis of the fixed elements of the contracts.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee were advised that as part of the response to the review carried out by Simon Worthington, Kate Atkinson and her team will be working on the key points in order to initiate some rapid responses and significant shifts in the Trust's run rate
- The planning process for 2025/26 will start with a planning day with all the divisions.
- The Committee was briefed on the status of the ongoing service reviews and noted that these need to be carried out at pace on all services.
- The committee received an update post transfer to One LSC and noted that plans for the next 30,60 and 90 days.
- It was agreed at the meeting that the Audit Committee will follow up on the issues raised and lessons learnt with the restatement of the in year financial position after the necessary external reviews have been carried out.

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.

- As part of the performance update, the Committee was informed that the Trust is hitting the trajectory to reduce long-term waiting times for treatment.
- The Committee noted that the planning for 2025/26 will consider the implications of the Strasys Review recently carried out for the ICB.

- The Committee was supportive of the view to hire a turnaround director to work with the executives and the organisation at pace to achieve financial stability for the Trust.
- The Committee received an update on Project Blue and noted the revised implementation date of 1 February 2025.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **20b**

15 January 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 16 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

- 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:	16 December 2024
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting Planning 2025/26 Update Finance, Performance and Workforce Divisional Meeting Summaries Board Assurance Framework Corporate Risk Register Improvement Update One LSC Update Integrated Performance Report 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 was advised that the ongoing cash position is still very tight due to the financial pressures.
- Changes to the forecast outturn position were noted and the assessment of the FOT, based on the same methodology used by the NHSE Nominated Finance Lead, is a deficit of £59.3 million, which is a significant risk as there is still unidentified CIP of £23.5 million for 24/25. The FOT review is underway by the Director of Finance.
- The Committee was updated on the financial challenges that the Trust will face in 25/26 given the levels of CIP required to move the Trust and wider system back into financial balance and the low levels of recurrent delivery by the Trust in previous years.

- The Committee noted that the PA Consulting work had also highlighted shortfalls in ERF Income due in part to the implementation of Cerner and work and discussions would take place to recoup as much of this as possible.
- The Committee heard that work is ongoing to better understand the changes in commissioning intentions as the ICB reviews the block contracts.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Trust moved to 1st position nationally for theatre utilisation this month on model hospital, but work will continue to improve productivity and efficiencies across all the services as part of the service reviews.
- The Committee requested a detailed timetable for all the service reviews being carried out in order to improve visibility of the outcomes and actions thereafter.
- The 25/26 commissioning intentions, once released, will form an integral part of the service reviews and involvement of both the unions and staff side to discuss the effects on services which may need to be cut or reduced as a result.
- It was noted that agency spend was down to 1.9%
- The Committee received an update from One LSC including the approach which will be taken to share resources of the finance teams across all the trusts in order to meet the significant demands for information from the I& I review and formal intervention actions.
- The Committee was updated on the work being carried out reducing the sickness absence rates across the Trust. The focus is on preventing illness and building resilience in staff by going back to the basics of ensuring staff get their breaks and sessions finish on time etc. There are ongoing reviews on the levels of variable pay and workshops are being held for teams on efficient rostering in an attempt to reduce bank and agency spend.

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.

- PWC will as part of their formal system intervention be involved in the planning process for 25/26 which has already started rather than waiting for the guidance from NHSE to arrive.
- The Trust's PFI partners have now made offers to rectify the issues in relation to RBH in answer to the contract notices previously issued by the Trust.
- MIAA -the Trust's Internal auditors have been briefed on the review being carried out by the Seagry team on financial governance within the Trust and parts of the internal audit work programme have been pushed back till after this review has been completed.
- UEC waiting time performance is just off trajectory as the teams are continuing to manage high attendances on the UEC pathways. Despite being the busiest unit in the North West for ambulance attendances the UEC team are managing ambulance handovers quicker than NW average times.
- Plans are in place to manage 65 week waits and achieve the target by end of December other than for the corneal graft patients due to the availability of the grafts.
- 62 day cancer performance has slipped mainly due to sickness within Urology and diagnostic delays in pathology and endoscopy.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**21**
15 January 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 18 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	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:	18 December 2024
Committee Chair:	Catherine Randall
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update – Urgent and Emergency Care Survey Results Winter Plan Update CNST / LTPS Scorecard Analysis Health Inequalities Update Cellular Pathology Backlog Clearance Quality Impact Risk Assessments Nurse Staffing Exception Reports: October 2024 and November 2024 Floor to Board Report for Maternity and Neonatology Services Trust Wide Quality Group AAA Report Patient Safety Incident Response Framework Report Customer Relations (Complaints) Annual Report 2023-24 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.

