

East Lancashire Hospitals NHS Trust Board Meeting



Safe | Personal | Effective



Safe | Personal | Effective

TRUST BOARD MEETING (OPEN SESSION) AGENDA

12 MARCH 2025, 12.30

BOARDROOM, BIRCH HOUSE

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

OPENING MATTERS					
TB/2025/028 12.30	Chairman's Welcome	Chairman	v		-
TB/2025/029 12.31	Apologies To note apologies.	Chairman	v		-
TB/2025/030 12.32	Declarations of Interest To note the directors register of interests and note any new declarations from Directors.	Chairman	d✓	Approval	5
TB/2025/031 12.35	Minutes of the Previous Meeting To approve or amend the minutes of the previous meeting held on 15 January 2025.	Chairman	d✓	Approval	12
TB/2025/032 12.40	Matters Arising To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v		-
TB/2025/033 12.42	Action Matrix To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information	36
TB/2025/034 12.45	Chairman's Report To receive an update on the Chairman's activities and work streams.	Chairman	v	Information	-
TB/2025/035 12.55	Chief Executive's Report To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information/ Approval	39
QUALITY AND SAFETY					
TB/2025/036 13.05	Staff / Patient Story To receive and consider the learning from a patient/staff story.	Deputy Chief Nurse	v	Information/ Assurance	-
TB/2025/037 13.15	Corporate Risk Register Report To receive an update on the Corporate Risk Register and approve revisions based on the Executive Risk Assurance Group, Committees' and Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Executive Medical Director	d✓	Assurance/ Approval	52
TB/2025/038 13.20	Board Assurance Framework To receive an update on the annual review of the Board Assurance Framework and risk appetite and approve the revisions based on the Executive Risk Assurance Group, Committees' and the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Executive Director of Service Development and Improvement	v	Assurance/ Approval	-

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

	b) February 2025		d✓		
TB/2025/045 14.16	Triple A Reports from Quality Committee To note the matters considered by the Committee in discharging its duties. a) January 2025 b) February 2025	Committee Chair	d✓ d✓	Information	311
TB/2025/046 14.17	Remuneration Committee Information Report To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information	319
TB/2025/047 14.18	Trust Board (Closed Session) Information Report To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information	321
CLOSING ITEMS					
TB/2025/048 14.20	Any Other Business	Chairman	v		-
TB/2025/049 14.25	Open Forum To consider questions from the public.	Chairman	v		-
TB/2025/050 14.26	Board Performance and Reflection To consider the performance of the Trust Board, including asking: 1. Have we, as the Board, via the agenda and our discussions fulfilled our objective of supporting our: a. Communities b. Staff c. Stakeholders 2. Have we, as the Board fulfilled our statutory obligations.	Chairman	v		-
TB/2025/051 14.27	Message from the Board	Chairman	v		-
TB/2025/052 14.30	Date and Time of Next Meeting Wednesday 14 May 2025, 12.30pm, Boardroom, Birch House	Chairman	v		-

TRUST BOARD REPORT

Item **30**

12 March 2025

Purpose Approval
Information

Title Declarations of Interests Report

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

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

Report linkages

Related Trust Goal -

Related to key risks
identified on Board
Assurance Framework -

Related to key risks
identified on Corporate
Risk Register -

Related to
recommendations from
audit reports -

Related to Key Delivery
Programmes -

Related to ICB Strategic
Objective -

Impact

Legal Yes Financial No

Equality No Confidentiality No

Previously considered by:

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

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

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

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

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

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

TRUST BOARD REPORT

Item **31**

12 March 2025

Purpose Approval

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

Summary: The minutes of the previous Trust Board meeting held on 15 January 2025 are presented for approval or amendment as appropriate.

Report linkages

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

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

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

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 13:00, 15 JANUARY 2025
MINUTES

PRESENT

Mr S Sarwar	Chairman	Chair
Mr M Hodgson	Chief Executive / Accountable Officer	
Mrs P Anderson	Non-Executive Director	
Professor G Baldwin	Non-Executive Director	
Mrs S Bridgen	Non-Executive Director	
Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive	
Mr J Husain	Executive Medical Director / Deputy Chief Executive	
Mrs C Randall	Non-Executive Director	
Mr K Rehman	Non-Executive Director	
Mrs S Simpson	Executive Director of Finance	

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

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

IN ATTENDANCE

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

APOLOGIES

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

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

TB/2025/001 CHAIRMAN'S WELCOME

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

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

TB/2025/002 APOLOGIES

Apologies were received as recorded above.

TB/2025/003 DECLARATIONS OF INTEREST

The Directors Register of Interests was presented for approval.

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

TB/2025/004 MINUTES OF THE PREVIOUS MEETING

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

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

TB/2025/005 MATTERS ARISING

There were no matters arising.

TB/2025/006 ACTION MATRIX

Directors noted that all items on the action matrix were reported as complete, had been updated via the action matrix report or were to be presented as agenda items at this, or at subsequent meetings. The following updates were provided:

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

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

RESOLVED: **Directors noted the position of the action matrix.**

TB/2025/007 CHAIRMAN'S REPORT

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

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

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

RESOLVED: Directors received and noted the update provided.

TB/2025/008 CHIEF EXECUTIVE'S REPORT

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

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

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

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

productivity and efficiency to the levels required to achieve this. He explained that the NHS was expected to achieve a 65% target against RTT in the 2025-26 financial year and highlighted that the Trust's performance currently stood at around 57%, in line with the national average. Directors noted that additional customer care training would be provided to non-clinical staff as part of the Further Faster 20 (FF20) programme and that national Getting It Right First Time (GIRFT) colleagues would be providing assistance to expedite care and improve the lifestyles of as many patients as possible.

Mr Hodgson went on to advise that the Secretary of State for Health and Social Care, Wes Streeting, had announced a series of measures that were linked to the elective care reform plan, including changes to allow GPs to have direct access to a range of tests and scans without having to do so via consultants. He added that there would be a significant push around reducing agency usage and spend and highlighted that the Trust continued to perform well in this area. Mr Hodgson referred to another recent announcement by the Government regarding the NHS moving back to a 'league table' system and noted that this would place even more pressure on trusts to maintain operational performance whilst living within their means financially. He confirmed that the Trust already made use of artificial intelligence (AI) in a few key areas and that this would continue to play a key role in the NHS becoming more efficient in the future.

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

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

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

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

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

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

Mr Hodgson concluded his update by presenting Directors with the list of wards applying for silver status as part of the Safe, Personal and Effective Care (SPEC) award process. These were: the Emergency Surgical Unit (ESU), the Elective Care Centre, Burnley General Teaching Hospital (BGTH) Day Theatres and Wilson Hey Theatres. He added that gold status was also being sought by wards C16 and C18a.

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

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

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

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

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

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

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

RESOLVED: Directors received the report and noted its contents.

TB/2025/009 STAFF / PATIENT STORY

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

The patient story can be viewed by clicking the link [here](#).

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

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

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

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

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

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

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

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

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

Mr Husain advised that the score assigned to risk **6190 (insufficient capacity to accommodate patients in clinic within timescales)** had been reduced to 12 and that this would be ratified by the Executive Risk assurance Group (ERAG) prior to it being removed from the CRR. He reported that there had been no changes to the scores assigned to any other risks and that the highest scoring remained those relating to finance, data and digital, the management of medical devices and demand and capacity imbalances.

Mr Husain advised that the total number of open risks had been reduced by a further 6% since the previous meeting but explained that this had been offset by an increase of 15% in moderate risks over the same period. Directors noted that there had been a similar decrease in the numbers of risks open for three years or more by 17% as well as an increase in overdue risks. Mr Husain highlighted that there had been a significant increase in Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) compliance from 56% to 71% over recent months and paid credit to all teams involved in achieving this.

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

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

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

TB/2025/011 BOARD ASSURANCE FRAMEWORK (BAF)

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

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

RESOLVED: Directors noted the update provided.

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

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

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

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

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

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

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

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

TB/2025/013 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson referred to the previously circulated report and provided a summary overview of the Trust's progress against the 10 maternity safety actions included in the Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Year Six.

Safety Action 1 - Perinatal Mortality Review Tool (PMRT): Miss Thompson explained that there had been a shortfall for four reviews regarding the two-month deadline for answering all

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TB/2025/014 FINANCIAL REPORTING

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

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

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

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

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

TB/2025/015 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

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

b) Safe

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

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

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

c) Caring

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

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

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

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

d) Effective

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

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

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

e) Responsive

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

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

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

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

f) Well-led

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

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

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

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

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

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

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

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

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

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

RESOLVED: Directors received the report and noted its content.

TB/2025/017 FREEDOM TO SPEAK UP REPORT

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

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

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

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

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

Professor Baldwin left the meeting at this time.

RESOLVED: Directors received the report and noted its content.

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

The Board met as a Corporate Trustee for this item.

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

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

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

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

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

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

RESOLVED: Directors received the report and noted its content.
Further discussions on the work being done to address the Trust's high sickness and absence levels will take place at the next meeting of the Trust Board.

TB/2025/020 TRIPLE A REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its content.

TB/2025/021 TRIPLE A REPORT FROM QUALITY COMMITTEE

The report was presented to the Board for information.

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

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

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

RESOLVED: Directors received the report and noted its contents.

TB/2025/022 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2025/023 TRUST BOARD (CLOSED SESSION) INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2025/024 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2025/025 OPEN FORUM

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

TB/2025/026 BOARD PERFORMANCE AND REFLECTION

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

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

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

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

RESOLVED: Directors noted the feedback provided.

TB/2025/027 DATE AND TIME OF NEXT MEETING

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

TRUST BOARD REPORT

12 March 2025

Item **33**

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.

ACTION MATRIX

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

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

TRUST BOARD REPORT

Item 35

12 March 2025

Purpose Information

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

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

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

Report linkages

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

attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.

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

Related to key risks identified on Corporate Risk Register -

Related to recommendations from audit reports -

Related to Key Delivery Programmes -

Related to ICB Strategic Objective -

Impact

Legal Yes Financial Yes

Equality No Confidentiality No

Previously considered by:

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

1. Background

This report is divided into sections covering the following:

- National headlines relevant to the NHS and wider health and social care economy
- News and information from across the North West and Lancashire and South Cumbria system area, including details from the Integrated Care Board (ICB) and Provider Collaborative Board (PCB)
- Local and Trust specific updates

2. National Updates

Busiest year on record for emergency services

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

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

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

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

NHS jabs tens of thousands more against flu than last winter

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

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

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

NHS staff treated record numbers last year

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

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

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

NHS targets halved under new guidance

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

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

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

NHS England Chief Executive to step down

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

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

NHS rolls out lifesaving home testing for bowel cancer to over 50s

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

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

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

NHS supports thousands more people back into work

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

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

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

Frontline workers in the North West have their say on the future of the NHS

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

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

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

World-leading AI trial to tackle breast cancer launched

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

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

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

3. Regional Updates

Four NHS organisations in Lancashire and South Cumbria entered into a programme of national support

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

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

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

New timetable for New Hospital Programme

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

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

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

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

LSC Pathology Services to scope plans for a pathology single service

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

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

Pop-up winter vaccines service visiting Lancashire locations

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

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

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

WorkWell support service launches across Lancashire and South Cumbria

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

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

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

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

Patients in the North West using NHS 111 service for winter virus advice

Data from North West Ambulance Service shows more than 23,000 additional calls were made in December by those suffering with the symptoms of winter viruses.

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

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

Targeted lung health checks in Lancashire and South Cumbria reach cancer diagnosis milestone

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

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

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

4. Local and Trust specific updates

Accrington Victoria Community Hospital

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

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

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

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

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

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

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

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

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

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

New provider for hospital shuttle bus

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

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

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

Alcohol Care Service to close after 31 March 2025

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

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

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

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

Working with care homes to save money by retrieving blankets and linen

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

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

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

Medicine recycling a success

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

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

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

Staff ideas to reduce spend and save money

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

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

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

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

Service reviews underway to identify savings

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

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

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

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

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

Walking aid recycling scheme at Royal Blackburn Teaching Hospital

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

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

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

Trust puts focus on community services

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

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

Improving urgent and emergency care experience for patients

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

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

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

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

Call for Concern - patient wellness questionnaire launched

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

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

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

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

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

Breast screening information day for people with learning disabilities

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

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

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

Maternity discharge videos will transform new parents' experiences

A raft of new videos designed to provide crucial information to new parents in an accessible format has now been launched.

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

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

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

Outpatients Pharmacy to move to a new provider

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

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

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

Colleagues get involved on World Hijab Day

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

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

New Bereavement Suite officially opens

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

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

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

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

Pop-up flu vaccinations at RBTH and BGTH

A pop-up flu vaccination service has been visiting Blackburn and Burnley hospitals.

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

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

SPEC success for teams

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

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

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

King Charles awards Dr Newport with humanitarian medal

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

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

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

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

Raising awareness of ketamine abuse

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

Specialist endometriosis centre accreditation achieved again

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

JAG accreditation achieved again

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

ENDS

TRUST BOARD REPORT

12 March 2025

Item 37

Purpose Approval
Assurance
Information

Title Corporate Risk Register Report

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

Executive sponsor Mr J Husain, Executive Medical Director

Date paper approved by Executive sponsor 18 February 2025

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

Recommendation: Directors are asked to note and approve the contents of this report.

Report linkages

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

- 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
- 6 (As Host of One LSC): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services.

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

**Related to key risks
identified on the
Corporate Risk Register**

Risk ID: Risk Descriptor
As described

**Related to
recommendations from
audit reports**

Mersey Internal Audit Agency (MIAA) Risk Management Audit Report

**Related to Key Delivery
Programmes**

Care Closer to Home
Placed Based Partnerships
Provider Collaborative
Quality and Safety Improvement Priorities
Elective and Emergency Pathway Improvement
People Plan Priorities
Waste Reduction Programme

**Related to ICB Strategic
Objective**

Improve population health and healthcare
Tackle inequalities in outcomes, experience and access
Enhance productivity and value for money
Help the NHS support broader social and economic development

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by:

For Trust Board only: Have accessibility checks been completed?

Executive Summary

1. A summary of key points to note since the last meeting.
 - a) The corporate risk register has twenty three risks, an increase since the last report. One risk has a reduced risk score of sixteen from twenty and one risk has a reduced risk score of twelve awaiting approval for it to be removed. There has been no movement or change in any other risk scores.
 - b) Highest areas of risk relate to financial sustainability, digital systems and storage of data, the management of medical devices, insufficient capacity to meet demand and sub optimisation of the electronic patient record system.
 - c) The Trust continues to advance its risk maturity and movement towards a more integrated risk management enterprise model.

Risk management and the impact of taking / not taking action

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

- l) Improves credibility, reputation and commercial viability.

Corporate Risk Register (CRR) Performance Activity

4. A summary of key points to note since the last meeting.
 - a) The CRR has twenty three risks, an increase since the last report. One risk has a reduced risk score of sixteen from twenty and one risk has a reduced risk score of twelve awaiting approval for it to be removed. There has been no movement or change in any other risk scores.
 - b) Highest areas of risk relate to financial sustainability, digital systems and storage of data, the management of medical devices, insufficient capacity to meet demand and sub optimisation of the electronic patient record system.
 - c) A breakdown of risks by risk type shows twelve (52%) are clinical management risks, four (17%) are data and digital risks, three are health and safety risks (13%), two are financial risks (10%) and one (4%) is a medical devices risk and one (4%) is a patient safety risk.
 - d) A breakdown of risks by division shows ten (43%) are Trust wide, six (26%) are corporate services, two (9%) are diagnostic and clinical services, two (9%) are surgical and anaesthetic services, two (9%) are within medicines and emergency care services and one (4%) is within family care services.
 - e) A summary and detail of risks held on the CRR is included within the appendices.

Risk Management Performance Activity

5. A summary of key points to note since the last meeting.
 - a) Numbers of open risks held on the risk register are down from 682 risks in Q4 2034-24 to 595 in Q4 2024-25 to present, a decrease of 13%.
 - b) Risks scoring between 9-12 identified as being significant or moderate have increased, from 215 risks in Q4 2023-24 to 233 in Q4 2024-25 to present, an increase of 8%.
 - c) Risks remaining open over 3 years old are down from 400 risks in Q4 2023-24 to 311 in Q4 2024-25 to present, a decrease of 22%.
 - d) Overdue risks have increased from 107 in Q4 2023-24 to 118 in Q4 2024-25 to present, an increase of 10%.
 - e) 8% of tolerated risks have currently surpassed their review date.
 - f) Highest numbers of risks held relate to clinical management i.e. medical, nursing or operational (41%) followed by health and safety (16%).

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

Mitigations for risks and timelines

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

- ii. A series of measures to drive improvements regarding the management of risks scoring fifteen or above not on the CRR.
- iii. Improved scrutiny and challenge of risk scores, controls and assurances against catastrophic, severe and moderate consequence scoring criteria.
- vi. More detailed assurance requirements within divisional reporting.
- vii. Specific inclusion, monitoring and achievement of KPI metrics.
- viii. More intensive focus and scrutiny by the RAM and Executive Risk Assurance Group (ERAG).
- ix. Targeted review of all live and tolerated risks whereby the current risk score has met its target score and of their subsequent closure.
- x. Engagement with relevant lead specialisms and subject matter experts to improve the management of clinical and corporate risk types.
- xi. Addressing challenges of risk handlers or leads being unable to present risks at risk assurance meetings due to conflicting priorities and urgent work activity.
- d) Improved risk management competencies of managers and key staff. These include:
 - i. The coaching of managers and staff with responsibility for managing risks, along with the issue of new guidance.
 - ii. The completion of a risk management training needs analysis and its approval by the Core and Essential Skills Group onto the competency framework.
- e) System improvements to the Datix risk management module. These include:
 - i. The review of RL Datix system upgrade and capabilities.
 - ii. Profiling and mapping of risks into new risk type and sub type categories.
 - iii. Review of approval statuses.
 - iv. Inclusion of nominated committees and or groups.
 - v. Linking of risks, in particular, those scoring fifteen or above on the CRR to the board assurance framework (BAF).
 - vi. The creation of a mandatory actions required to be taken section.
 - vii. Limiting access to the risk register to improve ownership and the management of risks and prevent the risk register from being inappropriately used.
 - viii. The removal of the 'other' risk type category as this does not add any value to the risk management process.
 - ix. The use of mandatory field and minimum characters to avoid sections of risks being left blank.

Challenges

7. A number of challenges have significantly impacted on and detracted away from continued focus and commitment to improving assurances of internal risk management systems, controls, culture and performance. These include:
 - a) External and internal drivers e.g. industrial action.
 - b) Financial pressures and budgetary constraints.
 - c) Major organisational system and process change e.g. electronic patient record system.
 - d) Changes to strategic direction and operational frameworks.
 - e) Changes to governance and assurance systems.
 - f) Increasing service demands and competing priorities.
 - g) Workforce transformation.
 - h) Resources and staffing limitations.
 - i) Staffing levels and pressures.
 - j) Evolving nature of risks e.g. digital systems and storage etc.
 - k) Resistance to change in established practices.
 - l) Past, historical risk management cultural norms and performance.
8. The decision not to implement a new total quality management system has restricted advancing internal systems and controls for risk management through system design and of the need to respond, readapt and realign the approach to risk management.
9. Delays in upgrading Datix servers, competing organisational priorities and work projects, in particular, in supporting system improvements due to implementation of the electronic patient record (e-PR) and of ensuring organisational compliance with national learning from patient safety event (LfPSE) requirements has further limited progression.
10. Matters to advance internal systems and controls for risk management, through development and review of risk management strategy and framework, has been further compounded due to increasing work activity and organisational review of risk governance and assurance systems.
11. Work to address risk management and risk assessment training and its delivery remains very challenging due to limited capacity and resource.
12. Despite these challenges, a significant amount of work has been undertaken prior to publication of the audit that focused on improvement work to avoid duplication, improve standardisation and the quality and quantity of risks held on the risk register.

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

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

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

Resource implications and how they will be met

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

Benchmarking Intelligence

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

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

Conclusion of Report

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

Recommendations

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

Next Actions

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

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

How the decision will be communicated internally and externally

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

How progress will be monitored

- 23. Progress in monitoring the quality and integrity of risks held on the risk register, in particular, those with a current risk score of fifteen or above, is undertaken at the RAM, Trust Wide Quality Governance (TwQG) and ERAG meetings.
- 24. A senior executive lead is nominated by the ERAG to monitor and review risks approved onto the CRR and ensure they are being managed and mitigated in accordance with the RMF.

Appendices

Summary of the CRR

Detailed CRR

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

18 February 2025

Summary of the Corporate Risk Register

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

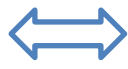
Corporate Risk Register Detailed Information

No	ID	Title						
1	10082	Failure to meet internal and external financial targets for 2024-25						
Lead		Risk Lead: A Hussain Exec Lead: S Simpson	Current score	25	Score Movement			
Description		There is a risk that the failure to meet the Trust financial plan and obligations together with the failure to meet the wider Lancashire and South Cumbria ICB system financial plan is likely to lead to the imposition of special measures and limit the ability of the Trust to invest in the services it provides. The financial risk is made up of insufficient funds to provide the services to the population of East Lancashire, a lack of control on how funds are allocated across partner organisations, a 7.7% efficiency target of £57.8m for the Trust, a level that has never been achieved previously and a Trust and system wide financial deficit that still needs closing.		Gaps and potential actions to further mitigate risk	Gaps / weaknesses in controls 1. A high efficiency target than has ever been achieved in the past to ensure the Trust is fully engaged and playing their part in reducing efficiencies and the cost base. 2. The financial regime is managed at a system level rather than at a Trust level. 3. The financial gap is across the system not just the Trust. Gaps / weaknesses in assurances 1. Lack of understanding of full system risks. 2. Lack of airtime for discussion of the full system risks.			
Controls and Assurances in place		Controls 1. Robust financial planning arrangements to ensure financial targets are achievable within the Trust. 2. Accurate financial forecasts. 3. Financial performance reports distributed across the Trust to allow service managers and senior managers to monitor financial performance. 4. Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made within delegated limits. Assurances 1. Frequent, accurate and robust financial reporting and challenge by the way of:- - Trust Board Report - Finance and Performance Committee Finance Report - Audit Committee Reports - Integrated Performance reporting - Divisional and Directorate Finance reports - Budget Statements - Staff in Posts Lists - Financial risks - External Reporting and Challenge						
Update since the last report		Update 17/02/2025 Risk reviewed. No change in risk score Progress Update Deficit: £41.6m, against a planned £8.6m, £33.0m shortfall from revised plan. Monthly Deficit: £9.3m, deterioration of £3.0m. Breakeven Plan: Revised annual plan includes a £59.7m waste reduction programme; reliant on non-recurrent deficit support funding. Cost Pressures: Extra ward areas, increased ED staffing, corridor care, sickness, waiting list initiatives, anesthetic, and theatre costs. ERF Overperformance: Potential for increased activity and income; overperformance was removed from financial position. Depreciation Income: Expected additional income for depreciation not received. Capital Programme: £33.6m funding, slight forecast expenditure increase. Year-to-date £16.0m ahead due to early lease expenditure recognition. Cash Balance: £10.2m as of 31st December, supported by £18.2m PDC; anticipated challenges in quarter four. Payment Performance: Withheld supplier payments; BPPC below target. Risk of falling below NHS invoice payment target in last quarter. Agency Staff Spend: 1.9% of total pay, below NHSE ceiling of 2.9%. Waste Reduction Programme: £16.2m achieved against £29.8m plan by Month 9. Next Review Date 14/03/2025		Date last reviewed	17/02/2025			
				Risk by quarter 2024-25	Q1	Q2	Q3	Q4
					25	25	25	25
						8-week score projection	25	
		Current issues	System wide external influences					

No	ID	Title				
2	10086	Lack of adequate online storage for images may result in missed or delayed diagnosis				
Lead		Risk Lead: D Hallen Exec Lead: S Simpson	Current score	20	Score Movement	
Description		There is a risk that capacity for the storage and transfer of ECHO images from ultrasound machines used within Chronic Obstructive Pulmonary Disease (COPD) and Neonatal Intensive Care Units (NICU) services may result in missed or delayed diagnosis if no suitable clinical management or digital storage solution can be found.				
Controls and Assurances in place		Controls - The existing service contract has been extended. - Current ultrasound images stored on scanning machines and McKesson software installed on NICU computers. - 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. - Patient transfer to other Hospitals for echocardiology review. - 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. - Organisational policy and procedural controls in place for the lifecycle management of medical devices. Assurances - Imaging incidents closely reviewed and monitored and linked to the management of risk. - 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. - 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. - 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. - 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. - 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. - Divisional Quality and Safety Meetings in place to review and support the management of this risk. - 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 - Additional cost implications for contract extension and a software storage solution. - Current ultrasound images stored on scanning machines have limited memory capacity. - 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. - Patient transfers to other Hospitals may be unnecessary, unsafe and reliant on bed availability. - Limited assurance Royal College of Radiologists standards are being used to benchmark or measure performance or compliance. - Additional staff training in system use is required. - Development of a virtual private network (VPN) tunnel is under trial and not embedded as clinical management process. - Cranial ultrasound scans and echocardiogram images cannot be separated and stored with further exploration of how scans are stored required. - A planned strategy and system solution being brought in by the ICB to increase storage capacity is awaiting implementation. - 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 - Common incident themes relate to equipment malfunction, delays in diagnosis, clinical symptoms warranting emergency transfer of patient to another Hospital and difficulties transferring images. - Cerner e-PR imaging module and set up requires further exploration to determine effectiveness. - Limited evidence of assurance current capacity levels are regularly checked and monitored. - Bridgehead solution remains fully dependent on the release of funding and approval by the ICB. - Solution offered by Siemens does not help image sharing with other Hospitals and effectiveness of direct image transfers still requires exploration. - Effectiveness of the Medical Devices Management Group to support management of this risk.				
Update since the last report		Update 07/02/2025 Change of risk lead. No change in risk score. Risk has been reviewed by the Chief X Information Officer. Assurance of compliance against national guidance for the storage of clinical images is being reviewed which will help support mitigation of this risk and a reduced risk score. Next Review Date 07/03/2025	Date last reviewed	07/02/2025		
			Risk by quarter 2024-25	Q1	Q2	Q3
				20	20	20
			8-week score projection	12		
			Current issues	System wide external influences		

No	ID	Title				
3	9755	Delays in undertaking elective caesarean sections				
Lead	Risk Lead: C Aspden Exec Lead: P Murphy		Current score	20	Score Movement	
Description	There is a deficit in capacity for elective caesarean sections against annual increasing demand. The current delivery model and mitigation to meet the gap have implications for clinical and patient safety risks and compromises emergency operative availability		Gaps / weaknesses in controls 1 Limitations for Antenatal Inpatient Manager and Consultant Obstetric Lead to undertake daily review of elective caesarean section demand. with potential single point of failure in times of sickness or unavailability. Business case seeks approval of elective admissions clerk to support the process and remove burden off clinical team. 2 Additional capacity sessions - unsustainable, costly, unreliable, dependent on availability of theatre/anaesthetic cover and midwifery staffing. There is a decline in staff who pick up bank shifts/capacity. Antenatal Ward Manager often stepping in to cover sections taking her away from substantive duties. 3 Availability of extra sessions further impacted by lifecycle works reducing number of lists available for re-utilisation, with activity moved from Blackburn to Burnley theatres. 4 Programme of theatre lifecycle work commenced that necessitates more elective work to be undertaken in the Lancashire Women & Newborn Centre. As a result maternity services will not have access to Gynae Theatre 4 as a 2nd emergency obstetric theatre during this time. On days elective caesarean section lists are taking place there will only be one available emergency theatre (obstetric theatre 1). 5 Category 3 caesarean sections should be risk assessed by the Obstetric Consultant on call and Band 7 Co-ordinator to be facilitated when safe to do proceed. 6 Additional elective work (category 4) should be conducted on days without concurrent elective lists, housed on gaps in the elective lists or escalated to the Maternity Triad to secure additional capacity if required. 7 Ongoing assessment of risk and work around the demand and capacity for caesarean sections is continuing. 8 Unable to guarantee requests for extra theatre capacity - if additional elective capacity is not available women are often listed from Central Birth Suite into emergency capacity, however given the above availability of gynae 4 due to Lifecycle works this mitigation is now not often an option. 9 Inefficient use of staffing resource which will cause additional hidden tasks for Acute lead consultant, midwifery leaders and ward clerks. 10 A business case was originally submitted in 2022/23 which proposed moving back to a 5-day delivery model, at the time it paused as part of the Trust Business Case Stock take exercise and put on hold due to the 22/23 financial position of the Trust. 11 Revised business case re-submitted in 2024/2025 - no decision taken as yet (17.09.24). In August 2024 current business case has been added to the urgent case review tracker. 12 Increasing elective work impacts availability of emergency theatre. Impact of grade 3s on acute workload, has caused delay to emergency work (increased requirement to break into a second emergency theatre, staffing pressures). 13 Approval of the business case will further exacerbate SAS risk 10139 availability of theatres, due to the fact that it will reduce			
Controls and Assurances in place	Controls 1 Antenatal inpatient manager and Consultant Obstetric lead undertake daily review of planned elective caesarean sections to monitor and manage planned waiting list. 2 Weekly meeting to pick up any reutilised list. Hoping that where there is an available list that obstetric capacity and midwifery bank will pick up the sessions. Where there isn't a list for reutilisation, a capacity request is submitted. 3 Using on-call obstetric staffing and central Birth Suite Midwifery and maternity support worker staffing to do elective activity in addition to their job planned work. 4 Improvement case drafted and submitted for decision (included in documents) proposal to move back to a 5-day model (Ockenden recommendation is to aspire to a 5-day (10 session model). 5 Established a task & finish group to maximise efficiencies and see improved utilisation of current capacity. Assurances 1 The only confidence in controls is that the overspill of elective caesarean sections are managed on the emergency pathway but this is not a sustainable or safe control. 2 Monthly escalation meeting hosted by Divisional Director of Operations and Divisional Director of Midwifery & Nursing. 3 Weekly review of capacity requirements and planned activity.		Gaps and potential actions to further mitigate risk			

			availability of a second emergency theatre on Mondays and Fridays. 14 Gynae 4 the second emergency obstetric theatre has planned elective work listed - where there is need to break into this theatre for an emergency obstetric case, this impacts on productivity of Trust level elective recovery plans and long waiting patients. Gaps / weaknesses in assurances 1 Limited assurance due to the lack formalisation of the processes identified within the controls and actions. 2 There remains an ongoing pressure on the emergency team and risk of delay to emergency cases, with the potential for poor maternal and/or foetal outcomes.			
Update since the last report	Update 06/02/2025 New Risk There remains a significant and daily risk whilst the service demand requires using the emergency team to undertake elective work. The controls currently in place do not mitigate these risks. Next Review Date 06/03/2025	Date last reviewed	06/02/2025			
		Risk by quarter 2024-25	Q1	Q2	Q3	Q4
		8-week score projection	20			
		Current issues	System wide external influences			

No	ID	Title				
4	9336	Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care				
Lead	Risk Lead: 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.		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 (NWS) directly to Ambulatory Emergency Care Unit. 5. Pathways in place from NWS to Surgical Ambulatory Emergency Care Unit (SAECU), Children's Observation and Assessment Unit (COAU), Mental Health, Gynaecology and Obstetrics and the Community. 6. ED streamer tool in place to redirect patients to an appointment or alternative service where required. 7. Daily staff capacity assessments completed and staff flexed as required. 8. Divisional Flow Facilitators established across all divisions to assist with clear escalation and 'pull through'. 9. Escalation pathway and use of trolleys in place for extreme pressures. 10. Zoning of departments to enable better and clearer oversight, staffing and ownership and isolation of infected patients, in particular, those with influenza and risks of cross contamination. 11. Corridor care standard operating procedure embedded. 12. Workforce redesign aligned to demands in ED. 13. Safe Care Tool designed for ED. 14. Full recruitment of established consultants. 15. Matrons undergone coaching and development on board rounds. 16. Reduced thresholds within critical care to support patient admissions. 17. Patient champions in post to support patients on corridors and volunteers utilised to support with non-clinical tasks. Assurances 1. Support provided by IHSS Ltd. in regularly reviewing admission avoidance. 2. Gold command in place to provide support. 3. Bed meetings held x4 daily with Divisional Flow Facilitators. 4. Hourly rounding by nursing staff embedded in ED. 5. Daily consultant ward rounds done at cubicles so review of care plans are undertaken. 6. Daily 'every day matters' meetings held with Head of Clinical Flow and Patient Flow Facilitators. 7. Daily visit by Infection Control Nurse to ED with patients identified as being not for corridor. 8. Increased bed capacity within cardiology. 9. High observation beds in place on AMU to support patients who require high levels of care. 10. Further in reach to departments in place to help decrease admissions. 11. Discussions ongoing with commissioners in providing health economy solutions via A&E delivery board. 12. Continuous review of processes across Acute and Emergency medicine in line with incidents and coronial process.					

Update since the last report	Update 10/02/2025 Risk reviewed. No change in risk score ED continue to see increased pressure on pathways and subsequent overcrowding and daily utilisation of corridor spaces. Additional medical wards have been opened whereby all clinical space at this point is in use. There has been an increase in the RN establishment so all ED corridor spaces can be fully recruited to and continuous positive RN recruitment, with minimal vacancies now.	Date last reviewed	10/02/2025			
	Next Review Date 10/03/2025	Risk by quarter 2024-25	Q1	Q2	Q3	Q4
			20	20	20	20
		8 week score projection	20			
		Current Issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title							
5	8941	Increased reporting time in histology due to increased activity outstripping resource							
Lead		Risk Lead: C Rogers Exec Lead: J Husain		Current score	20	Score Movement			
Description		Increased reporting times in histology due to increased workload and reduced staffing numbers can lead to the mismanagement of patient care with long term effects, the non-compliance with national standards with significant risk to patients, poor patient experience if results are delayed, multiple complaints, low performance rating i.e. NHSE cancer performance, uncertain delivery of key objectives or service due to lack of staff and low staff morale			Gaps and Potential actions to further mitigate risk	Gaps / weaknesses in controls 1. Dissection workload not adequately covered by clinical staff. 2. Activity increase higher than technical staff can complete, despite the issue of overtime and use of locum staff. 3. Failure of medical devices and equipment is adding to delays. 4. Volume of work marked urgent has increased by c.45%. 5. Gaps in recruitment of junior doctor posts remain. Gaps / weaknesses in assurances 1. Unexpected cancers found after waiting in backlog. 2. Surges in incidents regarding histology reporting times. 3. Poor monitoring and escalation of issues and meetings often stood down. 4. Some breaches fall outside the control of the Trust e.g. patients breaching targets due to complexity of pathways, comorbidities and patient choice.			
Controls and Assurances in place		Controls 1. A 5 year workforce plan is in place to support recruitment and retention. 2. Recruitment of locum staff, additional senior BMS 3. MLA posts filled. 4. Triaging of cases to prioritise cancer cases. 5. Increased outsourcing of breast workload, colposcopy screening cases and routine cases to neighbouring NHS Trusts and external providers and reporting services. 6. Additional dissection bench created to increase capacity Assurances 1. Consultant staff supporting with dissection. 2. Work being triaged based on clinical urgency given the information provided upon the request form. 3. Weekly cancer performance meetings in place and attended by the histology/performance manager. 4. Escalation process for priority cases is well established. 5. Pathology collaborative exploring support.							
Update since the last report		Update 04/02/2025 Risk reviewed. No change in risk score. Position is showing signs of improvement with a reduced backlog of cases from the use of mutual aid, additional bank work and external reporting services. Turnaround times remain above target and recruitment of locums and outsourcing remains challenging due to financial constraints. Increasing numbers of complaints relating to turnaround times and delays. Next Review Date 04/03/2025			Date last reviewed	04/02/2025			
					Risk by quarter 2024-25	Q1	Q2	Q3	Q4
						16	20	20	20
					8 week score projection	20			
		Current issues			System pressures				

No	ID	Title				
6	8126	Poor records management due to sub optimal implementation of new e-PR system				
Lead	Risk Lead: D Hallen Exec Lead: J Husain		Current score	20	Score Movement	
Description	A lack of continuous optimisation and investment may lead to frustration and create disillusionment, leading to poor usage and productivity, unsafe workarounds, substandard data and ineffective clinical decision making.		Gaps / weaknesses in controls <u>General</u> - 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 <u>Clinical management</u> - 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 <u>Emergency preparedness, response and resilience</u> - limited assurance policy and or procedural requirements remain effective, are being monitored, reviewed or followed <u>Governance</u> - there is no robust document management solution currently in place e.g. imaging, documentation etc. <u>Digital</u> - 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 <u>Patient and staff safety</u> - limited assurance staff related health and wellbeing support systems are being used, monitored or reviewed for Cerner related issues Gaps and potential actions to further mitigate risk			
Controls and Assurances in place	<u>Controls</u> <u>General</u> - 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 <u>Clinical management</u> - 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 <u>Communication</u> - 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 <u>Education, training and competency</u> - 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 / weaknesses in assurances <u>Clinical management</u> - 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 (ferral 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 <u>Digital</u> - completion of build work and excessive technical testing - all critical systems directly and indirectly managed by data and digital - 24/7 systems support in place - significant amount of business intelligence system data quality and usage reporting - consistent monitoring of clinical management systems and support via IT helpdesk - service desk e-PR tickets are continuously monitored - robust process in place for change requests <u>Patient and staff safety</u> - no patient or staff harm at present <u>Task based</u> - evaluation of issues undertaken by multi-disciplinary teams e.g. digital, clinical operational teams, learning and development, improvement hub, system support and leadership etc. through in person and observations utilising SPE+ improvement methodology					
Update since the last report	Update 18/02/2025 Risk reviewed. No change in risk score Data and digital board is working on addressing the risk by segmenting into various functional components. These will reflect challenges that range from embedding of the system to upgrades required to maintain the functionality of EPR. A number of work stream are currently looking into coding, training, data accuracy and optimising of the pathways to improve the functionality of EPR Next Review Date 07/03/2024	Date last reviewed	18/02/2025			
		Risk by quarter 2024-25	Q1	Q2	Q3	Q4
			20	20	20	20
		8-week score projection	15			
		Current issues	System wide external influences			

No	ID	Title							
7	10062	Risk of significant harm and poor experience for patients attending with mental health concerns							
Lead		Risk Lead: M Illingworth Exec Lead: P Murphy		Current score	15	Score Movement			
Description		The Trust is registered with the Care Quality Commission for the assessment and treatment of patients on the emergency care pathway who are subject to sections 136, 5,2 or 5.4 of the Mental Health Act. Patients are being admitted onto hospital wards who, whilst their acute physical health needs are being met, can present a risk in relation to their mental health needs when awaiting a more formal mental health assessment, a suitable mental health bed or transfer to other more suitable clinical pathways outside of the Trust and lead to patients not receiving coordinated care against standards, poor patient experience in the absence of specialist care and a deterioration in mental health condition.			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 12/02/2025 Risk Reviewed. No change in risk score. A regular review of incidents is taking place to understand causation and address issues. There has been a 44% reduction in numbers of self-harm incidents compared to the previous financial year to date. Increased resistance from local Trusts to support transfers and absence of formalised pathway. A full review of this risk and internal controls and assurances is being undertaken by the newly appointed mental health nurse which will support mitigation of this risk and a reduced risk score. Next review date 14/03/2025			Date last reviewed	12/02/2025			
					Risk by quarter 2024/25	Q1	Q2	Q3	Q4
					8-week score projection	12			
					Current issues	System wide influences			

No	ID	Title							
8	9777	Loss of Education, Research and Innovation Accommodation and Facilities							
Lead		Risk Lead: A Appiah Exec Lead: T McDonald		Current score	16	Score Movement			
Description		There is a risk that the buildings at Park View Offices at Royal Blackburn Teaching Hospital and the Training and Development Centre at Burnley General Hospital hosting will be decommissioned due to disrepair and investment that will impact on the teaching hospital accreditation with no other alternative accommodation to enable DERI to meet current and future training needs.			Gaps and Potential actions to further mitigate risk				
Controls and Assurances in place		Controls 1 Estates and Facilities Premises Assurance Model 2 Business continuity plan in place 3 Relocation of a number of services to alternative accommodation 4 Investment made into maintaining classroom and teaching IT portable equipment should DERI need to move location 5 Ward simulation suite has been built and completed Assurances 1. Scoping exercise undertaken to determine type and size of space required and alternative locations in readiness for any potential move of the service 2. Walkaround building environmental assessment completed. Whilst investment was required to fix the external fabric of the building it was safe and fit for purpose for DERI services to remain in situ for the time being. 3. Building issues monitored weekly via DERI SLT meetings and monthly safety meetings. 4. Daily monitoring and observations undertaken by education centre team 5. Discussions taking place between estates and facilities and DERI with Calico developers to explore potential opportunities for relocation. 6. Maintenance issues reported via Equans / Estates and Facilities helpdesk and via Datix where appropriate 7. Steering Group established to review remedial work requirements							
Update since the last report		New Risk There is a significant impact on already existing pressures within education and research with no sufficient alternative accommodation to enable DERI to meet current and future training needs, minor works undertaken to improve seminar rooms Next Review Date 07/03/2025			Date last reviewed	07/02/2025			
					Risk by quarter 2024-25	Q1	Q2	Q3	Q4
								16	16
					8 week score projection	16			
		Current issues							

No	ID	Title							
9	9746	Inadequate funding model for research, development and innovation							
Lead		Risk Lead: J Owen Exec Lead: K Quinn		Current score	16	Score Movement			
Description		The Research, Development and Innovation Service within DERI is not centrally funded by the Trust. It is financed through complex funding streams such as the National Institute for Health Research (NIHR), Clinical Research Network (CRN) Greater Manchester and from income generated from commercial and non-commercial research activity. This model of funding is no longer sustainable			Gaps / 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.							Gaps and potential actions to further mitigate risk
Update since the last report		Update 29/01/2025 No change in risk score. Lead of finance project handed over in Jan-25. Work progressing with new delivery teams joining to organise finance. Since Dec-24 project has added £57k of finance activity into the tracking system EDGE. Prioritisation exercise took place to close studies where contractual targets have been met and not accept amendments to studies where targets were met to allow teams to focus on income generating activity Next Review Date 28/02/2025			Date last reviewed	29/01/2025			
					Risk by quarter 2024-25	Q1	Q2	Q3	Q4
					8-week score projection	12			
					Current issues	System wide external influences			

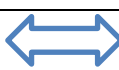
No	ID	Title							
10	9545	Potential interruption to surgical procedures due to equipment failure							
Lead		Risk Lead: J Preston Exec Lead: S Simpson		Current score	16	Score Movement			
Description		Theatre items that are out of service or obsolete pose a significant risk of complete failure which will impact on service delivery and patient safety. These items include theatre stack systems and Integrated theatre solutions which are now out of service contract. Additional critical medical devices and items are also due to be without support in the short and medium term			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									<u>Controls</u> 1 Loan kit ordered when equipment broken if available (parts and items dependent) 2 Theatre staff fully trained and competent to work the equipment 3 Specialty scheduling and theatre oversight in place 4 Service contracts in place jointly managed between EBME and Theatres 5 Policy in place for the lifecycle management of medical devices monitored by the Medical Devices Management Group 6 Managed service in place for some equipment <u>Assurances</u> 1 Capital bids process in place 2 Business case to propose moving to a managed service and potential solution to the risk accepted by Board 3 Good relationship with and support from EBME, supplier and company representative 4 Breakages of choledoscopes fully investigated with theatres, EBME and supplier with the outcome of investigations finding no particular trend, with some breakages due to fragility of equipment and increased complexity of cases 5 Task and Finish Group established to progress replacement of equipment and managed service option 6 Monitoring at theatre and divisional meetings 7 Monitoring of incidents linked to risk and likelihood scoring criteria 8 Regular updates provides to Senior Exec Team
Update since the last report		Update 10/02/2025 Change of risk lead. Risk score reduced from 20 to 16 Upgrades to integrated theatres delayed due to lifecycle works at RBH being delayed for delivery. New programme to be confirmed, but likely to be done Apr-May 25 Next Review Date 10/03/2025 Reminder issued to risk handler to review risk.			Date last reviewed	10/02/2025			
					Risk by quarter 2024-25	Q1	Q2	Q3	Q4
						20	20	20	16
					8-week score projection	12			
		Current issues			Management of Medical Devices				