- A recent Never Event had occurred in the Trust involving a patient who did not have a swab removed after undergoing a caesarean section. It was confirmed that the swab was removed 24 hours later and that no harm had come to the patient.
- The Committee was informed of an influx of critically ill children over recent weeks that were beyond the ability and capability of the Trust to properly treat. It was

confirmed that this had been escalated to the Integrated Care Board and that no harm had come to any of the children involved.

- Members received an update on the progress being made with the management of the Trust's histopathology backlog. It was confirmed that good progress was being made and further updates would be provided at future meetings of the Committee and to the executive team.
- It was reported that urgent and emergency care pathways remained extremely pressured, and that an additional 11 beds had been put in place through various ward moves.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- A story was presented to members from a patient who had been recently treated by the Trust. The patient described their initial experiences with the Trust, which had been less than positive, but praised the more personalised care that they had received at a later date.
- An update on the work taking place in the Trust and in the wider system around health inequalities was provided to the Committee. It was noted that work was underway to further raise awareness around health inequalities both across the Trust and local communities.
- The Committee received an update on the Trust's winter plan for 2024-25, with additional bed capacity being provided via the mobilisation of an additional ward and improvements to patient pathways being achieved through ward moves. It was noted that work was ongoing around bed reconfiguration in community areas and that a dedicated project group had been established to progress this.
- The latest update from the Trust's maternity and neonatal services was provided to the Committee. The latest patient survey results were reported as being very positive and it was noted that the Trust's maternity services were considered as one of the best in the country.

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 Clinical Negligence Scheme for Trusts (CNST) scorecards, providing an overview of 10 years of claims data. It was noted that the number of claims made against the Trust were higher than average, with the top causes including inappropriate treatment and failure or delays in diagnosis.
- The Committee was also provided with an overview of the Trust's Liabilities to Third Parties Scheme scorecard. Members noted that slips, trips and falls was the highest contributory factor to the claims made against the Trust.

TRUST BOARD REPORT		**Item**	**22**
15 January 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 meeting held on 20 November 2024 is presented for information.

Report linkages

Related Trust Goal	-
Related to key risks identified on assurance framework	-

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	Yes

Meeting: **Remuneration Committee**

Date of Meeting: **20 November 2024**

Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 20 November 2024, the following matter was discussed in private:

a) Proposed Recruitment Timeline and Remuneration Arrangements for Executive Medical Director

b) Arrangements for Operational Director of Finance for Remainder of 2024-25 Year

c) Executive Director Succession Planning Process

TRUST BOARD REPORT **Item** **23**

15 January 2025 **Purpose** Information

Title	Trust Board (Closed Session) Summary Report
Report Author	Miss K Ingham, Corporate Governance Manager
Executive sponsor	Mr S Sarwar, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 20 November 2024.

As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders would not be applicable in this instance.

Report linkages

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

	5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to here.
Related to ICB Strategic Objective	State which ICB Strategic Objective the paper relates to here.

Impact

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

Previously considered by:

Meeting: **Trust Board (Closed Session)**

Date of Meeting: **20 November 2024**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 11 September 2024 were approved as a true and accurate record.

ITEMS DISCUSSED

At the meeting of the Trust Board on 20 November 2024, the following matters were discussed in private:

a) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.
b) One LSC (Post Go Live Update)
c) Financial Performance Update
d) Project Blue Update
e) Pathology Update
f) NHS Green Plan Update
g) Ratification of Appointment of External Auditors
h) Responsible Officer's Report Regarding Doctors with Restrictions
i) Fire Remediation Programme Report
j) Communications Update and Horizon Scanning
k) Trust Board and Committee Dates 2025-26 and Committee Membership

ITEMS RECEIVED FOR INFORMATION

None.