No	ID	Title								
11	8061	Patients experiencing delays past their intended clinical review date may experience deterioration								
Lead		Risk Lead: A Marsh Exec Lead: S Gilligan		Current score	16	Score Movement				
Description		Patients are waiting past their intended date for review appointments and subsequently coming to harm due to a deteriorating condition or from suffering complications as a result of delayed decision making or clinical intervention.								
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 specialties 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 specialties undertaking own review of the holding list to identify if patients can be managed in alternative ways. 9 Updates provided weekly to Executive Team.			Gaps and Potential actions to further mitigate risk				Gaps / weaknesses in controls 1 Holding list remains high due to backlog from COVID-19. 2 General lack of capacity across specialties impacting on reducing holding list numbers. 3 Not all staff are following standard operating procedures for RAG rating of patients, leaving some patients without a rating. Gaps / weaknesses in assurances 1 Automated reporting system in development that will ensure oversight of risk stratified lists by specialty. 2 Current level of patients without a RAG rating classed as uncoded and unknown. 3 Patient appointments not RAG rated will drop onto the holding list if appointments are cancelled. 4 Patients added onto the holding list from other sources such as theatres, wards etc will not have a RAG identified.	
Update since the last report		Update 06/02/2025 Risk reviewed. No change in risk score Continuing increase in volume of patients and time constraints due to competing waiting list demands. Upward trend in the last three months. More accurate reporting now available Next Review Date 07/03/2025			Date last reviewed		06/02/2025			
					Risk by quarter 2024-25		Q1	Q2	Q3	Q4
							16	16	16	16
					8 week score projection		16			
		Current issues			Recovery and restoration pressures, recruitment and retention					

No	ID	Title				
12	8033	Increased requirement for nutrition and hydration intervention in patients resulting in delays				
Lead		Risk Lead: M Davies Exec Lead: P Murphy	Current score	16	Score Movement	
Description		Failure to meet nutrition and hydration needs of patients as set out within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which sets out the requirements for healthcare providers to ensure persons have enough to eat and drink to meet nutrition and hydration needs and receive support in doing so.				
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 bridge, mouthcare, malnutrition identification and management, fluid balance, Percutaneous Endoscopic Gastronomy (PEG) management and food hygiene. Assurances 1 Nutrition and hydration prompt on ward round sheets 2 Inclusion within ward manager audits. 3 Monitoring of incidents and levels of harm, complaints, patient experience outcomes etc. as part of divisional reports. 4 Outcome results form part of the work plan of the Nutrition and Hydration Steering Group. 5 Inclusion via Nursing Assessment and Performance Framework (NAPF).				
Update since the last report		Update 12/02/2025 Risk Reviewed. No change in risk score Rise in nutrition and hydration related incidents primarily related to SLT and MUST performance. Full risk review required Next Review Date 06/03/2025	Date last reviewed	12/02/2025		
			Risk by quarter 2024-25	Q1	Q2	Q3
				16	16	16
			8 week score projection	16		
			Current issues	Recovery and restoration pressures, recruitment and retention		

No	ID	Title				
13	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	Gaps and Potential actions to further mitigate risk	Gaps / weaknesses in controls 1. Delays determining RIDDOR due to increasing volume and complexity of accidents and incidents requiring review and investigation 2. Limited assurance managers and staff are following policy or procedural controls regarding reporting of accidents or incidents, of this being highlighted or captured within management systems or processes or it being performance managed 3. No standardised investigation process or quality management system used to capture total numbers of days lost off work (LTI) as a result of workplace accident or injury leading to absence, avoidance or duplication 4. Introduction of patient safety learning response timescales identified as part of the new Patient Safety Incident Response Framework (PSIRF) may delay incident investigations and their subsequent impact on external regulatory reporting requirements 5. Improvements in compliance heavily reliant on major changes to incident management and triage processes and limited capacity and resource within the health and safety team 6. Lead specialisms and or SME's not being utilised effectively regarding review and investigation of incidents within their own areas of responsibility and control and determining external reporting requirements of RIDDOR when undertaking investigations 7. Investigations to determine RIDDOR highlighting gaps in quality safety management systems or processes, policy and procedural controls in particular risk assessments, not being followed or undertaken by managers and staff Gaps / weaknesses in assurance 1. RIDDOR performance increasingly attracting the interest of the HSE and CQC 2. No evidence of assurance lead specialisms or SME's in safety critical roles benchmarking or using RIDDOR performance as an important driver in reducing mitigating risks or improving safety management systems, processes or behaviours 3. Numbers of accidents and incidents being reviewed or investigated by the health, safety and risk team to determine RIDDOR status account for 25-30% of all accidents and incidents reported in DATIX. This continues to significantly impact on the work and resources of the team i.e. 6,539 were reviewed or investigated in 2021/22, this increased to 6,713 in 2022/23 and 6,725 in 2023/24. Current FYTD incidents total 5,947 (Jan-25) with numbers projected to exceed previous year figures 4. There has been a 50% increase in RIDDOR reportable incidents compared to the previous FYTD from 38 in 2022/23 to 57 in 2023/24. A total of 37 RIDDOR reportable incidents have occurred this FYTD, 11 of which have been reported outside of timescales 5. The threshold level of achieving 95% compliance continues to remain in place		
Controls and Assurances in place		Controls 1. Responsibilities of staff to report accidents and incidents in a timely manner using Datix contained as part of the incident management policy 2. RIDDOR reporting requirements contained as part of the incident management policy controls 3. Responsibilities of staff to report any health concerns contained within health and safety at work policy 4. Improved data capture and utilisation of incident management module of DATIX 5. Centralised process firmly established for health and safety team to review and submit RIDDOR reportable incidents externally to the HSE 5. Days lost off work as a result of a workplace accident or injury captured as part of the HR sickness management and return to work processes 6. Increased management and staff awareness and understanding of RIDDOR i.e. what is and what is not reportable, consequences and timescales involved, relevant work examples and the issue of guidance 7. RIDDOR awareness training rolled out to targeted staff groups i.e. members of the health and safety committee, lead specialisms and or subject matter experts, occupational health services, divisional quality and safety leads and teams and patient safety investigation leads. Further ad hoc training across divisional groups available, where necessary 8. Increased senior management awareness of RIDDOR to help drive and reinforce importance of ensuring legislative compliance 9. New Occupational Health Management System OPAS-G2 now being used to capture and inform of the types of medically diagnosed occupational related disease, infections and ill health identified as being RIDDOR reportable 10. New RIDDOR process introduced in Oct-24. Refresher RIDDOR awareness training completed in Sep-24 to support new process Assurances 1. Review of legal requirements and compliance regularly undertaken 2. Specialist advice, support and guidance on RIDDOR reporting requirements readily available 3. Continuous monitoring and review of all accidents and incidents to staff, patients, contractors and members of public undertaken by health, safety and risk team 4. Thematic review of RIDDOR performance included as an agenda item of the Health and Safety Committee, with escalation and or exception reporting to the TWQG and Quality Committee, where necessary 5. RIDDOR reportable occupational disease more explicitly included within occupational health performance reporting 6. Collaborative working partnerships strengthened with clinical and non-clinical service specialisms and safety critical roles e.g. matrons, ward managers, patient safety lead investigators, incident and triage team, infection control, occupational health, estates and facilities, human resources, legal services, falls lead, manual handling lead, security management etc. should any significant trends be identified 7. Attendance of health and safety team at weekly complex case review meetings to identify and determine RIDDOR reportable incidents to patients 8. RIDDOR performance included as part of QG KPI metrics for senior management oversight and review 9. A 10% target to reduce numbers of RIDDOR reportable incidents remains in place for 2024-25. A 35% reduction has been achieved this FYTD 10. Steady increase in RIDDOR reporting compliance rates from 56% in 2023-24 to 70% at present (end Jan-25)				
Update since the last report		Update 05/02/2025 Risk Reviewed. No change in risk score. Compliance rates have improved from 56% to 71% at present that will support mitigation of this risk and a reduced risk score. Next Review Date 07/03/2025	Date last reviewed	05/02/2025		
			Risk by quarter 2024-25	Q1	Q2	Q3
				16	16	16
			8 week score projection	12		
			Current issues	Systems, capacity and workforce pressures		

No	ID	Title						
14	10095	Cardiology PAC issues impacting on efficiency and ability to meet targets and obstructive workflow						
Lead	Risk Lead: K Thomson Exec Lead: S Simpson		Current score	15	Score Movement			
Description	The current change cardiology PACS system used is EOL. There is a risk of cardiology PAC issues impacting on efficiency and ability to meet targets.			Gaps and Potential actions to further mitigate risk	Gaps / weaknesses in controls 1 Poor functionality of existing system. 2 System supplier unable to resolve issues. 3 Compatibility with existing IT infrastructure in supporting upgrade 4 Potential cyber vulnerability of Change healthcare 5 Business continuity plans for failure revert to paper copy with no image storage availability 6 Impact on existing workforce pressures, clinical time and delayed diagnosis and treatment Gaps / weaknesses in assurances 1 Delays in estimated target date for new platform 2 Failure to meet deadline and resulting contract extension and upgrade at financial cost 3 No assurance of upgrade installation 4 Unpredictability of reporting system workflows and demands 5 Numbers of incomplete reports increasing 6 No assurance of upgrade installation			
Controls and Assurances in place	Controls 1 Purchase of cardiology PACS system upgrade 2 Change contract with maintenance support 3 IT member trained in change cardiology PACS system solution 4 Local super users for frequent basic troubleshooting 5 Business continuity plans up to date for major incident and failure. Assurances 1 Still running on old system 2 Finance directed towards upgrades. 3 Meetings with IT and IBC for future solutions 4 Engagement with system engineers to resolve current system issues 5 Incident reporting system and process in place							
Update since the last report	New risk Funding has been released for upgrade of the system but no indication at present when this will take place Next review date 07/03/2025			Date last reviewed	10/02/2025			
				Risk by quarter 2024-25	Q1	Q2	Q3	Q4
							15	15
				8 week score projection	15			
Current issues								

No	ID	Title							
15	10065	Pharmacy Technical Service refurbishment programme							
Lead		Risk Lead: M Randall Exec Lead: J Husain		Current score	15	Score Movement			
Description		The aseptic units are not being maintained to external standards and there is a risk the air handling units, specialist equipment such as pharmaceutical isolators and HEPA filters in both units will fail due to planned and reactive failure in the maintenance and replacement schedule and a number of potential issues: ▪ Temperature fluctuations may lead to environmental breaches. ▪ Product degradation may lead to contaminated products being administered to patients. ▪ Delays in chemotherapy service provision when equipment fails may hinder cancer recovery plans and breaches in cancer targets. ▪ An increased higher risk of dispensing and reconstitution of high risk products in clinical areas if incorrect stock is used or staff exposure to products that may cause health issues. ▪ A reduced ability to support clinical trials of investigational medicinal products requiring aseptic preparation. ▪ Outsourcing is not possible for supporting research and development where aseptic preparation is required due to air handling unit or equipment failure. ▪ The clinical trials team are based in the aseptic unit and if the unit closes, clinical trials dispensing will cease and research will stop which may impacts on commercial viability, reputational damage.			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 03/02/2025 Risk Reviewed. No change in risk score. Still awaiting closure of actions, NICU response, URS for aseptic unit approval, change of maintenance contract, 24 hr support and estates and PFI team review of actions. Aseptic unit closed and works commenced Next review date 04/03/2025			Date last reviewed	03/02/2025			
					Risk by quarter 2024/25	Q1	Q2	Q3	Q4
						15	15	15	15
					8-week score projection	15			
		Current issues			Systems, capacity and workforce pressures				

No	ID	Title							
16	9900	Poor identification, management and prevention of delirium							
Lead		Risk Lead: P McManamon Exec Lead: J Husain		Current score	15	Score Movement			
Description		National Institute of Clinical Excellence (NICE) guidance relating to the identification, assessment, management and prevention of delirium in acute hospital settings is partially and or not being met			Gaps and Potential actions to further mitigate risk	Gaps / weaknesses in controls 1. Existing digital flow requires doctors to complete delirium assessment through task list and not through ad hoc to complete task with additional training required 2. Staff awareness of SQID / Digital Delirium Care Plan requires additional awareness and training 3. Compliance with dementia audits and outcomes requires stronger divisional support. Deputy Chief Nurse requested dedicated monthly delirium audit data to be escalated 4. The training module for delirium is not a mandatory training requirement and does not fully mitigate the risks associated with delirium. 5. Published guidance and recommendations (agitated delirium in elderly) are not always followed. Gaps / weaknesses in assurances 1. Poor compliance with pilot assurance measures with further monthly audits planned required 2. New delirium workflow not embedded in daily practice with further training devised and planned 3. Work to create an investigation prompt for clinicians as part of the delirium diagnostic work flow and to assist clinical judgement underway.			
Controls and Assurances in place		Controls 1. Single Question to Identify Delirium (SQID) now live on Cerner. A positive SQID issues a delirium diagnostic assessment task to doctors lists 2. Digital delirium bundle and assessment in place for clinical teams investigating and managing delirium. This utilises 4AT as advised by NICE 3. Digital delirium prevention and management care plan now in place to support patients identified or at risk of delirium which issues a delirium diagnostic assessment is positive or unsure 4. A delirium awareness training module is available to staff with rapid tranquilisation training in support. 5. Available guidance on agitated delirium in elderly persons. 6. Patients with suspected delirium can be referred to relevant specialist nursing teams for support and review where required. Assurances 1. Delirium reports and updates produced and shared at dementia strategy meetings and the patient experience group. 2. A dementia champion documentation audit is being piloted monthly that includes seeking assurances of the effectiveness of delirium assessments. 3. Additional monthly delirium data reports for escalation 4. A share point site has been created for signposting and resource identification. 5. A training programme is in place to deliver delirium awareness key points training with training delivered to c.150 staff members between Jan-24 to May-24. 6. Further training packages for nursing and resident doctors will be implemented in Q4 2024/25 to ensure new digital delirium flow is embedded 7. A nationally accredited delirium awareness e-learning module has been added to the learning hub.							
Update since the last report		Update 10/02/2025 Change of risk handler. No change in risk score. The initial results from a national audit of dementia has identified limited assurances regarding the effectiveness of delirium assessments on patients that require them with the delirium pathway significantly reducing effectiveness. Next review date 10/03/2025 Reminder issued to risk handler to review risk			Date last reviewed	10/02/2025			
					Risk by quarter 2024/25	Q1	Q2	Q3	Q4
						15	15	15	15
					8-week score projection	15			
		Current issues	System wide influences						

No	ID	Title						
17	9895	Patients not receiving timely emergency procedures in theatres						
Lead	Risk Lead: N Tingle Exec Lead: J Husain		Current score	15	Score Movement			
Description	There is a risk that increasing demand on the emergency theatre due to increased hospital acuity may lead to delays in patients not receiving timely emergency procedures.			Gaps and Potential actions to further mitigate risk	Gaps / weaknesses in controls 1. No systematic approach in alerting and reviewing patients once listed. 2. No alert system when emergency patients have breached NCEPOD categorisation and not had timely emergency procedure. 3. Standing down of elective theatres or opening second theatres not always possible due to capacity and clinical priorities of elective patients. 4. Financial impact of cancellations on day of elective patients. 5. No bed capacity for surgical patients. 6. Not all cases are appropriately listed due to MDT requirements, times unknown, case complexity etc. which impacts on oversight at scheduling. 7. Known complex overruns are not always staffed requiring emergency staff to cover. 8. Regular overrun of elective theatres requires staff to relieve others who have to go home. Only six theatre staff available resulting in stopping of theatre six. 9. Limited assurance policy and procedural controls are effective or are being followed. 10. Reliance on voluntary staffing of capacity lists. 11. Weekend capacity stopped due to financial challenges Gaps / weaknesses in assurances 1. Potential for inappropriate categorisation when booking emergency patients. 2. Failure to discuss patient safety and risk at theatre triad and at divisional and directorate meetings. 3. Incident reports not always completed or capture severity of harm as unknown if there is a delay to surgery or disease progression. 4. Issues not highlighted if coordinator is not on duty. 5. Actions from meetings may not be enacted upon 6. Failure to manage capacity list due to lack of resource. 7. Additional sessions cancelled due to financial challenges			
Controls and Assurances in place	<u>Controls</u> 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. <u>Assurances</u> 1. Daily review of acuity of emergency list and capacity to assess availability of opening a second emergency theatre where required. 2. Theatre triad, directorate meetings held to discuss patient safety and risk at divisional and theatre directorate level. 3. Monitoring and review of incidents. 4. Emergency coordinator highlights capacity issues to duty anaesthetist and theatre operational manager. 5. Scheduling and oversight meetings in place for elective lists 6. Business case being made for additional theatre sessions.							
Update since the last report	Update 07/02/2025 No change in risk score Additional Sunday capacity list for emergency patients stood down due to financial challenges Next review date 07/03/2025			Date last reviewed	07/02/2025			
				Risk by quarter 2023-24	Q1	Q2	Q3	Q4
					15	15	15	15
				8 week score projection	15			
				Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title						
18	9851	Lack of standardisation of clinical documentation process and recording in Cerner						
Lead		Risk Lead: C Owen Exec Lead: S Simpson		Current score	16	Score Movement		
Description		The introduction of Cerner e-PR system has created changes in documentation processes with numerous ways to navigate system and document information resulting in a lack of document standardisation requiring coordination, of providing policy and procedural guidance, education and support and effective ways to audit compliance of new systems and processes. This could result in omission of documentation, evidence of care, duplication or contradictory information relating to provision of care and potential that processes no longer align to clinical management policies, standard operating procedures and national guidance, with elements of documentation captured in existing audits no longer available to view.		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 Chief Nursing Information Officer (CNIO) in post. 2. New Integration Architect recruited to assist and upskill system analysts to execute change requests. 3. Head of Nursing leading review of effectiveness of clinical management policy and procedural controls, risk assessment processes and care plans. 4. Library of quick reference guides on step by step instructions on common processes available via e-coach. 5. Training videos available on OLI, YouTube and Learning Hub. 6. Review of clinical documentation included as part of Nursing Assessment and Performance Framework (NAPF). 7. Standardisation of clinical information and records management now obtained and can be audited. 8. Ward manager training delivered by CNIO to all ward managers to standardise nursing documentation. 9. EPR Adoption and Optimisation Group established to tackle lack of standardised work through production and ratification of policy and standard operating procedures Assurance 1. Key processes lacking in standardisation are being identified. 2. Assurances provided by policy authors of effectiveness of policy, procedure and risk assessment controls being aligned to Cerner. 3. Escalation process for Cerner related issues in place. 4. Engagement groups with staff and subject leads in progress to understand the issues. 5. A clinical records management group has been established to monitor and receive assurance of compliance. 6. Nursing risk assessments now available via systems reporting portal with other reports awaiting development. 7. Mini NAPF and audits of clinical areas undertaken by matrons with outcomes shared and enacted upon. 8. 93% of staff received training on Cerner e-PR before 'go-live' date. All new staff complete training on start of employment. 9. Ongoing updates, including changes or handy tips, issued via trust wide approved communication systems. 10. Creation of One LSC model allows for pooling of resources across the region that will help address capacity. 11. Upskilling of SA by IA ongoing. 2 team members can also now build in system 12. Ward manager training completed and positive						
Update since the last report		Update 14/01/2025 Risk reviewed. No change in risk score Ward manager training has been undertaken and care plan training video is due for release later in the month. Due to a lack of compliance reporting unable to provide assurance training has had the desired impact. ICS wide EDMS task and finish group set up and led by LTH. A separate risk regarding scanning and uploading of documentation is being created to capture clinical management and organisational oversight risk. Next Review Date 07/03/2025		Date last reviewed	14/01/2025			
				Risk by quarter 2024-25	Q1	Q2	Q3	Q4
					15	15	15	15
				8 week score projection	15			
				Current Issues	System wide influences			

No	ID	Title							
19	9653	Increased demand with a lack of capacity within ELHT can lead to extreme pressure							
Lead		Risk Lead: J Dean Exec Lead: P Murphy		Current score	16	Score Movement			
Description		There is an increased risk extreme escalation to increase capacity within hospital environments will result in patient and staff physical and or mental harm as well as increasing privacy and dignity issues, hospital acquired infection, complaints, poor patient experience and reputational damage.			Gaps and Potential actions to further mitigate risk				
Controls and Assurances in place		Controls 1. Ward area risk assessments in place and reviewed where escalation bed space is to be opened. 2. Patients assessed by senior nurse on duty to ensure most appropriate patient is identified to be cared for in escalation bed. 3. Portable nurse call systems in place for additional beds to enable patients to alert staff when required. 4. Temporary storage made available as required. 5. Patient medications are stored within ward medication trolleys. 6. Patients placed onto the escalation bed are to be self-caring and able to stand to aid transfer to bathroom where possible. 7. Patients requiring electrical equipment or oxygen therapy are not to be allocated bed space. 8. Emergency equipment available if unexpected deterioration is experienced. 9. All staff to ensure adherence to infection prevention control policy and procedural controls. 10. Standard operating procedure in place to support and strengthen decision making of patient selection and placement when using escalation bed and trolleys. Assurance 1. When escalation trolley is in use, the ward risk assessment is reviewed each day. 2. Assessment is signed by appropriate staff to confirm required needs are being met each time the area is opened. 3. A signature sheet is kept with the ward assessment and compliance of its use audited as required. 4. Extra equipment in use to support bed space e.g. patient call alarm, bedside table and crate for any belongings are being managed as per policy and procedural controls. 5. When equipment is not in use, it is the wards responsibility to ensure the electronic patient buzzer is kept on charge at the nurses station and checked twice daily as part of safety huddles. 6. Use of extreme escalation trolleys is monitored, incidents are reviewed, linked to the risk and investigated as appropriate, with lessons learned shared with staff. 7. The Electronic Patient Tracking System is updated to ensure the correct ward area is used at all times of extreme escalation. 8. Quarterly review of risk assessments are undertaken by the health and safety team via use of audits and incident review. 9. Monthly meeting are set up to review any incident reports received to identify any ongoing themes or increased risk. 10. When appropriate patients cannot be sourced to fill a surge trolley and the Trust is under extreme pressures and requires this capacity, beds will be utilised in the surge spaces as appropriate to maximise the use of these areas and increase overall capacity on the wards across MEC and SAS							
Update since the last report		Update 17/01/2025 Risk reviewed. No change in risk score. Difficulties in sourcing appropriate patients at times of extreme pressure to be nursed on trolleys as a surge patient on the ward. SAS have reviewed this position and have sourced beds to allocate patients onto instead of surge trolleys to maximise the use of these areas. This does reduce space between these two bed and has been risk assessed. Next Review Date 07/02/2025			Date last reviewed	17/01/2025			
					Risk by quarter 2024-25	Q1	Q2	Q3	Q4
						15	15	15	15
					8 week score projection	15			
		Current Issues			System wide influences				

No	ID	Title				
20	9301	Risk of avoidable patient falls with harm				
Lead		Risk Lead: A Duerden Exec Lead: P Murphy	Current score	15	Score Movement	
Description		Failure to prevent patient slips trips and falls resulting in avoidable harm due to lack of compliance / assurance with Local and National policies / procedures				
Controls and Assurances in place		Controls 1. Patient falls included as part of the Trust's Patient Safety Incident Response Framework as a local priority for learning 2. 5 investigations completed on falls leading to #NOF and themed to identify safety improvements 3. Completion of investigations for all inpatient falls resulting in moderate or above harm in line with the ELHT Patient Safety Incident Response Framework 4. Falls investigation reports are carried out by appropriately trained nurses from the clinical areas which are reviewed through the DSIRG process for Patient Safety Response investigations at Divisional level and by PSIRI for STEIS reportable incidents monthly 5. Enhanced care scoring tool in place with appropriate SOP (SOP004 Levels of enhanced care) enhanced care e-learning accessible on the learning hub, enhanced care lead nurse in post and developing a digital solution for staff to undertake a patients enhanced care score (this is currently a paper process) 6. Multifactorial patient falls risk assessments in place monitored through monthly ward audits for assurance (following the implementation of e-PR) it was evident that a change request was urgently required as the information from the falls risk assessment was not being correctly pulled through to request a multi-factorial falls risk assessment which potentially led to lack of risk assessment compliance at patient level - this change request has now been actioned and issue resolved) 7. Falls strategy group meets monthly and represented by all divisions 8. Divisional falls action plans monitored through the falls steering group and uploaded to the risk quarterly. themes and trends following falls investigations are shared for learning across all divisions at the falls strategy group 9. Yellow ID badge introduced to identify staff undertaking enhanced care for patients at high risk of falls 10. Cohort bays are identified through appropriate "C" logo on doors entering the bay to increase staff awareness 11. Patients at risk of falls are identified daily at ward safety huddles 12. Enhanced care lead is recruiting a team of 30 enhanced care support workers who will support the most vulnerable patients in our care with appropriate supervision, interaction and observation 13. Falls checklist now aligned with PSIRF Assurances 1. Good monitoring tools in place across the wards and also links into Trust meetings at all levels (Directorate, Divisional sharing of incidents and lessons learned) 2. Falls summit action plan approved 3. Workshop planned with the falls strategy group to use a start stop continue approach to share and spread falls prevention strategies Trust wide				
Update since the last report		Update 05/02/2025 Risk reviewed. No change to risk score. Falls summit undertaken and actions agreed. No falls with lapses in care with catastrophic consequences since Jan-24. Also data showing reduced number of falls generally since Apr-24 which will support a reduced risk score should no further catastrophic harm be seen. Next Review Date 05/03/2025				
		Date last reviewed	03/02/2025			
		Risk by quarter 2024-25	Q1	Q2	Q3	Q4
				15	15	15
		8 week score projection	12			
		Current issues	System wide influences			

No	ID	Title							
21	8808	Breaches to fire stopping and compartmentalisation at BGH							
Lead		Risk Lead: J Houlihan Exec Lead: T McDonald		Current score	15	Score Movement			
Description		There is a risk that breaches in fire stopping and compartmentalisation works within Phase 5 at BGH, a PFI building not owned by the Trust, may lead to rapid fire and smoke spread, endangering lives and critical healthcare service provision if rigorous fire safety inspection, maintenance and staff training protocols are not followed							
Controls and Assurances in place		Controls 1. Fire safety design aligned to health technical memorandum and building requirements 2. Fire safety management policy and procedural controls in place 3. Fire safety risk assessments conducted for occupied (Trust) and non-occupied (Consort) areas to identify breaches 4. Fire stopping maintenance program for walls, doors and service penetrations 5. Project management of fire protection remedial works and find and fix processes established 6. Upgrade of suitable building fire detection systems to provide early warning of fire 7. Fire risers and firefighting equipment in place, tested and maintained 8. Fire safety awareness training forms part of core and statutory training requirement for all staff 9. Relevant staff trained in awareness of alarm and evacuation methods 10. Emergency evacuation procedures and business continuity plans in place across services 11. Random sampling and audit of project works being undertaken 12. Contractual arrangements in place with PFI partners in establishing duty holder responsibilities of building controls, testing and servicing of alarm systems and planned preventative maintenance			Gaps and Potential actions to further mitigate risk	Gaps / weaknesses in controls 1. Older hospital building areas may not meet modern standards 2. Backlogs in implementing works due to competing priorities 3. Inspections to determine the adequacy of fire stopping and compartmentalisation works may be infrequent, lack detail or integrity e.g. missing hidden voids, integrity of fire door architrave surrounds and general gaps around or underneath fire doors etc. 4. Robustness of fire safety management plan, policy and risk assessment processes and effectiveness of fire wardens 5. Not all locations within occupied areas have updated completed fire safety risk assessments 6. Limited funding for proactive maintenance 7. Contractors or sub-contractors may not be suitably trained on NHS specific fire standards 8. Collaborative working arrangements regarding the completion, review and sharing of fire safety risk assessments for both occupied and non-occupied areas requires strengthening			
		Assurances 1. Independent consultant employed to oversee project 2. Certification of fire safety materials e.g. EN 1366-3 3. Prioritisation of higher risk areas and of addressing remedial works and defect corrections to fire barriers in external cavity walls, doors and frame sealings 4. All before and after photographic evidence of remedial works recorded and appropriately shared 5. Fire wardens in place with additional fire wardens provided by partner organisations where necessary to maintain vigilance, patrol common areas across hospital sites and undertake fire safety checks 6. Provision of on-site fire safety team response where required 7. External monitoring, servicing and maintenance of fire safety alarm system 8. Suitable fire safety signage in place 9. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England 10. Incident reporting system in place to track repeat issues 11. Fire safety committee established, chaired by an exec lead, to seek assurances, monitor progress and compliance 12. Target rate of 25% reduction of fire safety incidents remains in place for 2024-25. A 30% reduction has been achieved this FYTD. Highest numbers of incidents relate to fire alarm activations and false alarm electrical defects 13. Sample survey and external intrusive survey completed and results shared with all relevant parties. Further exploratory surveys to determine materiality of any issues raised				Gaps / weaknesses in assurances 1. Materials may be certified but incorrectly installed 2. Lack of cooperation from partner organisations in relation to construction drawings, test evidence and materials in situ slowing down survey and remedial project management works 3. Lack of traceability for materials used in historical works e.g. combustible material identified above ceiling voids with fire detection present omitted from original fire safety documentation 4. Limited independent verification of contractor workmanship 5. Additional issues identified with fascial cavity barrier and external wall survey, with Kingspan render insulation present but no test evidence to show fire resistance properties have been provided by Project Co or Kingspan			
Update since the last report		Update 05/02/2025 Risk reviewed. No change to risk score. No change to risk score - Fire Safety Committee informed a formal review of risk is to be undertaken by key stakeholders and reported on at the next Committee meeting in Dec-24 for approval. Agreement between stakeholder of no change in risk score			Date last reviewed	05/02/2025			
					Risk by quarter 2024-25	Q1	Q2	Q3	Q4
						15	15	15	15
					8 week score projection	12			
		Current issues			Recovery and restoration pressures, recruitment and retention				

No	ID	Title				
22	4932	Patients who lack capacity to consent to hospital placements may be being unlawfully detained (Tolerated Risk)				
Lead		Risk Lead: R Woods Exec Lead: P Murphy	Current score	15	Score Movement	
Description		Patients referred to Lancashire County Council (LCC) and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DoLS) authorisation are not being assessed by these agencies within the statutory timescales, or at all, which means the DoLS is in effect unauthorised.				
Controls and Assurances in place		Controls 1. Policy and procedures relating to the Mental Health Capacity Act (MCA) and DoLS updated to reflect 2014 Supreme Court judgement ruling. 2. Mandatory training on MCA and DoLS available to all clinical professionals. 3. Improvement plan introduced for the management of DoLS applications following internal audit to enable timely and accurate recording of applications made and to demonstrate application of MCA in absence of Local Authority (LA) review. 4. Applications being tracked by the Safeguarding Team 5. Changes in patient status relayed back to the LA acting as the Supervisory Body. 6. Ability to extend urgent authorisations for all patients up to 14 days in total. 7. LCC hospital DoLS process now in place to priorities any urgent DoLS applications where increasing restrictions are being put in place to keep the patient safe. Assurances 1. Risk known to both Local Adult Safeguarding Boards for Blackburn with Darwen and Lancashire Local Authority. 2. Quarterly audits of MCA and DoLS being undertaken by the Safeguarding Team and reported to the NMLF and Safeguarding Committee on a quarterly basis. 3. DoLS data monitored via the Safeguarding Committee each month via the dashboard. 4. Additional legal advice obtained via Trust legal Team regarding current DoLS escalation process. 5. Patients not known to suffer any adverse consequence or delays in treatment.				
Update since the last report		Update 17/01/2025 Tolerated Risk. Risk reviewed. No change in risk score. Mitigation of this risk continues to remain outside the control of the Trust. Assurances required from supervisory body it is advancing mitigation of this risk and addressing resource requirements for assessment of patients as part of its statutory obligations that will support a reduced risk score. Next review date 14/02/2025	Date last reviewed	17/01/2025		
			Risk by quarter 2024/25	Q1	Q2	Q3
				15	15	15
			8-week score projection	12		
			Current issues	External influences regarding mitigation of risk beyond the control of the Trust		

No	ID	Title						
23	6190	Insufficient capacity to accommodate patients in clinic within timescales						
Lead		Risk Lead: Michelle Montague Exec Lead: Sharon Gilligan	Current score	12	Score Movement			
Description		Insufficient clinic capacity for patients to be seen in outpatient clinics resulting in unbooked new patients and very large holding lists of overdue patients, in some cases, there is significant delay and increased risk to patients. The demand far outweighs capacity and waiting lists have increased significantly over the past few years. All patients are risk stratified (red, amber, green rated) but still cannot be seen within timescales with an added risk those patients identified as amber could become red over time.		Gaps and Potential actions to further mitigate risk	Gaps / weaknesses in controls 1. Clinical management policy and procedural controls for managing patient lists requires full review in line with implementation of Cerner Millennium. 2. Relaunch of Outpatient Transformation Group to take place, with all services looking at project streams with the support of improvement managers. 3. Insufficient workforce and resource to provide capacity or carry out validation of all waiting lists. 4. Limited outpatient space to provide required clinics. 5. Increasing service demand and improved medical advancements are resulting in increased appointments and complexity of cases. 6. Data quality issues within EPR following migration. Gaps / weakness in assurance 1. Limited funding to recruit additional staff and equipment to be able to increase activity e.g. medical, nursing, administration 2. Challenges in extending outpatient estates capacity for additional clinics. 3. Increasing staff burnout and wellbeing due to constant pressures. 4. Data quality reporting issues. 5. Need to test logics built in reports to be able to remove duplicate patients.			
Controls and Assurances in place		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 04/02/2025 Risk reviewed. Risk score reduced. Awaiting approval of risk removal from CRR Significant improvement in building and replicating worklists within e-PR to support validation of waiting lists and enable automated closure of pathways where patients have been seen, have future appointments or duplication. New reports are now available to allow directorates to manage patients more appropriately however these are showing a number of data errors. A change request has been made for data and digital to test the logics built in order to cleanse the data within the worklists. Teams continue to micromanage waiting lists and create additional capacity where possible and clinical teams are able. A review of gaps in controls and assurances as a result of improvement works is being undertaken to help mitigate this risk. Next Review Date 04/04/2025		Date last reviewed	04/02/2025			
				Risk by quarter 2024-25	Q1	Q2	Q3	Q4
					16	16	16	12
				8 week score projection	12			
		Current Issues	Recovery and restoration pressures, recruitment and retention					

TRUST BOARD REPORT

12 March 2025

Item 39

Purpose Information
Decision

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

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: No formal Committee

Patient Safety Incident Response Framework Report

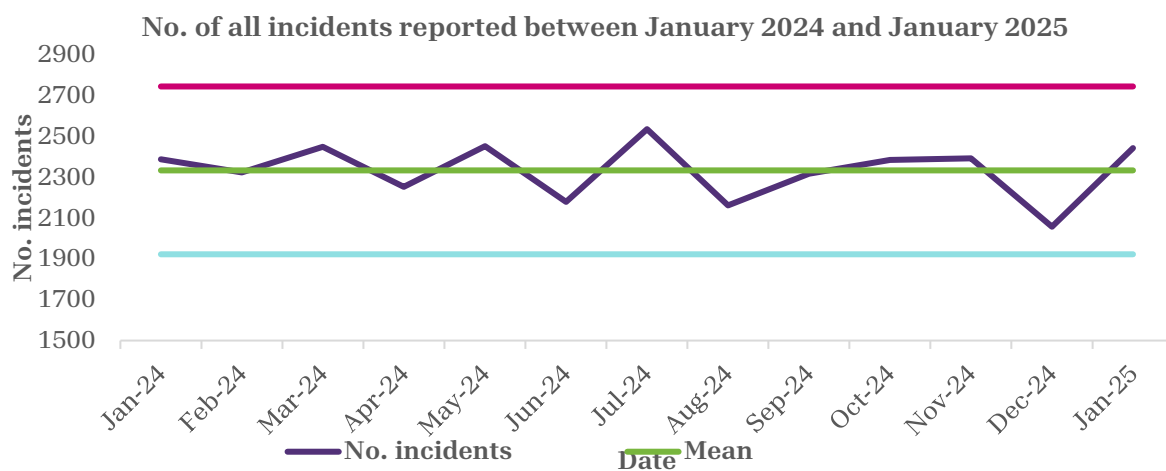
Reporting Period:		December 2024 to January 2025
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group, however, this was stood down in January but information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

1. Incident Reporting

1.1 The Trust reports and manages incidents in line with the New National Patient Safety Incident Response Framework. Over the last year, there continues to be expected variation in the number of incidents reported per month. However, reporting levels remain with control limits, this is common cause variation which we would expect with the nature of incident occurrence and reporting.

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

Figure 1: Incidents reported over last 12 months.



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

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

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

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

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

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

- 1.7.2 One is being investigated as a PSII and is related to a potential poor management of a course of antibiotics.
- 1.7.3 One has been recorded as Fatal but is related to an incident that has occurred outside of the Trust regarding dispensing error by an outside pharmacy, currently being investigated.

2. Duty of Candour

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

3. Safety Incident Responses (IR2s)

- 3.1 In line with the New Patient Safety Incident Response Framework all incidents not being investigated as a Patient Safety Response, or a Patient Safety Incident Investigation the Trust has set a target that these should be reviewed and actioned within 30 days of reporting. A KPI of 90% has been set and appendix B provides an overview by division.
- 3.2 There has been an overall decrease in **December 2024** in IR2 completion in all but two divisions, this has reported by the divisions as due to annual leave over the Christmas break.
- 3.3 Corporate Services has seen a significant increase of IR2s actioned with 30 days from 28.95% to 62.50%, the incident and policy team will continue to work with corporate services to make further improvements.

4. Patient Safety Responses (PSR)

- 4.1 All incidents that are of moderate or above harm and/or have key safety issues identified, and do not meet the national or local reporting priorities for a PSII are required to have a Patient Safety Response (PSR) completed and are managed within Division. Appendix C provides a breakdown of the number of open PSRs by division and number of any open more than 3 months.
- 4.2 There has been an overall slight increase in the number of open PSRs and the number of those that have been open more than 90 calendar days.

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

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

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

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

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

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

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

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

6 PSIRI Panel Approval and Learning from Reports

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

7 Mandatory National Patient Safety Syllabus Training Modules

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

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

National Patient Safety Training	Target	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec24	Jan 25
Level 1a	95%	91.4%	92.30%	93.30%	93.60%	93.80%	93.30%	94.10%	94.30%	94.90%	94.80%	95.20%	95.40%
Level 1b		76.6%	81.0%	83.50%	84.40%	83.50%	84.20%	84.70%	85.10%	85.90%	85.60%	86.00%	87.30%
Level 2		85.6%	87.0%	88.30%	88.80%	89.90%	90.10%	90.90%	91.10%	92.10%	92.00%	92.10%	92.70%

8 Trust Wide Policies and SOPs

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

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

8.3 Of the 3 overdue policies for Quality Governance

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

Figure 2: Trust wide policies and SOPs overdue by Directorate

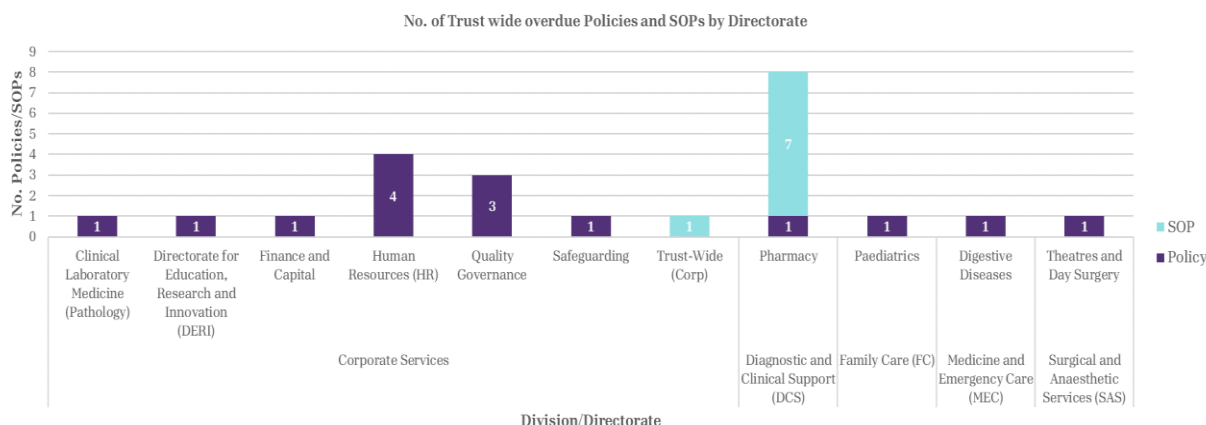


Table 2: Trust wide policies and SOPs within review date:

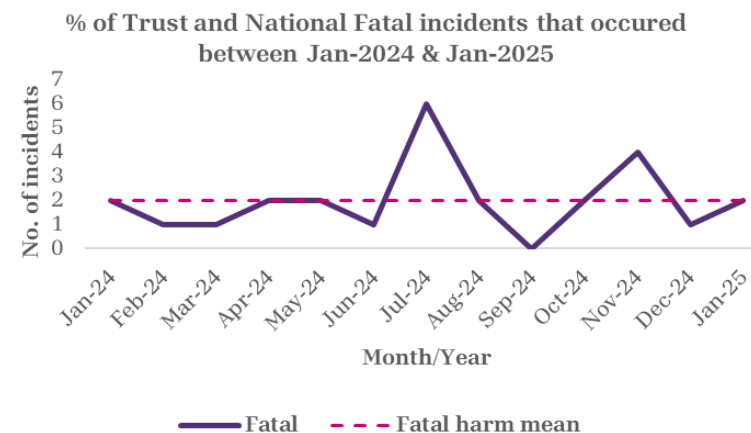
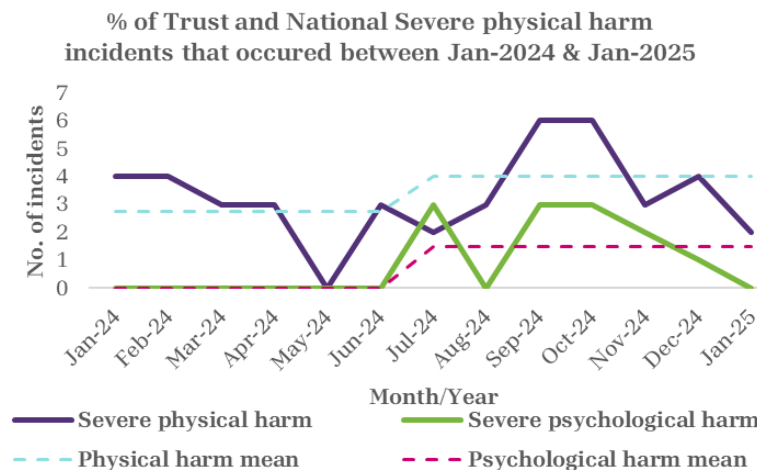
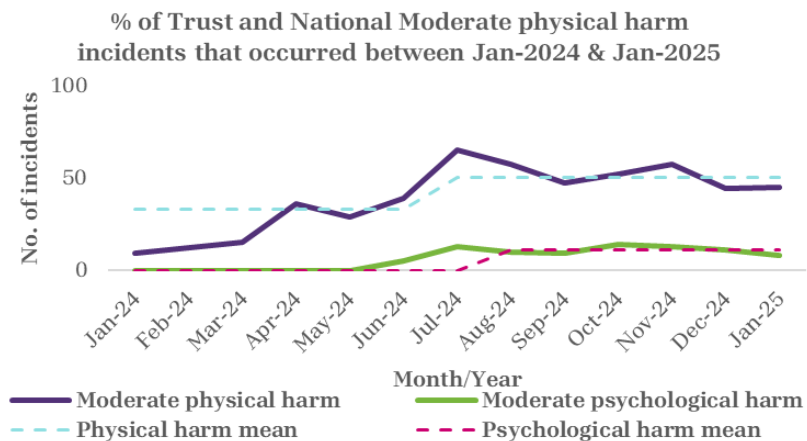
Policies / SOPs	Target	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Trust wide Policies	90%	90.88%	88.15%	86.11%	84.83%	83.10%	88.97%	88.70%	93.20%	94.56%	95.56%	95.58%	94.28%
Trust wide SOPs		90.78%	93.06%	93.75%	95.86%	93.75%	88.37%	86.90%	100%	98.63%	100%	97.92%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

9 Maternity specific serious incident reporting in line with Ockenden recommendations

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

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

Appendix A: ELHT Incidents by Moderate harm and above



Appendix B: KPI Dashboard for IR2s

Division	Number of SIRs (IR2s) by Month Trust Target 90%	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Trend
CIC	Total IR2 reported	410	378	341	315	360	344	471	375	398	444	405	405	↓
	(total number investigated) % complete within 30 calendar days	(354) 86.34%	(333) 88.10%	(300) 87.98%	(281) 89.21%	(323) 89.72%	(289) 84.01%	(424) 90.02%	(316) 84.27%	(344) 86.43%	(388) 87.39%	(373) 92.10%	(356) 87.90%	
DCS	Total IR2 reported	138	129	110	112	136	103	149	125	116	164	189	118	↓
	(total number investigated) % complete within 30 calendar days	(101) 73.19%	(90) 69.77%	(85) 77.27%	(93) 83.04%	(91) 66.91%	(75) 72.82%	(103) 69.13%	(77) 61.60%	(82) 70.69%	(124) 75.61%	(154) 81.48%	(85) 72.03%	
FC	Total IR2 reported	237	221	284	283	314	239	272	232	259	235	268	210	↑
	(total number investigated) % complete within 30 calendar days	(177) 74.68%	(185) 83.71%	(222) 78.17%	(228) 80.57%	(240) 76.43%	(189) 79.08%	(198) 72.79%	(169) 72.84%	(228) 88.03%	(179) 76.17%	(224) 83.58%	(187) 89.05%	
MEC	Total IR2 reported	947	915	992	903	899	873	936	849	945	936	921	778	↓
	(total number investigated) % complete within 30 calendar days	(823) 86.91%	(762) 83.28%	(863) 87.00%	(762) 84.39%	(752) 83.65%	(742) 84.99%	(804) 85.90%	(694) 81.74%	(768) 81.27%	(758) 80.98%	(707) 76.76%	(495) 63.62%	
SAS	Total IR2 reported	415	397	434	344	426	371	393	346	347	341	357	326	↓
	(total number investigated) % complete within 30 calendar days	(304) 73.25%	(335) 84.38%	(291) 67.05%	(276) 80.23%	(362) 84.98%	(291) 78.44%	(315) 80.15%	(304) 87.86%	(312) 89.91%	(298) 87.39%	(310) 86.83%	(248) 76.07%	
Corp	Total IR2 reported	82	89	83	87	97	85	82	52	67	74	76	32	↑
	(total number investigated) % complete within 30 calendar days	(40) 48.78%	(44) 49.44%	(37) 44.58%	(47) 54.02%	(63) 64.95%	(33) 38.82%	(45) 54.88%	(24) 46.15%	(35) 52.24%	(30) 40.54%	(22) 28.95%	(20) 62.50%	
Trust Total	Total IR2 reported	2229	2129	2244	2044	2232	2015	2303	1979	2132	2194	2216	1869	↓
	(total number investigated) % complete within 30 calendar days	(1799) 80.71%	(1749) 82.15%	(1798) 80.12%	(1687) 82.53%	(1831) 84.95%	(1619) 80.35%	(1889) 82.02%	(1584) 80.04%	(1769) 82.97%	(1777) 80.99%	(1790) 80.78%	(1391) 74.72%	

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

Division	CIC	DCS	FC	MEC	SAS	Corp
No. open	23	127	12	261	83	232

Appendix C: KPI Dashboards for PSRs

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

Appendix D: KPI Dashboards for PSIs

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

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

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

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

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

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

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

- Incident resulting in death (eIR1289888) – The report was a PSR and was not approved, the report required re submission to the panel with some additional information to be added. Below is a summary of safety recommendations identified in the report:
 - Share the dermatology team education video around ‘skin conditions (rashes)’ which highlights the difference between a skin rash and a low platelet rash with medical staff within UCC.
- Incident resulting in death (eIR1283620) – The report was not approved and required a discussion to take place outside of the meeting to agree the amendments required. Below is a summary of safety recommendations identified in the report:
 - The safety recommendations focus on implementing and educating staff about the updated Headache Pathway, developing a monitoring process for patients identified for the Intensive Home Support Service outside working hours, and ensuring effective monitoring of end-of-life care decisions in Ward B2.
- Maternal death (eIR1279248) – The report was produced by MNSI and was approved by the panel. The investigation did not identify any safety recommendations.

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

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

Appendix F: Overdue Trust wide Policies/SOPs

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

TRUST BOARD REPORT

12 March 2025

Item

40

Purpose

Approval

Assurance

Information

Title

Maternity and Neonatal Services Update

Report Author

Miss T Thompson, Divisional Director of Midwifery and Nursing (Maternity Safety Champion) supported by Maternity & Neonatal transformation lead

Executive sponsor

Mr P Murphy, Executive Director of Nursing.
(Board Level Maternity/Neonatal Safety Champion)

Summary: The purpose of this report is to provide:

1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Perinatal Safety Ambitions, specific to the ten CNST (Clinical Negligence Scheme for Trusts) maternity safety actions included in year six of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. (Appendix 1 - CNST Year 6 criteria)
2. Updates regarding ELHT (East Lancashire Hospitals Trust) maternity services response to the NHS England/Improvement (NHS E/I) – Ockenden recommendations and maternity/ Neonatal Three-year delivery plan.
3. Safety intelligence within maternity or neonatology care pathways and programmes that pose any potential risk in the delivery of safe care to be escalated to the trust board.
4. Continuous Quality and Service improvements, progress (Bimonthly report presented at trust wide quality committee) with celebrations noted.

Recommendation: The Board of Directors are asked to.

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

Report linkages

Related Trust Goal

Deliver safe, high-quality care

Compassionate and inclusive culture

Improve health and tackle inequalities in our community

Healthy, diverse, and highly motivated people

Drive sustainability

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

Related to key risks
identified on Board
Assurance Framework

Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.

- 2 The Trust is unable to fully deliver on safe, personal, and effective care in line with the requirements of the NHS Constitution, relevant legislation, and Patient Charter.
- 3 A risk to our ability to deliver the National access standards as set out in the 2023-24 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
- 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) because of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
- 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

Related to key risks
identified on Corporate
Risk Register

Risk ID: Risk Descriptor (None)

Related to
recommendations from
audit reports

Audit Report Title and Recommendation/s (None)

Related to Key Delivery
Programmes

State which key delivery programmes the paper relates to Maternity incentive Scheme (MIS) Year 5.

Related to ICB (Integrated
Care Board) Strategic
Objective

State which ICB Strategic Objective the paper relates to continue to deliver on the National Maternity and Neonatology Safety Ambition.

Impact

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

Previously considered by:

1. INTRODUCTION

The purpose of this report is to provide:

1. An overview of ELHT maternity and neonatal quality and safety programmes resulting from national policy and Maternity and Neonatology safety ambitions. The Secretary of State's ambition to halve the number of stillbirths, neonatal deaths, maternal deaths, and brain injuries by 2025 is a key focus. This will also include a reduction of the pre-term birth rate from 8%-6% by 2025.
2. A monthly progress summary with any exceptions will be evidenced at ELHT trust boards with clear plans specifically relating to the ten CNST maternity safety actions included in year six of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. **(Appendix 1)**
3. Regular updates with schedules regarding ELHT maternity and neonatology services in response to the NHS England/Improvement (NHSE) Ockenden review- immediate and essential actions, Three Year maternity and neonatology Delivery Plan, all party parliamentary group (APPG) birth trauma report are submitted to sub-group Quality Committee to inform Trust Board.

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

2. CNST - MATERNITY INCENTIVE SCHEME

2.1 Summary overview

Blue indicates complete

Green indicates progressing without concern

Orange indicates barriers/ risk to compliance identified

Red indicates non-compliance identified

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

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

2.2 Key updates and exceptions per Safety Action

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

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

Table 1 Perinatal Mortality Review Tool – Dashboard of PMRT Cases

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

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

		CNST - PMRT														Monthly Tren
Reporting Measure		Threshold	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
SAFETY ACTION 1	PMRT01 Total Number of Stillbirths (= 24 weeks)		1	1	1	2	3	0	1	1	2	4	1	2		
	PMRT01 Number of Neonatal Deaths		0	1	1	3	3	3	3	0	0	0	1	1		
	PMRT01 Number of late fetal loss between 22+0 and 23+6 weeks		0	1	0	0	0	0	1	0	0	0	0	1		
	Total Eligible Cases		1	3	2	5	6	3	5	1	2	4	2	4		
	PMRT02 a) i Number of cases reported to MBRRACE	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%		
	PMRT02 c) i Number PMRT tool started 2 months	95%	100.0%	100.0%	100.0%	100.0%	83.3%	66.7%	100.0%	100.0%	100.0%	50.0%	-	-		
	PMRT02 c) ii Number PMRT published reports by 6 months	60%	100.0%	66.7%	100.0%	60.0%	100.0%	100.0%	-	-	-	-	-	-		
PMRT05	Number PMRT published reports not due		0	0	0	0	0	0	5	1	2	4	2	4		

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

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

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

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

As an immediate response to this, the maternity safety champions have further reviewed all failsafe processes, to ensure that all criteria are met for PMRT reviews. The Quality and Safety team complete a weekly check of compliance with all timescales for reviews.

A summary report is submitted to the perinatal transformation team, Divisional Director of Midwifery, Assistant Director of Midwifery, Clinical Director, and Deputy Clinical Director for assurance with all aspects of governance aligned with CNST requirements. A weekly meeting is also in place every Thursday for any exceptions for PMRT and timescales.

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

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

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

Organisation Name
EAST LANCASHIRE HOSPITALS NHS TRUST

Reporting Period
December 2024



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

1. **CQIMAppar**

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

CQIMBreastfeeding

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

CQIMPPH

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

CQIMPreterm

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

CQIMTears

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

CQIMVBAC

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

CQIMRobson01

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

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	60	90	66.7	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	65	80	81.2	Passed

CQIMSmokingBooking

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

CQIMSmokingDelivery

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

2. **EthnicityDQ**

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	530	555	95.5	Passed

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

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

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

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

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

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

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

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

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

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

The second bi-annual midwifery staffing report for the period 1st of July to 31st of December 2024 was submitted to January 2025 Trust Board. This covers all actions taken to meet safety action 5.

A business/ improvement case has been completed in March 2023 following the birth are plus assessment in September 2022 for the deficit in funding to meet the midwifery staffing establishment as set out in the Birthrate+ report.

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

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

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

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

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

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

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

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

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

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

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

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

The Divisional Director of Midwifery, Assistant Director of Midwifery, and Maternity and Neonatal Transformation Team continue to work alongside the MNVP leads and newly appointed MNVP Project Lead at Healthwatch to coordinate feedback collection efforts.

An MNVP Update Day is taking place on the 14th of March at which ELHT, MNVP, and Healthwatch colleagues will meet to plan for the next year of activity. Actions such as updating current feedback methods and processes will be discussed at this meeting to ensure that feedback is received in a timely manner to inform actions within the service. A focus will also

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

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

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

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

2.2.9 Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

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

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

Perinatal Quality Surveillance Dataset

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

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

Metric	Standard	Sept 24	Oct 24	Nov 24	Dec 24
Maternity NICE red flags		0	0	0	0
Dedicated obstetric consultant presence on labour ward	90hrs/week	90	90	90	90
Midwife to birth ratio (establishment)	<1.28	<1.28	<1.28	<1.28	<1.28
Midwife to birth ratio (in post)	<1.28	<1.28	<1.28	<1.28	<1.28
Training compliance for all staff groups (CNST)	>90%	>90%	>90%	>90%	>90%

Perinatal Data:

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

Stillbirth rate:

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

Term admission to NICU:

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

3rd/4th degree perineal tears

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

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

Training Compliance:

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

Feedback	Metric	Standard	Sept 24	Oct 24	Nov 24	Dec 24
	Service user feedback (MNVP)		1 sessions attended	0 sessions attended	0 sessions attended	1 sessions attended
	FFT satisfaction rated as good	>90%	88.13%	84.03%	91.19%	90.53
	Number of level 4 complaints	-	2	2	2	2
	Executive safety walkaround	Bi-Monthly	1	1	1	1
	Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly				
External Reporting	Metric		Sept 24	Oct 24	Nov 24	Dec 24
	Maternity incidents graded moderate or above		2	3	4	4
	Cases referred to MNSI		1	3	1	2
	Cases referred to coroner		1	0	0	0
	Coroner reg 28 made directly to the Trust		0	0	0	0
	HSIB/CQC with a concern or request for action		0	0	0	0
CNST	Metric		Sept 24	Oct 24	Nov 24	Dec 24
	Progress with CNST 10 safety action compliance					
Formal staff feedback annual metrics						
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)						
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)					86.56% (GMC survey 2023) National mean 81.8%	

MNVP Service User Feedback:

MNVP meetings held in December. Ongoing work planning engagement events for 2025.

FFT satisfaction rated as good:

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

Level 4 Complaints

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

Executive Safety Walkarounds:

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

Moderate or above incidents:

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

Coroner referral:

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

MNSI referral:

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

CNST:

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

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

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

This group is attended by the Board and Maternity Safety Champions, the Quality and Safety Team, and the Transformation Team. At this meeting, an update will be provided on the ongoing actions resulting from the triangulation exercise in September 2024.

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

The culture improvement plan as informed by the results of the Safety, Communication, Operational, Reliability and Engagement (SCORE) culture survey is monitored and lead by the Maternity and Neonatal Quadrumvirate (Quad), who meet monthly with a direct focus on safety and culture listed within the agenda.

The Perinatal Quadrumvirate is working with the Maternity Transformation Team to explore options for disseminating the results and themes of the survey. In addition to the infographic shared previously, a podcast will be produced to support with this dissemination, led by the Quadrumvirate and area leads. The podcast is due to be recorded on the 19th of March 2025.

Following on from previous updates, ELHT maternity and neonatal services were offered the opportunity to train Culture Coaches to hold regular culture conversations and support the delivery of local culture improvements. The Culture Coaches have completed initial training and are due to attend follow up sessions. They have also held the first cultural conversation in February and will feedback to the Quad on the findings of this session. All four ELHT culture coached attended a training day on Friday 28th February to further educate and inform the ELHT culture improvement plan.

2.2.10 Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

The Perinatal Quality Surveillance Model – Minimum Data Set as above contains monthly data of the number of HSIB/MNSI cases reported and accepted or rejected. The Rationale and further detail are also included within the data set for assurance and/or discussion where needed.

A detailed overview of cases within the reporting period to present are provided in the quarterly reports produced by the Quality and Safety Lead. The quarter 3 report is attached as an appendix for submission (**Appendix 4**)

3. MATERNITY AND NEONATAL 3 YEAR DELIVERY PLAN

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

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

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

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

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

4. CONCLUSION

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

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

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

Perinatal Quadrumvirate:

Tracy Thompson, Divisional Director of Midwifery and Nursing

Martin Maher, Clinical Director of Obstetrics

Savi Sivashankar, Clinical Director of Neonatology

Charlotte Aspden, Directorate Manager of Maternity and Neonatology

March 2025

Appendix 1 – CNST-MIS Y6 Guidance

Appendix 2 – PMRT Quarter 3 Report

Appendix 3 – Consultant Attendance Quarter 3 Audit

Appendix 4 – MNSI Quarter 3 Report

Appendix 5 – Maternity and Neonatal 3 Year Delivery Plan

Appendix 6 – ELHT MPOP Quarter 3

TRUST BOARD REPORT

Item 41

12 March 2025

Purpose Information

Title Financial Performance Report Month 10 2024-25

Report Author Ms C Henson, Deputy Director of Finance

Executive sponsor Mrs S Simpson, Executive Director of Finance

**Date Paper Approved by
Executive Sponsor** 6 March 2025

Summary: The Trust is reporting a deficit of £47.3m, against a planned deficit of £5.6m for the 2024-25 financial year to date. £41.7m behind the revised plan. A deficit of £5.8m in month, an improvement of £3.5m in month (M9 £9.3m).

Recommendation: To note the content.

Report linkages

Related Trust Goal

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

Related to key risks identified on Board Assurance Framework

- 1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
- 2 The Trust may be unable to fully deliver on safe, personal, and effective care in line with the requirements of the NHS Constitution, relevant legislation, and Patient Charter.
- 3 A risk to our ability to deliver the National access standards as set out in the 2024-25 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
- 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result its inability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
- 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring

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

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

Related to key risks
identified on Corporate
Risk Register

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

Related to
recommendations from
audit reports

Assurance Framework
Key Financial Controls
Risk Management Core Controls

Related to Key Delivery
Programmes

Finance Strategy and Waste Reduction Programme

Related to ICB Strategic
Objective

Improve population health and healthcare.
Tackle inequalities in outcomes, experience, and access.
Enhance productivity and value for money.
Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:
Finance and Performance Committee

Executive Summary

1. At M10, the Trust is reporting a deficit of £47.3m, against a planned deficit of £5.6m for the 2024-25 financial year to date. £41.7m behind the revised plan. A deficit of £5.8m in month, an improvement of £3.5m in month (M9 £9.3m).
2. Funding for the 2024-25 capital programme has increased by £2.2m to £36.0m for four additional externally funded schemes with forecast expenditure now £0.3m below plan, which the Trust expects to be able to manage.
3. The cash balance on 31st January 2025 was £2.1m, a reduction of £8.0m compared to the previous month, largely due to the Trust withholding £7.0m received to fund the 2024-25 pay award payment made in November at the end of the previous month, which the ICB deducted from the core contract payment.

Recommendation

4. The Trust Board is asked to:
 - Note the contents of this report.
 - Discuss the financial performance for 2024-25.

Financial Update

Trust Board – Part 1

Wednesday, March 12, 2025

Month 10 Financial Position

Month 10 Key Headlines



East Lancashire Hospitals

NHS Trust

A University Teaching Trust

- The Trust is reporting a deficit of £47.3m, against a planned deficit of £5.6m for the 2024-25 financial year to date; £41.7m behind the revised breakeven plan. A deficit of £5.8m in month, an improvement of £3.5m in month (M9 £9.3m).
- The Trust had an agreed deficit financial plan of £21.9m, and a result of the allocation of the deficit support funding (DSF), all of which was received and recognised at month 6, the Trust's revised annual financial plan is to deliver a breakeven plan. This is a non-recurrent benefit in year.
- Due to the phasing of the Deficit Support Funding (DSF) the year-to-date position of £47.3m is understated by £3.6m so would be a deficit of £51.0m.
- Excluding the DSF, the year-to-date deficit is £69.2m.

Month 10 Key Headlines

	NHSE Plan £000	In month			Cumulative		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Operating Income							
Operating Income from Patient Care Activities	715,127	58,110	58,432	322	605,217	611,472	6,255
Other Operating Income	40,800	4,568	4,283	(285)	37,141	38,938	1,797
Employee expenses	(526,530)	(43,713)	(47,126)	(3,413)	(436,935)	(477,156)	(40,221)
Operating expenses excluding employee expenses	(206,916)	(14,119)	(19,214)	(5,095)	(192,327)	(202,382)	(10,055)
Operating (Deficit)	22,481	4,846	(3,625)	(8,471)	13,096	(29,128)	(42,224)
Net Finance Costs	(34,556)	(521)	(819)	(298)	(33,509)	(32,776)	733
Gains/(Losses) on disposal of assets	0	0	(2)	(2)	0	64	64
(Deficit) for the period/year	(12,075)	4,325	(4,446)	(8,771)	(20,413)	(61,840)	(41,427)
Remove impairments	0	0	0	0	0	0	0
Remove impact of PFI liability remeasurement	12,102	(1,350)	(1,378)	(28)	14,799	14,509	(290)
Remove capital donations/grants I&E impact	(27)	(9)	36	45	(14)	(17)	(3)
Breakeven duty financial performance (deficit)	0	2,966	(5,788)	(8,754)	(5,628)	(47,348)	(41,720)
Less Non-Recurrent Deficit Funding	(21,886)	0	0	0	(21,886)	(21,886)	0
Breakeven duty financial performance (deficit) excluding Non-Recurrent Deficit Funding	(21,886)	2,966	(5,788)	(8,754)	(27,514)	(69,234)	(41,720)

- Excluding the DSF, the year-to-date deficit is £69.2m.
- £1.5m of the improvement relates to pay costs, specifically a reduction of £1.1m in the usage of bank, £729k to the reduction in the usage of agency, offset by substantive costs increasing by £426k.
- £1.4m relates to an increase non-patient care related income, £0.8m relates to system depreciation income with £0.6m relating to DERI income

Month 10 Key Headlines

	NHSE Plan £000	In month			Cumulative		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Clinical Divisions							
Medicine & Emergency Care		(9,523)	(10,804)	(1,281)	(103,957)	(116,037)	(12,080)
Surgery and Anaesthetic Services		(3,616)	(5,854)	(2,239)	(46,710)	(62,609)	(15,899)
Community & Intermediate Care		(4,241)	(4,396)	(155)	(40,183)	(43,286)	(3,103)
Diagnostic and Clinical Support		(8,211)	(8,993)	(782)	(83,043)	(88,889)	(5,846)
Family Care Division		(5,323)	(5,603)	(280)	(54,621)	(58,746)	(4,125)
Sub Total		(30,913)	(35,650.96)	(4,738)	(328,515)	(369,568)	(41,053)
Non-Clinical Divisions							
Estates and Facilities		(5,019)	(5,319)	(300)	(50,045)	(53,807)	(3,762)
Corporate Services		(4,182)	(4,616)	(434)	(43,048)	(45,475)	(2,427)
Central Services & Income		46,075	43,460	(2,615)	456,282	458,891	2,609
Education, Research & Innovation		920	454	(466)	(1,242)	923	2,165
EBITDA : Earnings before interest, taxation, depreciation and amortisation	46,893	6,880	(1,672)	(8,552)	33,433	(9,036)	(42,468)
Depreciation	(20,984)	(1,748)	(1,619)	129	(17,480)	(16,379)	1,101
Amortisation	(3,428)	(286)	(335)	(49)	(2,857)	(3,713)	(857)
Impairments	0	0	0	0	0	0	0
Operating Surplus/(Deficit)	22,481	4,846	(3,625)	(8,472)	13,096	(29,128)	(42,224)
Finance Income	1,203	101	160	60	1,005	1,675	670
Finance Expense	(35,474)	(598)	(644)	(46)	(34,276)	(34,116)	160
PDC dividends payable/refundable	(285)	(24)	(335)	(311)	(238)	(335)	(98)
Net Finance Costs	(34,556)	(521)	(818)	(298)	(33,509)	(32,776)	733
Other gains/(losses)	0	0	(2)	(2)	0	64	64
	(12,075)	4,326	(4,446)	(8,771)	(20,413)	(61,840)	(41,427)
- remove impact of PFI liability remeasurement	12,102	(1,350)	(1,378)	(28)	14,799	14,509	(290)
- capital donations/grants I&E impact	(27)	(9)	36	45	(14)	(17)	(2)
Breakeven duty financial performance (deficit)	0	2,966	(5,788)	(8,754)	(5,628)	(47,348)	(41,720)
Less Non-Recurrent Deficit Funding	(21,886)	0	0	0	(21,886)	(21,886)	0
Breakeven duty financial performance (deficit) excluding Non-Recurrent Deficit Funding	(21,886)	2,966	(5,788)	(8,754)	(27,514)	(69,234)	(41,720)

Month 10 In-month

- There has been a favourable movement of £3.5m from the month 9 position of £9.3m, to £5.8m in month 10
- Key movements to note between month 9 and month 10, are:
 - **Income** has increased by £3.1m month-on-month, largely due to retrospective negative income adjustments in the previous month relating to ERF (£2.5m) and Depreciation Funding (£1.1m), although the latter has been revised at Month 10 due to developments within the system. Other variances relate to reduced pass-through income for Drugs and Devices, and monies received relating to Community Diagnostics Centre activity,
 - Total Pay movement has improved by £0.5m, with significant improvement in bank (**£0.9m**)
 - Total non-pay actuals improved by **£0.2m**, relating to a reduction in endoscopy insourcing costs, theatre Lifecycle works and energy costs offset by pressures from increased blood products costs and external testing.

Waste Reduction and Financial Improvement Performance

WRP/ CIP Performance to date

Division	WR & FIP Annual Target 2024/25	YTD Performance					Recurrent Actuals	
		2425 Annual Delivered	YTD Delivered	YTD Target Plan	Variance	% Varr.	Recurrent YTD Act. (2425)	Recurrent YTD Act.
MEC	11,620	£5,695	£5,360	£7,747	£-2,387	-31%	£5,570	£5,256
SAS	11,649	£1,993	£1,774	£7,766	£-5,993	-77%	£1,245	£1,133
FC	6,686	£1,687	£1,412	£4,457	£-3,046	-68%	£1,606	£1,331
DCS	8,485	£1,919	£1,567	£5,657	£-4,090	-72%	£1,168	£986
CIC	3,619	£1,250	£1,235	£2,413	£-1,178	-49%	£236	£220
Corp.	2,956	£1,810	£1,550	£1,971	£-421	-21%	£1,234	£973
Est.	4,498	£1,007	£994	£2,999	£-2,005	-67%	£523	£518
DERI	1,175	£1,175	£1,036	£783	£252	32%	£1,175	£1,036
Central	8,991	£2,513	£2,498	£5,994	£-3,496	-58%	£2,513	£2,498
ELHT Total	59,679	£19,049	£17,425	£39,787	£-22,362	-56%	£15,270	£13,951

- **£17.4m** has been delivered in 2024-25 to date, **£22.4m** behind plan at M10. In-month delivery has increased by **£1.1m**.
- WR & FIP for the year has increased to **£19m**, up by **£500k** from £18.5m at M9
- There is ongoing work to review the **non-recurrent schemes (£3.8m)** to be able to convert these into recurrent savings, as scoping around the workforce transformation needed continues. The non-recurrent schemes remain a pressure into 25/26 that will need addressing recurrently.
- **242 QIRAs** completed for M10, with all schemes transacted having an approved QIRA in place. All schemes require a QIRA before they can be transacted and become level 4 schemes.

WRP/ CIP Performance to date

Division	Delivery Status					
	Delivered YTD	Fully developed / in delivery	Plans in Progress	Opportunity	Unidentified	TOTAL
MEC	£5,360	£335	£176	£252	£5,497	£11,620
SAS	£1,774	£219	£0	£120	£9,537	£11,649
FC	£1,412	£275	£41	£22	£4,936	£6,686
DCS	£1,567	£352	£0	£30	£6,536	£8,485
CIC	£1,235	£15	£709	£30	£1,630	£3,619
Corp.	£1,550	£260	£205	£95	£846	£2,956
Est.	£994	£13	£79	£150	£3,262	£4,498
DERI	£1,036	£139	£0	£10	£0	£1,185
Central	£2,498	£15	£0	£0	£6,468	£8,981
ELHT Total	£17,425	£1,624	£1,209	£709	£38,712	£59,679

- Unidentified across all areas is £38.7m. Divisional discussions suggest there will not be any further material schemes identified for this financial year, with all schemes that have been mobilised in the last months captured in plans in progress or opportunity.
- Plans in progress has some significant schemes relating to ward closures and additional opportunities to improve the forecast outturn position and improve the £19m, with work continuing to progress these plans into delivered schemes.

Cash

Safe | Personal | Effective

ELHT. *Because that's who we are*

Statement of Cash Flows

31st January 2025

Cash Flow Statement	As at 31st March 2024	As at 31st January 2025	Prior month
	£000	£000	£000
Operating Activities			
Operating Surplus/(Deficit)	(16,883)	(29,128)	(25,502)
Depreciation and amortisation	22,831	20,092	18,138
Impairments and reversals	19,385	0	0
Donated assets received credited to revenue but non cash	(173)	(377)	(377)
(Increase)/decrease in trade and other receivables	11,976	(13,442)	(15,509)
(Increase)/decrease in inventories	(759)	128	(113)
Increase/(decrease) in trade and other payables	(23,797)	19,859	17,068
Increase/(decrease) in other liabilities: deferred income	(5,875)	1,801	10,959
Increase/(decrease) in provisions	(511)	(210)	(175)
Net cash inflow from Operating Activities	6,194	(1,277)	4,489
Cash Flows from Investing Activities			
Interest received	2,051	1,665	1,518
(Payments) for property, plant and equipment	(42,483)	(10,974)	(10,094)
Proceeds from disposal of property, plant and equipment	9	528	530
(Payments) for intangible assets	0	0	0
Net cash outflow from Investing Activities	(40,423)	(8,781)	(8,046)
Net cash inflow before Financing	(34,229)	(10,058)	(3,557)
Cash Flows from Financing Activities			
Public dividend capital received	31,250	19,428	18,581
Loans from Department of Health - repaid	(200)	(100)	(100)
Capital element of lease payments	(5,927)	(6,233)	(5,658)
Capital element of PFI payments	(12,276)	(11,627)	(10,464)
Interest paid	(479)	(462)	(354)
Interest element of PFI obligations	(5,982)	(5,303)	(4,773)
PDC dividend (paid)/refunded	(5,464)	4,924	4,924
Net cash outflow from Financing Activities	922	627	2,156
Decrease in cash	(33,307)	(9,431)	(1,401)
Cash at the beginning of the year	44,882	11,575	11,575
Cash at the end of the financial period	11,575	2,144	10,174

Cash position

- The PDC application for a further £20.0m of revenue support was submitted, as approved by the Board, and the outcome is expected 6/7 March 2025.
- The cash balance on 31st January was £2.1m, a reduction of £8.0m compared to the previous month, largely due to the Trust withholding £7.0m received to fund the 2024-25 pay award payment made in November at the end of the previous month, which the ICB deducted from the core contract payment.
- The value of aged payables as at 31 January 2025 had risen to £27.2m and with the Trust having to prioritise non-NHS suppliers.

	Number	£000s
Non-NHS payables		
Total non-NHS trade invoices paid in the year	64,923	367,187
Total non-NHS trade invoices paid within target	48,770	336,428
Percentage of non-NHS invoices paid within target	75.1%	91.6%
NHS payables		
Total NHS trade invoices paid in the year	1,629	29,430
Total NHS trade invoices paid within target	1,341	28,083
Percentage of NHS invoices paid within target	82.3%	95.4%

- As a result of the continued effect of the Trust having to withhold payments to suppliers due to its cash position, Better Payment Practice Code (BPPC) performance remains well below target in January.
- While the Trust continues to only meet the target to pay 95% of invoices on time for the financial year to date by value for NHS invoices.
- Performance against the remaining BPPC measures is also now expected to remain below target for 2024-25.

Statement of Financial Position

- All stocktakes are arranged for the end of the financial year.
- The valuation of the estate is arranged for March 2025
- A £2.2m reduction in receivables and a £3.5m increase in payables are the main factors which offset the impact of the £4.4m in month deficit before technical adjustments on the cash position.

	As at 31st March 2024 £000	As at 31st January 2025 £000	Year to date movement £000	Prior month £000	In-month movement £000
Non-Current Assets:					
Intangible assets	25,257	22,957	(2,300)	23,081	(124)
Property, plant and equipment (PFI)	97,553	96,266	(1,287)	96,103	163
Property, plant and equipment (other)	166,079	163,857	(2,222)	163,749	108
Right of use assets	19,060	31,657	12,597	32,278	(621)
Receivables	675	675	0	675	0
Total non-current assets	308,624	315,412	6,788	315,886	(474)
Current assets:					
Inventories	9,969	9,841	(128)	10,082	(241)
Receivables (NHS)	24,031	25,543	1,512	27,829	(2,286)
Receivables (non-NHS)	17,109	23,984	6,875	23,893	91
Assets held for sale	475	0	(475)	0	0
Cash and cash equivalents (GBS/NLF)	11,562	2,126	(9,436)	10,156	(8,030)
Cash and cash equivalents (other)	13	18	5	18	0
Total current assets	63,159	61,512	(1,647)	71,978	(10,466)
Total assets	371,783	376,924	5,141	387,864	(10,940)
Current liabilities:					
Trade and other payables (capital)	(7,254)	(3,816)	3,438	(3,216)	(600)
Trade and other payables (non-capital)	(60,849)	(80,901)	(20,052)	(77,918)	(2,983)
Borrowings / DHSC loan	(6,500)	(11,162)	(4,662)	(6,837)	(4,325)
Other financial liabilities (PFI)	(12,586)	(14,018)	(1,432)	(13,875)	(143)
Provisions for liabilities and charges	(609)	(554)	55	(573)	19
Other liabilities: deferred income	(1,522)	(3,323)	(1,801)	(12,481)	9,158
Total current liabilities	(89,320)	(113,774)	(24,454)	(114,900)	1,126
Net current assets/(liabilities)	(26,161)	(52,262)	(26,101)	(42,922)	(9,340)
Total assets less current liabilities	282,463	263,150	(19,313)	272,964	(9,814)
Non-current liabilities					
Borrowings / DHSC loan	(13,015)	(20,986)	(7,971)	(25,886)	4,900
Other financial liabilities (PFI)	(220,032)	(235,273)	(15,241)	(236,579)	1,306
Provisions for liabilities and charges	(2,912)	(2,807)	105	(2,819)	12
Total non-current liabilities	(235,959)	(259,066)	(23,107)	(265,284)	6,218
Total assets employed	46,504	4,084	(42,420)	7,680	(3,596)
Financed by taxpayers equity					
Public dividend capital	309,890	329,318	19,428	328,471	847
Revaluation reserve	19,225	18,748	(477)	18,748	0
Income and expenditure reserve	(282,611)	(343,982)	(61,371)	(339,536)	(4,446)
Total taxpayers equity	46,504	4,084	(42,420)	7,683	(3,599)

Safe | Personal | Effective

LETT. Because that's how we are

Capital

Safe | Personal | Effective

ELHT. *Because that's who we are*

Capital

- Funding for the 2024-25 capital programme has increased by £2.2m to £36.0m for four additional externally funded schemes with forecast expenditure now £0.3m below plan, which the Trust expects to be able to manage. The new PDC funded schemes are:- £0.9m of funding for LED lighting, £0.5m of funding for PFI PACS legal costs, £0.5m of funding for RAAC related design costs and £0.4m of digital funding.
- At £26.9m, the year-to-date position is £16.4m ahead of plan, largely due to the Trust recognising £17.3m of right of use asset related expenditure for six Community Health Partnerships properties used by the Trust where the existing lease expired in December 2024, but related expenditure had been planned for March 2025.
- The £7.9m of year-to-date capital spend, excluding the CHP lease renewals, represents 60% of the forecast £13.1m of remaining capital funding, excluding the £2.2m of additional externally funded schemes, which compares favourably with the position for previous years. It is not expected at this stage that the cash position of the Trust will impact on the delivery of this year's capital programme.

	YTD actuals	Forecast
	£m	£m
Total funding available		36.0
IFRS 16 Right of use assets	19.0	20.7
Externally funded schemes	1.5	4.7
Estates	2.6	5.0
Information technology	1.5	2.6
PFI lifecycle	1.8	2.1
Medical equipment	0.1	0.1
Donated	0.4	0.5
Total capital expenditure	26.9	35.7
Forecast underspend		0.3

2024-25 Workforce vs Plan

YTD Workforce vs Plan to update

	YTD Plan	YTD Actuals	
	Jan-25	Jan-25	Movement
Staff Type	wte	wte	wte
Total Substantive	9,385.27	9,680.23	294.96
Total Bank	561.79	606.01	44.22
Total Agency	87.05	71.32	-15.73
Total	10,034.11	10,357.56	323.45

	YTD Plan	YTD Actuals	
	Jan-25	Jan-25	Movement
Staff Group	wte	wte	wte
Regst'D Nurses & Others	3,174.30	3,246.00	71.70
Medics	1,061.44	1,122.11	60.67
Hcare Sciencs & Others	1,080.16	1,129.37	49.21
Support Clinical Staff	2,031.67	2,159.40	127.73
Nhs Infrastructure Supp	2,686.54	2,709.33	22.79
Other Staff Costs	0.00	-8.65	-8.65
Total	10,034.11	10,357.56	323.45

- Compared to the submitted workforce plan for 2024-25, the Trust is 323.45 wte above the plan for January 2025.
- This is an increase of 30 wte from March 2024 and includes 122 wte related to service transfers so a net reduction of 92 wte

YTD Workforce Movement M9 to M10

- Workforce reported externally, is '**Contracted wte**' for substantive staff, and '**Worked wte**' for bank and agency staff.
- The actual WTE has decreased by **131.44 wte** from the previous month overall, with reductions in bank and agency but an increase in substantive.
- There has been a reductions in all staff groups in January 2025.

	Actuals	Actuals	
	Dec-24	Jan-25	Movement
Staff Type	wte	wte	wte
Total Substantive	9,665.51	9,680.23	14.72
Total Bank	749.34	606.01	-143.33
Total Agency	74.15	71.32	-2.83
Total	10,489.00	10,357.56	-131.44

	Actuals	Actuals	
	Dec-24	Jan-25	Movement
Staff Group	wte	wte	wte
Regst'D Nurses & Others	3,300.28	3,246.00	-54.28
Medics	1,138.14	1,122.11	-16.03
Hcare Sciencs & Others	1,129.99	1,129.37	-0.62
Support Clinical Staff	2,187.77	2,159.40	-28.37
Nhs Infrastructure Supp	2,742.47	2,709.33	-33.14
Other Staff Costs	-9.65	-8.65	1.00
Total Workforce	10,489.00	10,357.56	-131.44

YTD Workforce Movement M9 to M10

- The actual WTE has decreased **174.86 wte** (*worked for all staff types*) from the previous month across all staff types and staff groups

	Actuals	Actuals		Actuals	Actuals	
	Dec-24	Jan-25	Movement	Dec-24	Jan-25	Movement
Staff Type	wte	wte	wte	£000	£000	£000
Total Substantive	9,363.28	9,334.58	-28.70	42,711	43,059	348
Total Bank	749.34	606.01	-143.33	4,296	3,412	-884
Total Agency	74.15	71.32	-2.83	623	655	32
Total	10,186.77	10,011.91	-174.86	47,629	47,126	-503

	Actuals	Actuals		Actuals	Actuals	
	Dec-24	Jan-25	Movement	Dec-24	Jan-25	Movement
Staff Group	wte	wte	wte	£000	£000	£000
Regst'D Nurses & Others	3,142.05	3,084.77	-57.28	14,450	14,380	-69
Medics	1,175.35	1,144.02	-31.33	12,683	12,257	-427
Hcare Sciencs & Others	1,084.28	1,078.58	-5.70	5,190	5,195	5
Support Clinical Staff	2,125.26	2,076.53	-48.73	6,340	6,312	-28
Nhs Infrastructure Supp	2,668.88	2,636.06	-32.82	8,857	8,786	-71
Other Staff Costs	-9.05	-8.05	1.00	110	195	86
Total	10,186.77	10,011.91	-174.86	47,629	47,126	-503

Thank You

Any further questions or comments?

TRUST BOARD REPORT

Item 42

12 March 2025

Purpose Assurance

Title Integrated Performance Report

Report Author Mr D Hallen, Director - Data and Digital

Executive sponsor Mrs S Gilligan, Chief Operating Officer

Date Paper Approved By Executive Sponsor

Summary: This paper presents the corporate performance data at January 2025

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

Report linkages

Related Trust Goal

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

Related to key risks identified on Board Assurance Framework

- 1 The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
- 2 The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
- 3 A risk to our ability to deliver the National access standards as set out in the 2024-25 Operational Planning Guidance from NHS England for elective and emergency care pathways and thereby creating potential health inequalities for our local community as an unintended consequence.
- 4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result its inability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
- 5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

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

Related to key risks
identified on Corporate
Risk Register

Risk ID: Risk Descriptor.

Related to
recommendations from
audit reports

Audit Report Title and Recommendation/s.

Related to Key Delivery
Programmes
(Delete as appropriate)

Care Closer to Home
Place-based Partnerships
Provider Collaborative
Quality and Safety Improvement Priorities
Elective and Emergency Pathway Improvement
People Plan Priorities
Waste Reduction Programme

Related to ICB Strategic
Objective
(Delete as appropriate)

Improve population health and healthcare
Tackle inequalities in outcomes, experience and access
Enhance productivity and value for money
Help the NHS support broader social and economic development

Impact *(Delete yes or no as appropriate. If yes, you must state reasons)*

Legal	Yes/No	Financial	Yes/No
-------	--------	-----------	--------

Equality	Yes/No	Confidentiality	Yes/No
----------	--------	-----------------	--------

Previously considered by:

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

Integrated Performance Report

Published: February 2025

Safe | Personal | Effective

How to read an SPC chart	Page 3
Summary	Page 4
Safe Summary	Page 5
Infection Control	Page 6
Staffing	Page 7
Harm Free	Page 8
Caring Summary	Page 9
Feedback	Page 10
Effective Summary	Page 11
Mortality	Page 12
Responsive Summary	Page 13
A&E	Page 14
RTT & Diagnostics	Page 15
Cancer	Page 16
Length of stay	Page 17
Cancellation and Utilisation	Page 18
Well Led Summary	Page 19
HR	Page 20
Learning	Page 21
Finance Summary	Page 22
Finance	Page 23
	Page 24

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart

The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits

In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse—blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

The matrix provides a summary of performance metrics included in this report. It highlights where metrics are showing assurance and variation.

18.6% of our metrics are consistently achieving target

37.3% of our metrics are inconsistently achieving target

8.5% of our metrics are not achieving target, however 2 of these are showing special cause improvement.

35.6% of our metrics do not have a target currently set.

		Assurance			
		Achieving target	Inconsistently achieving target	Not achieving target	No target set
Variation	Special cause improvement	Appraisal (consultant)	31d cancer	VTE, Appraisal (AFC)	RN/MW agency spend, >62d urgent cancer GP referral
	Common cause	Fill (RN/MW night & care staff day), Inpatient and Outpatient F&F, Complaints, Appraisal (other medical), Safeguarding children training, Turnover	MRSA, Staffing red flags, Wards <80%, Community and Maternity F&F, A&E 4hr, Cancer 28d and 62d, Vacancy, BPPC NHS value invoices, Variance to capital programme	A&E F&F, Information governance training	C. diff, E.coli, P.aeruginosa, RN/MW bank spend, Crude mortality rate, Beds occupied by patients 7+, 14+, 21+, Income run rate, Other operating expenses
	Special cause concern	Fill (RN/MW day and care staff night)	Wards <80% fill, CHPPD, Maternity F&F, Handovers >60 mins, BPPC NHS no invoices, BPPS Non NHS no and value invoices, Liquidity days, Variance to planned financial performance, WRP	SHMI, Operations cancelled on the day	Klebsiella, In hospital deaths, A&E attends, Avg arrival to handover, Handovers >30 mins, Bed occupancy, Over 12hr TiD, Employee expenses run rate, Emergency average LOS

Metric	Latest Date	Value	Alt. Target	Variation	Assurance
Average Fill Rate Registered Care Staff (Day)	JAN 25	0.95	0.90		
Average Fill Rate Registered Care Staff (Night)	JAN 25	1.05	0.90		
Average Fill Rate Registered Nurses (Day)	JAN 25	0.90	0.90		
Average Fill Rate Registered Nurses (Night)	JAN 25	0.97	0.90		
MRSA	JAN 25	0.00	0.00		
Patients Risk Assessed for Venous Thromboembolism	JAN 25	0.86	0.95		
National Nursing Red Flags	JAN 25	0.00	0.00		
Wards <80% Registered Nurse (Day) Fill Rate	JAN 25	4.00	0.00		
Care Hours per Patient Day (CHPPD)	JAN 25	7.76	8.00		

Metric	Latest Date	Value	Variation
C Diff per 100000 Rate	JAN 25	20.45	
E. coli per 100000 Rate	JAN 25	27.27	
Klebsiella per 100000 Rate	JAN 25	34.09	
Pseudomonas per 100000 Rate	JAN 25	3.41	
Registered Nurse Agency Spend	JAN 25	243146.58	
Registered Nurse Bank Spend	JAN 25	866304.24	

Alert

We have seen increasing numbers of positive Klebsiella blood stream infections in January 7 HOHA, 3 COHA cases, a full review of the cases ongoing to identify any themes and trends.

During January 2025 there remained challenges with Nurse staffing. This was due to unexpected unavailability, and redeploying staff to support patients in the Emergency Department. 4 wards were below the fill rate % of 80% for the month of January. This was due to unexpected unavailability, and redeploying staff to support patients in the Emergency Department. All staffing gaps were mitigated and covered by internal moves across Directorates and Divisions.

There has been an increase in the number of incidents being reported from 45 in December 2024 to 79 in January 25. The ED department experienced high attendances of complex and high acuity patients resulting in long waits within the ED department, following a decision to admit, despite increasing the bed base across the inpatient sites. However since 1 April 2024, 537 pressure damage have been reported under the care of ELHT with 86 confirmed lapses in care (16%) – these figures continue to demonstrate a significant improvement on the 2023-2024 position.

Advise

We are still seeing cases of Influenza although now on a downward trend, masks are still required in the entry point areas, this will be reviewed at the end of February.

Nurse staffing continues to be monitored twice daily in a trust wide staffing meeting. Midwifery staffing continues to be monitored four times a day. Where pressure are increased, the calls are then attended by each Divisional Director of Nursing and 1 Deputy Chief Nurse. The ICB have now agreed a new pathway for management of pressure damage that develop on residents within the Regulated Care Sector. Which will reduce the number of investigations being undertaken by Community Services. This is planned to go live from April 2025. January achieved 48% compliance in the Pressure Damage Quality Indicator (target 65-80%) which is a decrease from 57% in Q2. The data and key messages have been shared with DDNs and Pressure Damage Leads with the Trust.

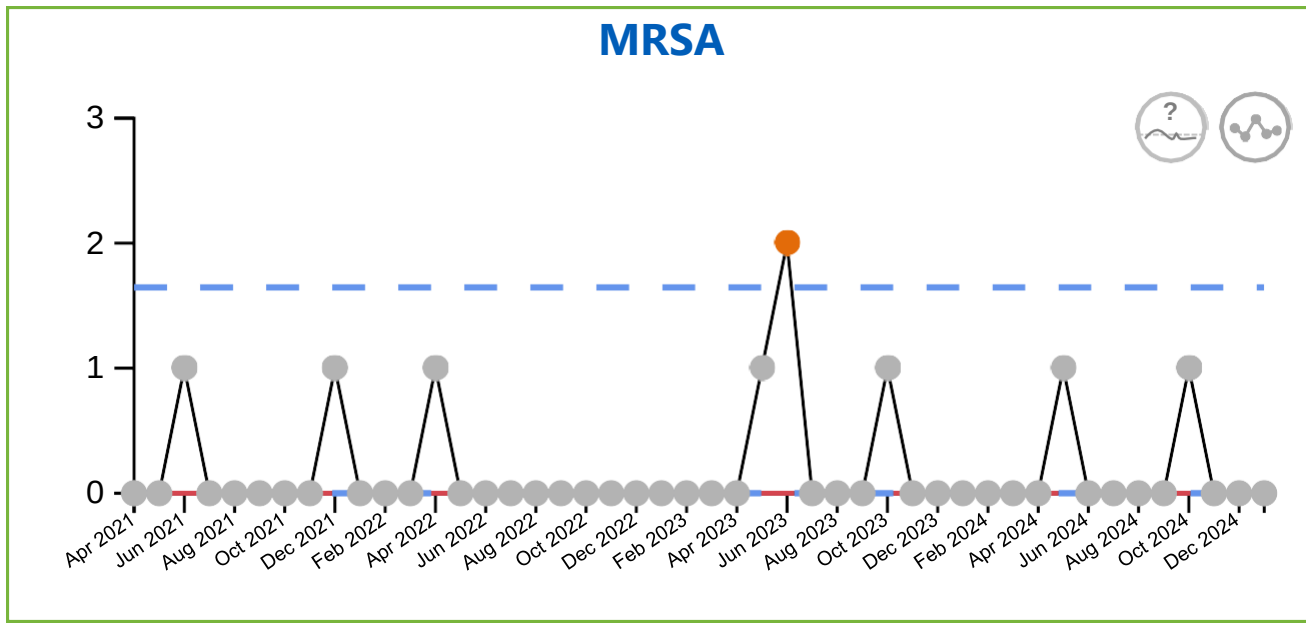
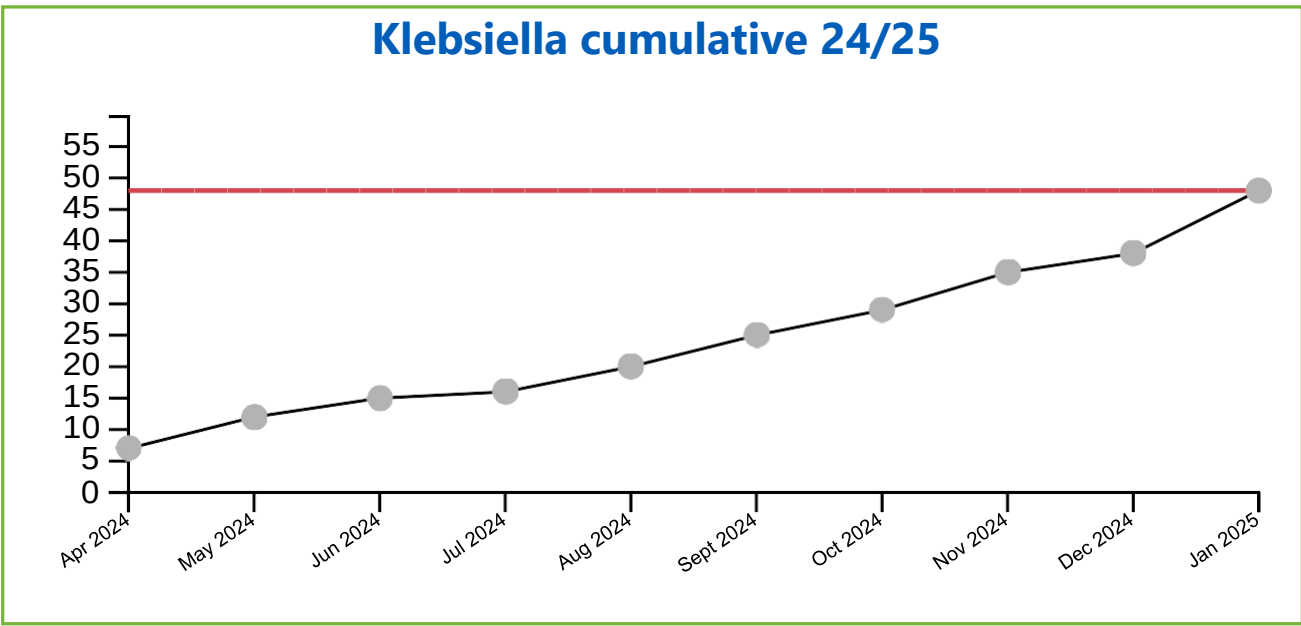
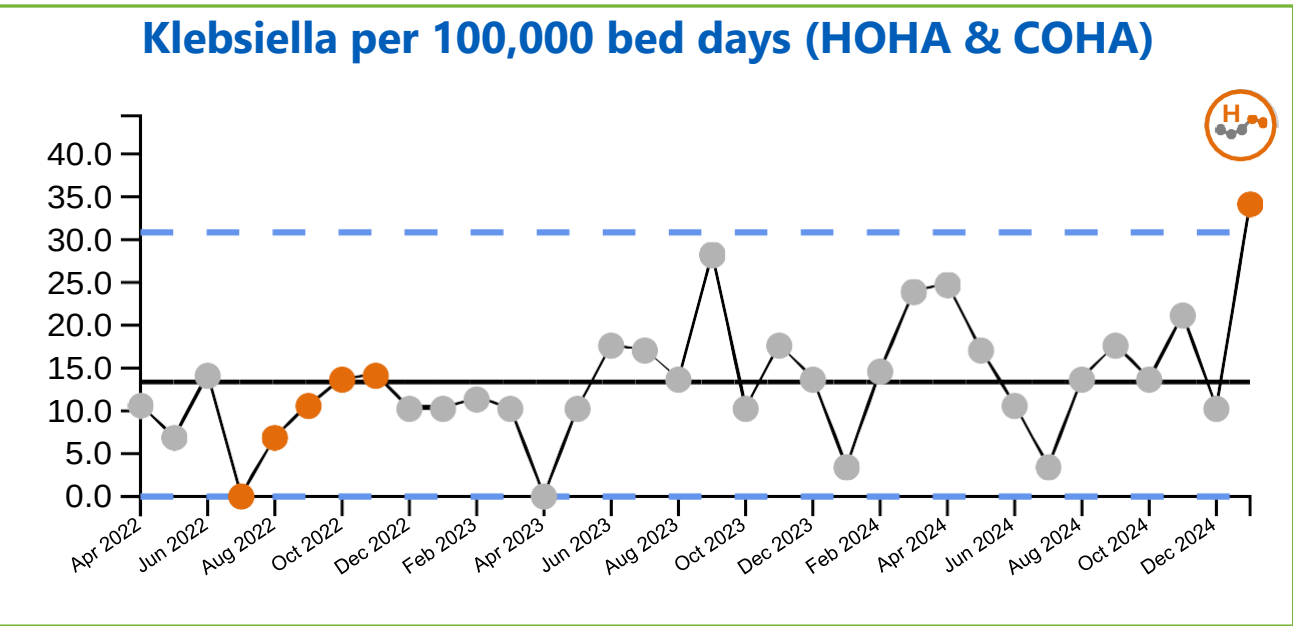
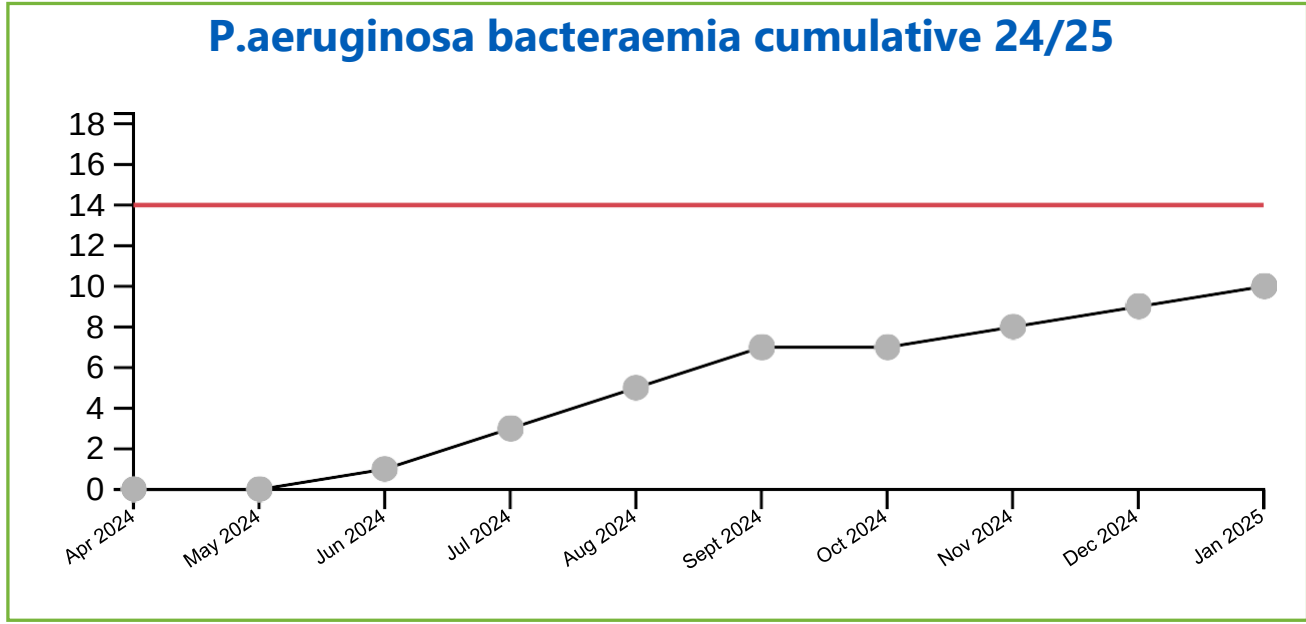
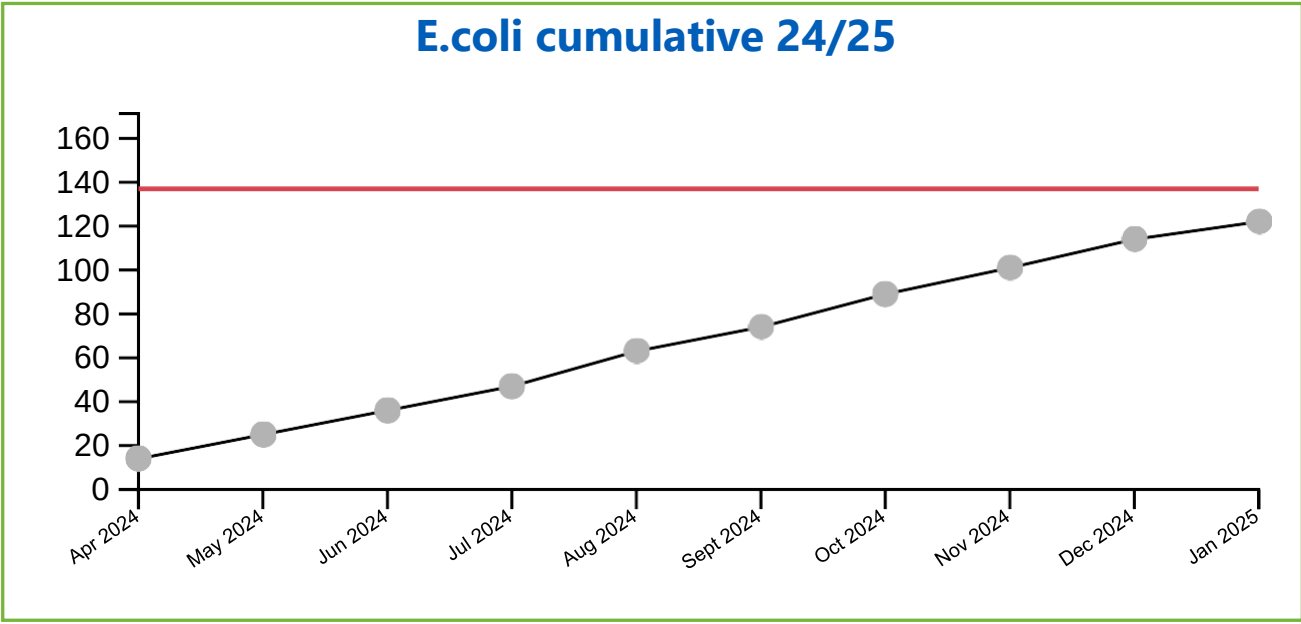
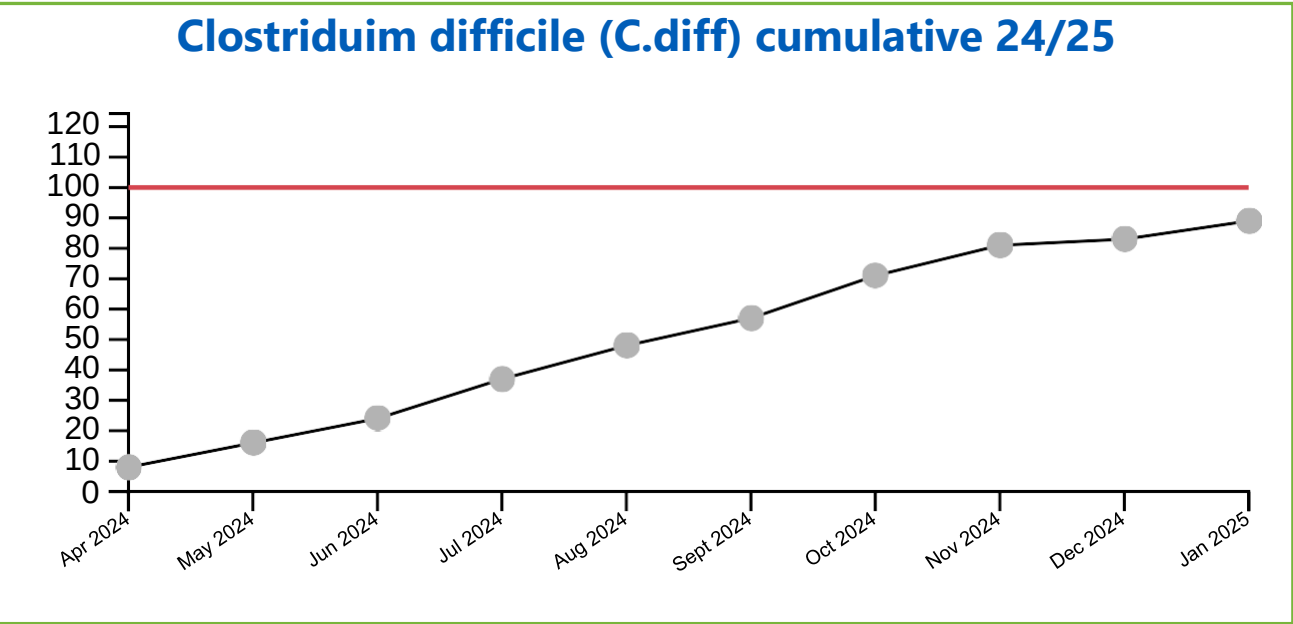
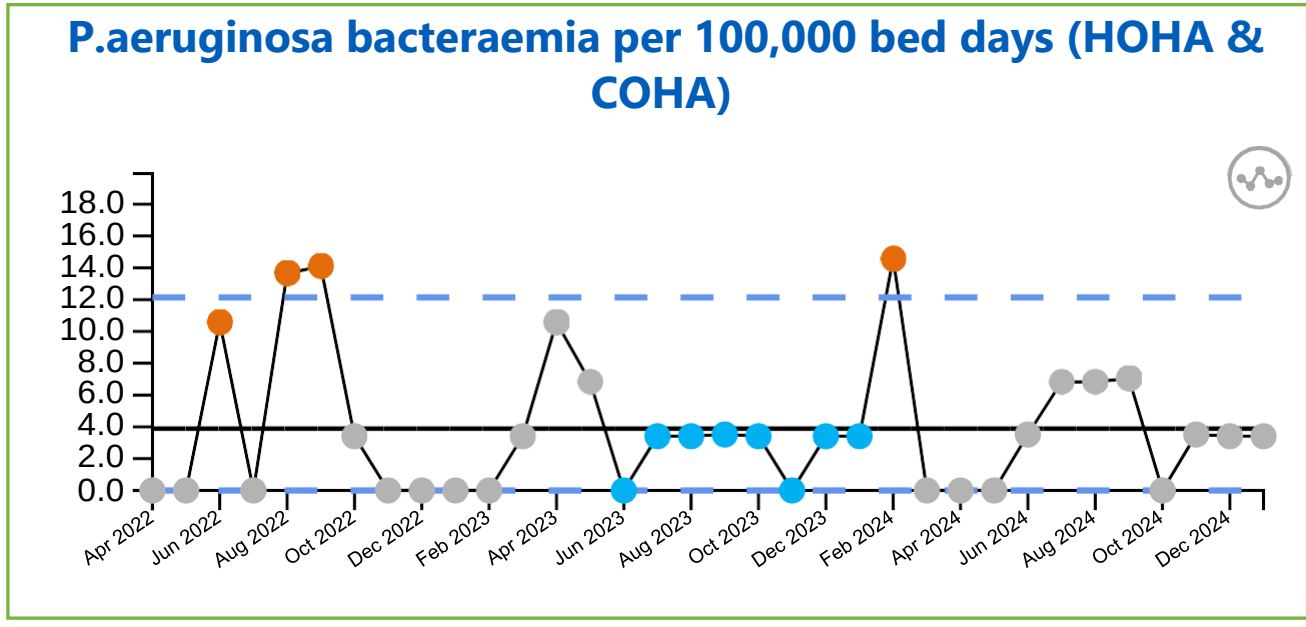
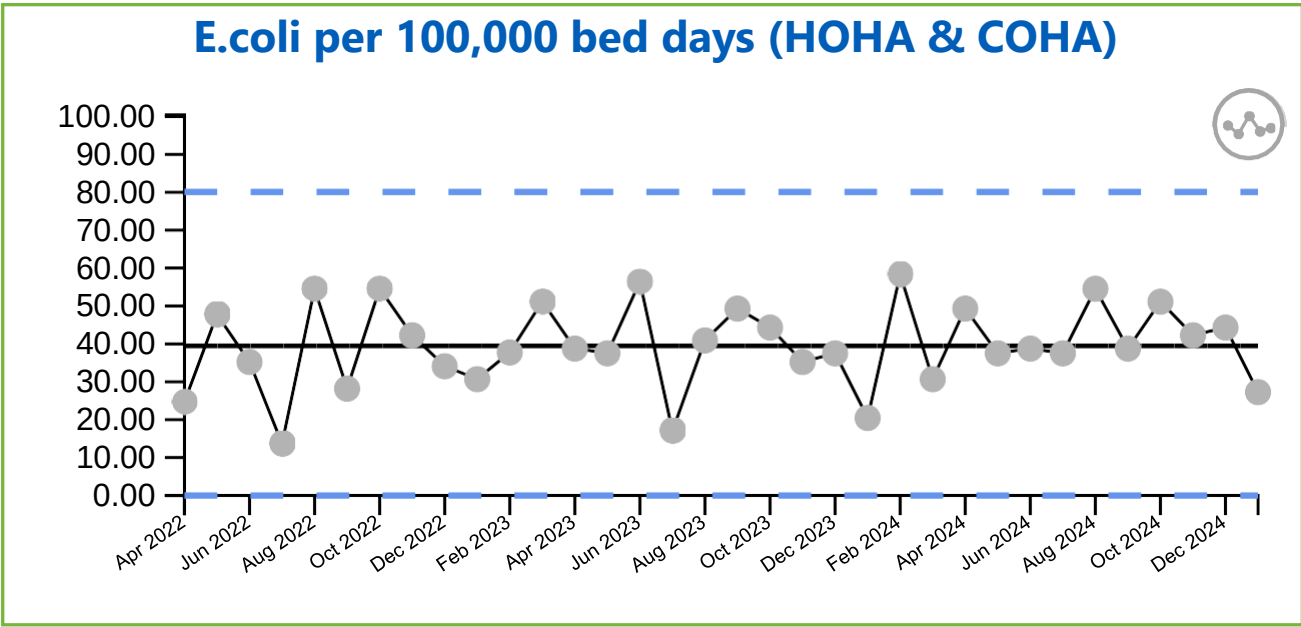
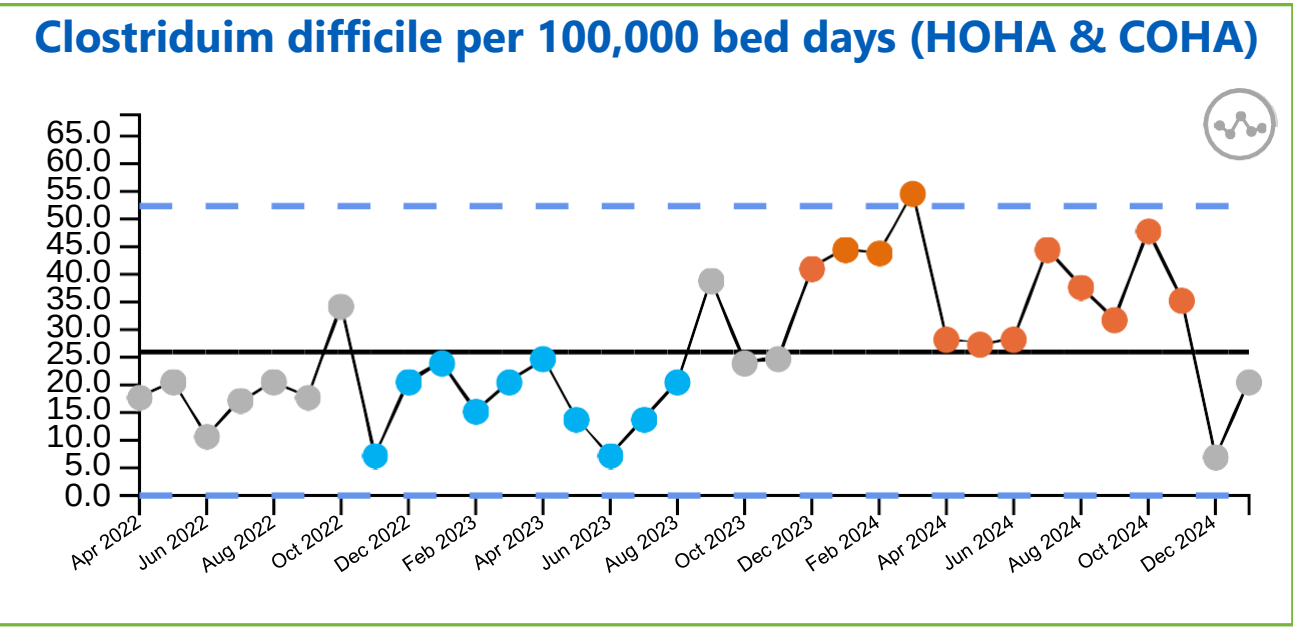
Assurance

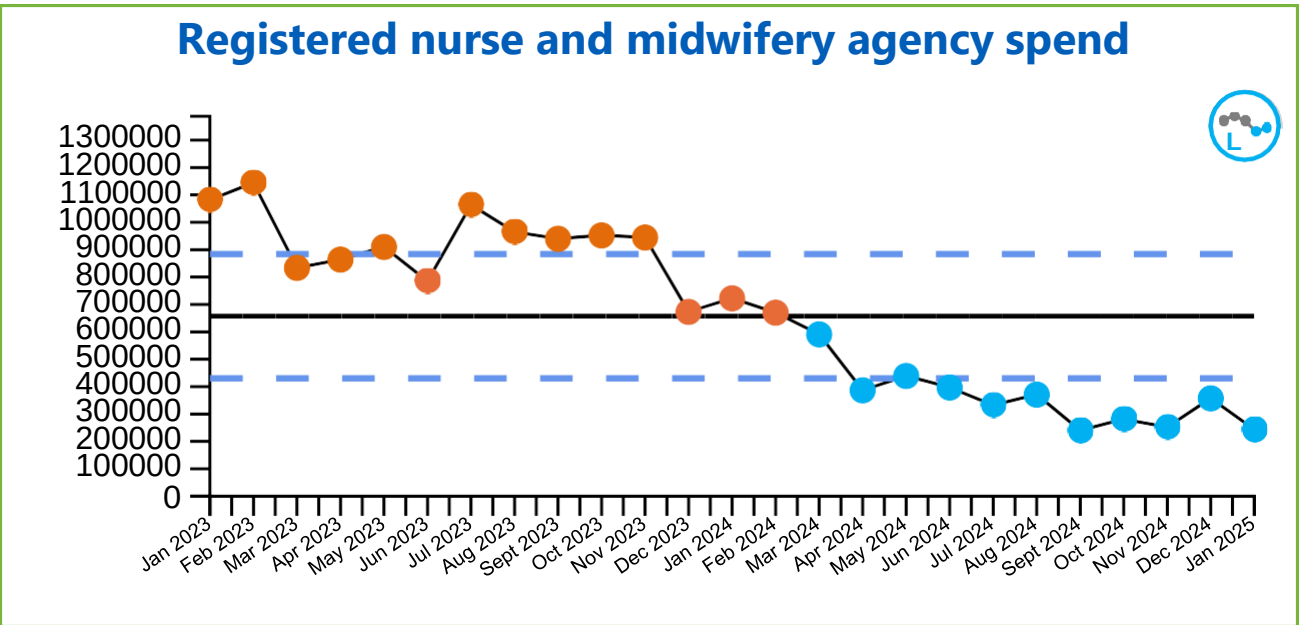
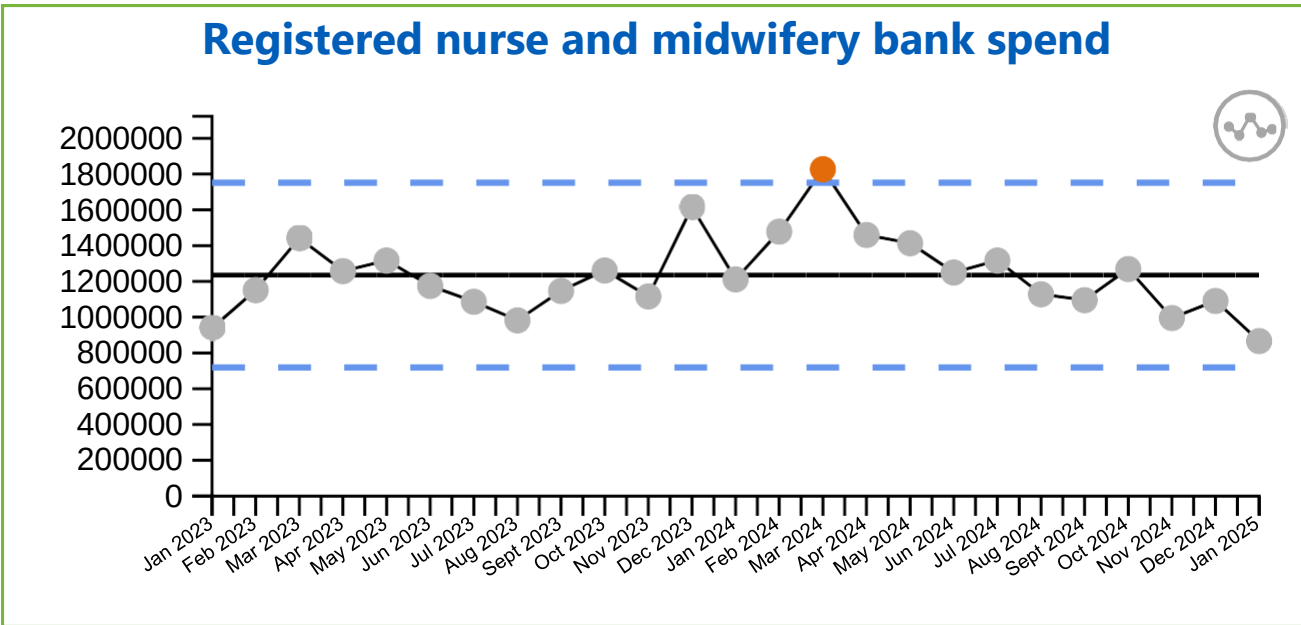
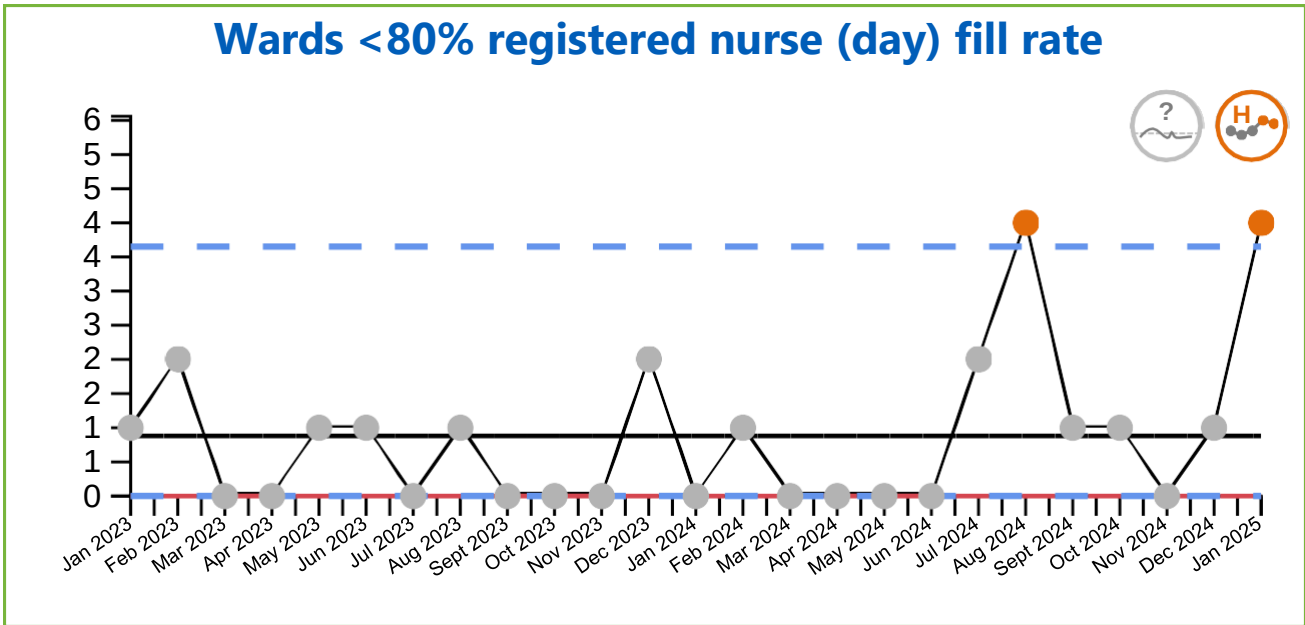
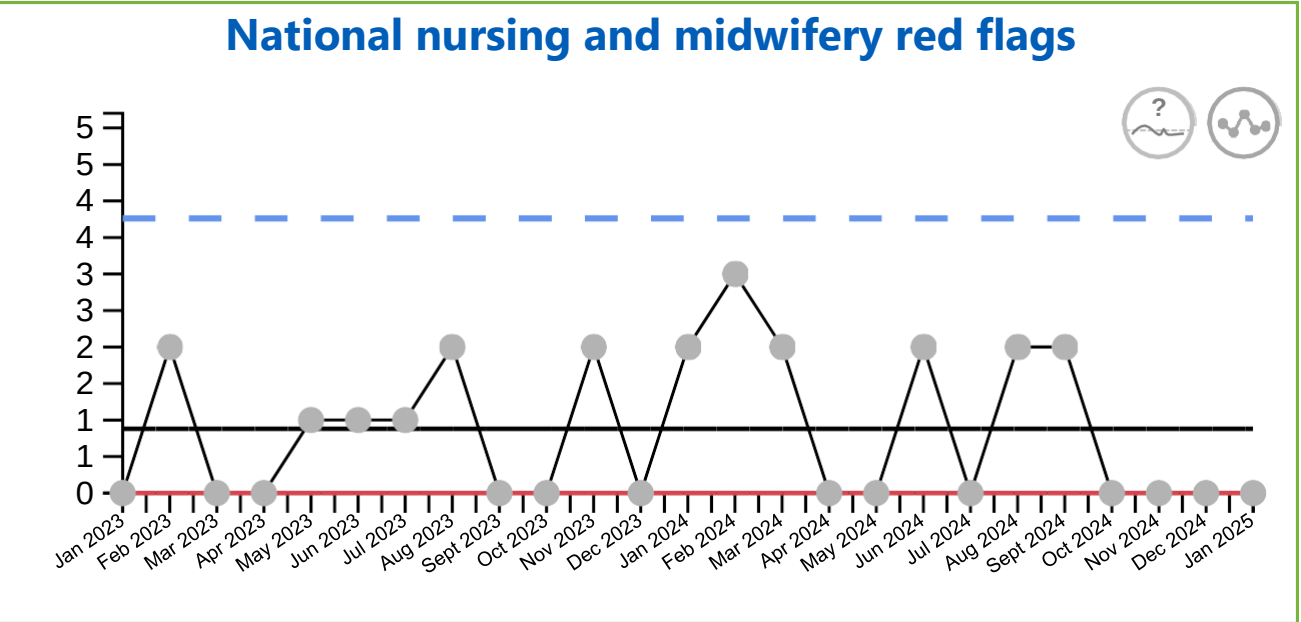
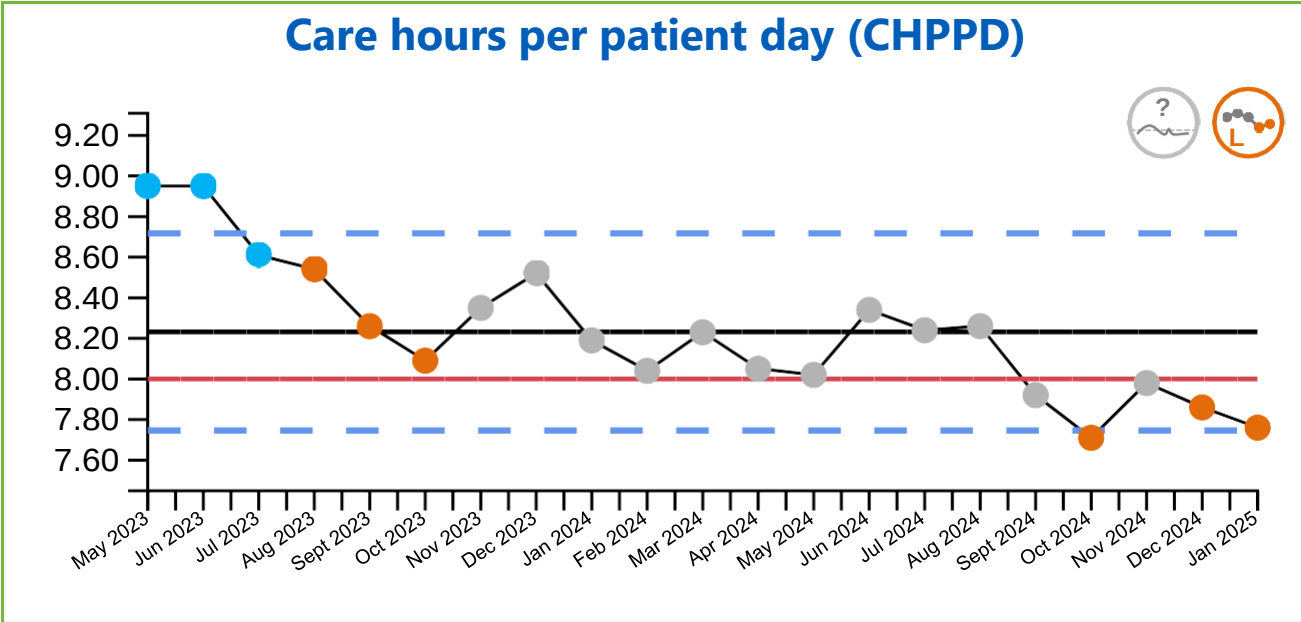
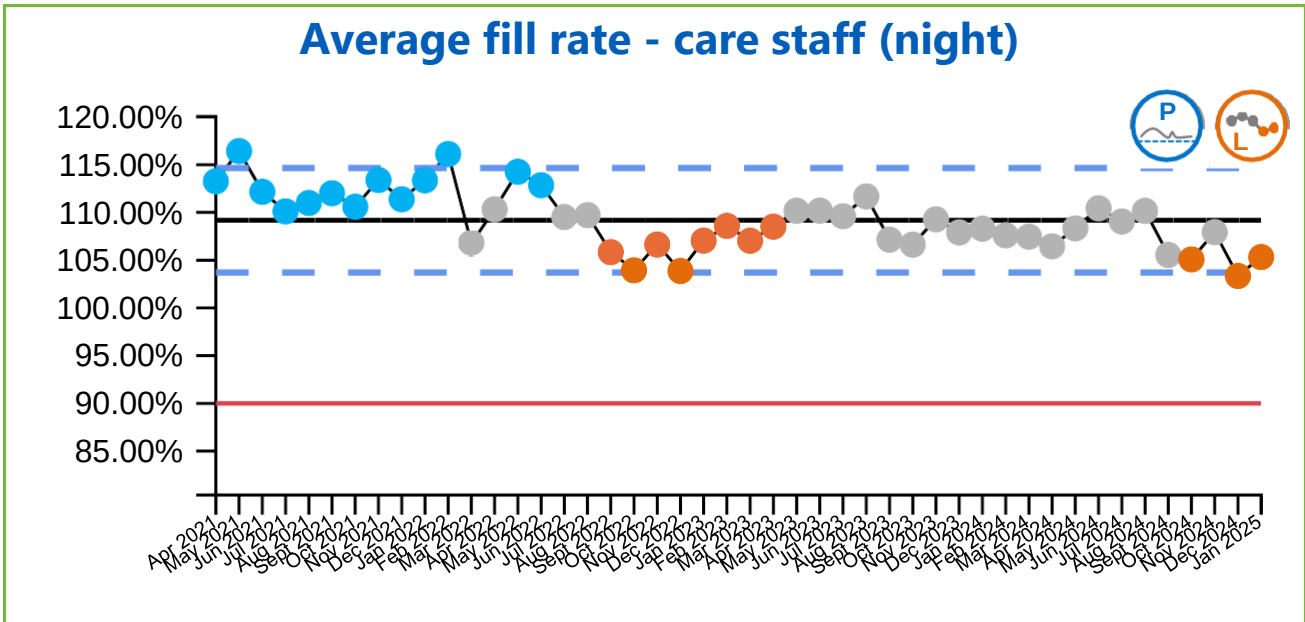
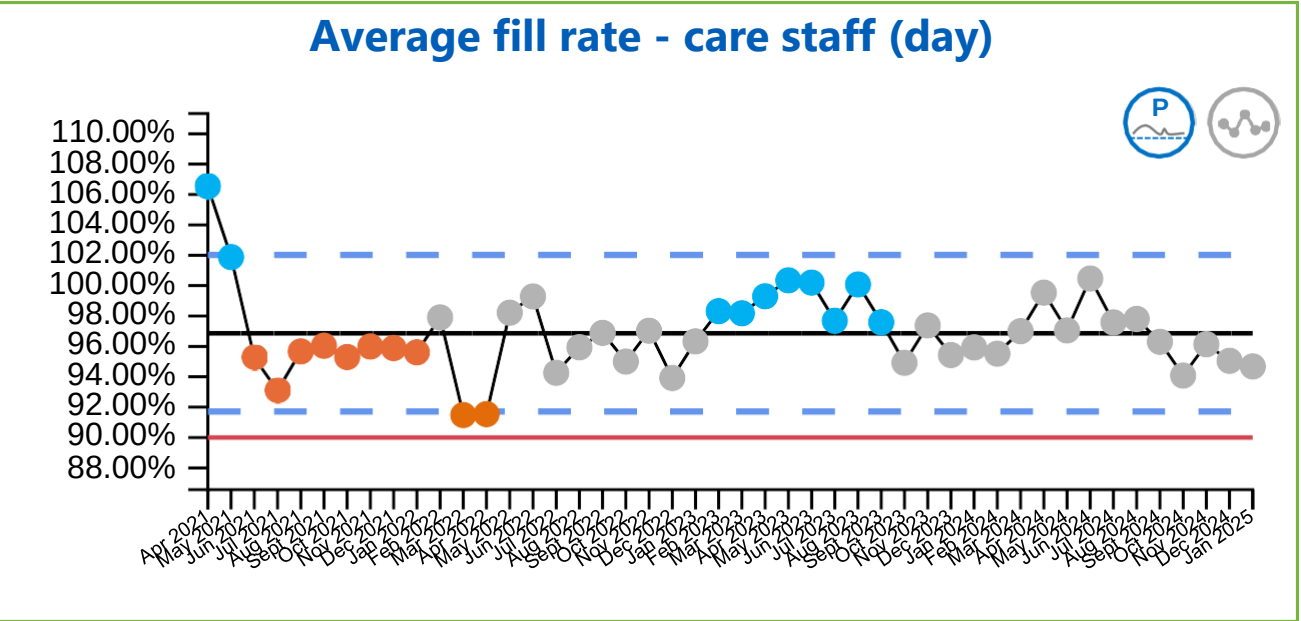
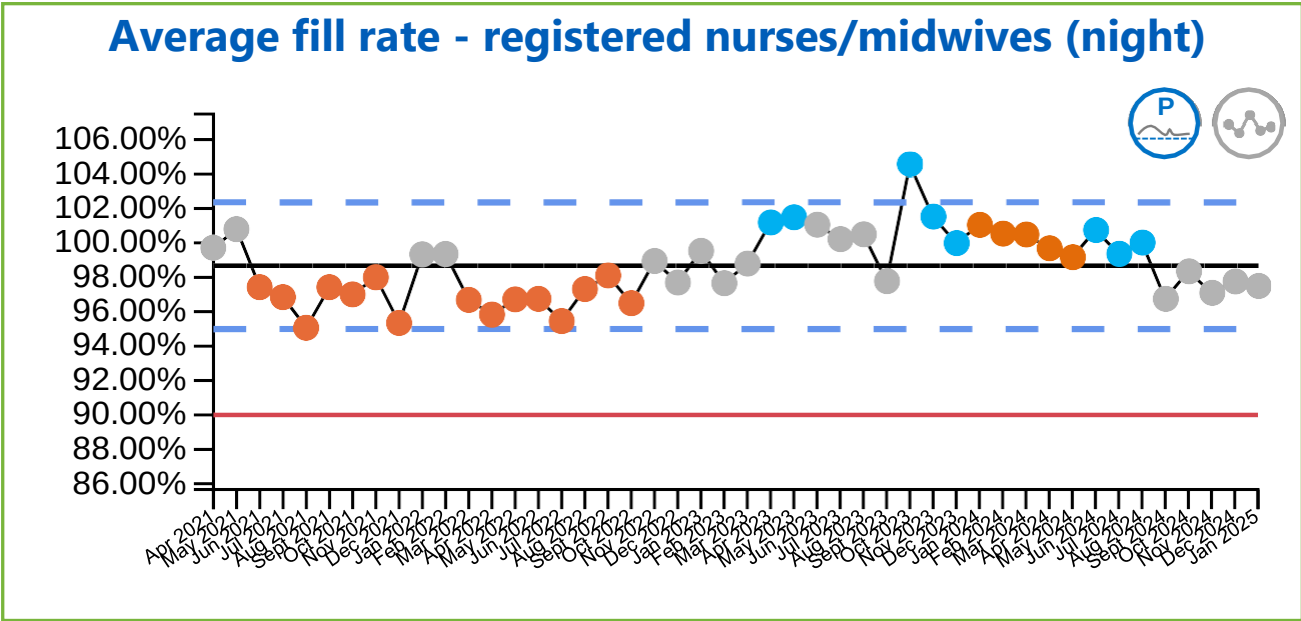
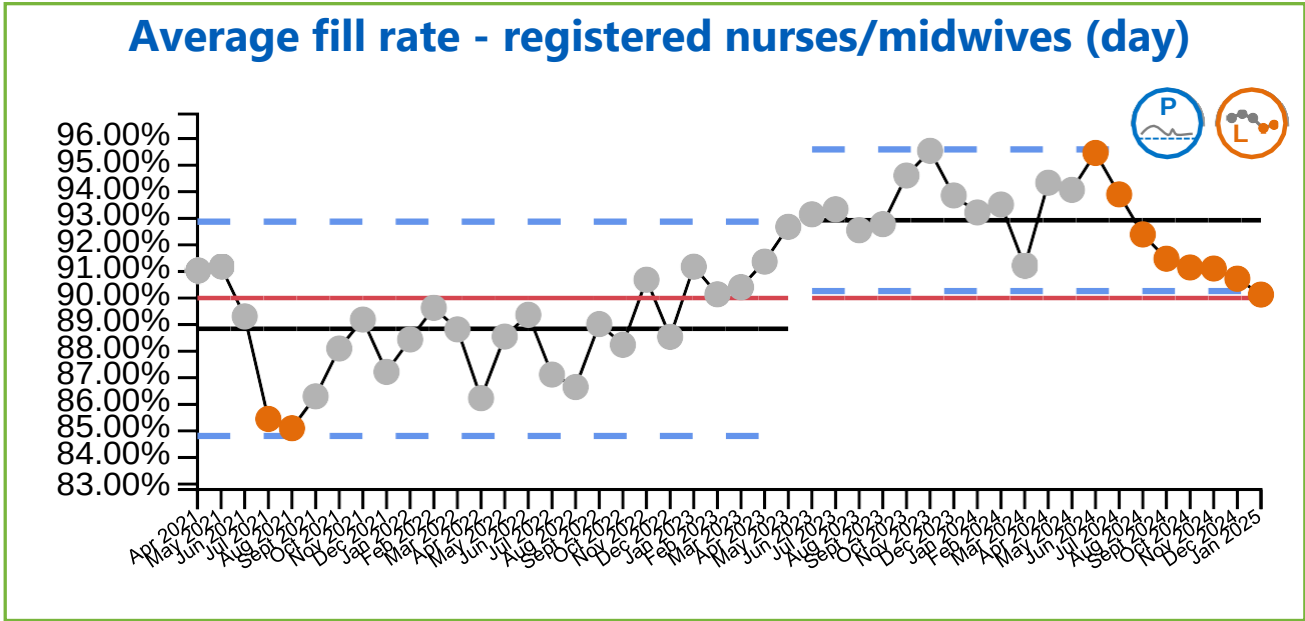
The NICU outbreak is under control there has been no further cases.

There were no red flags reported in relation to safer nurse/midwifery staffing. The overall percentage fill rate for RNs for days and nights was above 90%. The overall percentage fill rate for CSW for days and nights was above 97%.

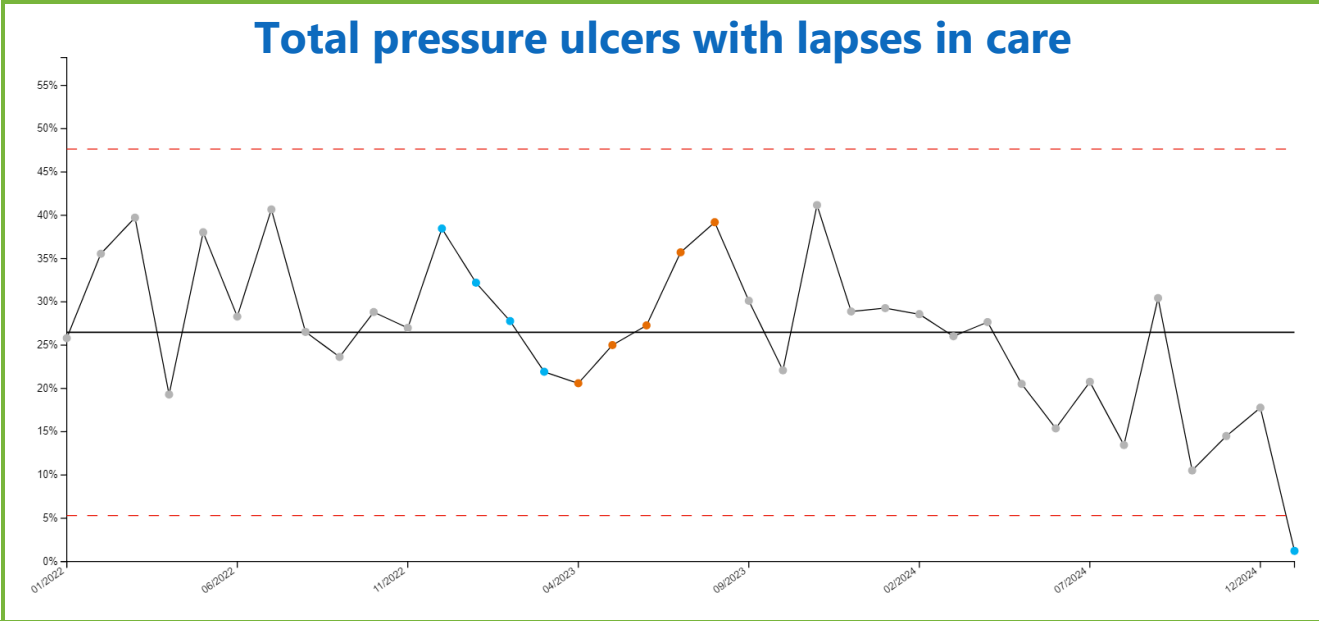
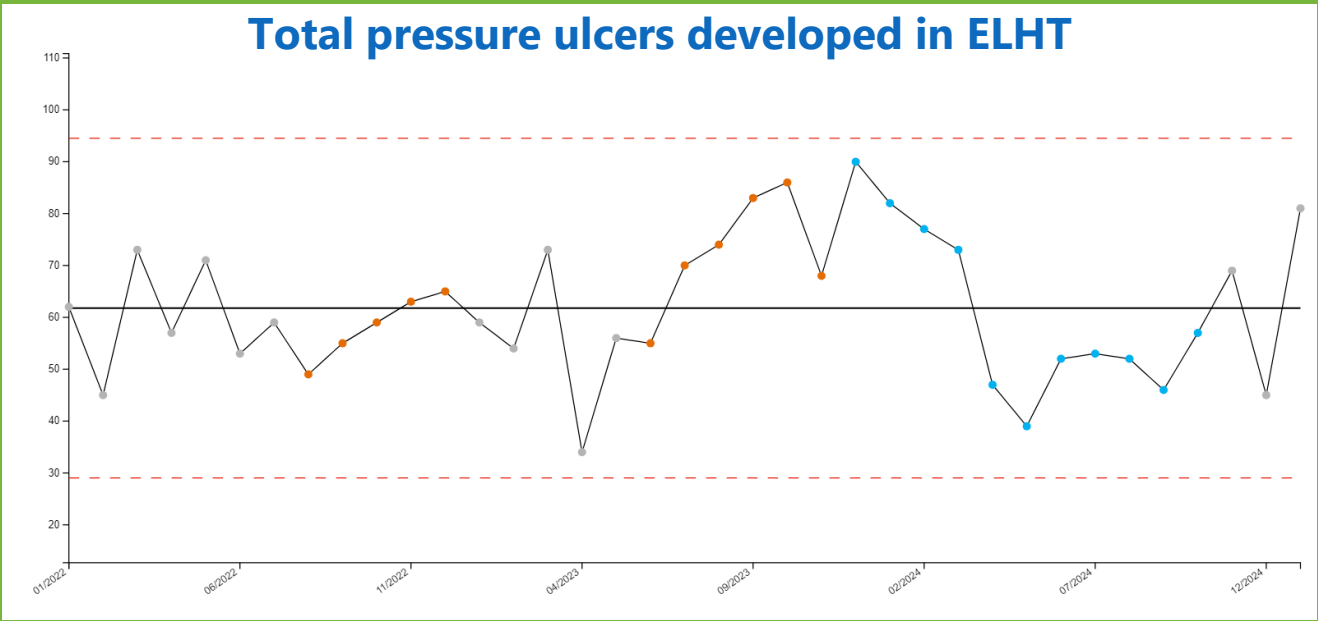
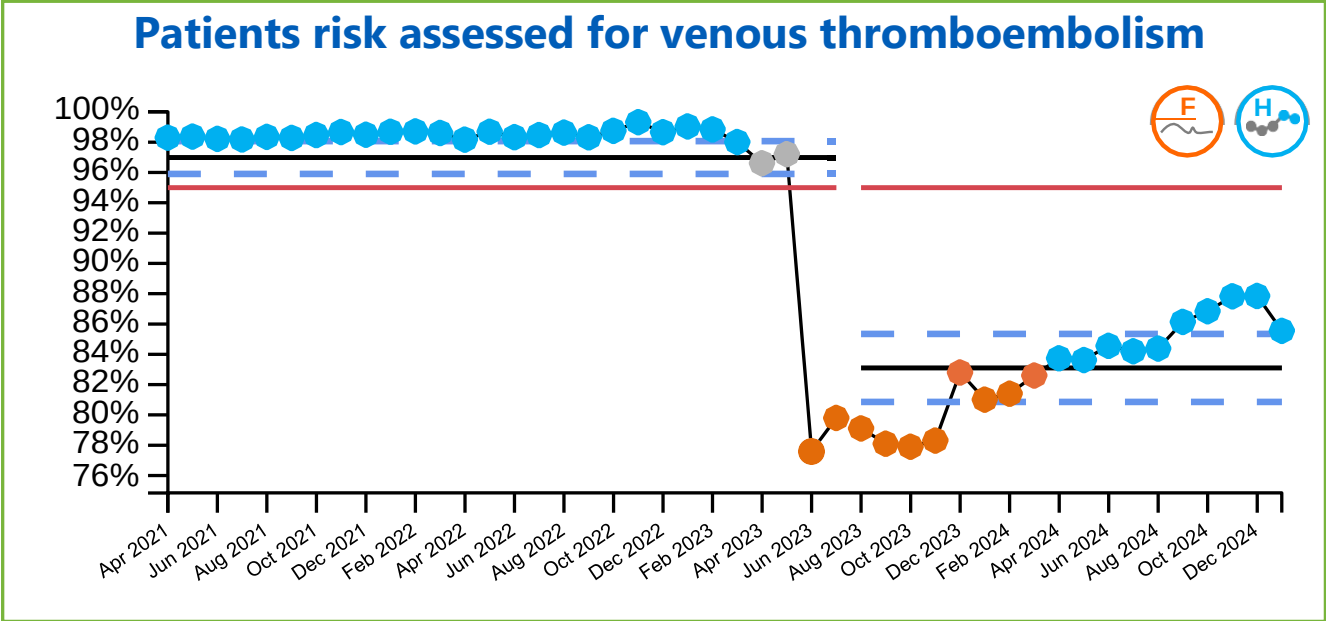
Compliance with the pressure damage and moisture associated damage e-learning in Dec has reduced to 90.38% and 90.47% respectively which will be addressed by the Pressure Damage Steering Group

1 CAS Alert overdue. NatPSA/2023/010/MHRA (bed rails) action plan in place, work on going to meet requirements of alert.





In month Never events 0	Year to date Never events 2	In month Medication errors serious/fatal harm 1	Year to date Medication errors serious/fatal harm 5	In month CAS alerts - Non-compliance 1	Year to date CAS alerts - Non-compliance 10
In month Serious incidents 2	Year to date Serious incidents 36	In month Slips trips falls serious/fatal harm 4	Year to date Slips trips falls serious/fatal harm 8		



A number of pressure ulcers in recent months remain currently under investigation. New reporting definitions were also introduced from April 2024.

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
A&E FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 25	0.66	0.90		
COMMUNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 25	0.94	0.90		
COMPLAINTS RATE PER 1000 CONTACTS	JAN 25	0.18	0.40		
INPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 25	0.96	0.90		
MATERNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 25	0.94	0.90		
OUTPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	JAN 25	0.94	0.90		

Alert

Our A&E Friends and Family Test (FFT) recommendation rate is 68%, down 1% from the last report. Given the extremely high demand on our A&E services, maintaining a recommendation rate in the upper 60s is a testament to the staff's dedication, even though it is below the national average of 76%. The A&E senior leadership team and Execs are working to mitigate factors impacting patient experience, but acknowledge that challenges persist for patients, their families, and staff.

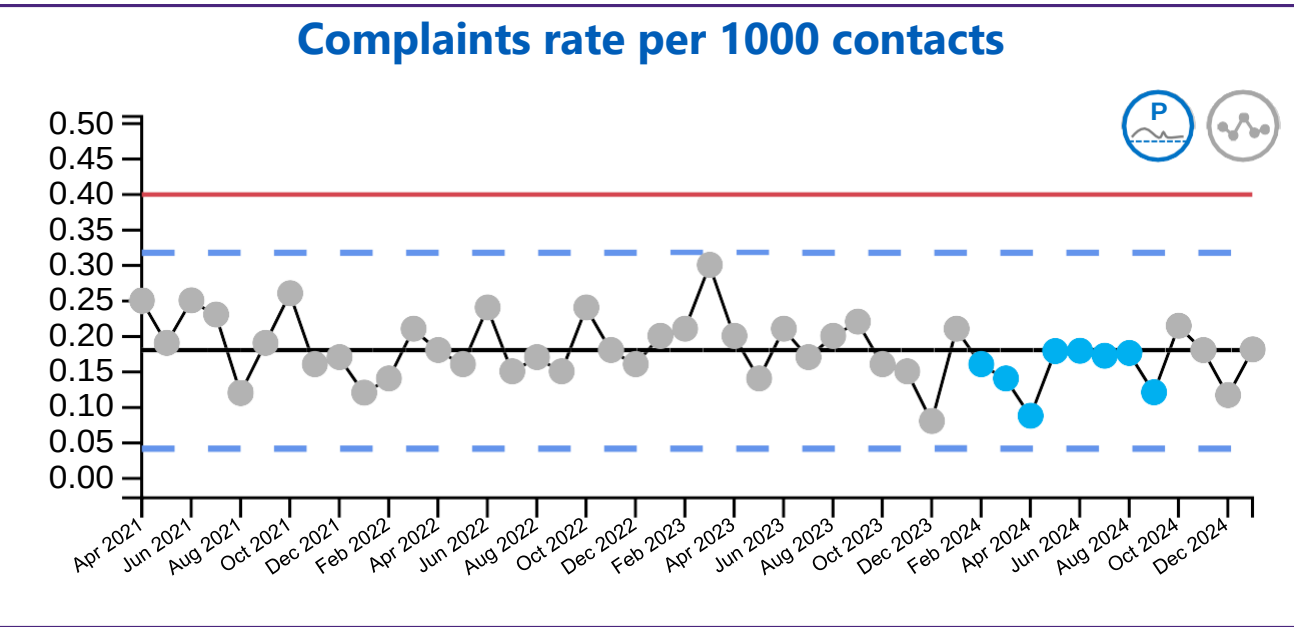
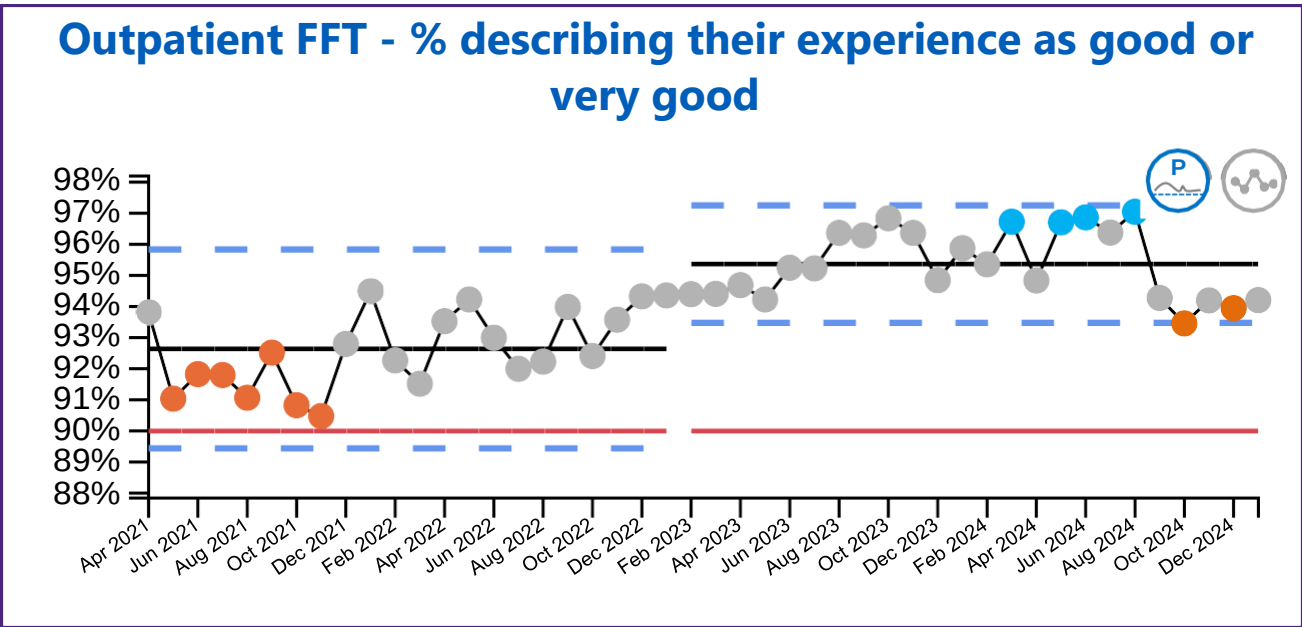
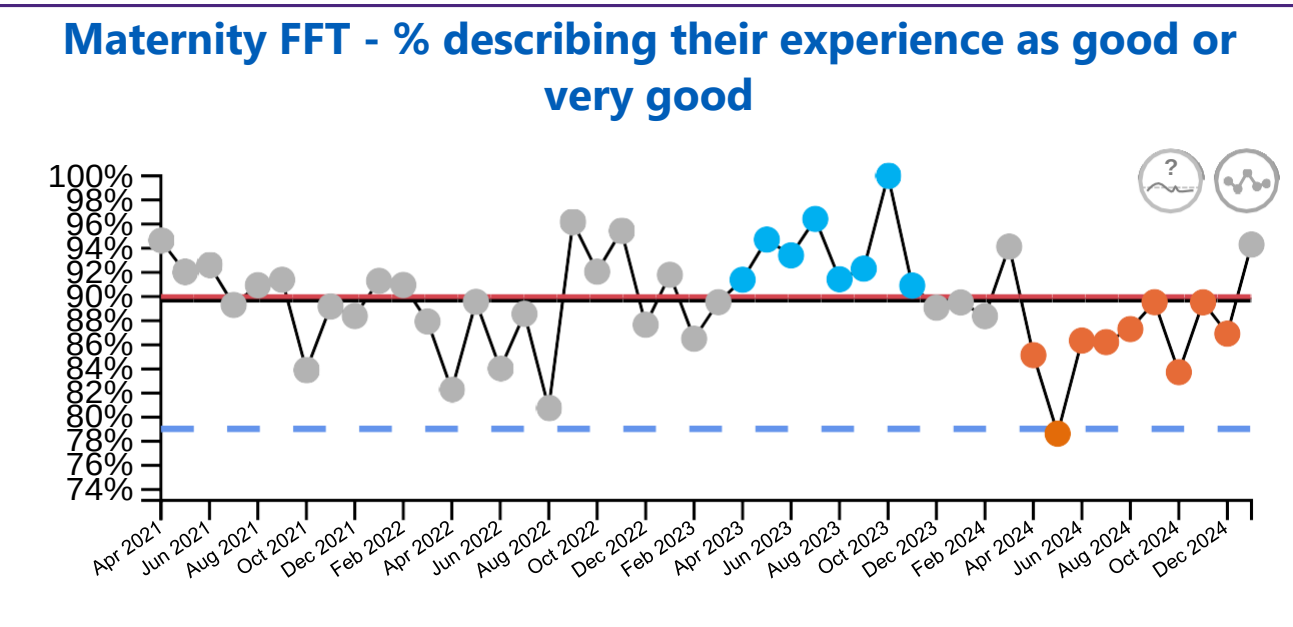
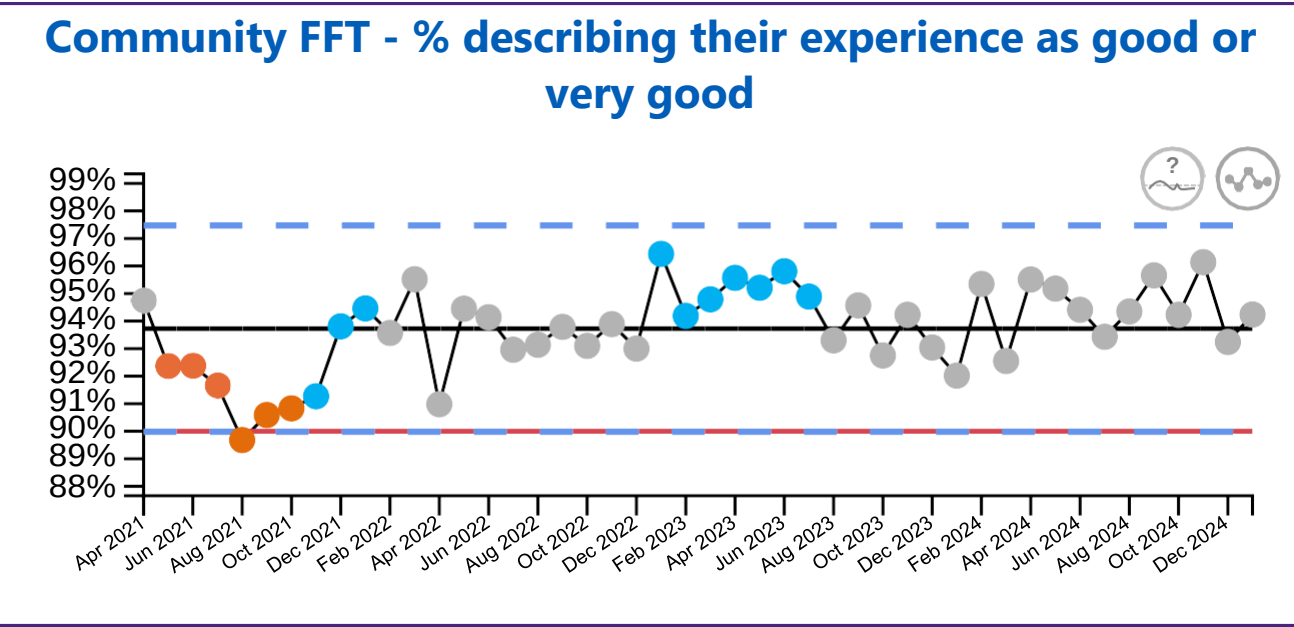
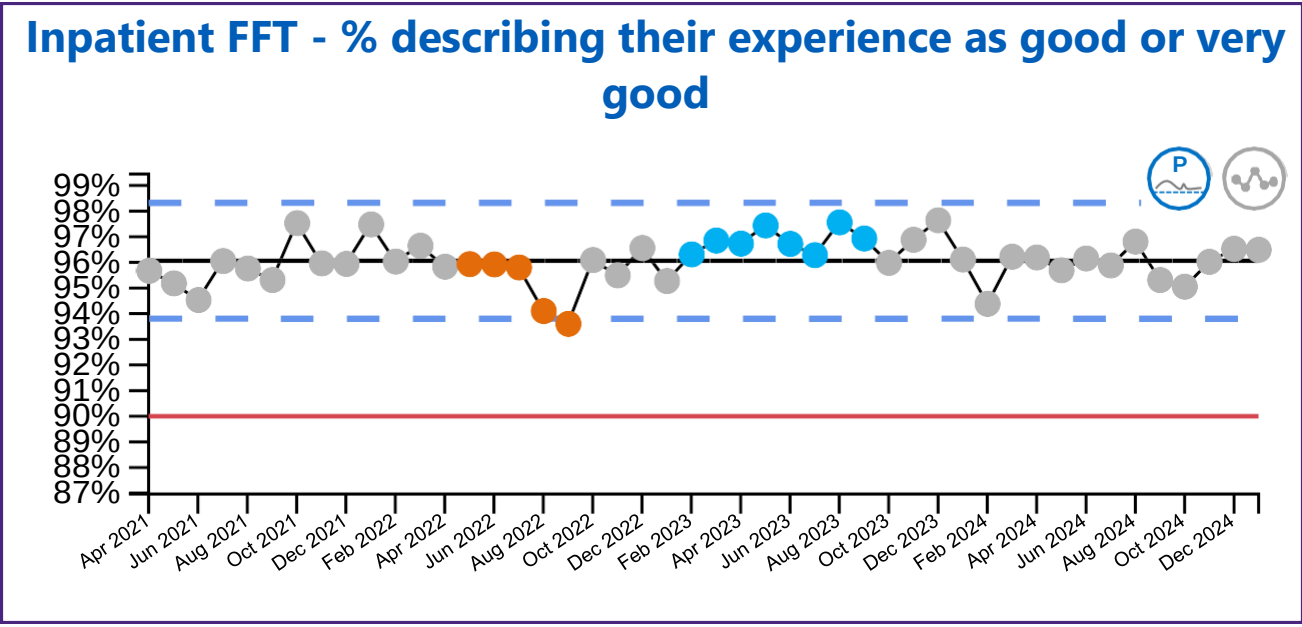
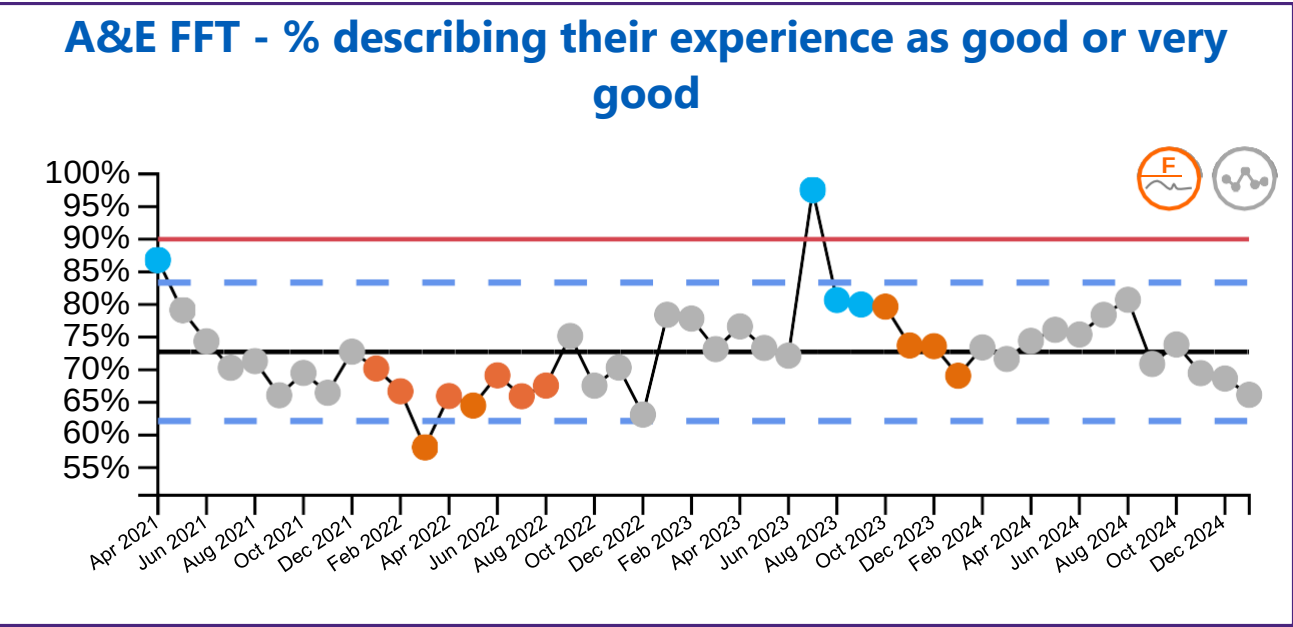
Advise

Maternity Friends and Family Test (FFT) recommendation improved from 87% to 93% in January. Work is ongoing to address the identified concerns in postnatal care.

Assurance

The percentage of patients recommending our inpatient, outpatient, and community services through the Friends and Family Test remains at or above the national average.

The Trust currently has 67 open complaints. The average time to close a complaint has slightly increased from 57 days in December to 57 days February. The formal complaints rate per 1,000 contacts remains within the expected range.



METRIC	LATEST DATE	VALUE	VARIATION
CRUDE DEATHS	JAN 25	184.00	
CRUDE MORTALITY RATE	JAN 25	0.04	
SHMI	JAN 25	1.32	

Alert

The Trust remains unable to provide assurance in relation to the HSMR and SHMI mortality indicators due to issues with data submission. Unfortunately, indications are that there are ongoing issues with reporting which means that the hoped for early access data will not be available for a further period.

HSMR is not currently calculated but has historically been above expected. SHMI is published and remains very high, although has plateaued (1.32), but confidence remains low. The data published nationally does contain a caveat that our data contains a high percentage of invalid diagnosis codes and also notes that the trusts that have removed SDEC activity are reporting higher SHMI.

Crude mortality has shown a further increase in January from December, although remains within process limits, and is not seasonally adjusted. There has been a significant increase in deaths in ED.

The post responsible for managing Doctors revalidation reports and the SJR process has been vacant since 30 June 24. The post has been recruited to and will commence work 4 March.

Advise

4 of the stillbirths were anticipated due to foetal anomalies. One was unexpected and is subject to the PMRT process.

Assurance

Some assurance with respect to trust mortality is provided by close monitoring of the crude mortality rate. This currently stands at 3.93% which shows an increase in this month, although this does not exceed control limits.

There are issues impacting the SHMI including:

- Backlog in coding
- Removal of Same day emergency care (SDEC) from Admitted Patient Care (APC) dataset
- Data quality issues with SUS submission impacting spell counts

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

Latest month SHMI banding

Higher than expected

Stage 1 SJR Reviews

Completed in most recent month

Reviews	Total
Number complete	6
Backlog	> 100
5 - Excellent Care	0
4 - Good Care	6
3 - Adequate Care	0
2 - Poor Care	0
1 - Very Poor Care	0

Stage 2 SJR Reviews

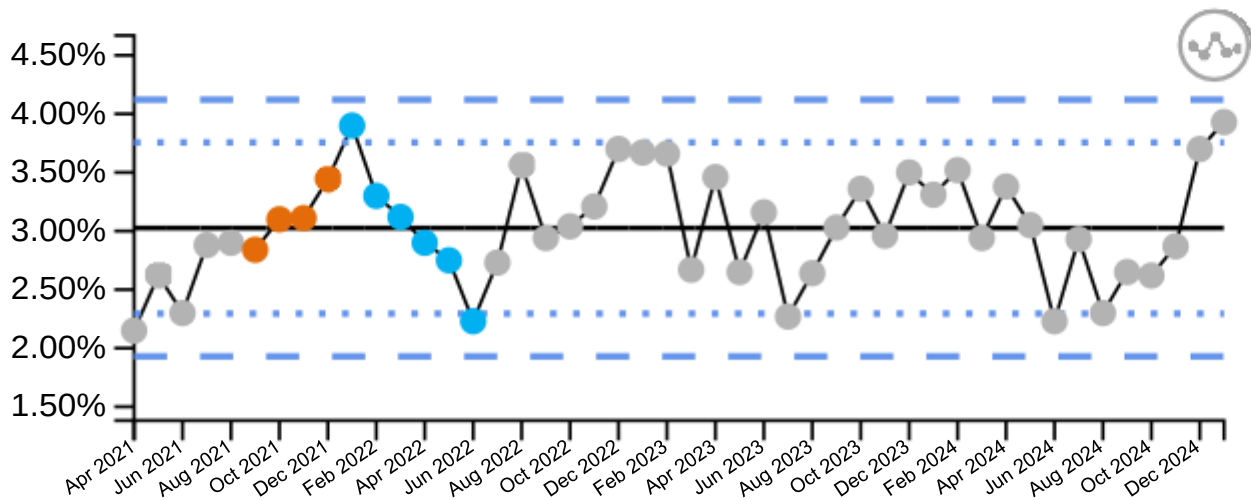
Completed in most recent month

Reviews	Total
Number complete	0
Backlog	0
5 - Excellent Care	0
4 - Good Care	0
3 - Adequate Care	0
2 - Poor Care	0
1 - Very Poor Care	0

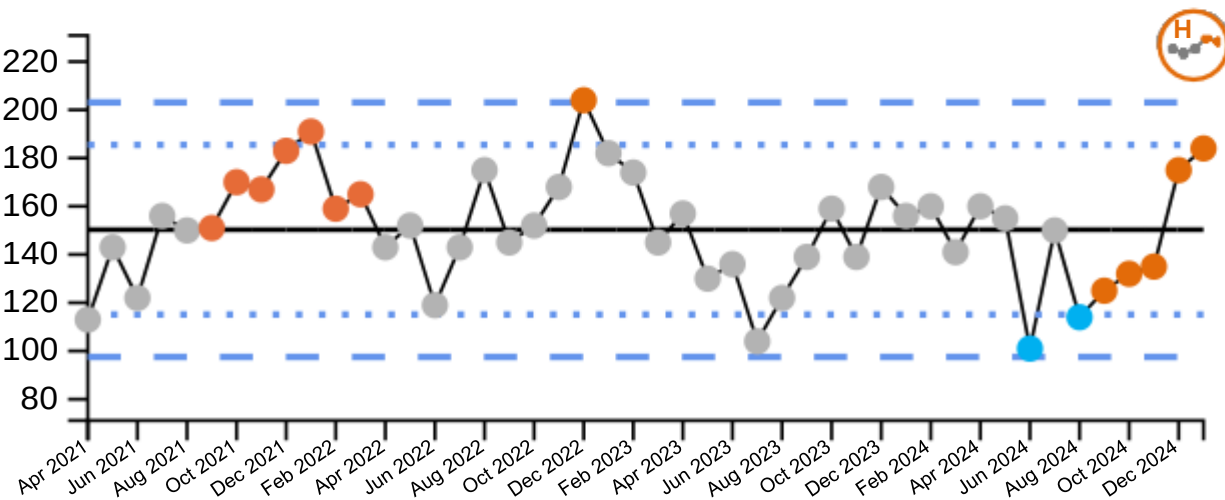
Learning Disability Mortality Reviews

- No update provided

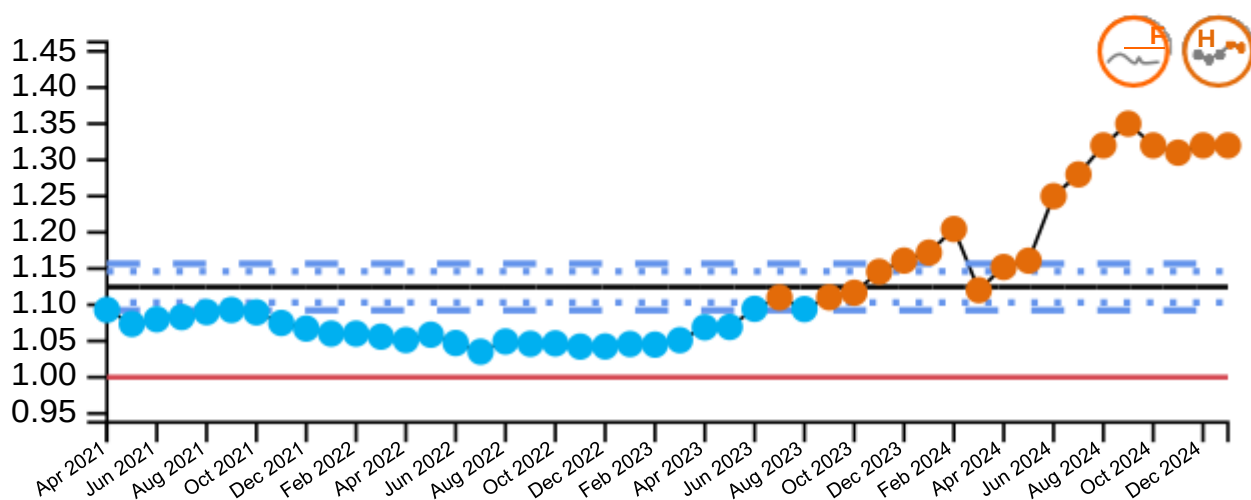
Crude Mortality Rate



In Hospital Deaths



Summary Hospital-level Mortality Indicator (SHMI)



Stillbirths

5

Year to date stillbirths

25

Maternal deaths

0

Year to date maternal deaths

1

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
A&E 4HR PERFORMANCE (TRUST)	JAN 25	0.74	0.78		
AMBULANCE HANDOVERS >60 MINUTES	JAN 25	438.00	0.00		
CANCELLED ON DAY OPERATIONS	JAN 25	75.00	0.00		
NOT TREATED WITHIN 28 DAYS OF LAST MINUTE CANC	JAN 25	6.00	0.00		
PATIENTS WAITING OVER 6 WEEKS FOR A DIAGNOSTIC TEST	JAN 25	0.10	0.05		
28D GENERAL FDS	DEC 24	0.80	0.75		
31D GENERAL TREATMENT STANDARD	DEC 24	0.96	0.96		
62D GENERAL STANDARD	DEC 24	0.75	0.70		

METRIC	LATEST DATE	VALUE	VARIATION
% HANDOVERS > 30 MINUTES	JAN 25	0.44	
A&E ATTENDANCES	JAN 25	22091.00	
BED OCCUPANCY G&A	JAN 25	0.95	
EMERGENCY AVERAGE LENGTH OF STAY (EXCL 0 AND 1 DAYS)	JAN 25	10.93	
OVER 12 HOURS IN DEPARTMENT	JAN 25	2575.00	
AVERAGE ARRIVAL TO HANDOVER	JAN 25	0.79	
MAX ARRIVAL TO HANDOVER TIME	DEC 24	12.18	
PATIENTS OVER 62 DAYS (URGENT GP REFERRAL)	JAN 25	193.00	

METRIC	LATEST DATE	VALUE
RTT ONGOING	JAN 25	63180.00
RTT OVER 52 WEEKS	JAN 25	2557.00
RTT OVER 65 WEEKS	JAN 25	9.00
RTT OVER 78 WEEKS	JAN 25	0.00

Alert

Ambulance Handover Data: This has not been verified due to the NWS data not being confirmed and validated at the time of reporting.

Emergency Department: (ED) 4-Hour Performance: January performance was 73.65%, with 22,091 attendances. National average performance was 73%. Improvement efforts continue, focusing on alternative pathways, deflection, and same-day emergency care to enhance ED performance.

12-Hour Waits (All Types): In December, 2,613 patients waited over 12 hours in the department. In January, this slightly reduced to 2,575. Of the 22,091 January attendances, 88% of patients spent less than 12 hours in the department. Improvement work is on-going, supported by a dedicated PMO lead with clinical and operational support to reduce the time spent in the department.

Advise

DM01 Performance: Continued improvement in January, reducing to 9.89%, progressing towards the national ambition of 5% by March 2025.

Cancelled On-the-Day Operations: Reduced to 75 (above the average of 65). Ongoing efforts focused on enhancing pre-operative pathways to reduce cancellations further.

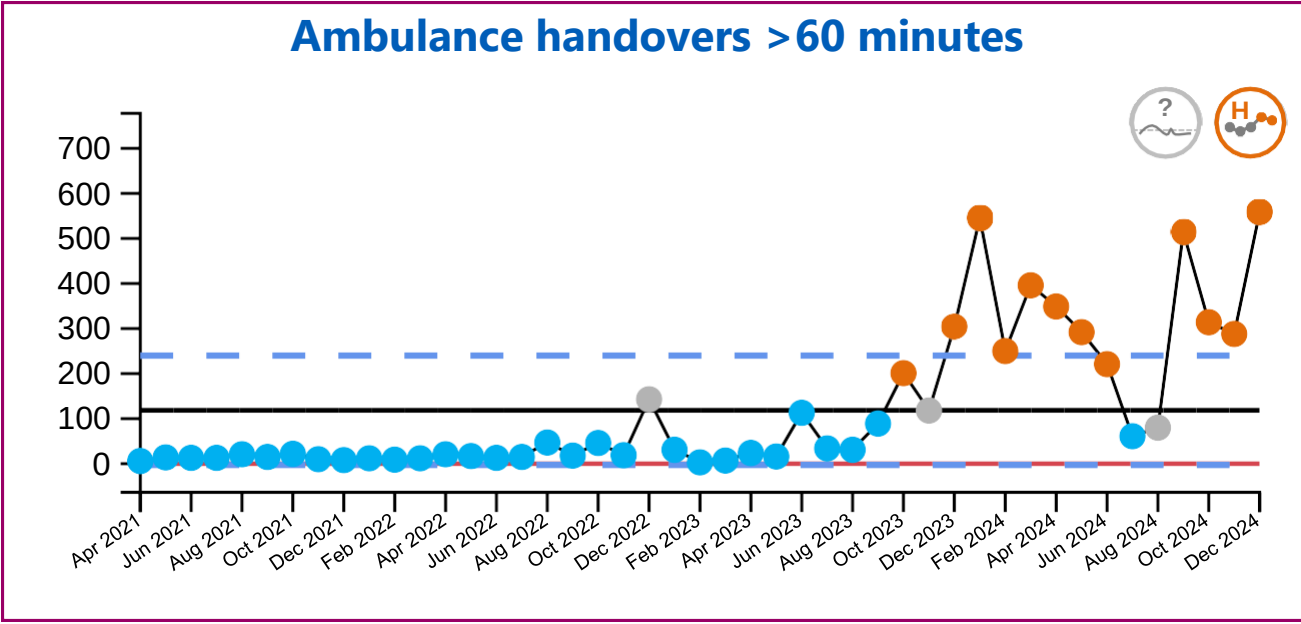
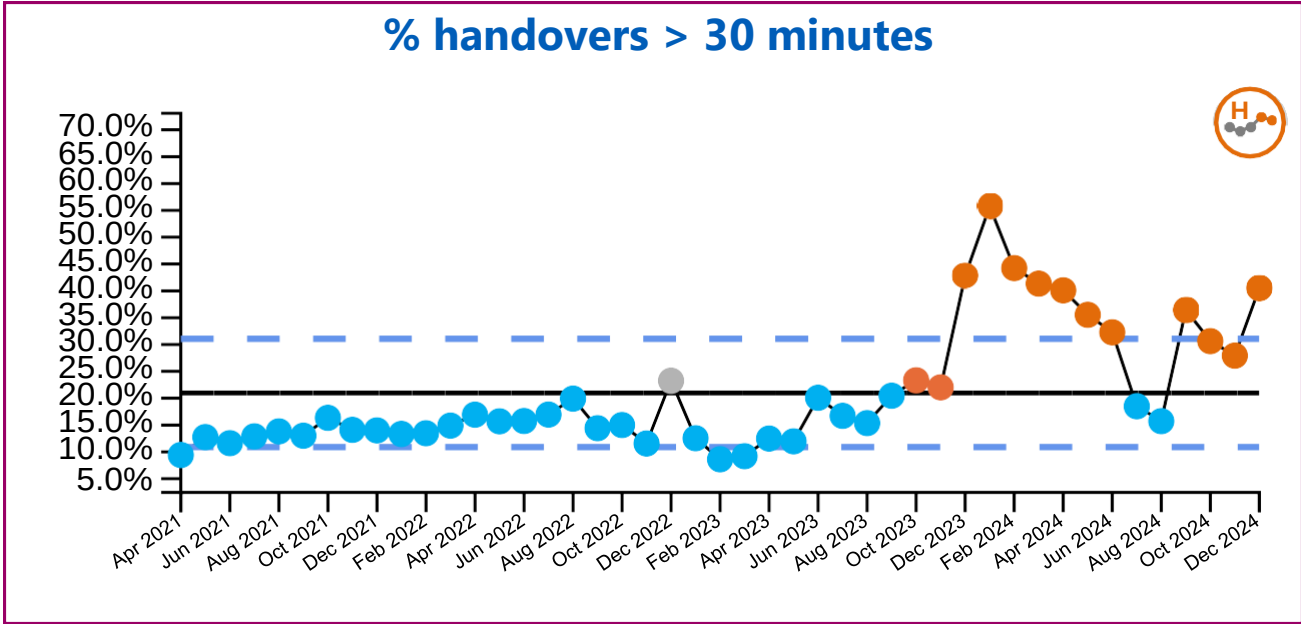
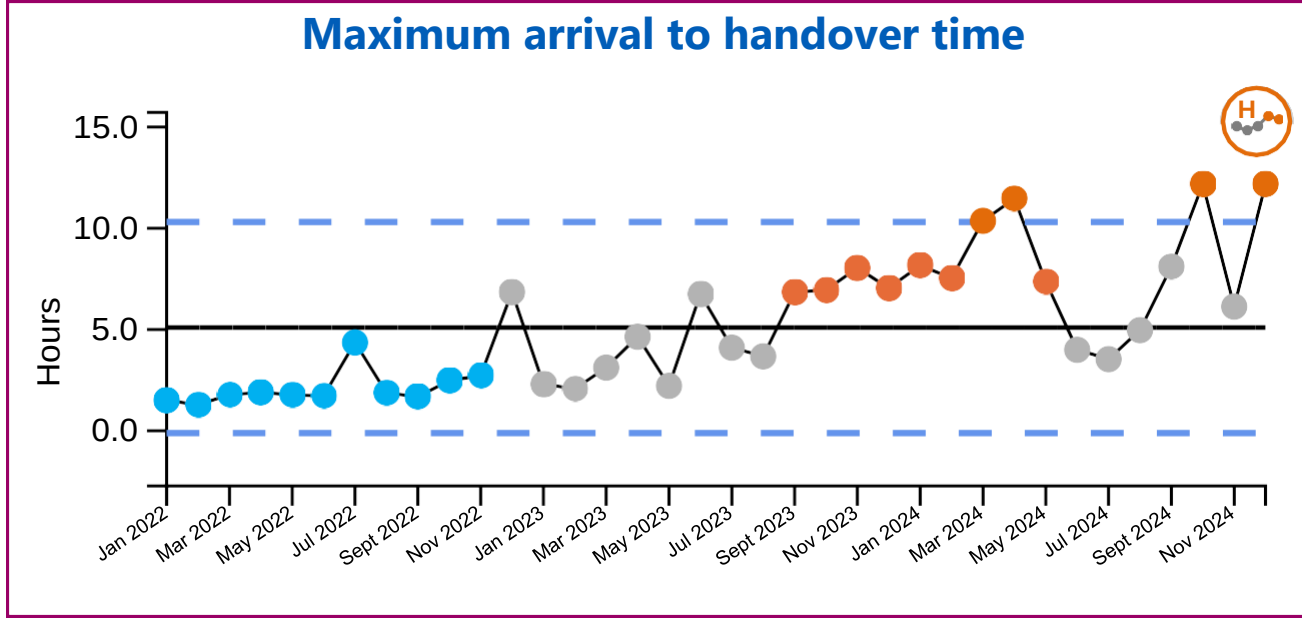
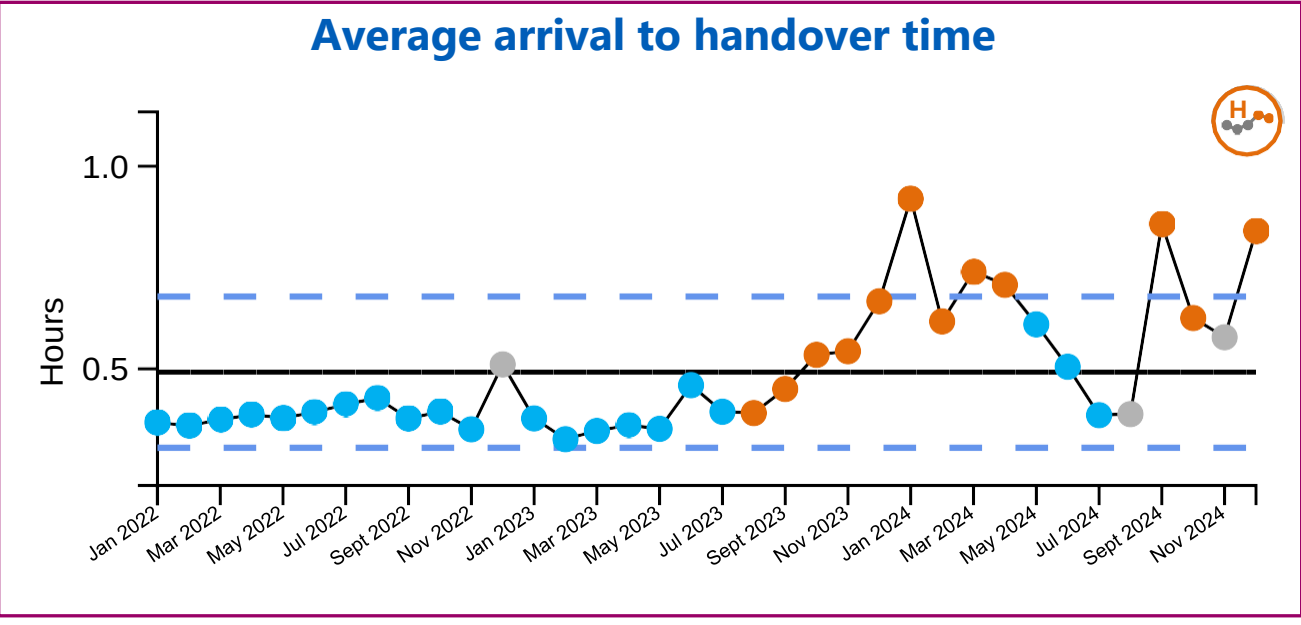
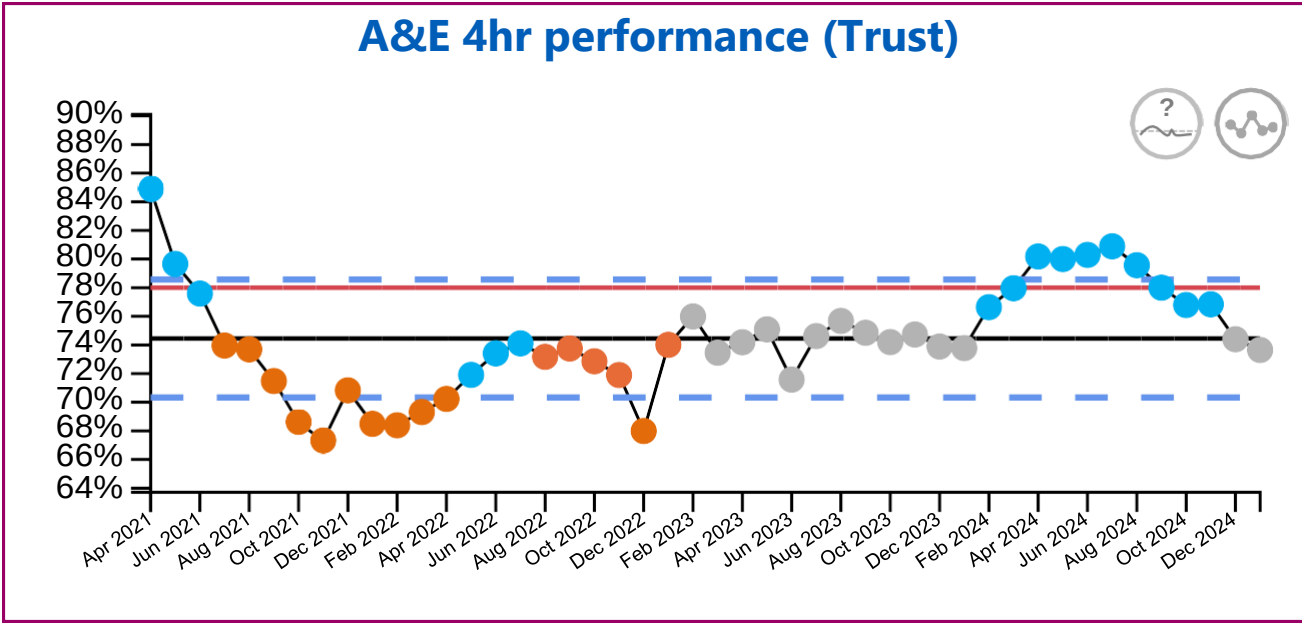
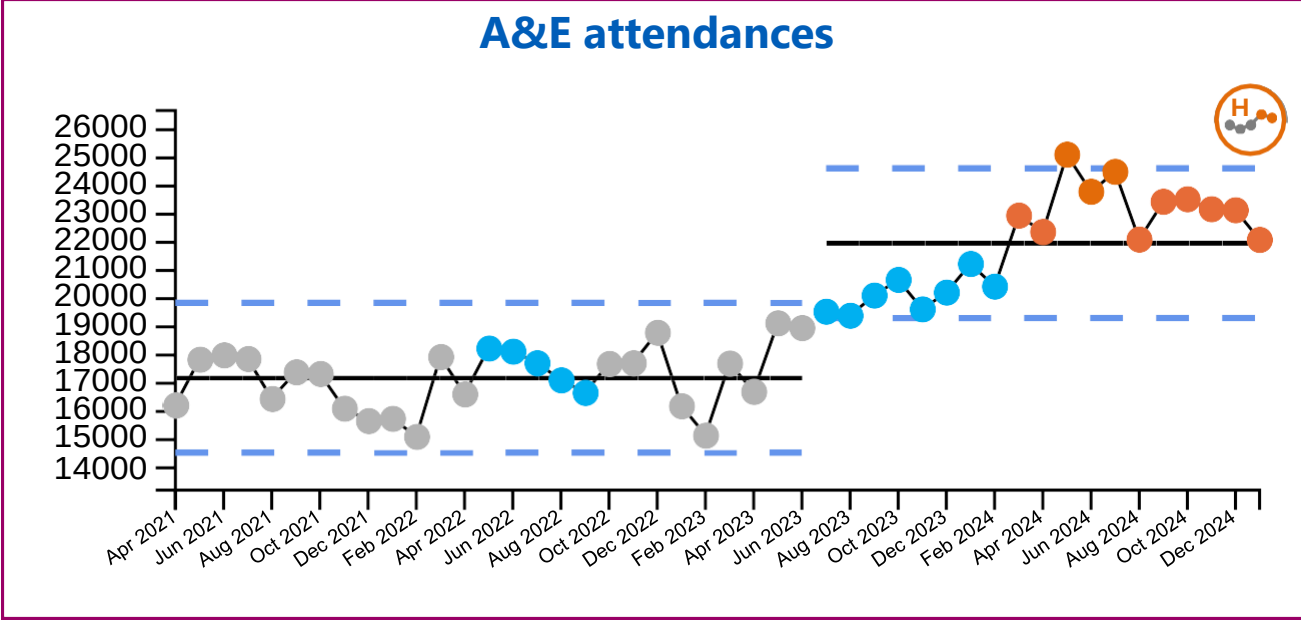
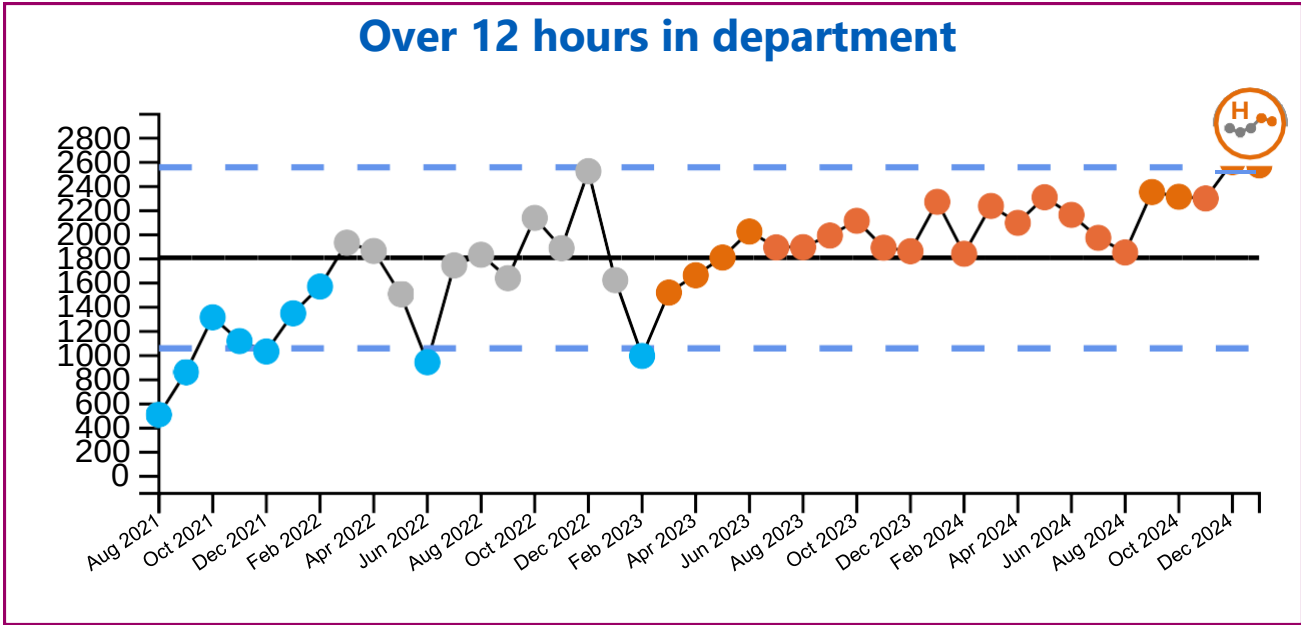
Assurance

Cancer Performance: FDS, 31-day, and 62-day targets all exceeded national ambition.

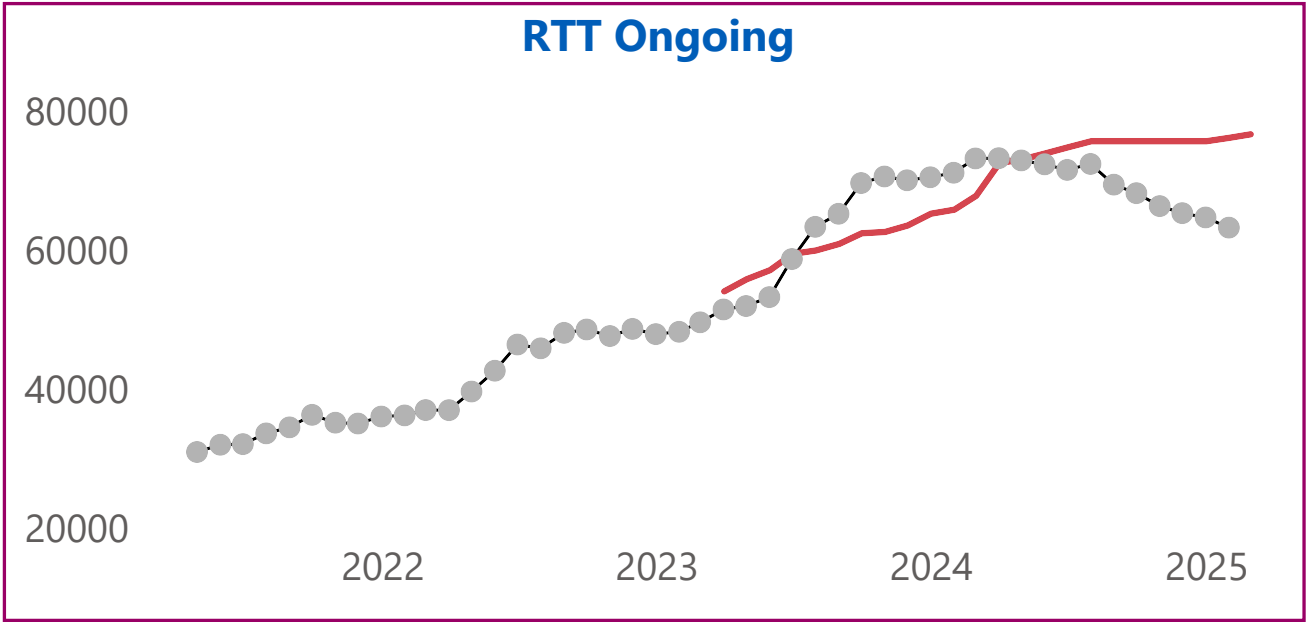
RTT Waits: 9 Ophthalmology breaches at 65 weeks due to limited tissue availability.

Theatre Utilisation: Maintains top quartile national performance.

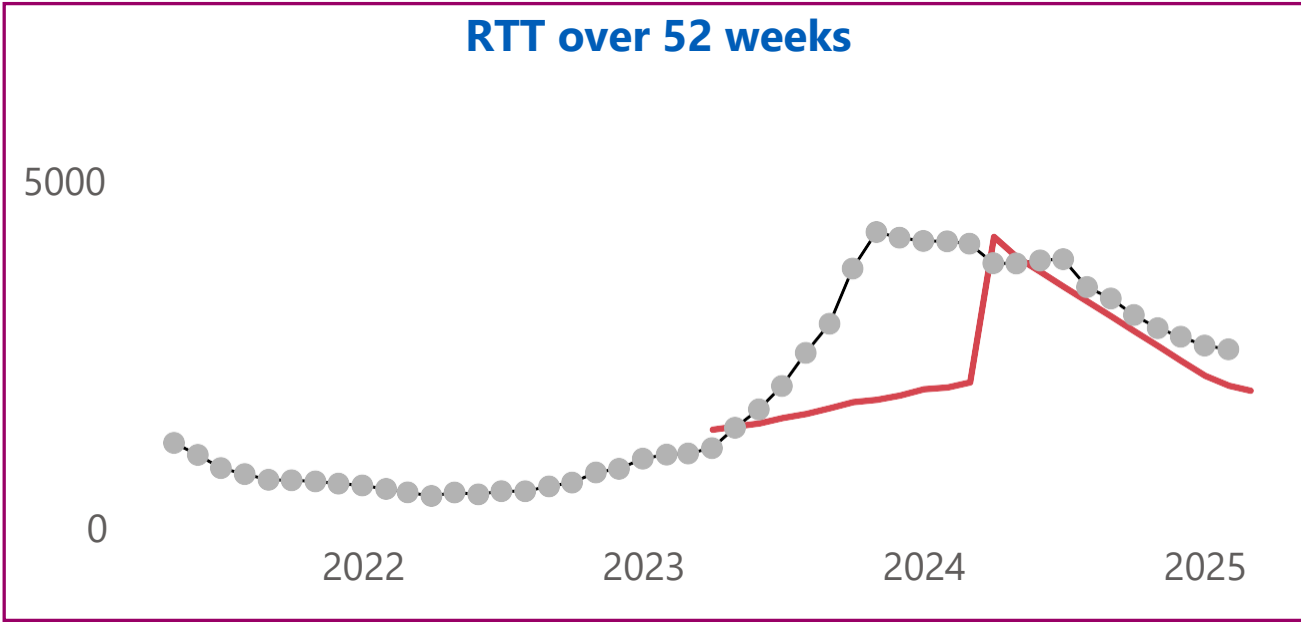
Daily Discharge Dashboard: Fully operational, supporting improvements in safe and timely patient discharge.



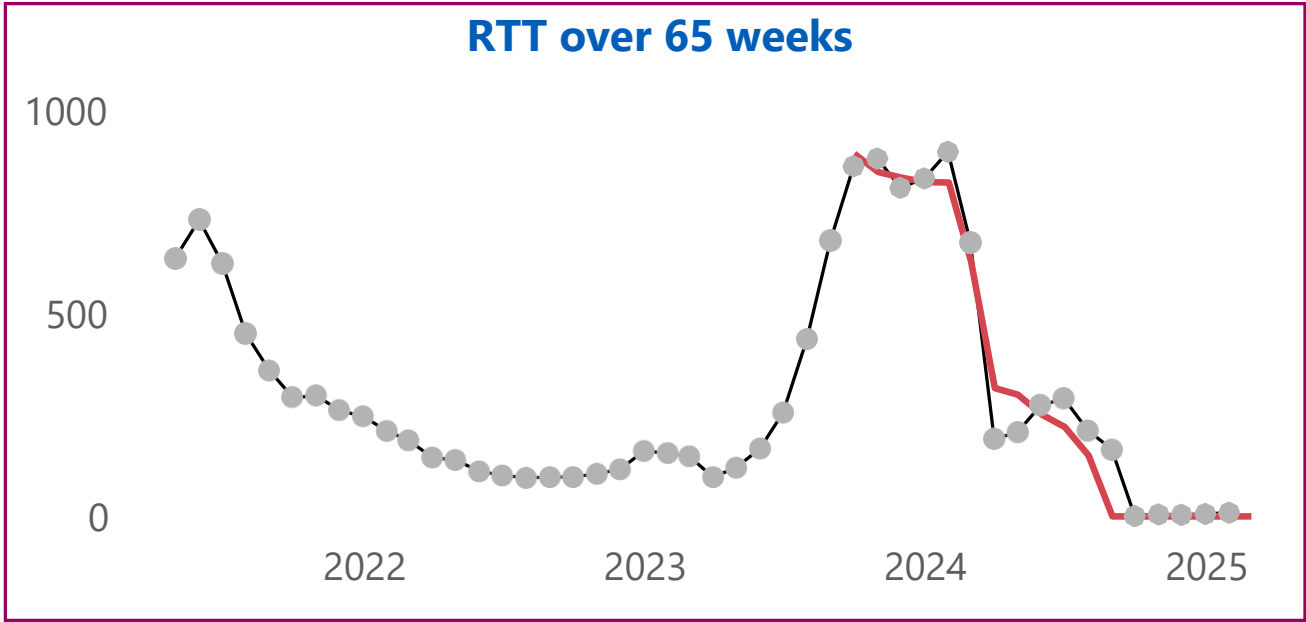
RTT Ongoing



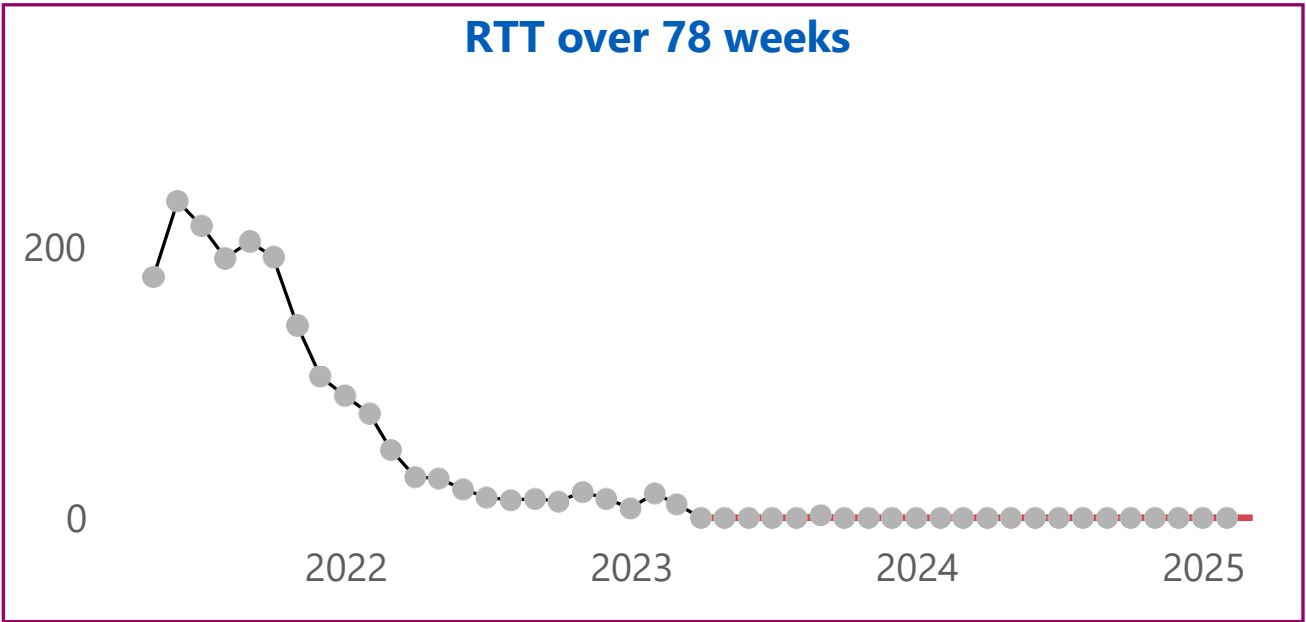
RTT over 52 weeks



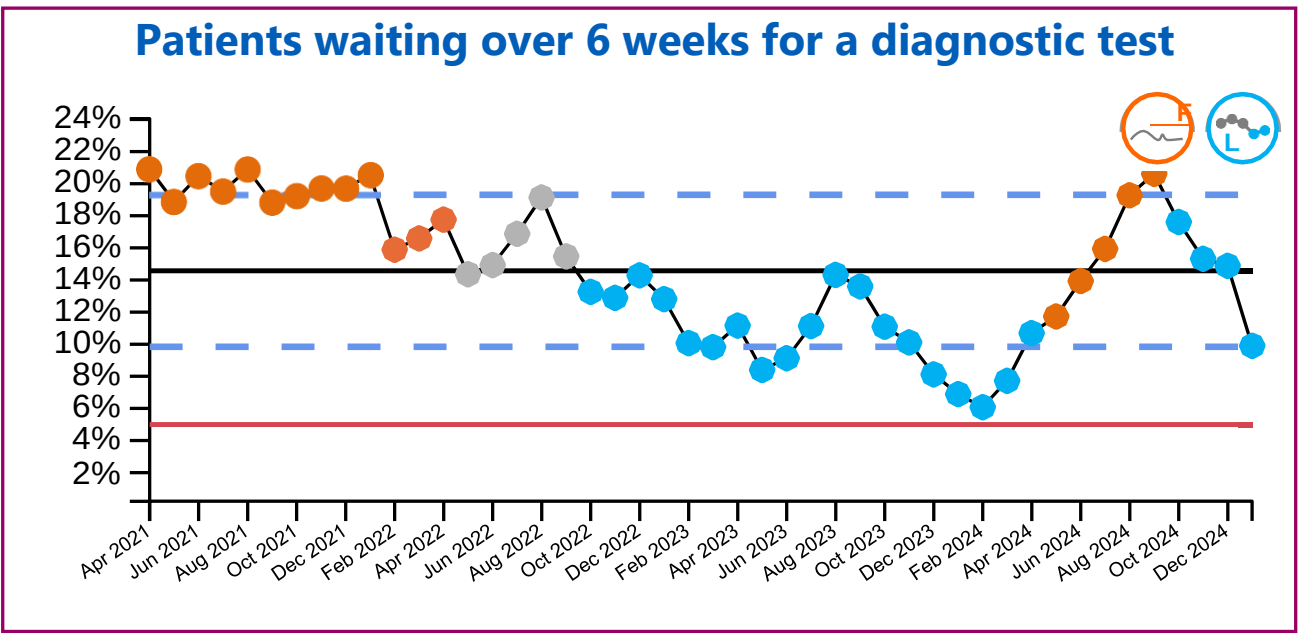
RTT over 65 weeks



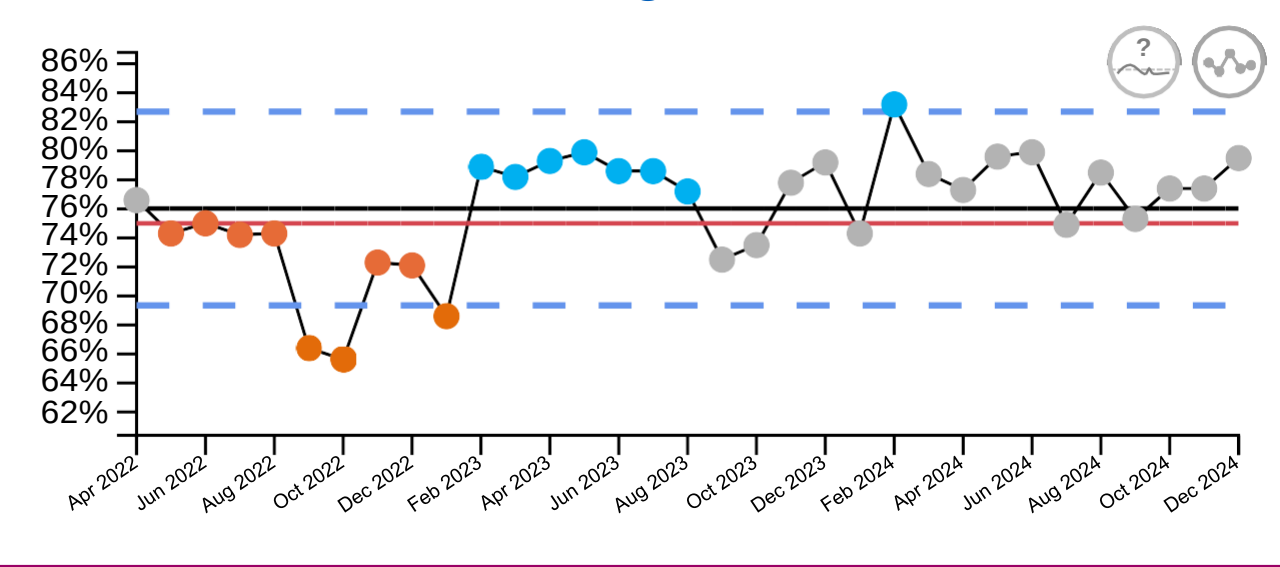
RTT over 78 weeks



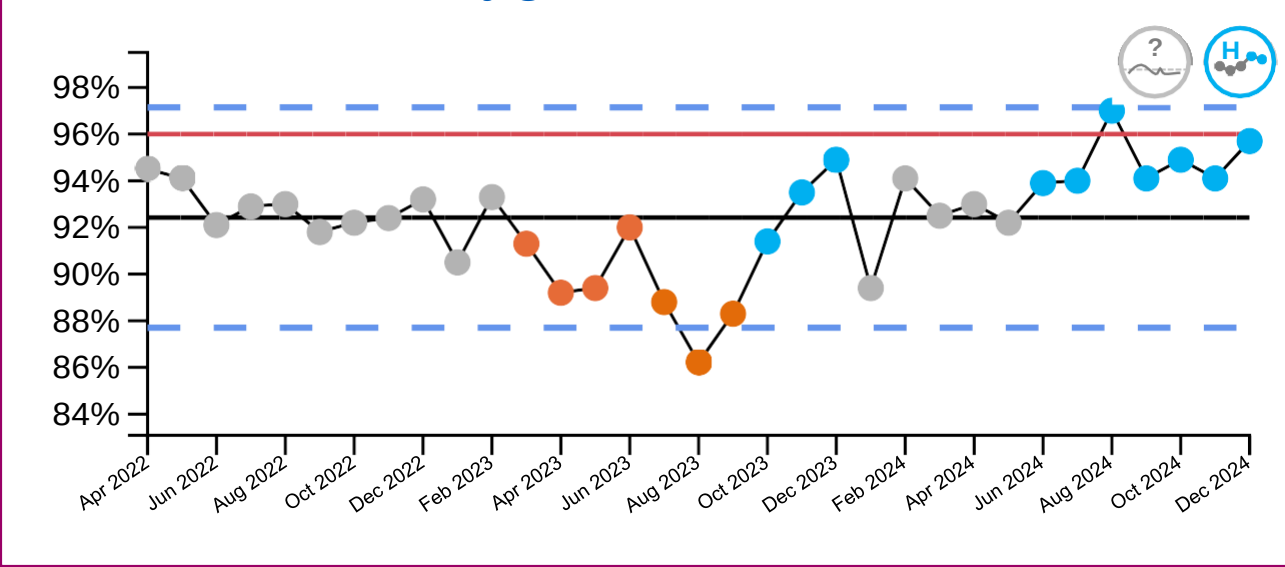
Patients waiting over 6 weeks for a diagnostic test



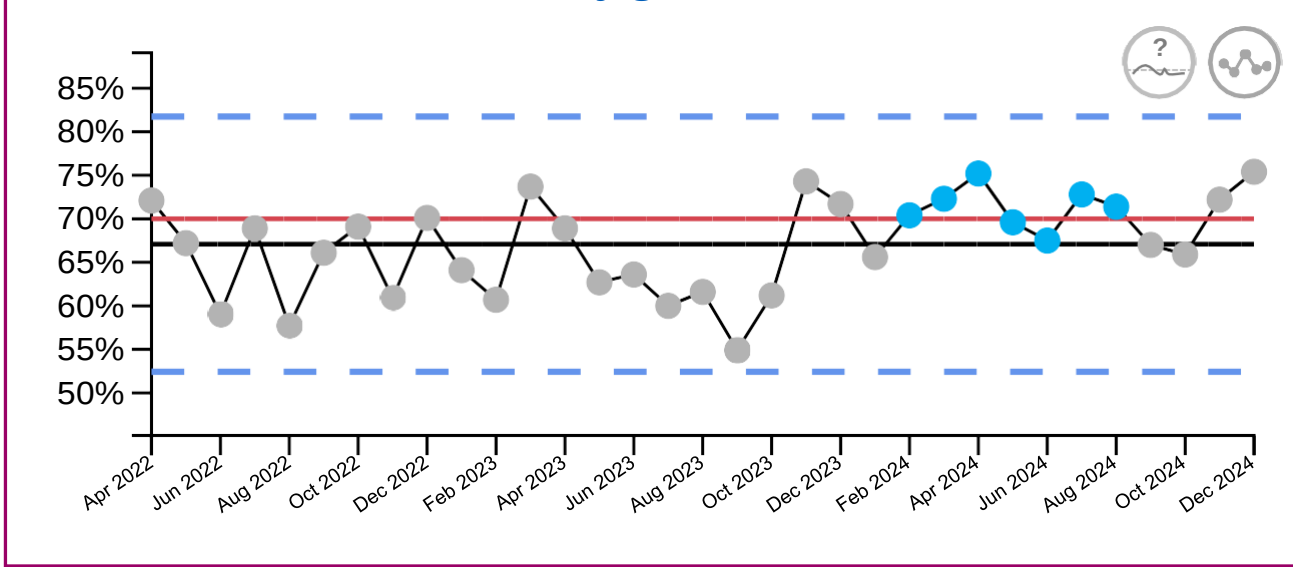
Cancer 28d general FDS



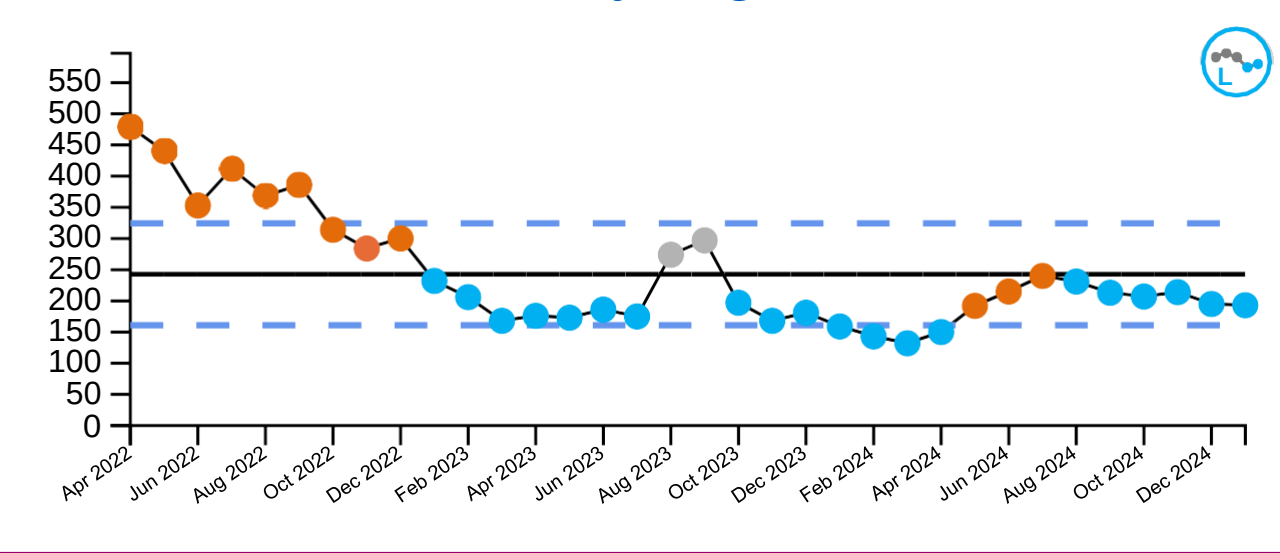
Cancer 31 day general treatment standard



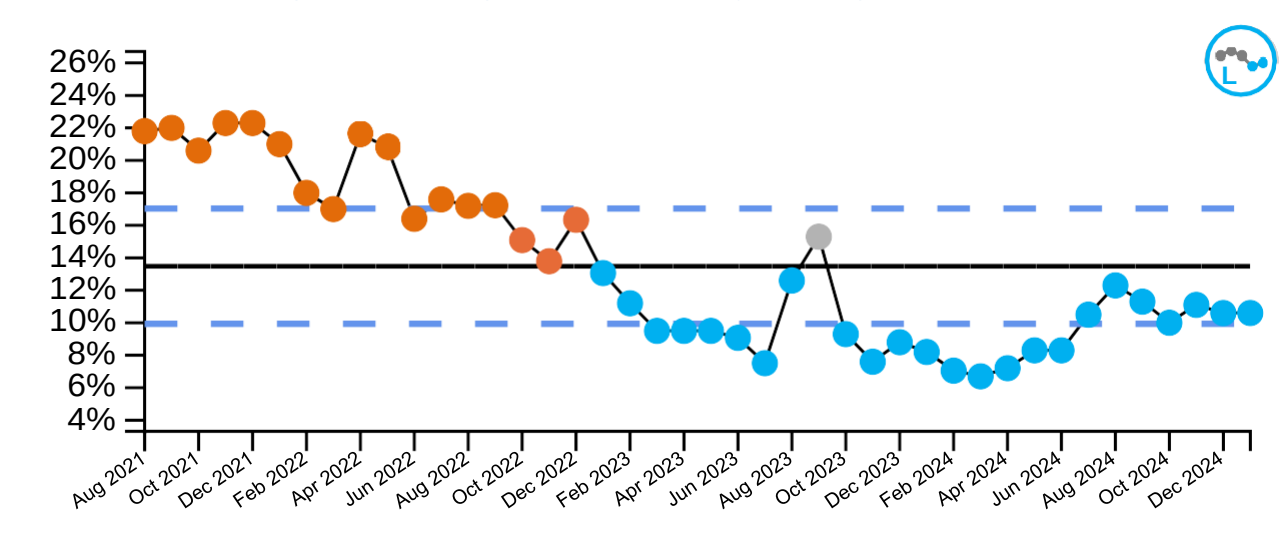
Cancer 62 day general standard



Patients over 62 days (urgent GP referral)

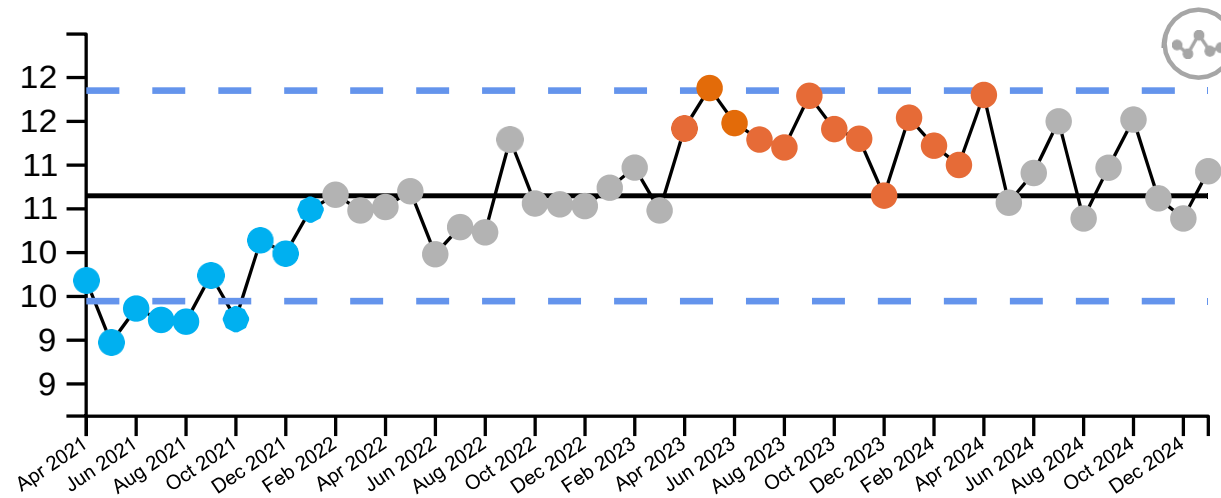


Percentage waiting over 62 days (urgent GP referral)

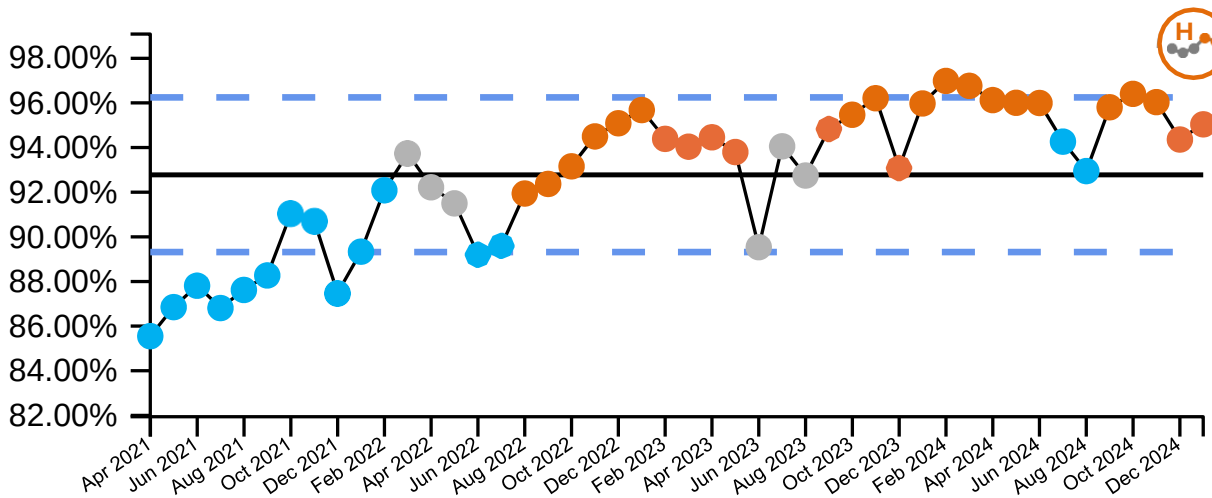


RESPONSIVE - Length of Stay and Bed Occupancy

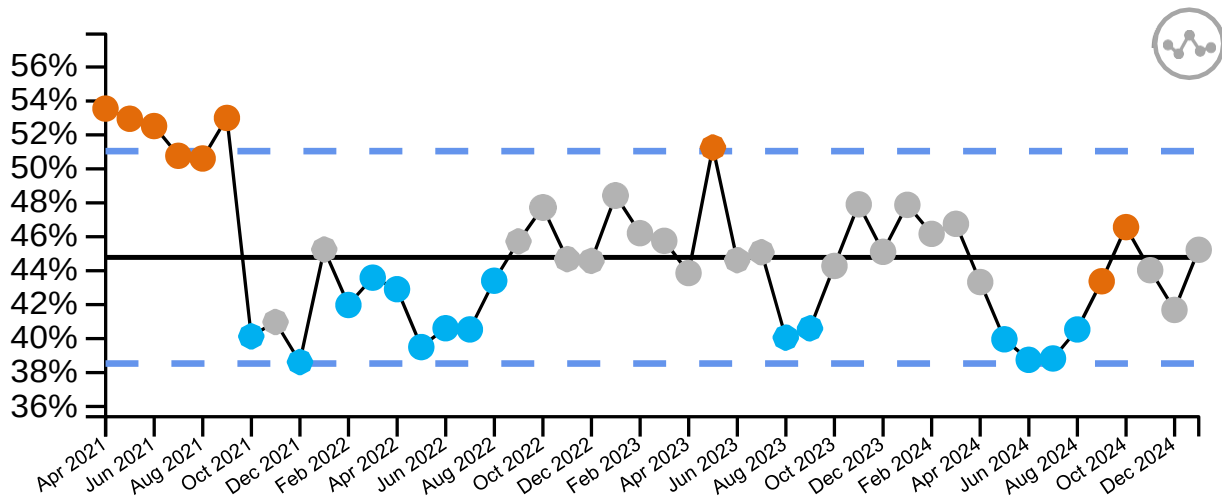
Emergency average length of stay (excluding 0 and 1 days)



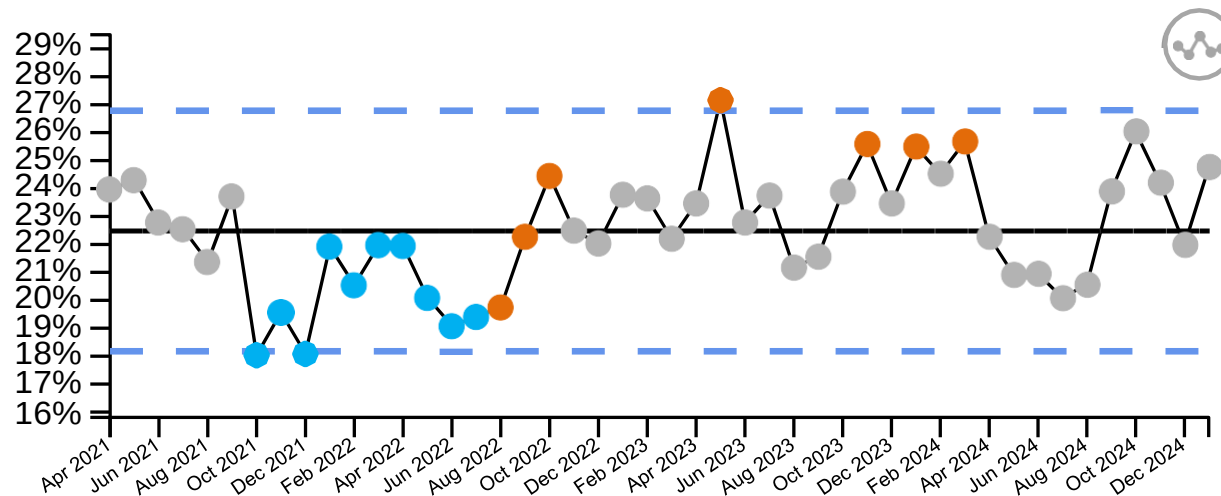
Bed occupancy G&A



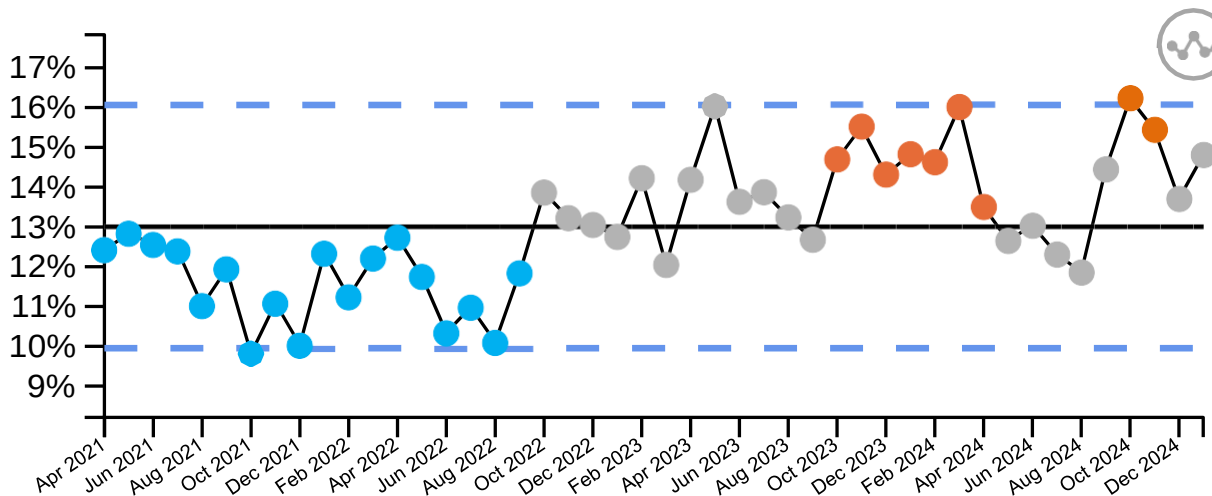
% Beds occupied by Long-Stay Patients 7+ days

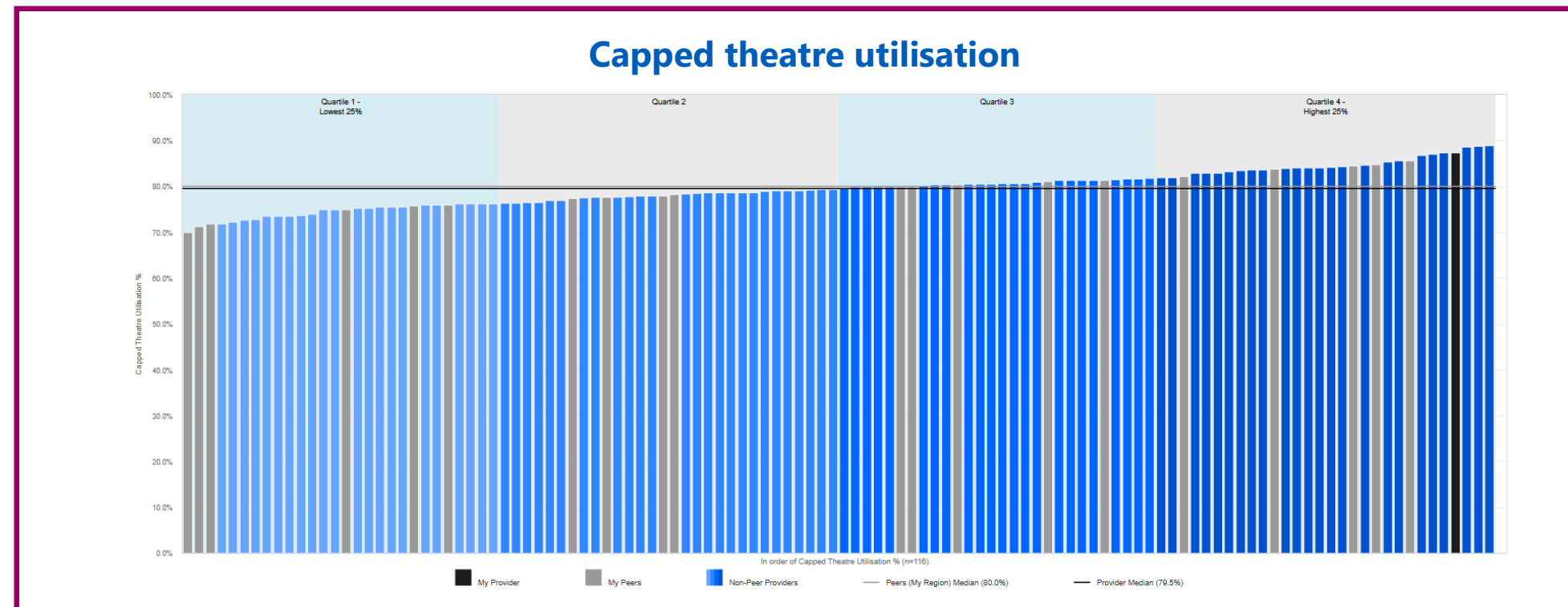
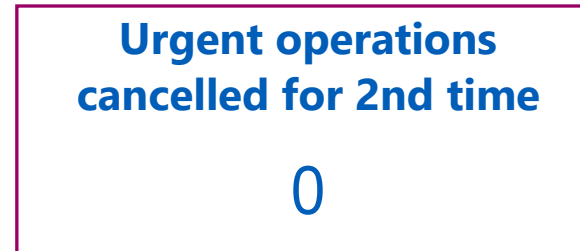


% Beds occupied by Long-stay patients: 14+ days



% Beds occupied by Long-stay patients 21+ days





METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
APPRAISAL (AGENDA FOR CHANGE)	JAN 25	0.83	0.90		
APPRAISAL (CONSULTANT)	JAN 25	0.98	0.90		
APPRIASAL (OTHER MEDICAL)	JAN 25	0.98	0.90		
INFORMATION GOVERNANCE TRAINING	JAN 25	0.94	0.95		
SAFEGUARDING CHILDREN L1	JAN 25	0.95	0.90		
SICKNESS	DEC 24	0.07	0.00		
TURNOVER	JAN 25	0.08	0.12		
VACANCY	JAN 25	0.06	0.05		

Alert

Non-medical appraisals remain below the 90% target, no movement from previous month at 83%. Slight improvements in Corporate Services and Family Care, offset by small declines in Community & Integrated Care, Surgery & Anaesthetics and DERI. Medicine & Emergency Care and Diagnostic & Clinical have not changed.

Information Governance training compliance has dropped to 88%, which is 7% off target. Individuals who are non-compliant are being contacted to complete the required training to push to the 95% target.

Advise

Sickness rate increased in January to 7.36%, up from 6.94% in December and significantly above the 4.5% national target. A review of all long-term sickness cases has been undertaken to confirm appropriate support and actions are in place. Specific posts being recruited to (redeployment opportunities) to support around reasonable adjustments, which has been identified as an area of improvement.

On average 53 concerns per quarter are raised, Q1 & Q2 were on par, however, Q3 saw an increase of 116%. The top concern remains perceived inappropriate attitudes and behaviours.

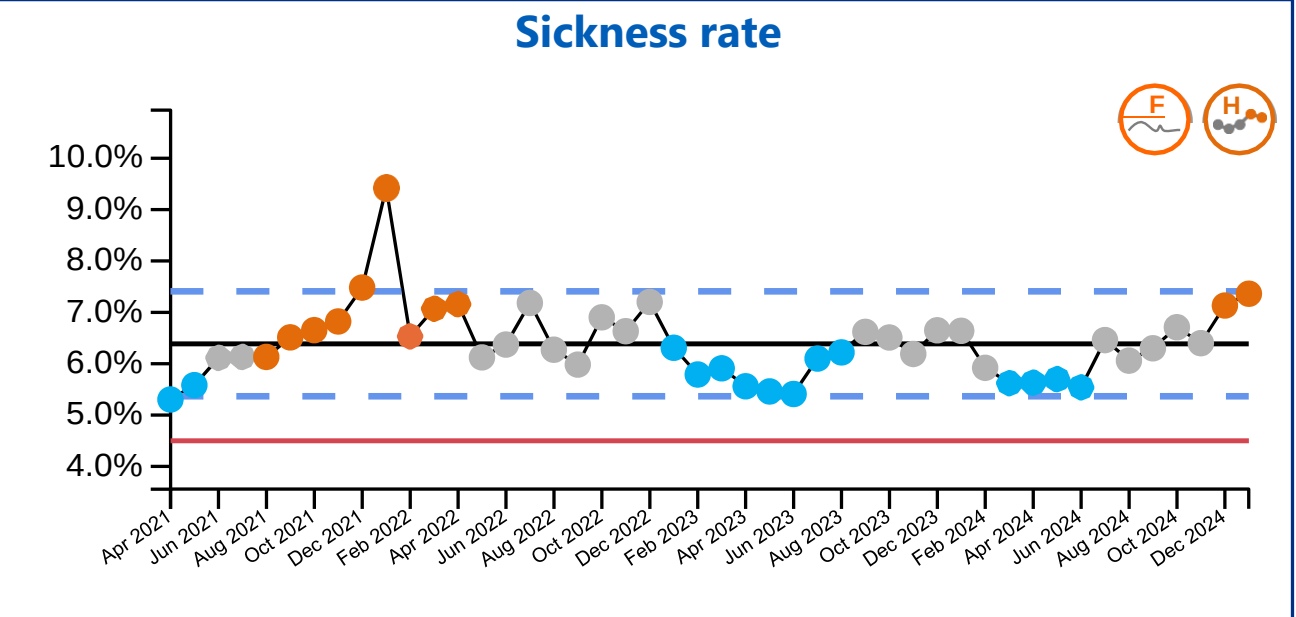
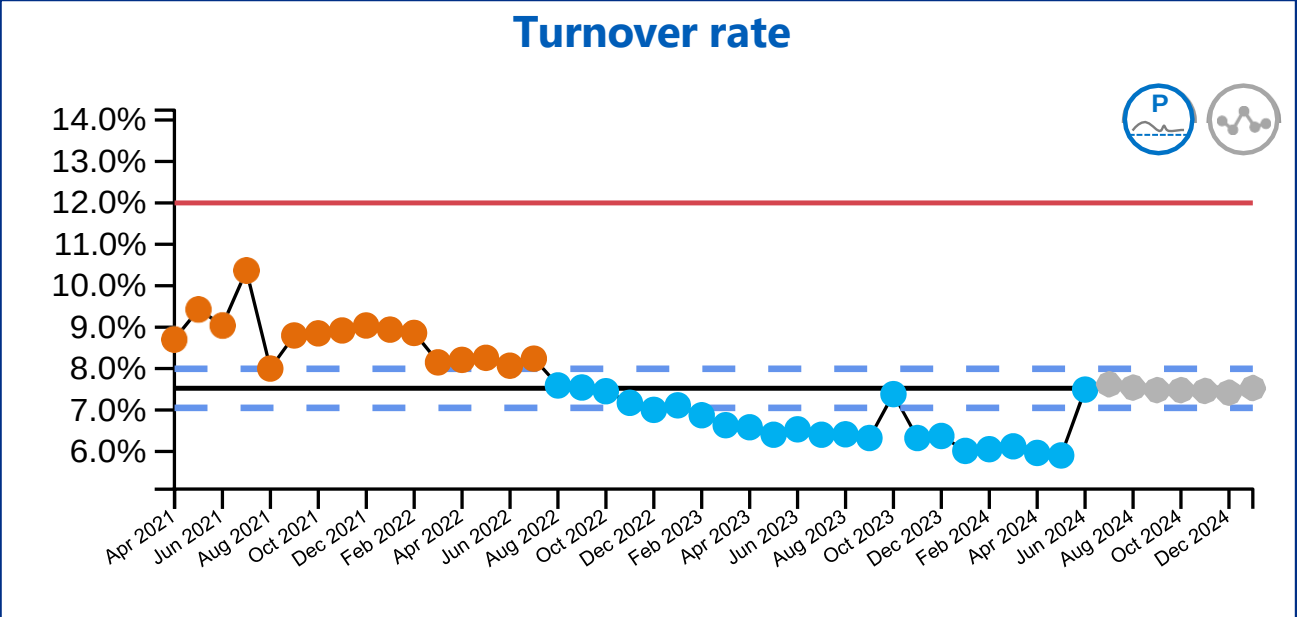
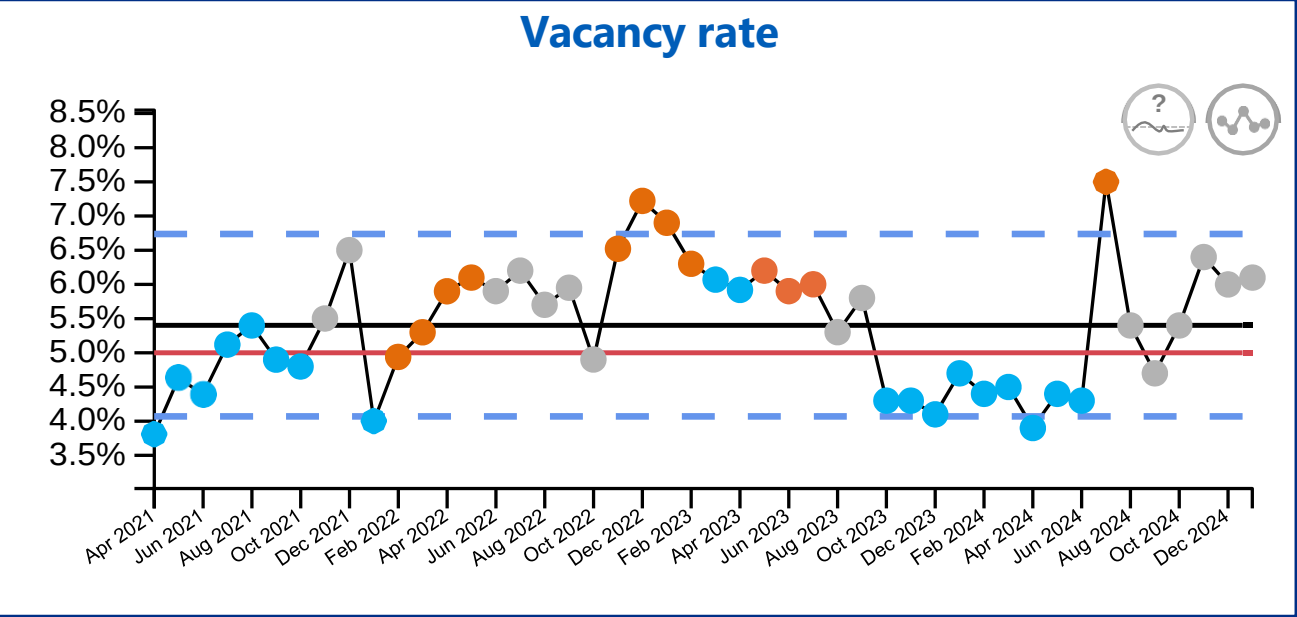
Assurance

Medical appraisals compliance remains high and above target, with a slight improvement with non-Consultant grades.

Safeguarding training remain consistently above target.

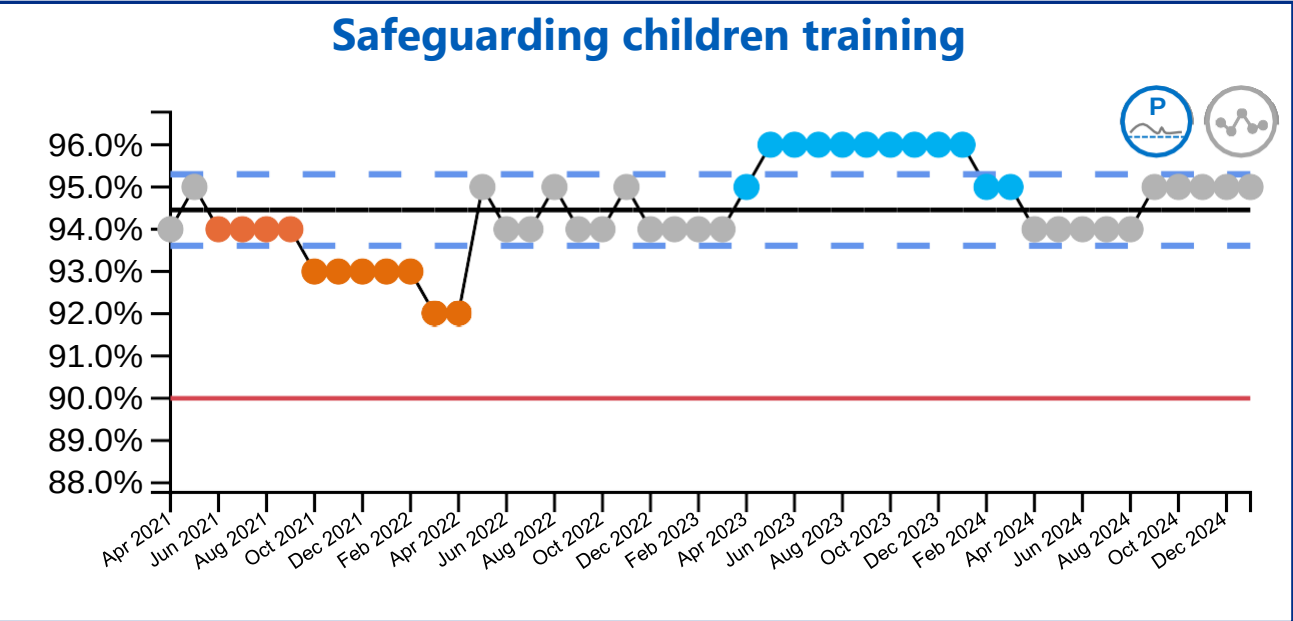
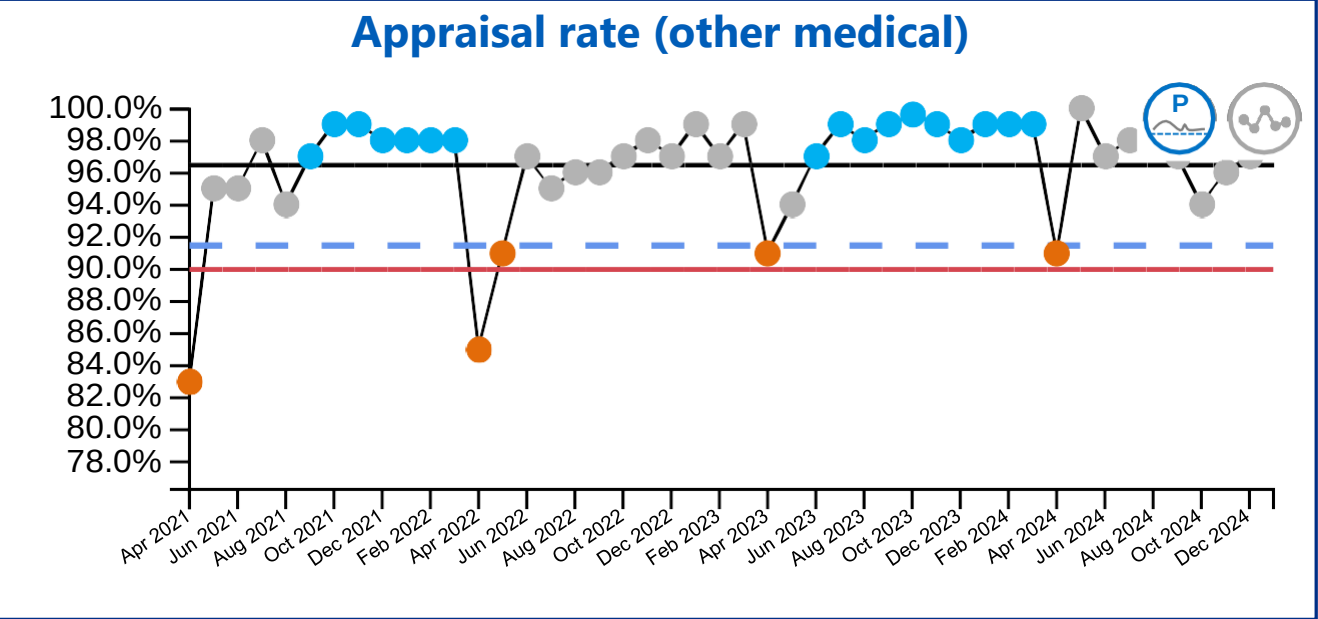
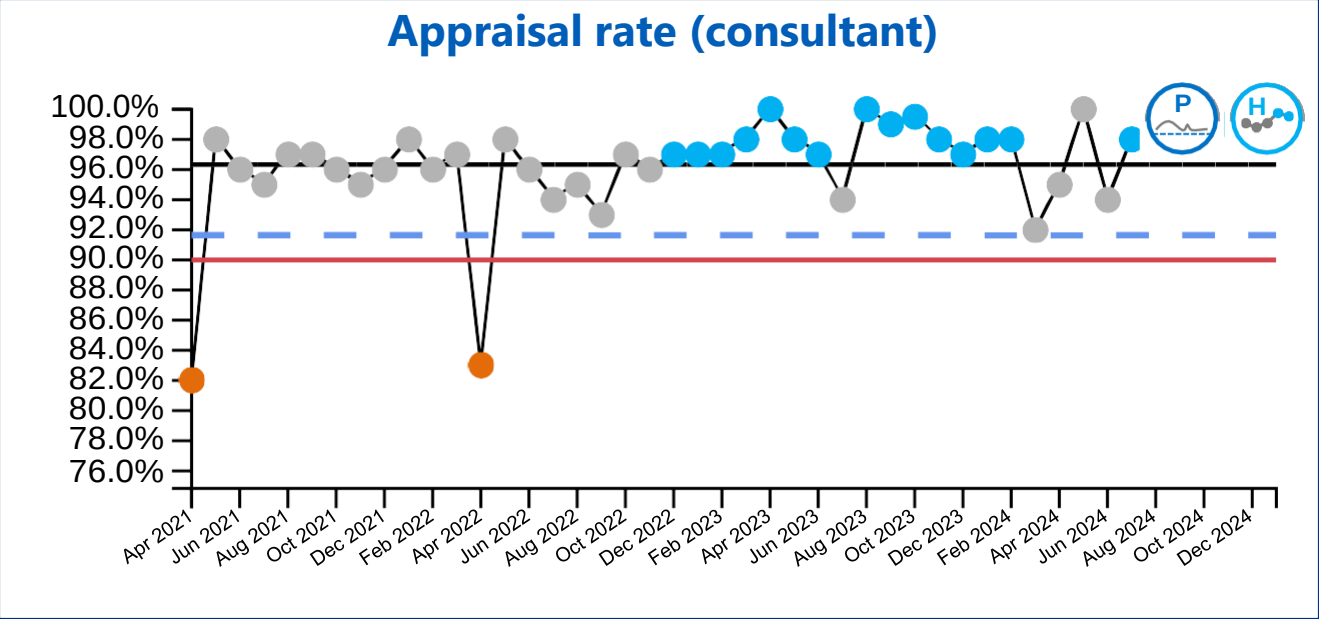
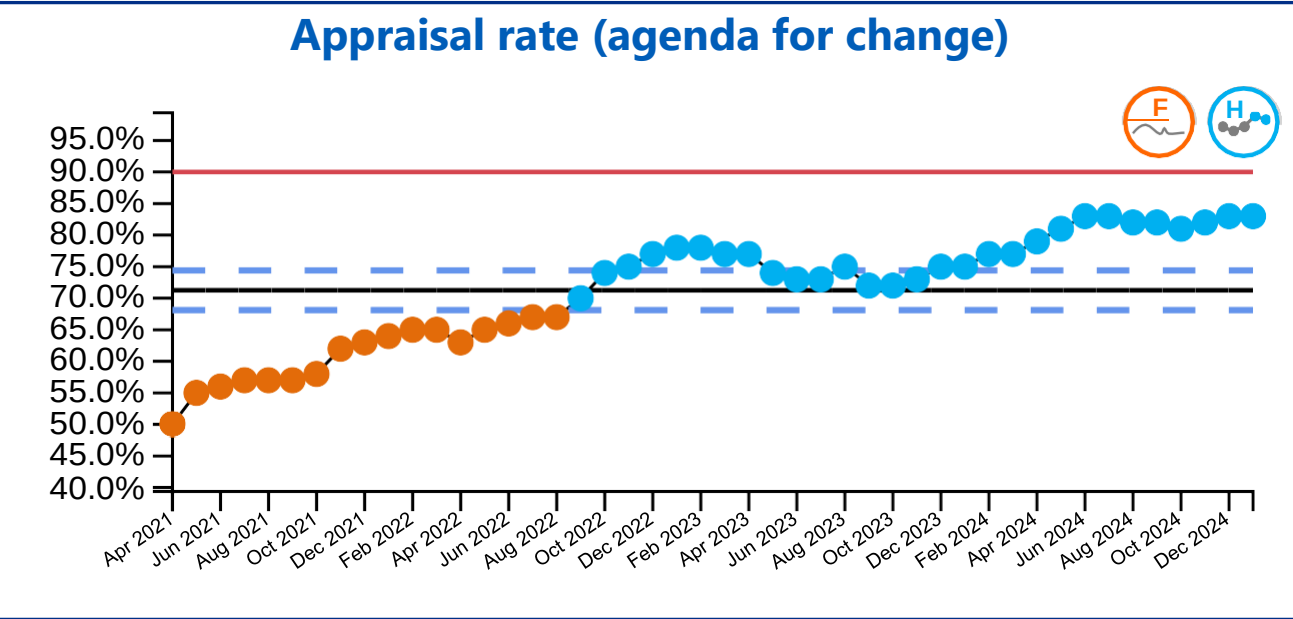
Turnover remains has dropped slightly since last month, well within Trust target.

Vacancies remain relatively low, but are seeing some increase linked to vacancy control measures.



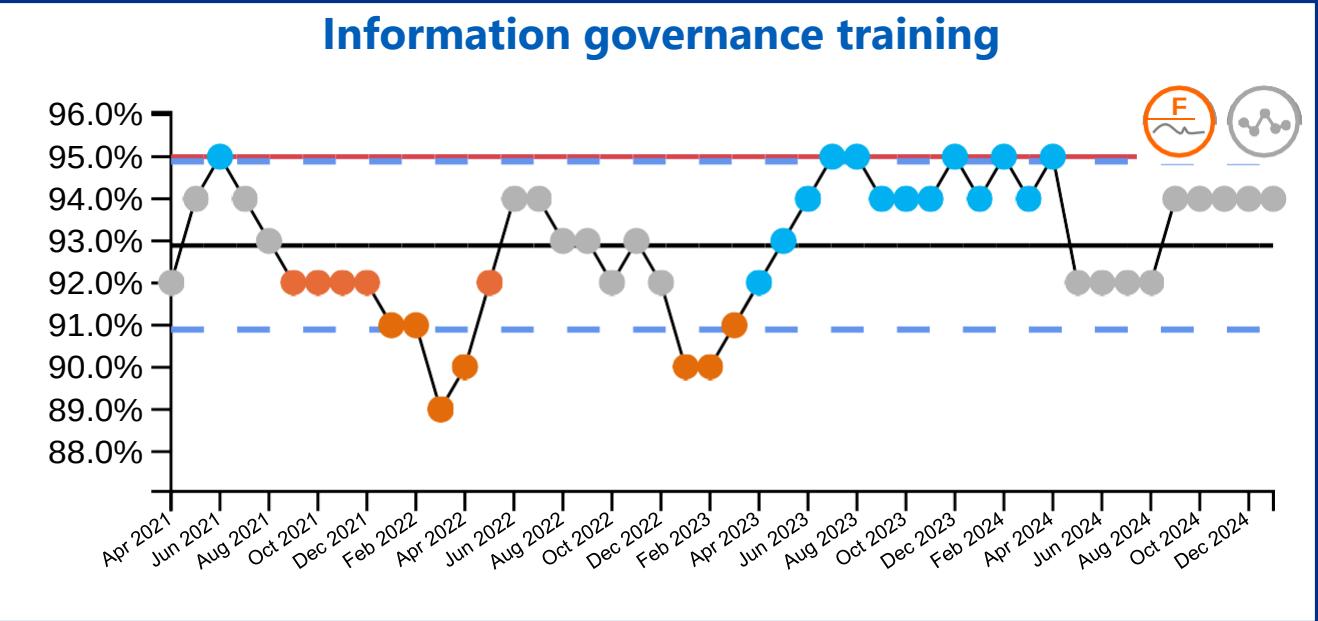
Freedom to Speak Up Cases by Elements					
Reporting Period	Cases	Patient safety	Behaviour & attitudes	Bullying & harassment	Worker safety
Q1 24/25	40	3	21	11	18
Q2 24/25	61	0	35	16	34
Q3 24/25	115	4	29	7	22
Total	216	7	85	34	74

Job Plans		
Stage	Consultants	Non consultants grades
Awaiting Signatures	138	24
Complete	60	17
Due Soon	52	26
In Progress	78	24
No Current Job Plan	13	8
Not Started	33	16
Referred Back	7	0
Uploaded	0	0
Total	381	115



Module	Target	Compliance
Basic Life Support	90.00	0.89
Conflict Resolution L1	90.00	0.97
Equality, Diversity and Human Rights	90.00	0.96
Health, Safety and Welfare	90.00	0.97
Infection Prevention L1	90.00	0.98
Infection Prevention L2	90.00	0.91
Prevent	90.00	0.96
Safeguarding Adults L1	90.00	0.96
Safeguarding Adults L2	90.00	0.97
Safeguarding Adults L3	90.00	0.86
Safeguarding Children L1	90.00	0.95
Safeguarding Children L2	90.00	0.96
Safeguarding Children L3	90.00	0.92
Safeguarding Children L4	90.00	1.00

Module	Target	Compliance
Fire Safety	95.00	0.96
Freedom to Speak Up	95.00	0.93
Information governance training	95.00	0.94
Safer Handling L1	95.00	0.96
Safer Handling L2 (Patient Handling)	95.00	0.90



METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
BETTER PAYMENT PRACTICE CODE (BPPC) NHS NO OF INVOICES	JAN 25	0.74	0.95		
BETTER PAYMENT PRACTICE CODE (BPPC) NHS VALUE OF INVOICES	JAN 25	0.95	0.95		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS NO OF INVOICES	JAN 25	0.72	0.95		
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS VALUE OF INVOICES	JAN 25	0.90	0.95		
LIQUIDITY DAYS	JAN 25	-28.80	-14.30		
VARIANCE TO PLANNED FINANCIAL PERFORMANCE (DEFICIT) (£M)	JAN 25	-8.80	0.00		
WRP ACHIEVED - VARIANCE TO PLAN (£M)	JAN 25	-8.90	0.00		
VARIANCE TO CAPITAL PROGRAMME (£M)	JAN 25	0.40	0.00		

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION
EMPLOYEE EXPENSES RUN RATE (£M)	JAN 25	47.10	0.00	
INCOME RUN RATE (£M)	JAN 25	62.70	0.00	
OTHER OPERATING EXPENSES RUN RATE (£M)	JAN 25	19.20	0.00	

Alert

The Trust is reporting a deficit of £47.3m, against a planned deficit of £5.6m for the 2024-25 financial year to date, £41.7m behind the revised breakeven plan, an adverse movement of £5.8m in month.

Performance against the Better Payment Practice Code (BPPC) continues to be adversely affected by the Trust’s financial position with only the measure relating to the value of NHS invoices paid on time not showing as a cause for concern.

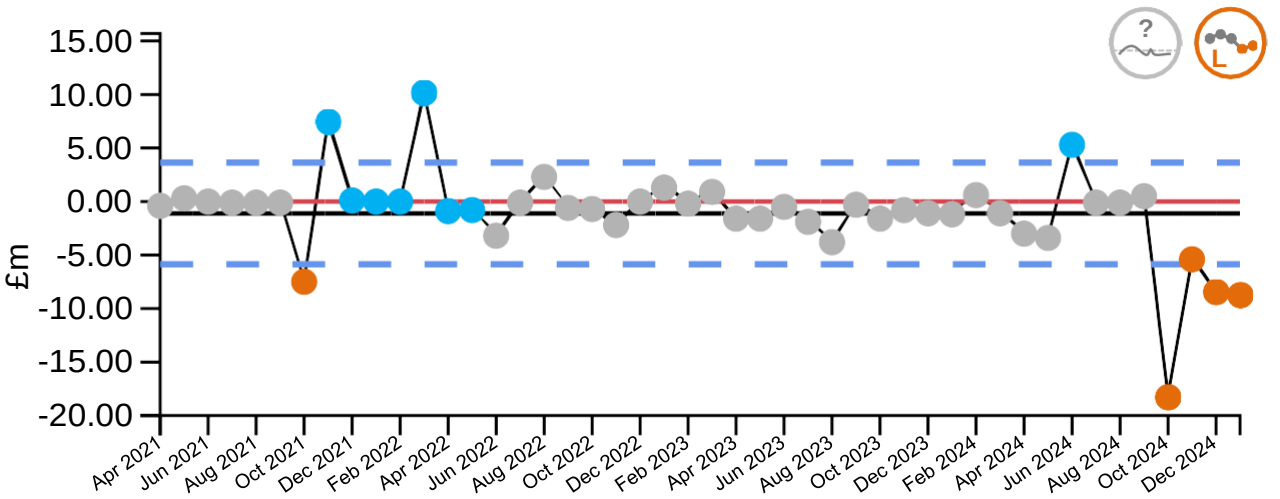
Advise

While year to date capital expenditure is significantly ahead of plan, the Trust is not forecasting to overspend against its 2024-25 capital programme. The main reason for the year to date variance continues to be due to the Trust recognising right of use assets for six Community Health Partnerships properties used by the Trust where the existing lease expired in December 2024 but related capital expenditure had been planned for March 2025.

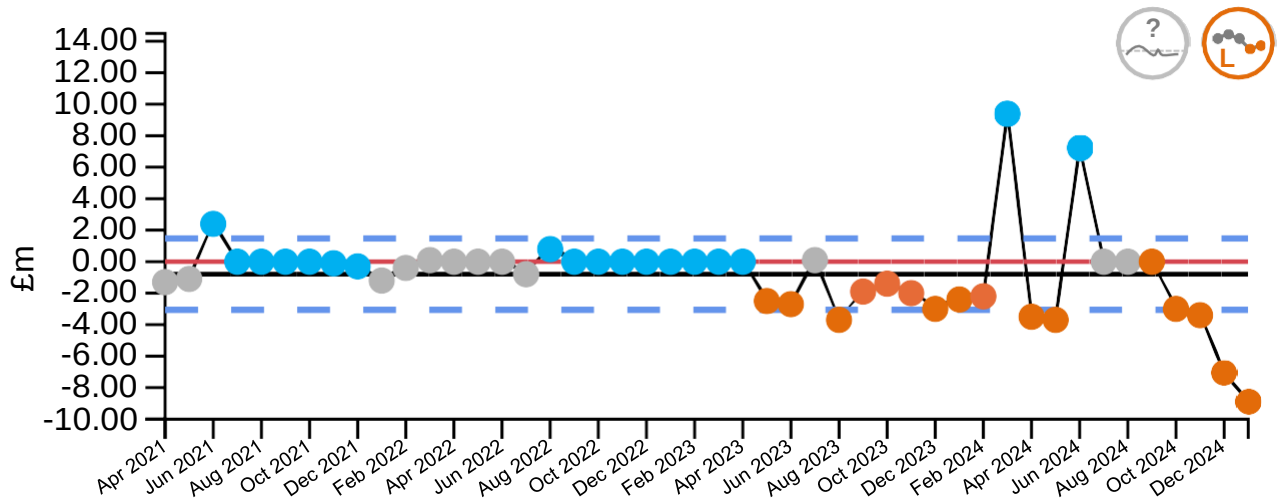
Assurance

Agency spend as a proportion of the total pay bill remains below the mean, with the target for 2024-25 of 2.9% being consistently achieved.

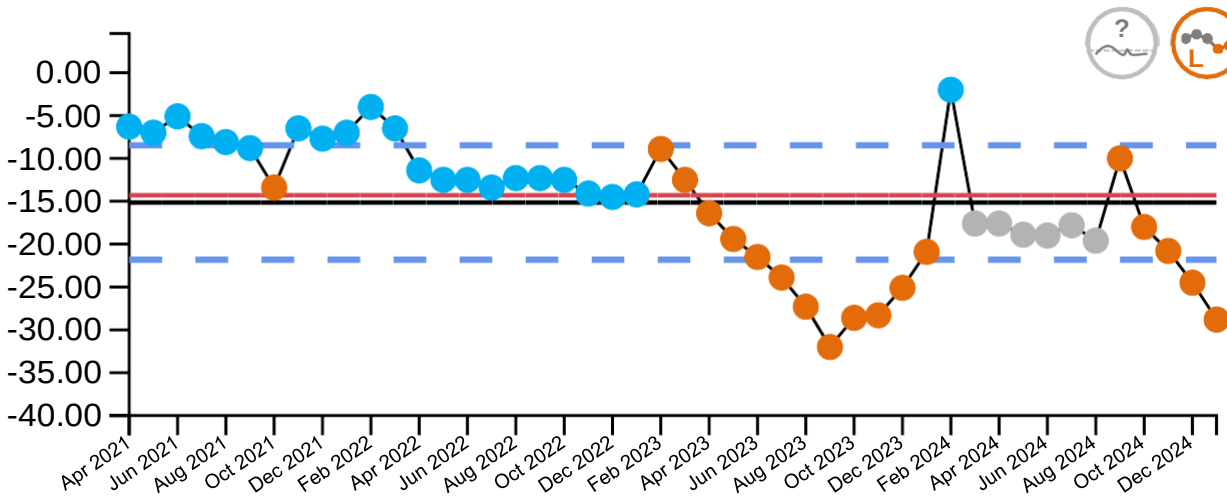
F1 - Variance to planned financial performance (deficit) (£m)



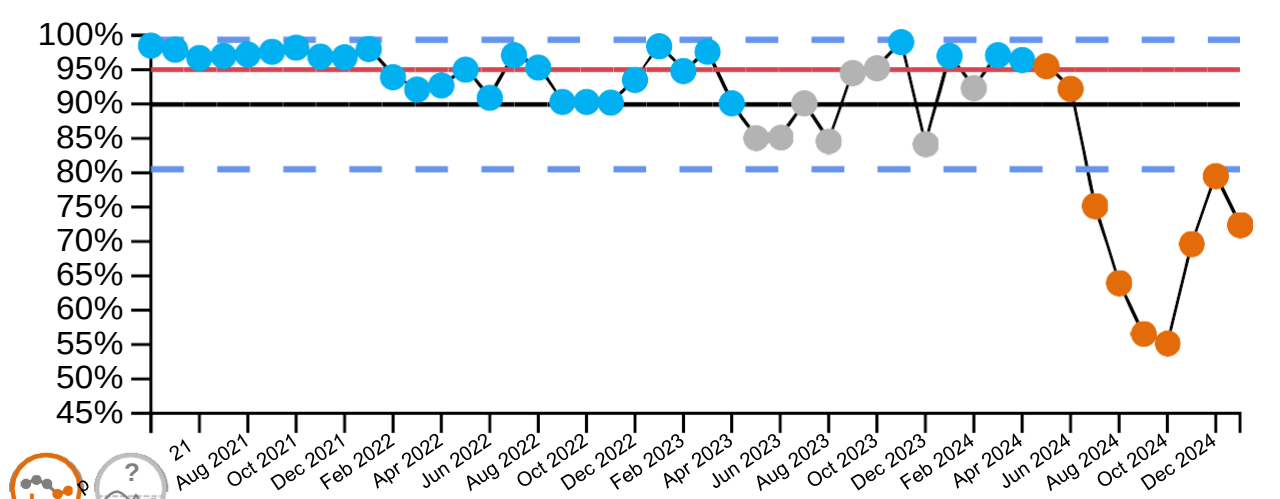
F2 - WRP achieved - variance to plan (£m)



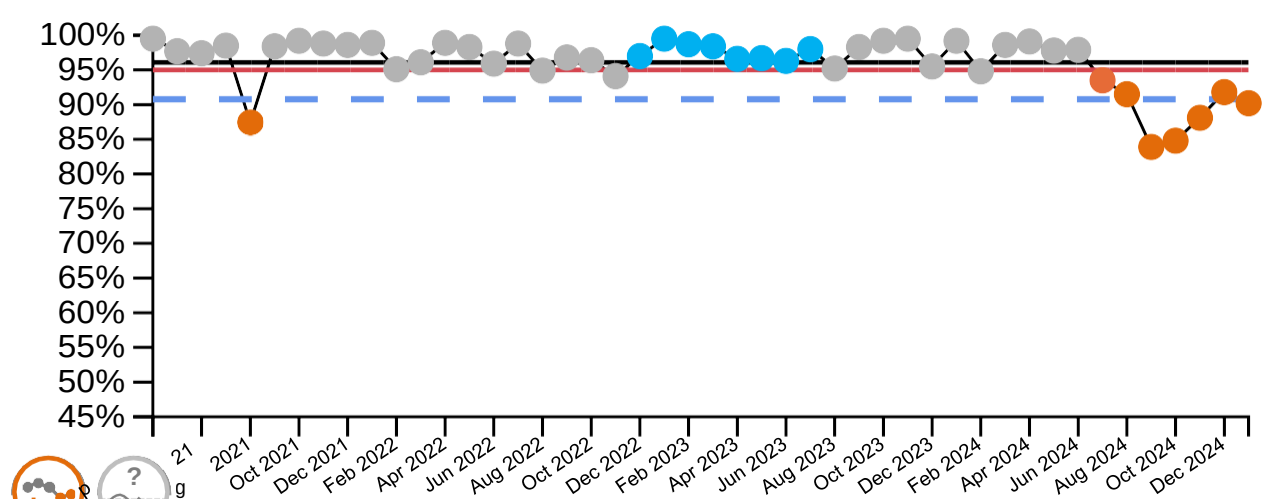
F3 - Liquidity days



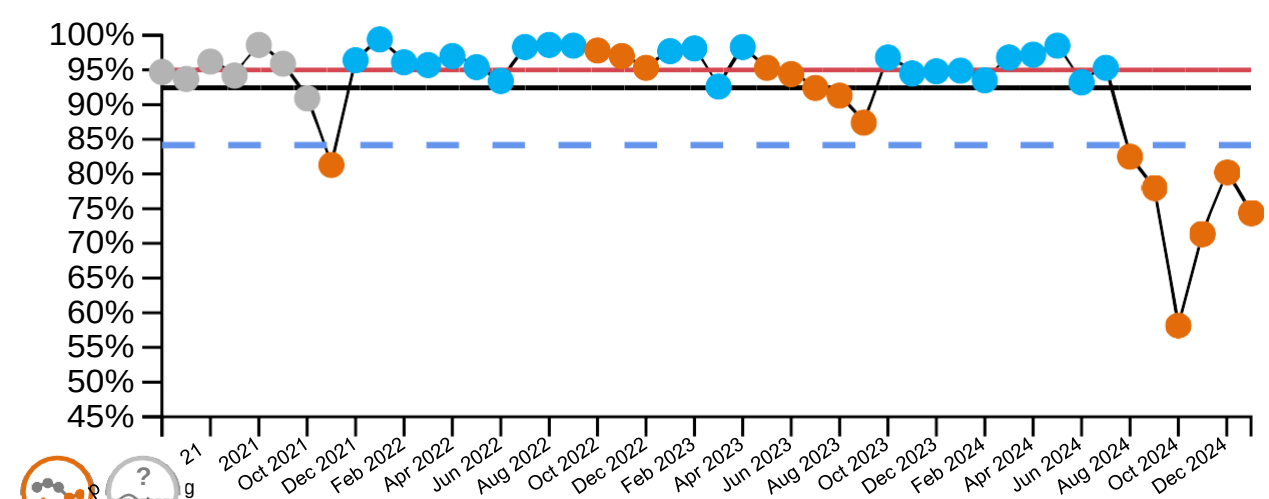
F12 - BPPC Non NHS no of invoices



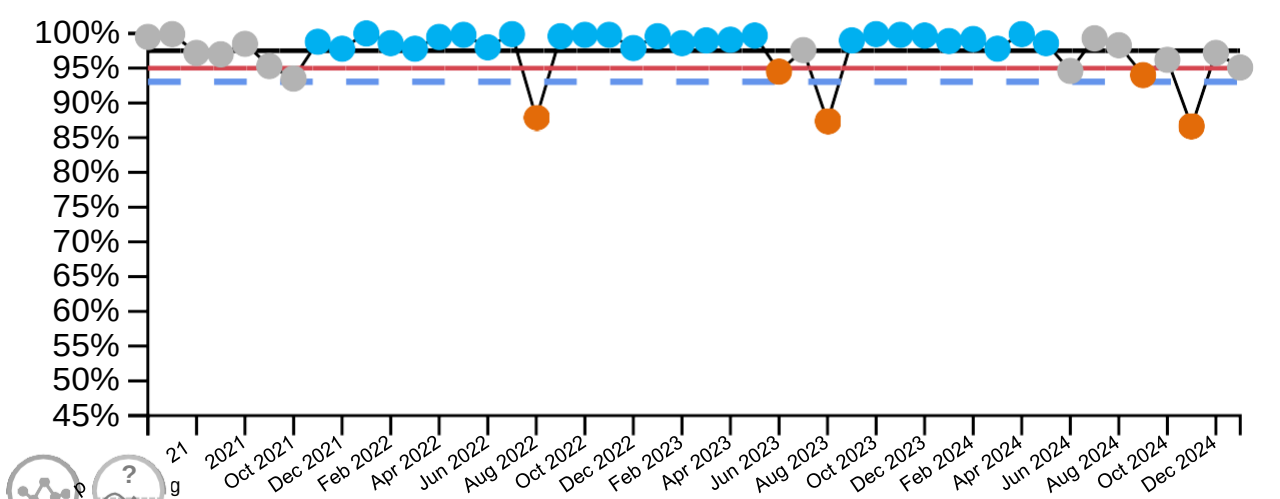
F13 - BPPC Non NHS value of invoices



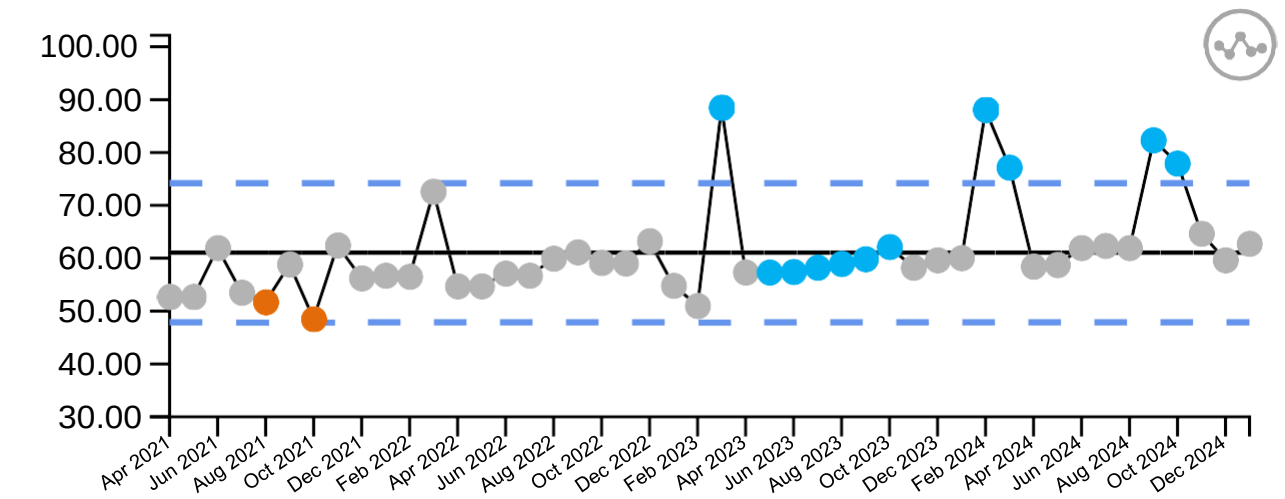
F14 - BPPC NHS no of invoices



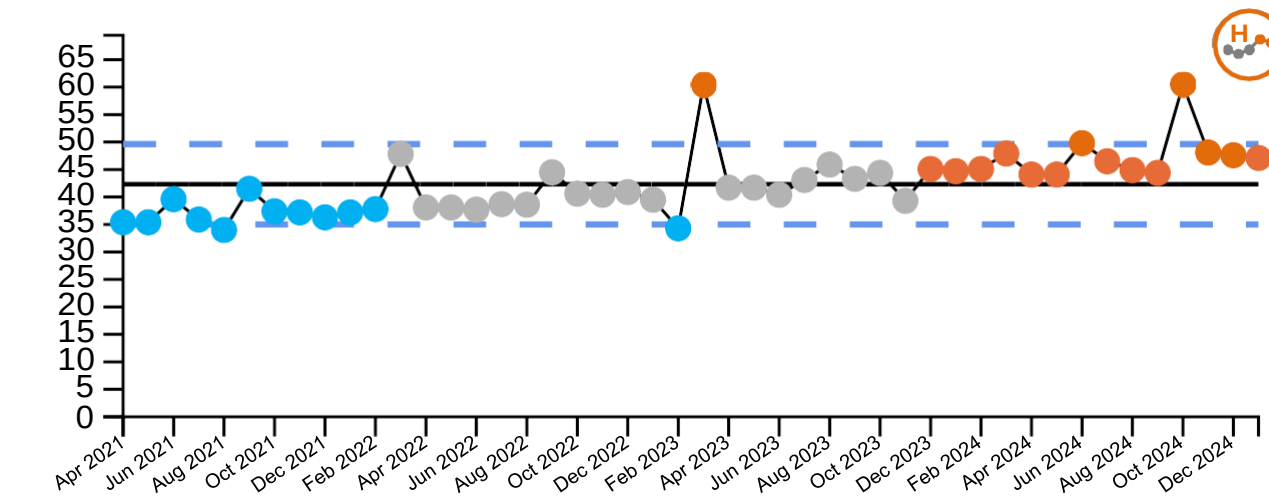
F15 - BPPC NHS value of invoices

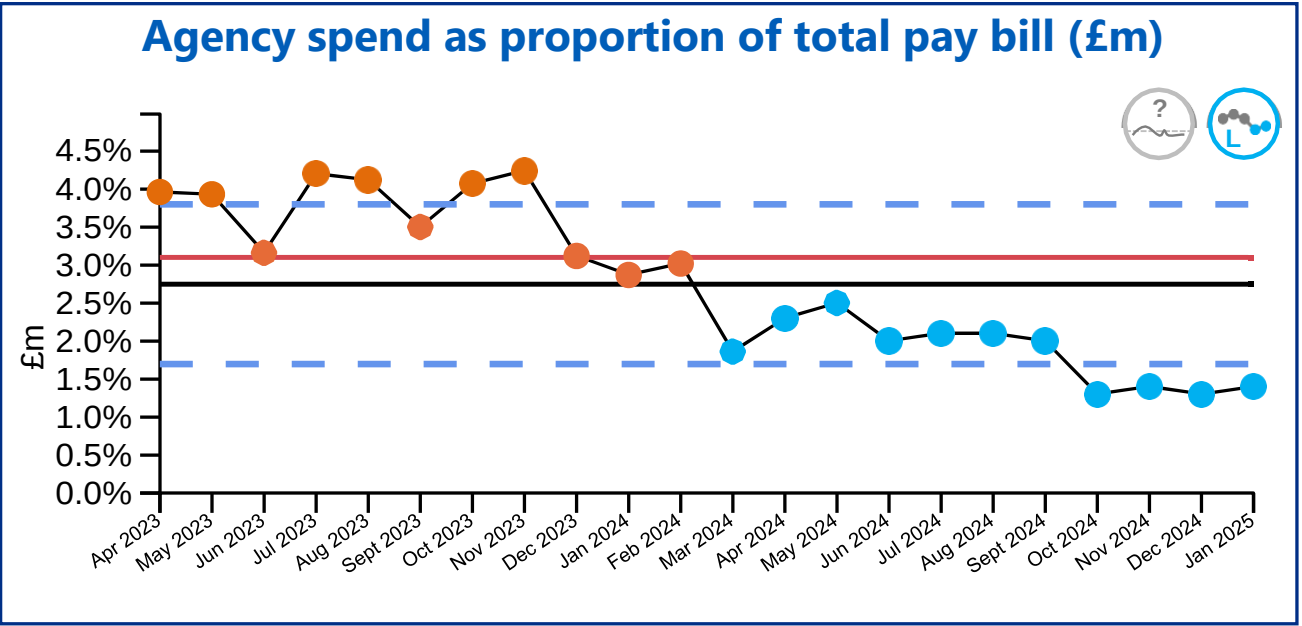
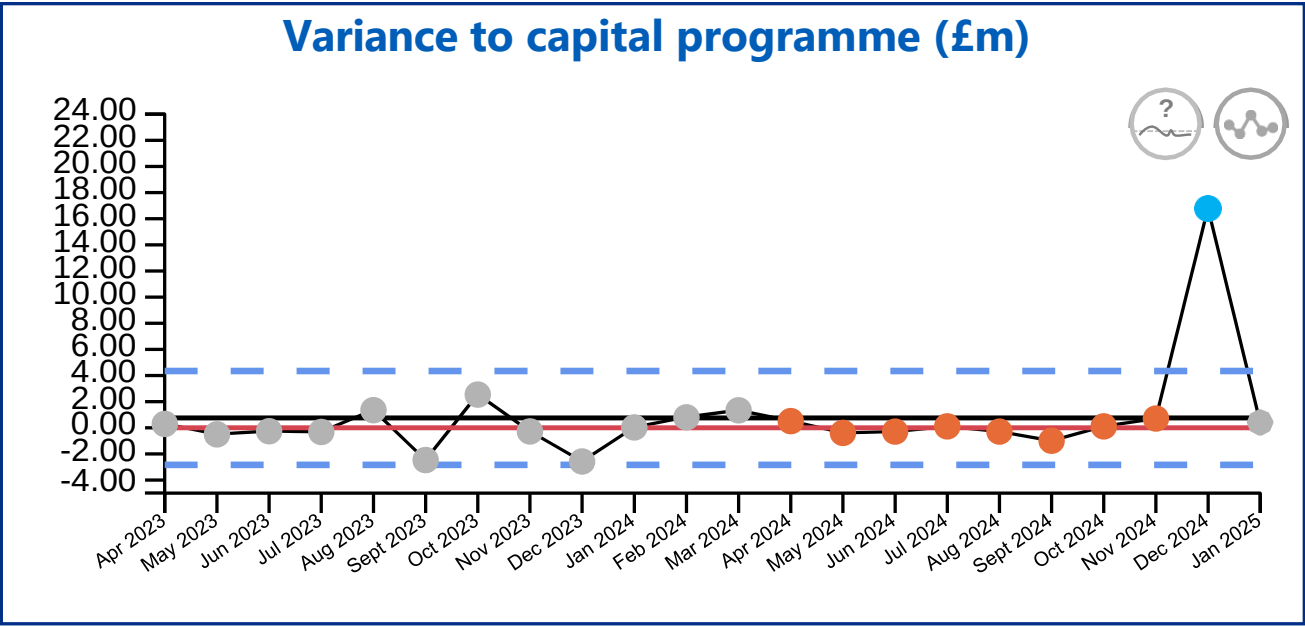
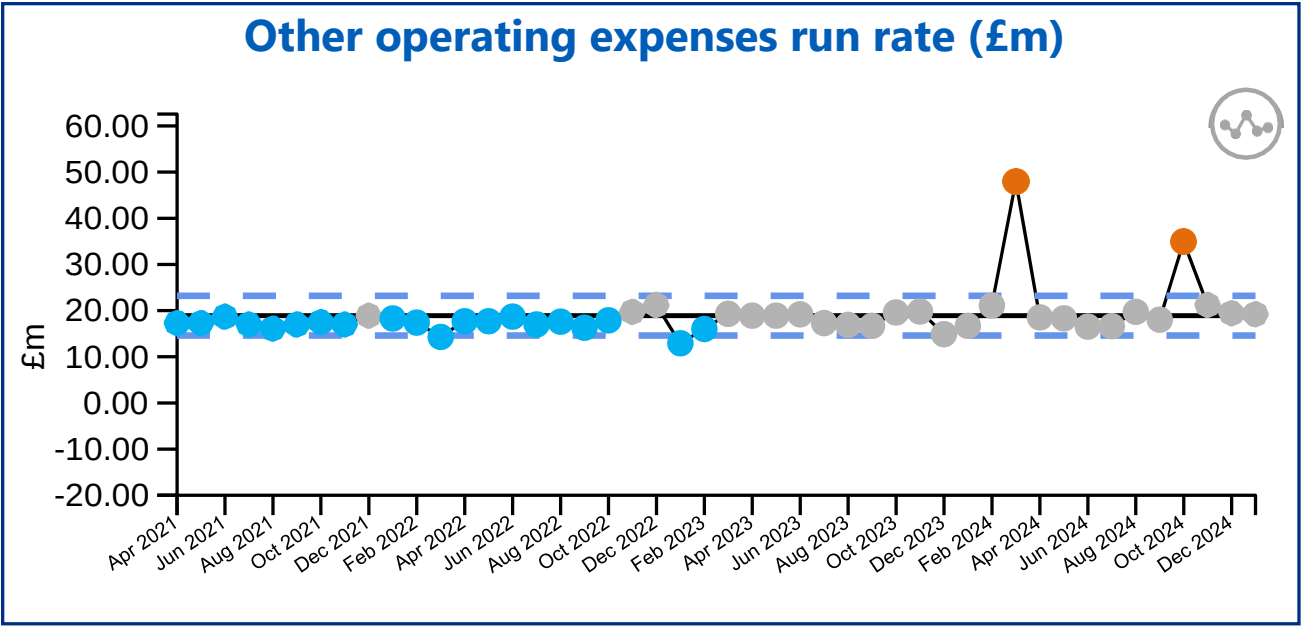


Income run rate (£m)



Employee expenses run rate (£m)





TRUST BOARD REPORT

12 March 2025

Item

43b

Purpose Information

Title People and Culture Committee Summary Report

Report Author Mr D Byrne, Corporate Governance Officer

Executive sponsor Mrs T Anderson, Committee Chair

Summary: This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 2 December 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal	Compassionate and inclusive culture Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
Related to key risks identified on Corporate Risk Register	ID 9746: Inadequate funding model for research, development and innovation
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	People Plan Priorities
Related to ICB Strategic Objective	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Committee Name: People and Culture Committee

Date of Meeting: 2 December 2024

Committee Chair: Trish Anderson

Attendance: Quorate

Key Items Discussed: Staff Story

People Promise Exemplar Progress Update

Development for One LSC

Professional Nurse Advocate Programme Update

Senior Support and Share Update

Core Skills Training Compliance Deep Dive

Freedom to Speak Up Report

Industrial Action Update

Review of Committee Terms of Reference and Workplan

Review of New Integrated Performance Report (IPR)

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- Members received a Freedom to Speak Up Report which highlighted that a total of 101 concerns had been raised. It was noted that numbers had increased in this quarter and more were being raised anonymously. It was highlighted that at least 4 people had chosen to leave the Trust after raising concerns.
- Concerns were also raised in terms of the teams capacity to manage the additional demand potentially arising from the transfer in of One LSC staff.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- Members received an update on the Senior Support and Share visits which occur on a weekly basis. Feedback is positive and of good quality
- Minutes from the JNCC and JLNC were received for information.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- Members were advised of the successful launch of One LSC on 1 November as planned. There were few issues arising from the transfer of the staff into the Trust.
- Members were updated on progress with the Professional Nurse Advocate Programme (PNA) programme. It was noted that as a result of significant operational pressures numbers receiving restorative clinical supervision had dropped. The Trust is unlikely to meet the 2025 deadline for PNS numbers.

TRUST BOARD REPORT

12 March 2025

Item **43b**

Purpose Information

Title People and Culture Committee Summary Report

Report Author Mr D Byrne, Corporate Governance Officer

Executive sponsor Mrs T Anderson, Committee Chair

Summary: This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 13 January 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal	Compassionate and inclusive culture Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
Related to key risks identified on Corporate Risk Register	ID 9746: Inadequate funding model for research, development and innovation
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	People Plan Priorities
Related to ICB Strategic Objective	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Committee Name: People and Culture Committee
Date of Meeting: 13 January 2025
Committee Chair: Trish Anderson
Attendance: Quorate
Key Items Discussed: Board Assurance Framework
Corporate Risk Register Report
Focus Spot: Staff Story
2024 Staff Survey Result Briefing
One LSC Update
People Promise Exemplar Progress Update
Update on Trust Financial Performance

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- Members received a report on core skills training within the Trust. Concerns had been expressed by a number of staff in relation to the volume of mandatory training required. There were concerns that the Trust was not compliant with the Information Governance (IG) training requirements which was closely linked to the level of cyber related risk to the organisation. A rise in incidents in the Trust of colleagues accessing inappropriately was also highlighted. A report on training compliance for One LSC staff will come to a future meeting.
- The Committee were alerted to some initial difficulties with regard to the transfer to One LSC. These covered interim arrangements leading to duplication, detrimental effect on staff due to additional pressures and some obstructive behaviours being exhibited as a result. It was highlighted that these areas needed to be addressed quickly to ensure transformation work can get underway. It was suggested that a formalised governance structure would be helpful to have in place.
- Findings from the latest staff survey were discussed. Overall response rate has deteriorated as in other LSC trusts which is against the national trends. The Trust is still above average in key areas such as Health and Well Being but had deteriorated

in 6 of the 9 People Promise themes. Members agreed a robust action plan was required and a 'heat map' would be of benefit.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- An update on the People Promise Exemplar was received and the pressures that staff were feeling given the financial situation was noted.
- Members were updated on the Trusts financial performance and that there would be a significant focus on variable pay over the coming months. A Mutually Agreed Resignation Scheme had been launched prior to Christmas.

TRUST BOARD REPORT

12 March 2025

Item **43c**

Purpose Information

Title People and Culture Committee Summary Report

Report Author Mr D Byrne, Corporate Governance Officer

Executive sponsor Mrs T Anderson, Committee Chair

Summary: This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 3 February 2025. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal	Compassionate and inclusive culture Healthy, diverse and highly motivated people Drive sustainability
Related to key risks identified on Board Assurance Framework	4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
Related to key risks identified on Corporate Risk Register	ID 9746: Inadequate funding model for research, development and innovation
Related to recommendations from audit reports	-
Related to Key Delivery Programmes	People Plan Priorities
Related to ICB Strategic Objective	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Committee Name: People and Culture Committee

Date of Meeting: 3 February 2025

Committee Chair: Trish Anderson

Attendance: Quorate

Key Items Discussed: Staff Story
Workforce Update
One LSC Update
People Promise Exemplar Progress Update
Senior Support and Share Update
Staff Side Update
Staff Health and Wellbeing Report
Guardian of Safe Working Hours Report
People and Culture Performance Dashboard

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- A workforce report was received which highlighted the challenge of reducing the workforce head count. A figure of 455 posts was highlighted as needed to go by the end of the year to meet the financial target. Focused work is taking place in each division through a reduction in staff roles and variable pay controls to meet this target. Complete service reviews are taking place in all divisions to determine what can be delivered within the financial framework and there is buy in and good engagement taking place with teams. Requests were made for detailed divisional information to come to the Committee.
- A detailed report was received from the Guardian of Safe Working in relation to safe working hours. It was highlighted that there are increases in the number of exception reports submitted reflecting an increasing amount of pressure Medical colleagues were under particularly in MEC (ED) and SAS. Concerns were noted in relation to the difficulties in colleagues not being able to take rest breaks which have not yet been addressed. Further information was requested.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- A detailed paper on progress with One LSC was discussed. Each organisation is now operating under the One LSC umbrella.
- Change is already evident through the sharing of good practice and an exploration of new ways of working are now being considered including the use of AI.
- A Target Operational model has now been developed and it was noted that several fragile services had been identified during the exercise with future work to be done on those.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- A People Promise Exemplar progress update was received and noted.
- A Senior Support and Share update report was received and noted.
- A detailed staff side report was received highlighting issues around on-site facilities, car parking, and activities on social media channels around redundancies and carry forward of annual leave.
- An update on work on the development of the People and Culture dashboard was provided.

TRUST BOARD REPORT

Item

44a

12 March 2025

Purpose Assurance
Information

Title

Triple A Report from Finance and Performance Committee

Report Author

Mrs L Sedgley, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 27 January 2025. The triple A format of this report sets out items for alert, action or assurance from the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal

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

Related to key risks identified on Board Assurance Framework

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

Related to key risks
identified on Corporate
Risk Register

Risk ID: Risk Descriptor.

Related to
recommendations from
audit reports

Audit Report Title and Recommendation/s.

Related to Key Delivery
Programmes

Care Closer to Home
Place-based Partnerships
Provider Collaborative
Quality and Safety Improvement Priorities
Elective and Emergency Pathway Improvement
Waste Reduction Programme

Related to ICB Strategic
Objective

Improve population health and healthcare.
Tackle inequalities in outcomes, experience and access.
Enhance productivity and value for money.
Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
-------	----	-----------	----

Equality	No	Confidentiality	No
----------	----	-----------------	----

Previously considered by:

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

Committee Name: Finance and Performance Committee

Date of Meeting: 27 January 2025

Committee Chair: Liz Sedgley

Attendance: Quorate

Key Items Discussed: Finance Reporting
Cost Improvement Programme Update
Planning 2025/26 Update
Improvement Update
One LSC Update
Integrated Performance Report
PFI PACS Contract
Contracts over £1,000,000
Private Finance Initiative (PFI) Update
Systems Issues

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The Committee notes the worsening financial position at Month 9 and also the ongoing challenges to improve the Forecast Outturn Position (FOT) for 24/25
- The Financial plan for 25/26 will be equally challenging given the lack of CIPs identified and enacted in 24/25 to reduce the Trust's run rate going into 25/26
- The Trust will face considerable challenge in managing its cashflow forecast if the application for additional PDS is delayed or the amount reduced.
- UEC attendances are still significantly higher than those across the ICS and the rest of the North West despite the continued focus on avoidance and treatment in alternative setting. This is driving significant financial, as well as operational pressures.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- The Committee had an update on the Trust's current and FOT cash position and the need to apply for a further £20m of Provider Revenue Support in order to meet liabilities and maintain the minimum cash balance. The committee supported this application and recommended that the Trust Board approves the application
- Work is being undertaken to appoint a Turnaround/ Recovery Director to support the Trust reduce the in-year run rate and also establish a PMO office to support the identification and implementation of CIPs in 25/26 and beyond in order to return the Trust to a position of financial stability
- The Committee heard about the work carried out at system level by Simon Worthington and team to ensure consistent planning across the ICS for 25/26 to align operational, workforce and financial plans
- The improvement team's update highlighted the start of the Variable Pay reviews was indicating that there would be significant opportunities to reduce variable pay in year. An update was given on the service reviews which have been completed to date and have identified 163 opportunities which are being scoped.
- Given the Trust's ongoing financial issues, it was recommended that the next Audit Committee has a discussion with the Trust's external auditors about Going concern, Value for Money rating and financial governance.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee noted the decline in the financial results for December, as the deficit for the month rose to £9.3m an increase of £3m on Month 8. The Trust is now £33m behind the revised breakeven plan.
- The increase in the deficit in the month is principally due to the removal of the forecast overachievement ERF income. This has been removed from the financial position as the additional income is not guaranteed and is high risk as the activity plan is phased towards the end of the financial year. There is also the impact on data capture and coding due to the implementation of Cerner, and work is underway with clinical and operational colleagues to evidence the activity undertaken.
- The CIP target for 24/25 was £59.7m of which only £16.2m has been delivered by month 9 against a plan of £29.8m.
- FOT at Month 9 is in the region of £88m worse case, excluding the £22.9m Deficit Support Funding. However, the committee was told that work will continue to improve this position.

- PwC is now providing support to the Trust and the LSC system, this meeting was observed by 3 members of the Trust's PwC team.
- The Chief Executive confirmed that LSC ICS is now in formal turnaround and that the second IAG meeting will take place on 29 January. He also outlined the significant decisions that the Trust had already made in order to address the financial deficit so far which include the transfer of service of services out of Accrington Victory Hospital, the cessation of the shuttle bus by ELHT and the closure of a community ward.

TRUST BOARD REPORT

Item

44b

12 March 2025

Purpose Assurance
Information

Title

Triple A Report from Finance and Performance Committee

Report Author

Mrs L Sedgley, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Finance and Performance Committee meeting held on 24 February 2025. The triple A format of this report sets out items for alert, action or assurance from the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal

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

Related to key risks identified on Board Assurance Framework

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

Related to key risks
identified on Corporate
Risk Register

Risk ID: Risk Descriptor.

Related to
recommendations from
audit reports

Audit Report Title and Recommendation/s.

Related to Key Delivery
Programmes

Care Closer to Home
Place-based Partnerships
Provider Collaborative
Quality and Safety Improvement Priorities
Elective and Emergency Pathway Improvement
Waste Reduction Programme

Related to ICB Strategic
Objective

Improve population health and healthcare.
Tackle inequalities in outcomes, experience and access.
Enhance productivity and value for money.
Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
-------	----	-----------	----

Equality	No	Confidentiality	No
----------	----	-----------------	----

Previously considered by:

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

Committee Name: Finance and Performance Committee

Date of Meeting: 24 February 2025

Committee Chair: Liz Sedgley

Attendance: Quorate

Key Items Discussed: Finance Reporting
Planning 2025/26 Update
Board Assurance Framework
Corporate Risk Register
Improvement Update
One LSC Update
Integrated Performance Report
Private Finance Initiative (PFI) Update
Scope of Work for the Turnaround Director
Systems Issues

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- The Trust together with 3 other acute trusts and the ICS have now formally been placed in NOF 4, due to its financial position.
- The Committee were advised that due to the ongoing monthly deficits the cash position has worsened by £8m to £2.1m at M10. An application for further financial support of £20m has been submitted in February. The Trust is managing its cash position by prioritising supplier payments resulting in aged payables rising to £27.2m
- The Committee had an update on the 25/26 draft plan which shows 25/26 deficit after inflation of £112m. The waste reduction and financial improvement plan currently stands at £12m which is £3m risk adjusted. Again, all these schemes meet the 4 tests to ensure their viability.
- Work continues to review and identify opportunities for 25/26 and beyond and the activity and performance plans will be fully triangulated to workforce and finance plans to ensure alignment and delivery.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- It was noted that agency spend was down to 1.8% of gross pay costs at £8.7m which is £4.6m below target
- Capital expenditure for 24/25 is on track at £26.9m at M10 with total spend for 24/25 forecast at £35,7m just £0.3m below plan
- The Recovery support director Mark Friedman is now working in the Trust 3 days a week, he will be working closely with PWC and our Improvement team to establish a PMO office to support the Trust in working towards financial sustainability.
- The Committee heard about the changes made to improve reporting and governance arrangements in particular around CIPs and FIP reporting and that all CIPs are now only included in the tracker once they have passed the 4 tests established by Simon Worthington
- The Committee were pleased to note the improvement in the finance papers in particular with regards to the cash position and the divisional performance and it was agreed that the meeting be extended further to 3 hours from March.
- The Committee had a verbal update on the progress made on the fire safety work at RBH where the good progress was noted by LFRS. However, it was noted that more pace is needed at BGH due to delays and more extensive work is required.
- The Committee noted the continued delivery of the 6 week RTT standard and improvement in the DM01 position.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- The Committee noted the improvement in the financial results for January, as the deficit for the month reduced by £3.5m to £5.6m mainly due to £3.1m of income being included as its recoverability has now been established. The Trust is now £41.7m behind the revised breakeven plan, this is £69.2m YTD excluding the deficit support funding.
- The CIP for 24/25 was £59.7m of which only £17.4m has been delivered by month 10 and the FOT is expected to be £19m.
- Forecast Outturn position (FOT) was in Month 9 established at £85.9m, with the additional elective income of £4.6m and a run rate reduction of £1.3m from grip and control measures the FOT for 24/25 is now expected to be £79.4m. However, the committee was told that work will continue to improve this position

- The committee heard the results achieved by the Variable Pay Rapid Improvement weeks; this is using the successful methods used at Leeds Teaching Hospitals to reduce variable pay across the organisation by establishing a financial daily management process for teams to use.

TRUST BOARD REPORT

Item

44b

12 March 2025

Purpose Assurance
Information

Title

Finance and Performance Committee Part 2 Summary

Report Author

Mrs L Sedgley, Non-Executive Director/Committee Chair

Summary: This report details the agenda items discussed in the Finance and Performance Committee Part 2 meeting held on 24 February 2025.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal

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

Related to key risks identified on Board Assurance Framework

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

Related to key risks
identified on Corporate
Risk Register

Risk ID: Risk Descriptor.

Related to
recommendations from
audit reports

Audit Report Title and Recommendation/s.

Related to Key Delivery
Programmes

Care Closer to Home
Place-based Partnerships
Provider Collaborative
Quality and Safety Improvement Priorities
Elective and Emergency Pathway Improvement
Waste Reduction Programme

Related to ICB Strategic
Objective

Improve population health and healthcare.
Tackle inequalities in outcomes, experience and access.
Enhance productivity and value for money.
Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
-------	----	-----------	----

Equality	No	Confidentiality	No
----------	----	-----------------	----

Previously considered by:

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

Committee Name: Finance and Performance Committee
Date of Meeting: 24 February 2025
Committee Chair: Liz Sedgley
Attendance: Quorate

ITEMS DISCUSSED

At the Finance and Performance Committee Part 2 meeting, held on 24 February 2025, the following matter was discussed in private:

- a) Seagry Report Discussion
-

TRUST BOARD REPORT

12 March 2025

Item

45a

Purpose Assurance
Information

Title

Triple A Report from Quality Committee

Report Author

Mrs C Randall, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Quality Committee meeting held on 29 January 2025. The triple A format of this report sets out items for alert, action or assurance from the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

Related Trust Goal

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

Related to key risks identified on Board Assurance Framework

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

Related to key risks
identified on Corporate
Risk Register

Risk ID: Risk Descriptor.

Related to
recommendations from
audit reports

Audit Report Title and Recommendation/s.

Related to Key Delivery
Programmes

Care Closer to Home
Place-based Partnerships
Provider Collaborative
Quality and Safety Improvement Priorities
Elective and Emergency Pathway Improvement
Waste Reduction Programme

Related to ICB Strategic
Objective

Improve population health and healthcare.
Tackle inequalities in outcomes, experience and access.
Enhance productivity and value for money.
Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
-------	----	-----------	----

Equality	No	Confidentiality	No
----------	----	-----------------	----

Previously considered by:

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

Committee Name: Quality Committee

Date of Meeting: 29 January 2025

Committee Chair: Catherine Randall

Attendance: Quorate

Key Items Discussed: Urgent and Emergency Care Update
Waiting Lists and Resultant Harms
Nursing Professional Judgement Review – January 2025
Electronic Patient Record Update
Quality Impact Risk Assessments
Trust Wide Quality Group AAA Reports
Patient Safety Incident Response Framework Report
Integrated Performance Report
CQC Update
AAA Report from the Safeguarding Committee
Minutes from the Mortality Steering Group

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- An update on the Trust's ongoing urgent and emergency care pressures was provided to the committee, including an update on the development of a new standard operating policy that was intended to improve the experience of patients being cared for on corridors.
- Members received an overview of the Trust's waiting lists and any resultant harms. It was explained that although there were only a small number of related incidents, it was likely that there were others which were being underreported. Members agreed for future updates to be provided on a six-monthly basis going forward.
- The committee was provided with an overview of the progress made with the implementation of the Trust's electronic patient record system. It was noted that there were a number of significant challenges still to be overcome, including the

ongoing need for financial investment to ensure that the system could receive the updates required to maintain full functionality.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- Members were informed that meaningful reductions were starting to be seen in the Trust's waiting lists and that there were no patients waiting 65 weeks or more for treatment.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- Members were provided with an overview of the Trust's latest professional judgement reviews for nurse staffing levels. No concerns were raised.
- The Committee was provided with a patient story that summarised the experiences of an elderly patient who had ultimately passed away in the Trust's care. Members noted that a significant amount of learning and work had taken place in the interim period and that the patient's family had played an active role in the improvements made since. The Committee agreed that the story should be escalated to the attention of the board.

TRUST BOARD REPORT

Item

45b

26 February 2025

Purpose Assurance
Information

Title

Triple A Report from Quality Committee

Report Author

Mrs C Randall, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Quality Committee meeting held on 26 February 2025. The triple A format of this report sets out items for alert, action or assurance from 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: 26 February 2025

Committee Chair: Catherine Randall

Attendance: Quorate

Key Items Discussed: Urgent and Emergency Care Update
Annual Mortality Report
Cancer Update
Histopathology Update
Admissions Avoidance and Health Inequalities
Quality Impact Risk Assessments
Nursing Assessment Performance Framework Update
Nurse Staffing Exception Report
Floor to Board Report for Maternity and Neonatology Services
Trust Wide Quality Group AAA Reports
Patient Safety Incident Response Framework Report
Patient Participation Panel Report
Board Assurance Framework
Corporate Risk Register
Integrated Performance Report
CQC Update

ALERT

Please include items that have been discussed at the Committee which the Board need to be alerted to. Items such as areas of non-compliance or matters that need addressing urgently with details of actions taken to address the matter.

- Members were informed Never Event had occurred in the Trust involving a child in the community whose nasogastric tube had been misplaced, this was later replaced but protocol was not followed properly leading to issues with fluid ending up in the patient's lungs. No harm was caused to the patient, and it was confirmed that appropriate actions had been taken to avoid similar incidents occurring in the future.

- It was confirmed that colleagues from the Integrated Care Board would be visiting the Trust later in the week and that a visit from the Care Quality Commission was planned in the near future.

ASSURE

Please include items that have been discussed at the Committee that the Board can be gain assurance from.

- An update on the work taking place in the Trust around its cancer performance was provided to members.
- The committee was informed that work was underway to inform stakeholders that the Trust was not commissioned to provide level two and three paediatric care.
- An update on the work taking place around the Trust's pathology backlog was provided to the committee. It was noted that positive progress had been made over recent weeks.

ADVISE

Please include items that have been discussed at the Committee which the Board need to be advised about, such as matters that have on-going monitoring or any new developments which need sharing.

- A patient story was presented to the committee that detailed a patient's journey through the Trust's stroke pathway. It was confirmed that work was ongoing to secure more stories from patients from diverse backgrounds or with protected characteristics.
- Members were informed that the Trust's Alcohol Care Team would be wound down by the end of the current financial year and that affected staff would be redeployed to other positions in the organisation.

TRUST BOARD REPORT

Item

46

12 March 2025

Purpose Information

Title

Remuneration Committee Summary Report

Executive sponsor

Professor G Baldwin, Non-Executive Director

Summary: The list of matters discussed at the Remuneration Committee meetings held on 23 January 2025 and 20 February 2025

Report linkages

Related Trust Goal

-

Related to key risks
identified on assurance
framework

-

Impact

Legal

No

Financial

Yes

Equality

No

Confidentiality

Yes

Meeting: Remuneration Committee
Date of Meeting: 23 January 2025
Committee Chair: Graham Baldwin, Non-Executive Director

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 23 January 2025, the following matter was discussed in private:

- a) Director of Communications and Engagement Arrangements
 - b) Proposed Recruitment and Remuneration Arrangements for Turnaround Director
 - c) Recruitment Process and Remuneration for the Executive Medical Director and arrangements for Interim Medical Director
 - d) Cessation of secondment of Executive Director of Integrated Care, Partnerships and Resilience
 - e) Ceasing arrangements for Interim Operational Director of Finance
-

Meeting: Remuneration Committee
Date of Meeting: 20 February 2025
Committee Chair: Graham Baldwin, Non-Executive Director

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 23 January 2025, the following matter was discussed in private:

- a) Executive Director Contract Standard Template
 - b) Executive Director and VSM Succession Planning
 - c) Confirmation of Appointment of Turnaround Director and Remuneration
 - d) Confirmation of Interim Medical Director and Remuneration
-

TRUST BOARD REPORT

Item 47

12 March 2025

Purpose Information

Title	Trust Board (Closed Session) Summary Report
Report Author	Mr D Byrne, Corporate Governance Manager
Executive sponsor	Mr S Sarwar, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 15 January 2025.

As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders would not be applicable in this instance.

Report linkages

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

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

Related to key risks identified on Corporate Risk Register

Risk ID: Risk Descriptor.

Related to recommendations from audit reports

Audit Report Title and Recommendation/s.

Related to Key Delivery Programmes

State which key delivery programmes the paper relates to here.

Related to ICB Strategic Objective

State which ICB Strategic Objective the paper relates to here.

Impact

Legal	Yes/No	Financial	Yes/No
-------	--------	-----------	--------

Equality	Yes/No	Confidentiality	Yes/No
----------	--------	-----------------	--------

Previously considered by:

Meeting: Trust Board (Closed Session)

Date of Meeting: 15 January 2025

Committee Chair: Shazad Sarwar, Chairman

ITEMS APPROVED

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

ITEMS DISCUSSED

At the meeting of the Trust Board on 15 January 2025, the following matters were discussed in private:

- a) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.
- b) Round Table Discussion: Site Operational Pressures
- c) Financial Reporting: Financial Performance
- d) Financial Reporting: Formal Intervention
- e) National Planning Guidance 2025-26
- f) One LSC
- g) Outpatient Pharmacy Project (Project Blue): Update and Decision Paper
- h) Pathology Update
- i) Microsoft Licence Contract
- j) Data Security and Protection Toolkit: Non-Compliance with the 2023-24 Return
- k) Communications Update and Horizon Scanning

ITEMS RECEIVED FOR INFORMATION

None.